PROTOCOLS FOR THE DELIVERY OF SOCIAL AND EMOTIONAL WELLBEING AND MENTAL HEALTH SERVICES IN INDIGENOUS COMMUNITIES:

Guidelines for health workers, clinicians, consumers & carers

FIRST EDITION
PROTOCOLS FOR THE DELIVERY OF SOCIAL AND EMOTIONAL WELLBEING AND MENTAL HEALTH SERVICES IN INDIGENOUS COMMUNITIES:

GUIDELINES FOR HEALTH WORKERS, CLINICIANS, CONSUMERS AND CARERS

Melissa Haswell, Ernest Hunter, Rachael Wargent, Brenda Hall, Ciaran O'Higgins and Roy West

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FOREWORD

Challenges for Indigenous Mental Health Services

There is strong evidence to support the statement that mental health services generally provide significant benefit to people who are experiencing mental health problems and mental illnesses. Thus the range of tools and approaches available for providing help can be effective in preventing mental illness and in managing acute and chronic illness. They can also assist in overcoming social, emotional and physical consequences of mental illness and in hoping for, and achieving, recovery.

The above statement is a sweeping generalisation and does not mean to discount the many cases when people accessing mental health services feel unhelped, or even harmed, by that experience. However it serves as a reminder that there is room for hope to people (consumers and carers) who are suffering from problems they feel unable to cope with or an illness they cannot control on their own. The statement also offers hope to service providers dedicated to making a positive difference.

Having a mental illness, experiencing a loved one or family member living with mental illness, taking on the role of a professional carer, or being a mental health service provider, are all significantly challenging experiences. There are no absolutes in mental health, no objective laboratory tests, no cut-off points or magic words, no automatically correct ways of diagnosing or managing a person’s illness. Every person receiving mental health care must be recognised as a unique individual with their own culture, history and strengths and a member of a family, social group and community. It is from consumers’ own hopes and aspirations, supported by family and community, from which the motivation and desire to recover must come. Services need to be designed and delivered in a way that fosters this motivation, desire and connection.

Some questions

When considering the content of these Protocols for supporting social and emotional wellbeing support and mental health services with Indigenous people, a number of questions were first asked. What is their purpose, given the complexity and individuality of wellbeing and mental health? How can they be helpful in successfully providing care that is so strongly determined by the consumer as an individual and family member? How can medical approaches to mental health be helpful across cultures as diverse as Aboriginal, Torres Strait Islander and European? As there are currently very few Indigenous Australian psychiatrists, psychologists and mental health nurses, how can non-Indigenous mental health professionals be assisted to understand the context in which Indigenous people live and make sense of their world? How can the involvement and professional development of a strong Indigenous mental health workforce to guide and achieve safer services be maximised? How can roles be defined to enable partnerships between Indigenous Health Workers and non-Indigenous clinicians that foster engagement and better outcomes with consumers and families? What lessons from mental health can be applied toward other areas of health?

Indigenous wellbeing support and mental health care remain areas where there is little evidence on which to base practice guidelines. A number of issues that have broad and profound influence on mental health have been explored in some depth. These include dimensions of history, social policy, alcohol and substance abuse, economic and social disadvantage, identity, adolescence and racism. Several authors have highlighted the mistakes and fallout that psychiatry as a profession has added to this equation over 200 years. It is a challenge and a privilege to assist Indigenous people to overcome a disempowering past and chaotic present and work toward a better future.
Despite the weight of history and harm Indigenous people have suffered, there is hope and optimism that things can improve. Advances in mainstream and Indigenous primary health care and empowerment/recovery interventions emphasise wellbeing and consumer-defined recovery as a goal worth aiming for. State and national mental health policies and plans now emphasise the essential importance of consumer, carer, family and community engagement and empowerment in mental health and Indigenous mental health focuses on building and appropriately supporting a confident and competent workforce. This document aims to help connect this potential to reality on the ground by providing background educational information, a guide to working with Indigenous consumers, practical how-to pathways of care in Primary Health Care settings to enable family and community engagement and modified evidence-based practice guidelines.

**Ingredients of change**

Current writing in Indigenous health and in general psychiatry has challenged old ways of thinking about mental health care. The focus has moved from specific therapeutic approaches delivered in isolation towards broader concepts of the helping process. In this way, mental health care becomes an empowering and enabling experience that involves many people with different skills and contributions. This necessarily demands a close understanding of each person’s context, not only in terms of the social environment, but also in terms of developmental and life-stage factors. These are very promising backdrops to responding to need in a way that strengthens consumer, carer and services as agents of change for the better.

This manual aims to translate these insights into practical and useful guidelines in a clinical context for mental health service providers, consumers, carers and communities. We adopt a model of the elements required for change from Lambert (1992) and emphasised in the book, *The Heart and Soul of Change: What Works in Therapy* by Hubble, Duncan and Miller (1999). This model was derived from a large body of research exploring the relative contributions of four components of psychotherapy which contribute to successful change.

According to Lambert, (1992) and supported by research from a range of sources, the largest determinant of positive change in mental health results from things happening in the person’s life outside of the clinical setting. This is followed by the quality of the therapeutic relationship established between consumer and service provider, the degree of expectancy or hope for change and the specific application of therapeutic techniques as shown below.

**Ingredients for Positive Change in Psychotherapy**

<table>
<thead>
<tr>
<th>Component</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Extratherapeutic Change</td>
<td>40%</td>
</tr>
<tr>
<td>Expectancy</td>
<td>15%</td>
</tr>
<tr>
<td>Techniques</td>
<td>15%</td>
</tr>
<tr>
<td>Therapeutic Relationship</td>
<td>30%</td>
</tr>
</tbody>
</table>

Clearly the specific ingredients within each component and the relative importance of each will vary a great deal for Indigenous people with a mental illness living in remote areas, compared to those who were involved in those research studies. These will also differ across disorders, with medication playing a varying role in positive change.
Nevertheless, the concept can assist health services to consider how all these key components of improvement can be systematically and comprehensively fostered. Few argue that mental health services that support positive life circumstances, better relationships and hope as well as alleviate symptoms can achieve better outcomes, especially in remote communities where supporting services are extremely limited. This manual attempts to provide a practical guide to how that can be achieved.

This Manual

This manual provides a set of protocols for the delivery of social and emotional wellbeing and mental health services in Indigenous communities. This version of the document is oriented towards communities in Queensland. It is designed to be used by a range of health professionals including the clinician, the primary health care worker and the Aboriginal and Torres Strait Islander health worker. But just as importantly, it is also written for the consumer, their carer and family, natural carers and organisations within their community, because each individual and group has a role to play in achieving positive change. The contents are divided into two parts.

Part One

This section provides an overview of mental health, the importance of a recovery orientation, appropriate assessment and management of mental health problems and how each of these aspects function in the context of remote Aboriginal communities.

- **Chapter One** discusses wellbeing, mental health and illness in an Indigenous context. It explains some of the terms and approaches used in mental health service delivery and the importance of “integrated care”: that is mental health care in a general health care setting. It introduces the members of the primary health care multidisciplinary team and explains their role in the continuing care and eventual recovery of the consumer within the community.

- **Chapter Two** provides a detailed guide to mental health assessment and treatment in remote Indigenous communities. It discusses the significance of rapport building, physical environment and consumer support and includes strategies for effective communication and interview techniques that recognise and respect cultural practices and belief systems. It also discusses the important role of families and carers in the delivery of mental health services.

- **Chapter Three** sets out five principles for directing the focus of service delivery onto partnership, recovery and empowerment. These principles (the five Cs) are: Consumer and Carer Focus; Context of Community; Continuity of Care; Checking for Change and Considered Clinical Care. General aspects of each component are described here and further detail is described under each specific disorder covered in Part Two.

- **Chapter Four** provides a blueprint for Pathways of Care in the Primary Health Care setting that aims to clarify roles, processes and tools to achieve optimum wellbeing and mental health outcomes. The Pathways and tools are designed to assist in:
  - identifying when people are experiencing a loss of wellbeing
  - providing appropriate social and emotional wellbeing support
  - providing tools to document decision-making and planning processes across wellbeing support, mental health and drug and alcohol services
  - delivering appropriate, continuous care across activities in the pathway
  - ensure that appropriate care is provided to anyone at risk of self harm.
Part Two
In this section we look at the major specific types of mental disorder, namely:

- Depression (Chapter Five)
- Anxiety (Chapter Six)
- Self-harming Behaviours (Chapter Seven)
- Schizophrenia and Bipolar Disorder (Chapter Eight).

These illnesses and their management are discussed in the context of the “Five Cs”, set out in Part One. The guidelines in this section are intended as practical steps for health professionals to follow when working with Indigenous consumers, their families and carers. They guide the user through the delivery of effective mental health care in a multidisciplinary, remote community context. There are guidelines for primary health care workers, consumers and carers, as well as for clinicians. They are designed to maximise consumer and carer participation in the recovery process. This section also includes fact sheets and suggestions for further reading.

Summary
What is captured in this manual aims to be a beginning, not an end, to the translation of evidence-based research in the mainstream into incrementally achievable best practice social and emotional wellbeing support and mental health service delivery in Indigenous Australian settings. Our goal is to stimulate the direction and intensity of reform, while underlining the necessity of consumer, carer and community empowerment in achieving change. Throughout the manual we have emphasised the extremely important role of Aboriginal and Torres Strait Islander health workers. As a profession, they are key members of the wellbeing and mental health promotion, prevention, early intervention and care pathway. The guidelines aim to support appropriately flexible, but well-informed and consistently applied pathways for Care Planning and management. We look forward to feedback from everyone providing and receiving care and making improvements in subsequent editions.
Some Voices from Community:

“See the healthy mind is that you know, you have to be, your mind have to be clear within yourself, you know.”

“It’s the whole community, you’ve got to get them involved, if you don’t get them involved nothing will come out of it.”

“… to holistically heal someone you need a whole community approach, one organization or one individual cannot deal with clients in isolation, they need to be dealt with by all people that have impact or affect on their lives … that’s the only true way you can heal someone of any affliction.”

“To do true healing especially in this setting, like in this community, and it probably applies to any community, you need your whole community to heal this person you know, not just someone who’s been to university and comes out and prescribes drugs every fortnight. There’s got to be more.”

“Grief and loss is big … especially here in the communities there’s no-one you can really talk to about grief and loss because a lot of people in the community, because they’re suffering a lot of these mental health problems as well and that’s only because of the environment they’re in. It’s not because of who they are. Yeah it’s really hard to find someone that you can talk to and share stuff like that with

“I think they’re lonely of their loved ones you know, there is a lot of grief in our community and that’s where the loneliness come in. They you know they shut themselves away from other people you know and they just dwell on that missing, you know the, missing their ,you know, someone close and they withdraw from society, from family.”
CHAPTER ONE: OVERVIEW OF CONCEPTS AND CARE PROCESSES IN MENTAL HEALTH AND WELLBEING

Key Concepts and Questions

Mental health and wellbeing of Aboriginal and Torres Strait Islander people can only be understood within the context of the Aboriginal concept of health which has been defined as:

not just the physical wellbeing of an individual, but the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total wellbeing of their community. It is a whole of life view and includes the cyclical concept of life-death-life (NACCHO 1997).

This chapter provides a basic introduction to the thinking and words used in mental health and wellbeing. It provides some general guidance in understanding the way that Indigenous Australians view these concepts, and in applying this understanding while working with Indigenous communities as a mental health service provider and providing support to mental health consumers. The chapter also introduces the range of people that need to be involved in wellbeing support and Care Planning. We start with some common questions.

What do we mean by social and emotional wellbeing? Why is it important?

For a long time, Indigenous health policies have argued for a holistic perspective on health care that recognises broadly accepted Indigenous definition of health being: “health is life is health”. This definition suggests upfront that the client or consumer who is accessing a service would like to be viewed as a whole person whose physical and mental health status and outcomes of care are inseparable from the social, emotional, mental, physical and spiritual components of their life. There is also an important concept of meeting basic needs and maintaining balance across these aspects of life – with social and emotional wellbeing representing the outcome of that balance. When there is a loss of balance or an important basic need is not being met across those five components of life, illness results. The illness may be manifested in a physical, social, emotional, mental or spiritual manner – the outcome may be a chronic disease, conflict and violence, depression and loss of motivation, incapacity to achieve despite potential and thoughts or attempts of suicide.

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Well Being (2004-2009) (page 9) identifies that:

In essence, issues of social and emotional well being cover a broad range of problems which can result from unresolved grief and loss issues, trauma and abuse, domestic violence, issues associated with the legislated removal of children, substance misuse, physical health problems, genetic and child developmental problems, gender identity issues, child removals, incarceration, family breakdown, cultural dislocation, racism and discrimination and social disadvantage. These factors can influence the way a person thinks, feels and responds to situations.
Regarding services, the Framework advises (page 8):

From the well being perspective, the issues to be addressed include the broader social determinants of health, promotion and prevention programs, as well as early intervention in high-risk groups or during early warnings signs. Therefore, many solutions are outside of the health sector and include, for example, housing and community infrastructure, education, employment, recreation, welfare services, crime prevention and justice services, family and children's services, and building on community capacity. Important components within the health sector include comprehensive primary health care, community health, maternal and early childhood services, child development services, occupational health, screening programs, counselling and social support and family reunification programs.

The challenge to health services is to integrate SEWB activities into all aspects of health care to aim for a service in which clients are viewed as a whole person whose physical and mental health status and outcomes of care are inseparable from the social, emotional, mental, physical and spiritual components of their life. A model of care that places Social and Emotional Wellbeing as a part of all initial assessments as an overarching component of health care regardless of the presenting complaint could avoid the usual pitfalls of non-integrated service delivery.

All service providers working in any sector should be mindful of the importance of social and emotional wellbeing to Indigenous people. They should also recognise that sustainable change can only be achieved by understanding and working from people's collective strengths to assist them to address their challenges.

What do we mean by mental health?

Mental health is not simply the absence of mental illness but describes the capacity of individuals and groups to interact with one another and their environment in ways that promote subjective wellbeing, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals (Australian Health Ministers 1991). The World Health Organisation defines mental health as a state of emotional and social wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively or fruitfully and is able to make a contribution to his or her community (WHO 1999).

What is the relationship between wellbeing, mental health and empowerment?

Social and emotional well-being and mental health are obviously closely related and difficult to distinguish in concept and definition. In practice, when talking about mental health, the focus is often on the activities that mainly involve the health sector, and the language tends to be more biomedical and illness focused. The impact of this can be seen in the way that Indigenous people often describe ‘mental health’ as ‘mental illness’ rather than as a positive state of health. Therefore ‘social and emotional wellbeing’ is considered a preferred term for Indigenous people when referring to the broad range of issues that assist people to achieve better (mental and physical) health and more meaningful lives.

People who have participated in an Aboriginal intervention called the Family Wellbeing Program describe empowerment as a similarly holistic concept like social and emotional wellbeing. It can be thought of as a process which supports people to regain
balance in their lives and work towards the sustainable achievement of greater wellbeing. The components of empowerment that are fostered by the Family Wellbeing Program include enabling people to gain understanding of their basic needs, experiences and emotions, establish stability and control over their situations and build strength to make changes in their lives and communities. As people become empowered, they experience feelings of wellbeing, greater energy, motivation and balance and increased harmony with others. Studies have shown that these changes are sustainable, and even enhanced, through time.

**Indigenous people's perception of mental health**

Emotional and social wellbeing issues and mental health problems have only recently been identified as priority issues by Aboriginal peoples and Torres Strait Islanders. Historically, mental health systems have not been attuned to the needs or perspectives of Aboriginal and Torres Strait Islander people (Swan, Mayers & Raphael 1994). Due to a failure to recognise and understand the Indigenous social and emotional and family and community, rather than individually-oriented, context of presenting problems, misdiagnosis and inappropriate treatment approaches in mainstream mental health services has been common. This, combined with alcohol and substance abuse and poor access, has sometimes resulted in highly visible consequences of extreme mental ill health by people in remote Indigenous communities. Stigma and fear, high rates of incarceration and lack of two way understanding about mental health have inhibited more effective community/service partnerships to develop and collectively improve Indigenous mental health outcomes.

The legacy of intergenerational trauma, loss of land and culture, profound grief and loss, forced collocation of people from traditionally separated groups into overcrowded houses and communities with poor services, Stolen Generation, unemployment and welfare-based economies, sudden introduction of access to alcohol and repeatedly failed government policy has clearly damaged the mental health and realised potential of Indigenous individuals, families and communities. An important factor to keep in mind when working in Indigenous mental health is that individualised mental health care, no matter how efficient, will always fall far short of its aims to improve mental health if it is not linked in with broader social and structural improvements in the strength of family and quality of life for the whole community.

As the dominant paradigms of western psychiatry and mainstream health care focusing solely on the individual doctor-patient relationship are shown to fall short of need, examples of more appropriate mental health care approaches for Indigenous people are emerging (Haswell-Elkins et al., 2005; Nagel, 2006, Norris et al., 2007). These latter approaches adopt the principles underlying and driving Aboriginal community-controlled services and thus have in built capacity to incorporate strengths, foster positive relationships and retain flexibility in addressing needs and Indigenous understandings. This philosophy of collaborative and consumer-oriented care is also growing within mainstream services across Australia. However, the evidence base demonstrating whether or not these approaches are more effective in achieving Indigenous mental health gains remains scanty. Building this evidence base is an urgent priority as huge disparities in mental health and wellbeing, along with physical health, of Indigenous Australians are increasingly identified.

**What is a mental health problem?**

A mental health problem interferes with a person's cognitive, emotional or social abilities, but to a lesser extent than a mental disorder. Mental health problems are more common mental complaints and include the mental ill health temporarily experienced
as a reaction to life stresses. Mental health problems are less severe and of a shorter duration than mental disorders, but may develop into mental disorders. The distinction between mental health problems and mental disorders is not well defined and is made on the basis of severity and duration of the symptoms.

Stigma and discriminatory beliefs and attitudes are often held against people with mental disorders. These beliefs and attitudes may come from the way people around us talk and act and are constantly promoted by news headlines, stories and images in the media. Terms like “psycho”, “schizo” and “freak” are disrespectful, stereotypical terms commonly and inappropriately used to label persons with a mental illness. It is our job as clinicians, family and community members to ensure that we positively promote the appropriate words in mental health. Respecting people’s rights to privacy is paramount, and sharing in their thoughts and feelings is a privilege.

What are the major types of mental illness experienced by Indigenous Australians?

The major mental disorders experienced by Indigenous Australians are depression, anxiety, psychotic illness such as schizophrenia and comorbidity with alcohol and drug problems. Self-harming behaviour and suicide, while not mental disorders, are also of great concern.

What are the general factors that determine mental health?

1. The early environment is extremely important to the physical, social, emotional and mental health of a child and his/her development into a healthy adult. This includes:
   - even before birth - healthy gestation without exposure to alcohol,**
   - developmental environment provided by family and carers;
   - nurturing, love, acceptance, security so that trust can grow; and
   - stimulation, role models, identity.

   ** Unfortunately exposure to alcohol and other drugs before birth can profoundly affect the person's potential for strong social, emotional and mental health and development. Damage due to alcohol exposure in utero is NOT reversible – that means it can’t be undone. However, a child’s potential can always be enhanced by providing an environment that recognises and fosters their strengths and capacity. **

2. Protective factors – Effectively promoting healthy pregnancies and parenting skills is a key to promoting mental health of both current and future generations. A healthy childhood sets the scene for developing resilience and a capacity to maintain balance throughout life in light of stresses and negative events.

   Some examples include:
   - having a good concept of self, hopes and dreams;
   - being involved in activities and relationships that support this;
   - being strengthened to meet needs in daily life;
   - having support to deal with difficult times; and
   - having strong connections and spirituality.

3. Risks to good mental health - When the following things are not in place, a person's mental health may be at risk:
   - having a background of unmet needs;
   - undeveloped spirituality and connection;
• lack of support network to provide security about oneself;
• lack of guidance in learning and understanding oneself;
• huge gaps between hopes/dreams and realities; and
• using drugs and alcohol to fill in the gaps.

4. Perpetuating factors - The risks to mental health mentioned above may be very difficult to overcome when the environment is not supportive in helping the person to deal with negative events. Perpetuating factors are things that keep problems from being solved and prevent the person from moving forward, such as:
• social disadvantage that keeps a person from feeling valued and belonging, and having something to contribute; and
• environmental disadvantage, lack of family strength, role models, pervasive use of drugs and alcohol, violence, abuse etc.

5. Precipitating factors – These are the often sudden events or conditions that trigger a mental health crisis, when the ability to cope is overwhelmed and causing a mental health problem to become an illness or causing return of symptoms (relapse) in someone with an existing disorder. For example:
• death or loss of someone/important something,
• excessive alcohol or drug use,
• sudden rejection or conflict; and
• diagnosis or difficulties in managing physical illness, like chronic disease.

Thus there are many factors that promote or threaten mental health and many stages people may pass through in their mental health. This also means that there are many points along the way that people can be helped by family, services and general society to maintain good mental health. The diagram which shows the Spectrum of Mental Health Interventions below provides a picture and ‘vocabulary’ of the ways that actions can be applied to assist in promoting, protecting and recovering good mental health at the individual, group and whole community and population level.

### Summary of the types of factors that influence mental health

<table>
<thead>
<tr>
<th><strong>Early Environment</strong></th>
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<tbody>
<tr>
<td>• Healthy pregnancy without alcohol, tobacco or drugs</td>
<td></td>
</tr>
<tr>
<td>• Secure developmental environment provided by family</td>
<td></td>
</tr>
<tr>
<td>• Nurturing, love, acceptance, stimulation, role models</td>
<td></td>
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<tr>
<td><strong>Protective Factors</strong></td>
<td>![Heart Emoji]</td>
</tr>
<tr>
<td>• Good concept of one’s self</td>
<td></td>
</tr>
<tr>
<td>• Involvement in positive activities &amp; relationships</td>
<td></td>
</tr>
<tr>
<td>• Strength and ability to meet needs in life</td>
<td></td>
</tr>
<tr>
<td>• Support to deal with difficult times</td>
<td></td>
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<tr>
<td>• Strong connections</td>
<td></td>
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<tr>
<td>• Spirituality</td>
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<tr>
<td><strong>Risks to good mental health</strong></td>
<td>![Sad Face]</td>
</tr>
<tr>
<td>• Unmet needs</td>
<td></td>
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<tr>
<td>• Undeveloped spirituality, Lack or loss of connection</td>
<td></td>
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<tr>
<td>• Lack of support network to provide security</td>
<td></td>
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<tr>
<td>• Lack of guidance in learning and understanding</td>
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<tr>
<td>• Huge gaps between hopes/dreams and realities</td>
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<tr>
<td>• Using drugs and/or alcohol to fill the gaps</td>
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<tr>
<td><strong>Perpetuating Factors</strong></td>
<td>![Sad Face]</td>
</tr>
<tr>
<td>• Social disadvantage, lack of access to resources</td>
<td></td>
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<tr>
<td>• A lack of feeling valued, feeling worthless</td>
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<tr>
<td>• Shame, not confident in abilities</td>
<td></td>
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<tr>
<td>• Lack of family strength and role models</td>
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<tr>
<td>• Violence, abuse, use of drugs and/or alcohol</td>
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<tr>
<td><strong>Precipitating Factors</strong></td>
<td>![Sad Face]</td>
</tr>
<tr>
<td>• Death of a loved one</td>
<td></td>
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<tr>
<td>• Chaos or crisis in the community</td>
<td></td>
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<tr>
<td>• Loss of job, reputation or something very important</td>
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<tr>
<td>• Diagnosis of a serious illness</td>
<td></td>
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<tr>
<td>• Feelings of anger, despair, jealousy or rejection</td>
<td></td>
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<tr>
<td>• Neglecting necessary medication</td>
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</tbody>
</table>

Many chronic diseases considered to have mainly a physical basis (eg heart disease, diabetes, kidney diseases) may also be strongly linked to mental health problems (eg stress, grief and loss, absence of hope for things to get better, unable to feel motivated, loss of control over life).
The diagram above demonstrates some of the key features of the inter-relationships between emotional wellbeing, mental health and physical health. While even painful emotions such as sadness, anger and anxiousness are appropriate and helpful at times, an excess of these negative emotions triggered by unmet needs can lead to mental and physical illness. These connections form the rationale for a wellbeing focus in health care.

In a similar way, normal physical processes, especially in adolescence, and physical illnesses can also affect emotional state. People sometimes show symptoms that look like mental health problems but are actually caused by a physical illness. Sometimes these are the early signs of a physical illness that has not yet been detected. It is therefore important to test for possible physical problems when someone is presenting with difficulty in controlling their emotions.
As in physical illnesses, some mental health problems are acute (possibly severe, but appear and then go away completely) while others are chronic. That means they may be ongoing for many years constantly, or the person may become better but then become ill again (relapse) through a set of circumstance or the person may be in a continual pattern moving from wellness to sickness and back. Consumers can be supported by health staff, family and friends to recognise the signs and circumstances that trigger the return, or relapse, of their illness. They can often take steps to avoid these situations or seek help quickly when they experience these signs. This awareness and action form the basis of relapse prevention.

It is important to remember that these are just general patterns and in reality every consumer’s experience is unique.

**Can people with mental illness hope for recovery?**

Although we might have a feeling that a chronic disease cannot be cured, we are learning from consumers that recovery is possible. Consumers who have recovered began to describe their own definitions and journey of recovery (Harding et al 1987; Leff 1988, Tooth et al, 2003, Ellis 2003). These stories highlight both positive encouragement but often negative influence of procedures and attitudes (which mainly promoted hopelessness for them) of mental health professionals. The stories explicitly identified the role of hope and strength in motivating consumers to achieve a fulfilling life, despite huge challenges and constraints.

Recovery for many consumers may not mean that medication or other therapy is not needed or that symptoms and episodes have disappeared, but it does mean that the person has taken control of their illness and reclaimed their life. People with mental illness can set and achieve goals and this process is often very important to their recovery. Carers and family members, health care providers and support services can also play a vital role in focusing on the health and strengths of the person and support and promote hope and encouragement for change. Research has shown that hope and expectancy for change is an important part of achieving improvement.

Andresen, Oades and Caputi (2003) examined fifty accounts of consumer recovery from schizophrenia and attempted to identify shared understanding of recovery and common processes and stages experienced by the consumers. They suggested that recovery begins with finding hope and proceeds to re-establishing identity, finding meaning in life and taking responsibility for recovery. Andresen et al found that recovery from the consumers’ perspective involved psychological recovery, referring to “the establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self-determination”.

While “recovery” is only beginning to be explored in the context of Australian Indigenous mental health discussions, a group (roopu) of Maori consumers from New Zealand have described their perspectives on Whanau Ora, which is something akin to the process of recovery and pathways to wellness, in a report called “Tuituia". Recovery is described as a self-determining, self-defining daily process that requires a diversity of approaches towards regaining a life worth living. It differs from the above non-Indigenous perspectives in that the Maori journey focuses on inclusiveness, collectiveness and interdependence as opposed to the autonomy and individual strength felt by some recovered non-Indigenous consumers. “Being Maori” is intricately tied to the health and wellbeing of Maori people as a whole and so recovery involves the reclaiming of that cultural identity and strength.
It is clear from the many stories that recovery is a different journey for each person and is much more than just alleviating symptoms or the absence of relapse. As such recovery cannot be achieved through medical interventions alone. However, recovered consumers often identify the role of medications, ongoing management of illness and hospitals as tools they control to assist in their recovery process (Deegan 1997). Tooth et al (2003) remind clinicians and researchers to be mindful of consumers’ voices and perspectives on recovery so that progress continues on a consumer-oriented track and is not “hijacked” into something else by professionals.

**Approaches and Processes of Care for Mental Health Consumers**

**How can processes of care promote better outcomes and recovery?**

**The Spectrum of Care**

In order to be effective, mental health services have to focus on the needs of consumers in Indigenous communities with mental health issues and provide services to meet these needs. Some organisational structures can cause considerable confusion and frustration for consumers with mental health disorders. Ideally consumers should be able to move easily between different service levels and service providers, according to their mental health needs. In order to address this, it is essential that services be designed on a needs-led rather than a service-led basis. This means adapting services to Indigenous communities’ needs and not the other way round. In order to overcome difficulties with divided services, it is necessary to integrate mental health care into general health services. Integrated care helps to reduce the stigma associated with seeking help from a stand-alone mental health service. In Indigenous communities, with shortages of mental health services, delivery of services through general health care is the most viable option for increasing access to mental health care. An integrated service encourages early identification and treatment of disorders and thus reduces disability. Other benefits include possibilities for providing care in the community and enabling community involvement in care.

It can be seen from the diagram below that a whole range of organisations is important to the promotion and improvement of mental health. It is very important for health professionals to recognise that good health care includes consideration of the available supports and services that:

- Promote consumers’ strengths (for example by playing a linking role to sports and recreation activities, arts and crafts opportunities and employment opportunities); and
- Help the consumers and families meet their needs (e.g. playing an advocacy role with Council for more appropriate housing if needed or assisting with connections to other services).

While fostering linkages to promote consumers’ strengths is a key part of promoting recovery, it is important to ensure that the consumer and carer play central roles in setting their own goals, meeting their own needs and promoting their own sense of self-reliance and capacity. Moving accounts written by consumers and carers that share their experiences in recovery can be accessed on the Internet. This can be a source of strength for consumers who feel that things will never get better for them.
Multidisciplinary Team
The complexity of mental health requires a range of skills, knowledge, access and experience and is best approached with a multidisciplinary team. A multidisciplinary team is an identifiable group of health personnel comprising a mix of professionals responsible for the treatment and care of people with a mental illness. Ideally this team is comprised of psychiatrists, psychiatry registrars, social workers, health workers, occupational therapists, psychologists, clinical nurse consultants and registered nurses. Where these positions play a pivotal role in provision of mental health services, access to these services is dictated by the availability of such resources to a remote community and the frequency they attend.

The structure of the Primary Health Centre’s multidisciplinary team in remote Aboriginal communities differs greatly and is vitally important to the success of mental health services in providing holistic care to consumers and their carers. These primary health centre teams vary from place to place and are usually comprised of:

- Director of Nursing (DON) and other Clinical Nurses
- Indigenous Mental Health and Indigenous Primary Health Care Workers
- Health Workers with skills in dealing with alcohol, tobacco and other drugs
- Administration Staff and Support staff (drivers, domestic staff)
- Non resident members providing specialist outreach (medical officer, dentist, nutritionist, allied health staff, diabetic/sexual health/mental health nurses).
Mental health services rely on the multidisciplinary team in these community settings to monitor and follow-up on mental health issues on a regular basis. The resident team members are a valuable resource for the visiting mental health clinician and provide local information, expertise and community links. They play a crucial role in the ongoing assessment, monitoring and case management of consumers and are seen as the primary care givers in many situations.

**Prevention activities of the team**

The prevention of mental health problems and mental disorders depends on identifying and modifying the needs of mental health and mental illness. Effective prevention requires an understanding of the risk and protective factors for mental health, identification of the groups and individuals who can potentially benefit from interventions, and the development, dissemination and implementation of effective interventions.

**Early intervention**

Mental illnesses detected early are much easier to manage than those left until late. A person left alone to deal with mental illness is a person at risk. A series of Screening Questions for Social and Emotional Wellbeing has been added to the Adult Health Check (see Chapter 4) because early detection and intervention are important in mental health. This enables the person to be supported earlier. The questions will be evaluated for their usefulness in increasing access of people who benefit from mental health services at an earlier time.

**Treatment and management**

Many people with mental illness still wait years for a diagnosis. This is especially true for Indigenous people living in remote areas. Late diagnosis often means years of uncertainty, confusion, high risk of self-harm, family disruption and people not knowing what is wrong and what to do. It can lead to feelings of anger, guilt and hopelessness. Good clinical care aims to address issues that are most important to the consumer and family.

Mental health care is delivered through a similar Care Planning process. The consumer and family/carers must be deeply involved in this process. Self-care and family care are vital to the health and wellbeing of the consumer and carers. Thus the goals of the Care Plan must reflect the consumer’s own goals and the capacity of the carer to provide ongoing assistance.

Unlike chronic physical disease, there are few laboratory tests that are helpful in diagnosis. However tests may be useful in ruling out physical cause of the illness, in making sure there are not harmful side effects occurring and in keeping the physical health of the person on track. Adult health checks and health promotion are very important for people with mental illness to have good health and wellbeing. Medications and therapies should be set by the clinician only as a means to support the consumer and carers to achieve their goals, and not an end in themselves.

Care Planning is a complex and dynamic process that involves a group of people:
- The consumer, the carer and the family;
- Mental health workers and nurses, generalist primary health care worker;
- Specialist psychiatrist/psychologist, primary care nurses; and
- ATODs workers and nurses if there is a drug or alcohol problem.
Other services may also be appropriate:

- Council, life promotion officers, etc;
- Traditional healers if available and needed;
- Disability services, perhaps HACC; and
- Priest, Father, or Spiritual Leader.

Implementing a well-developed Care Plan effectively needs good management skills, excellent communication pathways with consumer and carer and other service providers and the ability to look ahead and set a framework of responses to ensure:

- ongoing supportive mental and physical health promotion;
- early alerts if a person is not doing well to prevent relapses;
- crisis management where required; and
- ways to monitor effectiveness through outcomes measurement.

This process must happen despite the added difficulties of barriers and stigma attached to mental illness, the lack of a trained Indigenous mental health worker in most places, staff turnover, time and workload excesses and pervasive social disadvantage (for example lack of employment opportunities, poor housing, poor access to services, etc).

Inclusion of mental health into the *Chronic Disease Strategy* (CDS) is vital to improvements in the way things currently happen. The CDS provides a range of useful tools for putting into operation the spectrum of prevention in your community, management pathways that work across services, and training programs for implementing action at all levels of primary health care.

These guidelines have been developed to support you, the primary health care provider, to play the best role you can in the pathway that aims for prevention, early detection, optimal Care Planning and recovery support for Indigenous people with mental illness.
CHAPTER TWO: CULTURALLY APPROPRIATE MENTAL HEALTH ASSESSMENT AND TREATMENT FOR INDIGENOUS PEOPLES

The current Aboriginal and Torres Strait Islander Queensland Mental Health Policy Statement advocates the promotion, improvement and maintenance of mental health amongst this diverse group of people. Hence, “diversity” is an apt word to use when speaking about the Aboriginal and Torres Strait Islander population, due to the different groups and communities that it comprises. It is not an easy task developing one set of rules that is expected to apply to all. This would be disrespectful, irrelevant and make light of a complex issue. Consequently, the following protocols should only be used as a guide and not be considered as an exhaustive account. It should further be noted that where “Indigenous peoples” is used in the text, it refers to the diversity within Aboriginal and Torres Strait Islander cultures.

Many Indigenous peoples define themselves as being part of a group, clan, or community, where there is common ownership of land, property and issues that arise. There are also shared beliefs and practices that promote harmonious living with each other and the land, and provide unique perceptions about life and a way of being in the world. This communal perspective sustained people traditionally and is still very much practised today. Hence, many Indigenous peoples view health within a holistic framework that encompasses the overall physical, social, emotional, spiritual and cultural wellbeing of their entire communities.

The 1994 United Nations (UN) declaration on “Discrimination against Indigenous Peoples” gives Indigenous peoples “the right to maintain, practise, develop, and teach their spiritual and religious traditions, customs and ceremonies”. Thus, provisions in the current Queensland Mental Health Act (2000) and National Standards for Mental Health Services also acknowledge that consumers must be allowed to maintain their cultural and religious values when making decisions about issues affecting their lives. This has immense implications for providers in the assessment, treatment, and management of mental illness. One of the problems of non-Indigenous attitudes to health care is its individualised approach that often does not involve and at times may inadvertently exclude families. However, taking an individualised approach to care requires tailoring treatment to suit the personal, cultural and religious beliefs of consumers. For many Indigenous peoples, this involves including family and community members into the therapeutic alliance. For all clinicians working outside their own cultural group, it is essential to open lines of communication with a range of people with cultural knowledge and understanding of the daily lives of consumers and their families. This involves working together with local practitioners, especially Indigenous Mental Health Workers or Primary Health Workers, to enable your understanding, language and practice to become more complimentary with, rather than alien or opposed to, the consumers’ own understandings. Conscious efforts to avoid making assumptions and challenging your own prejudices and professional practice will enable these cultural informants to guide you. It is important to utilise all avenues that provide support and strength to consumers and their families. It will also help mental health professionals make the right decisions about appropriate therapeutic interventions that will be successful, realistic, and workable.
This chapter attempts to give staff an insight into some of the cultural beliefs and practices of Indigenous peoples and offers guidance in the following areas:

- Rapport Building;
- Families and Carers;
- Assessment;
- Treatment; and
- Compliance.

### Rapport building

In many instances, Indigenous consumers with psychiatric problems do not access mainstream mental health services. Those services that have had some success have demonstrated flexibility and adaptability in work patterns and service development. Ultimately, it has required a genuine shift in the ways non-Indigenous mental health providers approach psychiatric assessments.

#### Location of interview

It is particularly important to interact with Indigenous peoples in an environment where they feel protected and comfortable. This may involve mental health providers travelling out into the community to see consumers, most likely in the home setting. This can be an invaluable strategy in the assessment process, because of the opportunity to access family members, who can be the richest source of information. Additionally, seeing the family in the home setting can aid in the process of determining the consumer’s customary level of self-care, in order to detect changes that might signify a mental disorder.

If Indigenous consumers present at the service, mental health providers should ensure that their work place is culturally friendly and appropriate. This may involve displaying Indigenous images and posters on the walls and distributing brochures that cater for Indigenous consumers. It may also involve team members endeavouring to see a consumer for an initial assessment at first presentation, instead of requesting the patient to return for a later appointment. All caring professionals working within the mental health care setting should be educated about Aboriginal and Torres Strait Islander cultures to enhance understanding.

#### Consumer support

Whenever possible, you should work in partnership with Indigenous mental health workers when engaging and working with Indigenous consumers. Thus, Indigenous mental health workers are invaluable in terms of culture and customary knowledge, accessing Indigenous supports and interacting with family networks. Their presence alone has the ability to place consumers at ease. They can also be utilised to act as cultural translators, due to their ability to communicate in a culturally appropriate manner. If an Indigenous mental health worker is not available, an Indigenous primary health worker should be involved. Another useful strategy could be advising consumers that they have the option of inviting a family member or nominating a support person to accompany them to the initial assessment.

#### Language and interview techniques

Mental health providers should begin by explaining their role and the purpose of the interview. Confidentiality and the rights of the consumer should also be discussed appropriately. This includes information about the complaints process. Be aware that an Indigenous person may not be willing or able to immediately and effectively engage in a discussion about the presenting illness. However, this does not mean that the consumer does not want to participate in the interview. Instead, factors such as
shyness, shame and wariness might be preventing immediate engagement. There might also be gender issues to consider.

Generally, when Indigenous peoples interact with each other for the first time, they often begin with making reference to where they are from (community and/or tribe) and whom their relatives are (immediate and extended family). In many ways, this serves to create a sense of identity and connection within oneself and between each other. Very rarely is the purpose of the visit immediately discussed upon meeting.

In consideration of these factors, it is generally a good idea to avoid asking questions about the presenting illness at the start of the interview, unless the consumer volunteers the information. Begin with non-threatening statements or topics to initially engage the consumer in conversation, placing him/her at ease. It is also more appropriate for mental health providers to be the same gender as the consumer whenever possible.

It is best to avoid using leading questions because Indigenous consumers should be encouraged to tell their own stories. This draws upon the strong Indigenous oral tradition and allows consumers to work at a pace that is comfortable for them. Mental health providers should also seek information from family and community members to assist in this process. This is an invaluable strategy, particularly in circumstances where consumers are unable to make decisions or have difficulty seeing things clearly. It will also help assess behaviours in a cultural context.

When questions are required, avoid using technical words or medical jargon and speak in an easy, open manner. Identify how to speak at a rate the person understands. The level of English understood will vary from individual to individual. If the consumer seems reluctant to answer, allow some additional time or even delay further questioning until later. Thus, some Indigenous peoples might take time to sit back and contemplate a question or point of view. Mental health providers should not be too hasty in determining this to be a sign of slow or impaired cognitive functioning. Rather, it could be simply a variation in communication styles. It is also worth keeping in mind that in some Indigenous communities, it is considered bad manners to be too inquisitive. Consequently, some consumers might resist answering too many questions because it contradicts their idea of privacy.

Some Indigenous peoples communicate using an indirect style of communication. This includes non-verbal as well as verbal interaction. For instance, direct questions might be considered rude in much the same way that too much eye contact could lead to feelings of being judged, especially if there are issues relating to shame. This should be used only as a guide, because this also differs from individual to individual.

**Sensitive areas**

Caution should be exercised when discussing bereavement, ceremonial business, sexuality, fertility, domestic habits and other sensitive areas. Bereavement or “sorry” business is a crucial part of culture. Funerals often involve entire communities and in some areas the name of the deceased is not uttered. It is not uncommon in some communities for Indigenous peoples to express their grief through self-injury, in the form of “sorry cuts” or other physical manifestations of grieving. Consequently, mental health providers should be aware of this when making their assessment. Community consultation should take place when determining what is acceptable to aid this process.
Examples of “men’s business” and “women’s business” could include discussions involving ceremonial business, sexuality, fertility, health and domestic habits. Generally, it is not appropriate to discuss “men’s business” in the presence of females and children. This is reciprocated when discussing “women’s business”. When engaging the consumer in a discussion about an area of sensitivity, it is best to speak in an honest and open manner. Acknowledge that it is a sensitive area, and explain the purpose of asking about that particular issue. Ask if the consumer is comfortable with proceeding, and if unsure, how to proceed.

**Summary**

When engaging with Indigenous consumers, the following points should be considered:

- Determine the best location for the interview, ensuring that it is an environment where the consumer will feel protected and comfortable;
- Arrange for an Indigenous mental health worker to be present, or a support person;
- Be aware of gender issues;
- Allocate more interview time;
- Begin with non-threatening statements or topics;
- Explain your role and the purpose of the interview;
- Speak in an easy, open manner and speak at a rate the person understands;
- If the consumer seems reluctant to answer, allow additional time or delay further questioning until later;
- Be aware of asking direct questions or too many questions;
- Avoid using leading questions and encourage the consumer to tell their own story;
- Do not make assumptions and clarify throughout the process;
- Use appropriate eye contact; and
- Use caution when discussing areas of sensitivity.

**Families and carers**

In many instances, it is primarily families and carers who sustain the operational effectiveness of mental health services. This is evident when considering the limited resources and funding given towards service provision. A large proportion of the Indigenous population lives in remote communities and does not have immediate access to specialist mental health services. Consequently, families and carers experience undue responsibilities and pressures due to significant gaps or inadequate practice in mental health service delivery.

**The home environment**

Without the contribution of families and carers, many consumers with complex needs could not be supported to live in a family or household environment. This would result in more expensive alternative care and possibly greater anxiety for consumers and their families. For Indigenous consumers, this would have devastating consequences, due to the importance of maintaining cultural links with one’s land, family and community. Consequently, it is in the best interests of all parties to provide emotional and social support to families and carers. Mental health providers must allow consumers to maintain continued participation in community life and keep existing supportive relationships.
Consultation
Mental health providers should be aware that families and communities play a huge part in the lives of Indigenous consumers. It is very common for them to have a number of carers, due to the extended family networks that many of them have. Those who are actively involved in the care of consumers should be consulted in all aspects of assessment, treatment and management. There may be many family and community members who need to be consulted and it may take time. However, this consultative process is necessary for developing a good working relationship with the consumer’s family and community. It will also enable mental health providers to make the right decisions about appropriate therapeutic interventions that will be successful, realistic, and workable. Staff will also have a greater range of key informants to access for information and assistance.

Information, education and training
It is imperative for families and carers to receive information about mental health services, mental disorders, mental health problems, available treatments and support services. This should include information about early warning signs, medications and side effects and the rights and responsibilities of all parties. It also includes information about local services and agencies that can be utilised for support, respite and back-up assistance, if needed.

Summary
When working with Indigenous consumers, the following issues need to be considered:

- It is important to provide emotional and social support to families and carers;
- It is more appropriate for the mental health provider to be of the same gender as the family member or carer;
- They should be consulted and encouraged to participate in all aspects of their care;
- It is common for Indigenous consumers to have an extended group of carers, and there might be many family and community members who need to be consulted;
- Families and carers are key resources to access for information and assistance;
- They should receive information, education and training about the consumer’s illness, early warnings signs, treatment options, medications, and rights and responsibilities; and
- Families and carers should be advised of local services and agencies for support, respite and assistance.

The assessment of mental health
Cultures are made up of values, personal experience, behaviour, concepts of shame and psychological and social reward. Current classifications tend to obscure the complex relationships between culture and mental disorder, because scientific rationality is sometimes in conflict with cultural aspects. There is no doubt that mental disorders exist within the Aboriginal and Torres Strait Islander cultures. However, cultural explanations for causation must also be fairly and thoroughly assessed before diagnosis can be successful.

Spirituality
Spiritual dimensions are a part of all cultures. Within Indigenous Australia, a diversity of tribes and clans traditionally had their own language, values and beliefs. Tribes and family groupings commonly had a sacred symbol or totem, and spiritual significance was attributed to certain sites. These values and beliefs were based on cultural lores,
which were conceived in the “Dreamtime” and covered such topics as morality and interaction with all living things. Thus, the “Dreaming” was widely accepted as being the origin of the creation of the land, animals and peoples.

Historical factors had a destructive impact on Aboriginal culture. Nonetheless, Indigenous peoples were able to maintain their spiritual connection with the “Dreaming”, and possibly survived because of it. Due to the diversity of peoples within Indigenous Australia, there are many different spiritual beliefs. For example, some might believe that when a person dies, death only occurs in a physical sense and the spirit returns to the “Dreaming” in the same form. Visions of deceased spirits might sometimes be talked about and there are many who believe they can communicate with their ancestors. Sometimes dreams are also considered to be visitations either by spirits or ancestors. However, others might believe that loved ones return to the dreaming in a different form, usually as an animal or other living thing of spiritual significance. What their identity has become is determined by signs or through some other method.

Other known beliefs include the following:

- Thoughts and feelings can be shared telepathically between closely related people;
- Magic spells can be cast in a multitude of ways;
- These include “pointing the bone,” being “sung” and being “caught” using certain parts of flora or personal items from the victim (e.g. a strand of hair);
- These spells can be used to cause ill health and death;
- These spells are sometimes cast as punishment for contravening traditional Aboriginal laws by tribal figures (for example, the “Kadaicha” man);
- Dangerous and unseen spirits can make people sick by various methods, including trying to consume people’s spirits;
- Someone who is acknowledged to be a traditional healer (for example, the “Ngangkari”) can be sought for help in all manner of spiritual, physical and psychological issues; and
- They have the ability to cure illness or strange behaviour and protect people from danger.

There are many other beliefs and values about spirituality that are held either by individuals, families, or communities. Consequently, mental health providers should avoid stereotyping and keep an open mind. When scientific rationality is in conflict with culture, caution should be used in making assessments. Spiritual experiences and beliefs should not automatically be labelled as hallucinations, delusions, pathological thinking, or a sign of emotional imbalance. Understanding the social and cultural relevance of these experiences requires respectful consultation with family, Indigenous health workers and other cultural informants from the community.

**Psychological processes**

Psychological processes refer to observations made by mental health providers about how a consumer is behaving, what they are thinking about, and how they are feeling. It is usually the first part assessed during a Mental Status Examination and is generally composed of five areas:

1. Appearance;
2. Behaviour;
3. Thought form;
4. Thought content; and
5. Emotion (otherwise known as ‘affect’).
1. Appearance

This is a brief description of how the consumer looks and presents. If the consumer’s self-care appears to be very poor, it is important to ascertain how long this has been the case. Other areas of interest include recent changes in the consumer’s appearance. Information can be sought from the consumer, family members and carers and by approaching local service providers (for instance, a health worker). It is also important to consider the distance or mode of travel the consumer experienced to reach the appointment. Another vital step is to find out what are acceptable standards of appearance in that community, before making a decision.

2. Behaviour

Behaviour can give many clues to how a person is feeling and what they are thinking. A consumer might be restless and have difficulty staying still. This could indicate a multitude of things, including withdrawal from alcohol or nervousness about being interviewed. Conversely, the consumer might be slumped in a chair and be difficult to engage in conversation. This could indicate depression, sadness, shyness or shame. The consumer could also be acting in a very strange way, displaying odd movements of the body or face. There might be behaviour that suggests they are listening to something or someone, or that they are angry or worried. Mental health providers need to be open-minded and observant about this area, be careful to separate signs of illness from culturally appropriate behaviours and avoid making assumptions.

3. Thought form

Thought form refers to how thoughts are connected. It looks at the way thoughts are ordered and put together and whether this is done in a logical and clear way. This is determined by the consumer’s speech.

The consumer might speak in a slow and hesitant manner, with many gaps and unfinished sentences. It might be fast and seem pressured, as if ideas are flying through their mind. The consumer’s speech might also be normal in pace, but odd as if there is a private code. Certain words might be used because they rhyme, or secret meanings might be attributed to words that are different to what the words actually mean. In some instances, the code might be impossible to guess. The consumer might begin discussing a subject and then talk about something else that is unrelated. In some instances, the new topic might be related to the initial discussion, but that connection is “loose” and illogical. The consumer might also seem to make up words, or use words that have no meaning or link to each other.

In assessing this area, it is advisable to firstly determine how well the consumer knows English. For many Indigenous consumers, English might not have been their first language. There might also have been factors that prevented the consumer from getting an adequate education. Consequently, the consumer might exhibit problems with pronunciation, comprehension and grammatical structure. Strategies that can be used to ensure a fair assessment is made include ensuring that an Indigenous mental health worker, Aboriginal health worker, or a support person is present to act as an interpreter or translator. It is also best to avoid using medical jargon or technical words. Delayed answers or minimal speech should not automatically be considered as a sign of slow or impaired functioning.

4. Thought content

Thought content refers to what the consumer is thinking about. Abnormalities in mental functioning can occur if there are problems relating to experiences in sensory modalities, which include hearing, sight, taste, smell and touch. These experiences are known as “hallucinations”. For instance, a consumer might speak of hearing voices, or seeing someone or something. Experiences with the other senses (taste,
smell and touch) are uncommon, but there have been instances where epilepsy sufferers and substance abuse users have reported sensations.

Abnormalities can also occur if there are problems relating to ideas. The consumer might become preoccupied about something to the point that it becomes too excessive. These ideas can be understandable given the circumstances, or clearly abnormal and obviously false. These experiences are known as “obsessions”. If the focus of the preoccupation places the consumer or another person at immediate risk, the mental health provider must take the matter seriously. An example would be a consumer constantly thinking about death.

In certain instances, some ideas can be so bizarre that it seems unlikely that they are true. However, the consumers are convinced about they are reasonable, even when faced with convincing evidence to the contrary. These ideas are known as “delusions”. The most common are delusions of persecution, whereby consumers are convinced someone or something is intent on seriously harming them (paranoid delusions). Other delusions include believing they are very important or famous people or have extraordinary powers (grandiose delusions).

As already noted, caution must be exercised where cultural experiences and ideas are concerned. This is because not all reported cases signify that there is a mental health problem. Staff should explore whether such experiences and ideas make sense in cultural terms and are consistent with values and beliefs expressed by the family or community the consumer identifies with.

5. Emotion
The purpose of this section is to get an understanding of the consumer’s mood. Areas assessed include the type of mood exhibited, its appropriateness in the interview setting and in consideration of what concerns are being expressed, and the mood’s consistency. This is generally determined by what consumers say about their feelings and how they present.

In some instances, how consumers look and sound may not correspond. Consumers might look very happy but talk about being down and depressed. On the other hand, consumers might look and sound sad at the same time, but be completely different later. Their mood seems to be continually changing from moment to moment (labile). Other examples include when consumers look and sound unusually happy (euphoria) or when they are very sad (depressed). Consumers might also not display any mood at all and appear flat (blunted).

From a cultural perspective, a common belief amongst many Indigenous peoples across the world, including Australia, is that revealing or showing emotion is a sign of weakness. Consequently, they might present as being reserved, even when discussing traumatic or happy experiences. This should be considered when determining flat affect. Caution should also be used in not confusing shyness or shame with sadness.

**Cognitive processes**
Cognitive processes are the second part assessed during the mental state examination. This area determines whether there are any signs or clues suggesting that there is something affecting the consumer’s level of consciousness. It also seeks to explore the mental functions that are necessary for thinking things through and obtain a rough estimate of intelligence.
This part is generally composed of six areas:

1. Attention and concentration;
2. Orientation;
3. Memory;
4. Intelligence;
5. Insight; and

1. **Attention and concentration**
   This area seeks to determine whether consumers are alert and conscious of what is happening in the interview. In some instances, consumers might be easily distracted or unable to keep their mind on one thing at a time, which could possibly require further exploration. In the event that it is not obvious whether there are problems, a simple test might be administered. In doing so, it is worth keeping in mind that many Indigenous consumers might have a vastly different concept of what is considered to be general knowledge in comparison with the general population. Therefore, it is best to ensure that whatever topic is used to test this aspect is one that the consumer is familiar and comfortable with.

2. **Orientation**
   Orientation is important to assess because it determines whether consumers understand their position in person, place, and time. Orientation in person refers to their awareness of who they are and who those around them are. Orientation in place refers to whether they recognise where they are. For example, they might think they are at home, when in fact they are at the hospital. They might also think they are in another community. Lastly, orientation in time refers to whether they know when it is. Most people might not know the exact date. Therefore, it might be more appropriate to ask the year, month, or day of the week. Obvious disturbances of orientation could indicate a serious problem.

3. **Memory**
   Generally, three areas are assessed:
   a. Immediate recall—whether the patient is able to remember things straight away;
   b. Short-term memory—whether the patient is able to remember things after a few minutes;
   c. Long-term memory—whether the patient can remember things from a long time past.

   It is best to ensure that the topics used to test these areas are familiar to consumers. For instance, in testing long-term memory, it would be more appropriate to ask consumers to recall the names of family members instead of the last five Prime Ministers of Australia.

4. **Intelligence**
   Evaluating intelligence is a very complicated and controversial subject. This is because of the cultural and educational differences between Indigenous Australians and mainstream society. In the Mental Status Examination, intelligence is assessed very generally. Factors considered include communication skills, ability to perform basic calculations and general knowledge questions. However, what if the consumer has a limited understanding of English and has only completed a minimal amount of schooling? These are some of the issues that need to be addressed before a fair assessment can be made.
Some strategies that can be used to aid mental health providers include:

- Establishing the level of education of consumers;
- Establishing how efficient consumers are with English and its usage and whether it is their first language;
- Ensuring that general knowledge questions are appropriate, considering that many Indigenous people have a different concept of general knowledge;
- Ensuring that how consumers present and how they communicate is not mistaken for slow or impaired functioning. For example, a consumer might be shy, or generally sit back and contemplate a question before answering;
- Actively involving Indigenous staff and support people for background information and assistance in the assessment process; and
- Being aware that the skills mainstream society value are not necessarily the same as what many Indigenous peoples view as important to survival, irrespective of how much schooling they have completed.

5. Insight

Insight refers to whether consumers are able to articulate whether they have a problem. Most people with mental health problems have some idea that something is wrong, even if they are unable to identify what it is. However, others might not be aware that something is amiss, despite it being obvious to everyone around them (for instance, many people suffering from schizophrenia). Some people who are aware they have a problem might be unwilling to admit it (for instance, someone suffering from alcoholism), while others might give the impression that they do not seem to care (for instance, some people with a serious personality disorder). An assessment of insight is very important because it can give mental health providers clues as to diagnosis. It can also determine what treatment is appropriate under the circumstances.

6. Judgement

The final section of the mental health examination involves determining whether the condition consumers are suffering from is affecting their ability to assess what is happening around them and to them, and to make important decisions. Thus, when judgment is impaired, consumers might not be able to make decisions in their best interest, or may make decisions that might cause harm to others. Judgment can be impaired temporarily or for a greater duration of time. For instance, a seriously depressed person might believe that there is absolutely no point in continuing to live and be planning to suicide. Another consumer might be hearing voices telling them to harm someone. Someone who is intoxicated might become extremely aggressive but be completely docile when sober. All of these people are at risk of making decisions that might result in harm to themselves or others and need to be protected. Mental health providers should consult with Indigenous staff, families and community members to ensure that an accurate assessment is made.

Summary

When assessing Indigenous consumers, the following issues need to be considered:

- Spiritual beliefs should not automatically be dismissed as hallucinations, delusions, pathological thinking or a sign of emotional imbalance;
- Find out what is considered to be an acceptable standard of appearance in the consumer’s community;
- Mental health providers need to be open-minded and observant when assessing behaviour and emotion and avoid making assumptions;
- Do not confuse shyness or shame with sadness, or a reserved response as evidence of flat affect;
- Establish how confident consumers are with English and if it is a first language;
• Delayed answers or minimal speech should not automatically be considered as a sign of slow or impaired functioning;
• Determine the level of education of consumers;
• Ensure that general knowledge questions are appropriate, considering that many Indigenous consumers might have a vastly different concept of what is considered general knowledge by the general population;
• Actively involve Indigenous staff, families and community members for background information and assistance in the assessment process; and
• Be aware that the skills mainstream society values are not necessarily the same as what Indigenous peoples consider important to survival, irrespectively of how much schooling they have completed.

Therapies for Mental Health
Mental health providers have an obligation to provide the best possible care to consumers. In formulating Care Plans to achieve this, staff need to consider how Indigenous peoples view mental health. In practice, this requires open-mindedness and being receptive to the idea that there are many pathways that lead to recovery.

The therapeutic relationship
The development of a positive therapeutic relationship at the onset of treatment is critical. This is because it can influence the final outcome. Generally, an individualised approach to care is taken with each consumer. This approach has met with universal approval from policy makers, educators, mental health providers and consumers. However, there appears to be a lack of shared understanding of its meaning. Further exploration of this term is needed for greater clarity.

Taking an individualised approach to care involves a commitment to treat each consumer as unique and tailoring care around his/her needs. It includes not making assumptions because of someone’s age, gender or ethnicity. It must be remembered that people with a mental illness have the same basic human rights as all persons. They have a right to dignity and respect as human beings. They also have a right to autonomy, choice and control over aspects of their lives, including their encounter with mental health services. By failing to recognise this, staff risk alienating consumers and treatment being unsuccessful.

Consumers are often the least powerful people in the health care system. This is due to their vulnerability in being unwell, and most often their lack of professional knowledge in the area of mental health. Consequently, an uneven distribution of power exists between mental health providers and consumers, which can act as a barrier in forming genuine partnerships. To counter this threat, there must be a sense of collaboration and equality in decision-making. These characteristics are extremely important because they promote independence by encouraging consumers to take responsibility for their own health. By establishing agreement at the beginning of treatment, there will be a greater understanding of what the needs of consumers are and how these can be met. Ultimately, this will increase the effectiveness, relevance and acceptance of treatment and the chances of success.

Close attention needs to be paid to how consumers cope with being diagnosed with a mental illness and the subsequent call for treatment. This is due to the stigmatisation and fear that exists within society about mental illness. On the one hand, a diagnosis may give some people understanding about the symptoms they have exhibited and establishes eligibility for assistance and intervention. However, it can also create social disadvantages for people who are labelled, due to the erroneous assumptions and stigmatisation of those who are considered different. This can sometimes act as a
barrier in forming a genuine partnership and adversely affect the outcome of treatment. Consequently, a great deal of sensitivity is needed.

Other important characteristics of forming a quality relationship include establishing a climate of trust and safety through openness. This can be attained through active listening and the communication of acceptance and respect. Staff should also verify with consumers their expectations about treatment and their readiness for change. This ensures that consumers have a realistic outlook and are not being set up to fail.

A positive relationship between consumers and staff can represent a therapeutic intervention in itself. It can be life sustaining for many consumers, in acting as a safety net and reducing hospitalisation. The evidence from the literature suggests that a psychotherapeutic relationship is very important to the ability of clients with severe and persistent illness to live in the community. This adds further weight to establishing a positive relationship at the onset of treatment.

**Traditional healing**

In respecting individuality, the needs of consumers from different ethnic backgrounds, including Indigenous Australians, must be accommodated. Mental health providers must ensure that consumers and their families maintain their cultural beliefs and practices. In order to achieve this, it is important to firstly identify what those beliefs and values actually are. Cultural beliefs and values still remain important for many contemporary Indigenous peoples. This is possibly because they provide meaning to life, and are a source of guidance, strength, and comfort, particularly in times of illness. Consequently, staff should work with consumers and their families to ensure that traditional modes of healing can be accessed for those who desire it, while continuing to provide appropriate psychiatric care.

In taking an individualised approach to care, staff need to be aware of the Indigenous concept of time. Unlike mainstream society, time is not seen as being the dictator of life. This has repercussions for what is considered important and when things are done. For instance, family and community for an Indigenous person are a high priority. If a family or community need arose, it would take precedence over a previously scheduled appointment, irrespective of how adversely it may affect the individual involved. Similarly, many Indigenous peoples live in the here and now, which is a combination of the past and present. Hence, the future is considered to be an alien concept. This would have implications if therapeutic interventions were focused on improving future health status, without immediate consequence. A useful strategy in this situation would be to provide brief, intensive, specific problem-orientated interventions that are effective and relevant.

Prior to colonisation, the Indigenous peoples of Australia had their own healers for the examination and restoration of health. This is still the situation today. These traditional healers are known by many names, due to the diversity of Indigenous dialects and languages. In Central Australia, they are often known as “Ngangkari”.

The Ngangkari are Indigenous healers who specialise in treating people with mental health problems. They can capture negative energy inside the body and expel it, mostly by using the mouth, hands and breath. This negative energy is generally caused by illness and disease, or afflictions from dangerous spirits. The Ngangkari see negative energy as forming something solid and physical, such as pieces of wood, sticks or stones. It can also come in the form of dirty blood. Consequently, treatment involves removal of objects from where they have been lodged in the bone or flesh, or using suction from the mouth to draw out mouthfuls of dirty blood, without damaging the body internally or externally. Sufferers are also able to see the sickness being
taken from their bodies and observe what caused their suffering. After removal, the Ngangkari generally dispose of objects by throwing them into the wind, or burying them somewhere. When removing dirty blood, it is always spat out and never swallowed. Ngangkari healing treatments clean wounds completely, which supports the healing of the flesh.

The Ngangkari can touch the spirit of people who are sad and depressed, or feeling not quite themselves. They might be feeling a displacement of their spirit, or believe that their spirit is missing. These traditional healers can locate a lost spirit or reposition a dislocated spirit, making a person feel whole again. The Ngangkari can also manipulate misaligned and dislocated bones to put them back into place, taking the pain away at the same time. They have an in-depth knowledge of the whole anatomy of the body and can detect changes quiet easily. They can also render assistance to people who are dying, to protect them from preying spirits. This is achieved by cleaning the body and spirit, to ensure that the afterlife is safe and unaffected.

The Ngangkari can also chase away unseen spirits. These are negative spirit powers that are troublesome and dangerous and who have the potential to physically harm people or make them very sick. These healers identify the negative spirits and pursue them until they no longer pose a threat to others. Additionally, they have the ability to heal people who have been inflicted.

A special power given to the Ngangkari is the ability to travel around in their spirit bodies. While asleep, their spirit bodies take flight and they can visit the sleeping spirits of others. When sick or injured spirits are identified, the Ngangkari are able to provide treatment straight away. Those who need assistance ask for help in their dreams, when their spirits call out. Many Ngangkari choose to treat people first from their spirit body, because they can make a better diagnosis and provide a more effective treatment. Ultimately, this gives them the power to look over the person externally and internally, where the spirit dwells.

The Ngangkari can be men, women or children. Children make the best Ngangkari because as they grow up, their powers increase. Knowledge and power is given to them to enter the spirits of others and to give the healing breath and touch. Instruction is by other Ngangkari who teach by example. They are taught from a long heritage of traditional healing. Powerful spirit figures, known as “Karparinypa”, also bring them special sacred tools known as “mapanpa”. These tools come in many forms, including slivers of bone and sharp stone blades. The Ngangkari use their own “mapanpa” to heal others, and generally store their tools inside parts of their own body, such as the palm of the hand. These tools help them to enter into people’s spirits and heal from within.

The Ngangkari have not had much success in treating substance misuse, particularly in cases where the body has started to deteriorate. However, they can help in other areas. It should further be noted that the Ngangkari are not comfortable with the shedding of blood during operations. This is because spilled blood is seen as wasted blood. They also do not agree with blood transfusions, because putting other people’s blood inside a sick person is viewed as very dangerous. Thus, these traditional healers clean blood using the old methods, without cutting or opening the skin. They consider new techniques used by medical practitioners to be unclean and unsafe.

The Ngangkari work on a level that other healing providers cannot. They heal in a way that can neither be seen, nor written down. They enter the body by way of the spirit and heal from within, using the healing breath and touch. The law for all Ngangkari has its origins in the Dreamtime and they have practiced their healing powers ever since.
For centuries, Indigenous peoples have consulted traditional healers, including the Ngangkari, for their ancient healing treatments. They are considered to be doctors, in much the same way that mainstream society views medical practitioners.

There are many obvious differences between the clinical approach and the Indigenous approach in treating mental illness. However, both share the same goal in working towards healing the sick and improving quality of life. The Ngangkari already work alongside clinical staff in some health centres and this has proven to be very successful. If Indigenous consumers seek the help of traditional healers, mental health providers should respect their values and cultural beliefs. It is also advised that staff use these beliefs in the care of those who hold them. In combining mainstream and Indigenous therapies, consumers will ultimately receive treatment that acknowledges diversity and is individualised in its approach.

It should also be noted that Indigenous peoples sometimes use bush medicines to treat illnesses and ailments. Mental health providers should check with consumers, particular if there are concerns about adverse effects when used in combination with psychiatric medications.

**Pastoral healing**
Christianity was introduced to Indigenous Australians in early colonial times, followed by other religious persuasions. Subsequently, many have incorporated religious beliefs and practices into their lives in varying degrees. Mental health providers are already required to ensure that consumers maintain their religious values when decisions are made about issues affecting their lives. Using these same principles in caring for those who hold them may increase the effectiveness of treatment.

It is important to fully utilise all avenues that provide support and strength to consumers. Religious beliefs are a great source of inspiration for many people, offering encouragement and hope for the future. Religious practices, such as prayer and meditation, can enhance self-awareness and provide peace from stress and anxiety. Hence, religion for some people offers guidance and a way of coping with the vicissitudes of life. It is quite common for consumers who have religious values to seek help from a clergy member. Most often this is in the form of pastoral counselling. Other methods employed by consumers could include joining a religion-based support group that offers support and assistance for them and their families. Mental health providers need to be aware of what the personal and religious beliefs of consumers are in order to take an individualised approach to their care. If clergy members are actively involved with consumers, providers should work in collaboration with them. It may involve providing education and skills to clergy about psychopathology in a consultative framework. In consideration of the increasing diversity of people’s worldviews, providers must also reflect on their own belief systems and ensure they do not prejudice others who hold different views.

**Alternative therapies**
There are other forms of alternative therapy that Indigenous Australians might be familiar with, particularly those living in metropolitan areas. Examples of these include naturopathy, homeopathy, acupuncture, aromatherapy and Chinese herbs. Alternative therapies are generally viewed with controversy, due to the lack of regulations within these industries. Mental health providers need to be aware if clients are accessing alternative therapies in combination with psychiatric care. This is to ensure that consumers do not suffer adverse effects, particularly if they are taking psychiatric medications.
Summary
When treating Indigenous consumers, mental health providers need to be aware of the following:

- There is more than one pathway that leads to recovery;
- Developing a positive therapeutic relationship is critical;
- An individualised approach to care involves tailoring treatment to suit the personal, cultural and religious beliefs of consumers;
- There must be collaboration and equality in decision-making in order to form genuine partnerships and increase the effectiveness, relevance and acceptance of treatment;
- Everyone needs to be aware of the stigmatisation of mental illness and the impact it has on consumers;
- A positive relationship between consumers and providers can provide therapeutic intervention in itself;
- Consumers and their families must be able to maintain their cultural beliefs and practices;
- Traditional Indigenous healers specialise in treating people with mental health problems;
- They use ancient healing treatments without damaging the body internally or externally;
- If Indigenous consumers seek the help of traditional healers, mental health providers should respect their decision, while continuing to provide appropriate psychiatric care;
- Indigenous people sometimes use bush medicines to treat illnesses;
- Consumers must maintain their cultural and religious values when making decisions about issues affecting their lives; and
- Mental health providers need to be aware if clients are accessing other forms of therapy in combination with psychiatric care, particularly if they are taking psychiatric medications.

Compliance
Compliance in health care is a complex issue and has been defined as being the extent to which the consumer’s behaviour coincides with medical or health care advice. Mental health providers are seen as the definers of “proper” treatment and this has been legitimised and reinforced through various legislative measures, including the current Mental Health Act (2000). If the patient does not follow medical advice, the Act allows the health professional to exert influence and legitimately override the wishes of the patient, based on a belief that the individual is deemed to lack competence. Indeed, it has been argued that one of the primary reasons for a high rate of non-compliance with treatment in mental health is that the impact and nature of illnesses interfere with the ability of individuals to make sound, “rational” judgments. However, mental health providers must exercise caution in this area. This is because there are a multitude of factors that can influence compliance with treatment, other than the impact and nature of illnesses.

Consumer-related influences: Non-compliance is seen by many mental health providers as an issue about cost and the effective use of resources and has become a major factor in developing new forms of medications and treatments. The introduction of depot injections is an example. However, non-compliance is also about individuals, their attitudes and perceptions and the consequences of non-compliance to themselves. There are many factors that determine a consumer’s compliance behaviours. These include gender, social class, ethnicity, cultural background,
education level and socio-economic status. These factors shape an individual’s values and beliefs, which guide actions and decisions regarding medical advice. When unrecognised differences in needs, values and expectations exist between consumers and mental health providers, these differences might have detrimental effects on the therapeutic process. One important predictor of compliance is whether consumers feel that the prescribed treatment is having a positive effect on everyday life. For example, negative feelings about taking medication and harmful side effects can adversely affect adherence to treatment regimes. Another important predictor is the relationship that consumers have with mental health services. Institutional racism can act as a barrier to health care for ethnic minorities, including Indigenous Australians.

Individual prejudice and a general lack of respect can also be barriers. This can have detrimental effects on the therapeutic alliance and compliance, further alienating Indigenous consumers and their families from mainstream services. It is necessary to be aware of these issues and ensure that services are welcoming to Indigenous consumers. Mental health providers need to be aware of their own values and beliefs systems and avoid making personal judgments. Indigenous consumers need to feel comfortable accessing services and staff to discuss treatment if problems arise. It has been argued that quality of care is dependent upon the abilities of consumers to verbalise their opinions and be articulate when questioning treatment. This can be prejudicial for Indigenous consumers, particularly if English is not their first language. There are also cultural factors to consider, in the sense that Indigenous consumers might have a fear of asking questions. Consequently, Indigenous mental health workers should be utilised whenever possible to provide support to consumers and to act as cultural interpreters. Significant others should also be included into the therapeutic alliance.

As noted earlier, the Indigenous concept of time can have repercussions for what is considered important and when things are done. If a family or community need arose, it would generally take precedence over a previously scheduled appointment, irrespective of how adversely it might affect the individual involved. This is because family and community for an Indigenous person are a high priority. Mental health providers need to be aware of this and avoid making assumptions.

Environment-related influences: Recent statistics indicate that the Indigenous population is still much sick, younger and poorer than the non-Indigenous population. In many Indigenous communities, there are issues relating to overcrowding, unemployment and a lack of on-site services and resources to cope with the growing needs of the community. These factors can adversely affect compliance. For example, overcrowding could impact on the ability of consumers to safely store medication in the home environment. Unemployment could prevent them from meeting ongoing prescription costs and having adequate transportation to attend appointments. Mental health providers need to explore and understand environmental constraints on consumers and develop realistic solutions and strategies in the best interests of all parties. In rural and remote areas, there are also the added burdens of isolation and a lack of access to specialist mental health services. This places more responsibility on local primary health care clinic providers, who might not have a background in mental illness. In periods of unwellness, Indigenous consumers often have no choice but to leave their communities in order to receive appropriate psychiatric treatment. This can be a frightening and daunting prospect because of the importance Indigenous peoples place on maintaining cultural links with one’s land, family and community. Consequently, this can have a detrimental impact on compliance and affect the therapeutic process. In such situations, mental health providers need to consult with those who are actively involved in the care of consumers to determine the best course of action to take. It may involve family members accompanying consumers when
leaving the community to assist with compliance. If such a course of action is taken, it is imperative that arrangements are made for family members as well that addresses accommodation and other vital supports.

**Professional-related influences:** Compliance is a complex ideology based on professional beliefs concerning the "proper" roles of consumers and mental health professionals. The dominant view is that the role of the professional is to diagnose, prescribe and treat, while the reciprocal role of the consumer is to comply with such diagnosis and treatment. Thus, consumers are considered passive recipients in their own health care. When consumers do comply with treatment, professionals sometimes assume that insight has been achieved and that a collaborative and trusting relationship has been developed. However, other factors may motivate compliance, including the perceived threat of withdrawal of treatment and rejection by the professional. The knowledge that non-compliance can lead to compulsory treatment by invoking the current *Mental Health Act (2000)* may also be a primary motivating factor. When consumers fail to follow rules, they are sometimes labelled as non-compliant, defaulters and as incompetent. This can be unfair however, due to the negative impact of labels and an inherent tendency to blame the consumer when they differ from professional opinion and prescription. Thus, consumers are individuals who construct and give meaning to their encounters with professionals, and actively evaluate treatments prescribed and advice given. They have a right to treatment that suits their personal, cultural and religious beliefs. Consequently, consumers need to be viewed as active participants instead of passive recipients in their own health care. This may involve mental health professionals letting go of some of their traditional roles and exploring how they can understand and participate in the decisions that consumers make about their treatment. The role of mental health professionals working with Indigenous consumers should be to challenge at an individual level their own prejudices and professional practice. A collaborative and trusting relationship is one that emphasises consumer rights, the need for culturally appropriate information and the importance of two-way communication and decision-making.

Many of the problems with non-compliance are associated with poor communication. Poor communication may be due to social and educational barriers and cultural differences in understanding the role of medicines. This can form inequalities in the relationship leading to an imbalance of power between professionals and consumers. When working with Indigenous consumers, it is advisable to communicate treatment regimes and advice with clarity, brevity and emphasis and to actively listen to what the consumer has to say. It is also important to offer enough time to the consumer and to leave space to talk about problems concerning medications or side effects. This is because a strong predictor of medication compliance has been found to be the consumer's perception of the provider's interest in him/her as a person. Indigenous mental health workers should be utilised, whenever possible, to assist in this process. Significant others of the consumer should also be included in discussions about treatment regimes. Mental health providers should ensure that they have received adequate training and/or resources on mental health and safe medication management to provide advice on these matters. An example of an interaction between a mental health worker and an Indigenous consumer in a remote North Queensland community as described by the worker illustrates some of these points:

“… one of them said to me; ‘I’m not gonna have that medication, I’m not gonna have your tablet, you think I’m mad, you think I’m going off’, and swore me deep, deep down. And I said; ‘That’s alright.’ And now he turned round said; ‘You know what, I needed medication because my little brains were tired, it was doing overtime … I just got into drugs, just so that I can …, I thought I’d shut it down.’”
Other factors that can hinder compliance behaviours include a high turnover of staff in mental health services. This is because of the unsettling effect this has on the recovery process. It takes time to build a therapeutic relationship with consumers, based on trust and continuity of care. This has particular relevance for Indigenous consumers, considering that many with psychiatric problems find it already difficult to access and engage with mainstream mental health services.

**Treatment-related influences**

Indigenous consumers are often coping with multiple issues in their lives and could already be taking medication for other health conditions. Mental health providers need to be aware of these medications and ensure that new medications are complementary. Treatment regimes should be as simplified as possible and compatible with existing routines that consumers already have. This is because complex dosage schedules can act as a barrier to compliance. Brand substitution can also cause confusion. Strategies to address this include dispensing medication in Webster Packs or Dosette Boxes. In the event that mental health providers suspect that consumers have other undiagnosed conditions that require intervention, referrals need to be made to such services. An example could be if the consumer has drug and alcohol issues.

As noted earlier, mental health providers need to be aware if consumers are experiencing any unwanted side effects from medication and make adjustments if needed. It is extremely important to provide sufficient information and support during this difficult phase of treatment, and evaluate the satisfaction of the drug with the consumer, including objective and subjective symptoms. Another factor affecting compliance is that treatment may not be as effective as a consumer expects because of unrealistic expectations concerning the medication’s benefit/risk ratio. Conversely, if treatment is working well, consumers may stop taking medication because they experience no further symptoms and think that it is no longer required. Mental health service providers need to be aware of these factors, have an open relationship with consumers and encourage discussion about treatment. Lastly, family members and carers also need to be included into the therapeutic alliance. This will help mental health professionals make the right decisions about appropriate therapeutic interventions that will be successful, realistic, and workable.

**Summary**

When treating Indigenous consumers, clinicians should consider the following:

- There are a multitude of factors that can influence compliance with treatment, other than the impact and nature of illnesses;
- One important predictor of compliance is whether consumers feel that the prescribed treatment is having a positive effect on everyday life;
- Another predictor is the relationship that consumers have with mental health services;
- Indigenous consumers may have difficulty verbalising their opinion and articulating themselves when questioning treatment, due to language barriers and cultural differences;
- The Indigenous concept of time can have repercussions for what is considered important and when things are done;
- Environment-related influences can adversely affect compliance, including issues relating to overcrowding, unemployment, and a lack of on-site services and resources to cope with the growing needs of the community;
- In rural and remote areas, there are also the added burdens of isolation and a lack of access to specialist mental health services;
• The role of mental health professionals working with Indigenous consumers should be to challenge at an individual level their own prejudices and professional practice;
• When working with Indigenous consumers, it is advisable to communicate treatment regimes and advice with clarity, brevity, and emphasis, and to actively listen to what the consumer has to say;
• It is also important to offer enough time to the consumer and to leave space to talk about problems concerning medications or side effects;
• Mental health providers should ensure that they have received adequate training and/or resources on mental health and safe medication management to provide advice or assistance on these matters;
• A high turn-over of staff in mental health services can hinder compliance;
• Mental health providers need to be aware if Indigenous consumers are taking other medications and ensure that new medications are complementary;
• Treatment regimes should be as simplified as possible and be compatible with existing routines that consumers already have, and may include dispensing medication in Webster Packs or Dosette Boxes;
• In the event that mental health providers suspect that consumers have other undiagnosed conditions that require intervention, referrals need to be made to such services;
• Mental health providers need to be aware if consumers are experiencing any unwanted side effects or have unrealistic expectations concerning the medication;
• Consumers may stop taking medication because they experience no further symptoms and think that they no longer require medication;
• Family members and carers of the consumers should be included in the therapeutic alliance;
• Indigenous mental health workers should be involved and their development fostered whenever possible.
CHAPTER THREE: NEW APPROACHES TO SERVICE DELIVERY: PUTTING FIVE PRINCIPLES INTO PRACTICE

Introduction

In this section, a set of five principles are described to maximise the impact of that social and emotional wellbeing support and mental health services in ways discussed and presented in the Foreword. These are changes driven by evidence and current policy documents focusing on outcomes-oriented service delivery. The sources that support this approach include the Aboriginal and Torres Strait Islander Health Strategy and the National Mental Health Strategy. They also draw on a large body of mental health, psychiatry, social and emotional wellbeing and empowerment research from around the world including Indigenous Australia, published perspectives and insights provided by consumers and carers and feedback and discussions with groups in Cape York communities following a clinical audit. As one of Cape York’s key stakeholders stated,

“"We want to bring service delivery up to national standards: we don’t want to see standards being dropped for our people".”

Five principle areas of focus have been identified in these protocols as necessary for ensuring that mental health consumers and carers in rural and remote communities receive a service from you, the service provider, which is oriented towards their empowerment and recovery from mental illness. Thus delivery of effective treatments and interventions should be informed by:

- Consumer and Carer Focus
- Context of Community
- Continuity of Care
- Checking for Change
- Considered Clinical Care

The following sections define these five features of service delivery, briefly identify the evidence and policy base and aim to assist you in thinking and orienting your daily activities towards these principles.

Consumer and Carer Focus

There is a growing body of evidence that indicates that recovery from a serious mental illness involves a difficult process of gaining control over one’s life and situation and rediscovering oneself in light of their experiences. Achieving a consumer focus in service delivery is no doubt a challenge made even more difficult in situations where comorbidity of mental illness with alcohol and substance abuse is common; communities are in constant struggle with grief and loss; consumers face seemingly insurmountable social and economic barriers; health resources fall way short of need; remoteness restricts access and the underlying social disadvantage prevents the development of strategies to build strength. Although these increased challenges make things even harder, the need to place the consumer at the centre is no less important.

Consumers, family members and carers have unique experiences of mental health problems and mental disorders. Their “lived” experience must be recognised and utilised by mental health professionals as a valuable body of knowledge. Consumer
participation in the development of short-term and long-term plans for their treatment and care promotes the development of a partnership between the consumer and the mental health professional and a commitment by both people to implement these plans over time. With the consumer’s consent, family members and carers must be supported to contribute to these plans. Consumers, family members and carers also have the skills and knowledge to contribute to service planning, implementation, evaluation and research. Their involvement encourages personal growth and assists in the quest for recovery and health.

How is this done? The following guide is designed to help you think about the ways you can ensure that your activities promote a consumer and carer focus:

- Acknowledge and encourage consumers, family/carers as team members;
- Encourage the cycle of empowerment, hope, independence and recovery;
- Acknowledge consumers’, family members' and/or carers’ understanding of their mental health problems, mental disorders and life issues and how they cope and manage symptoms;
- Recognise the value of the healing potential in relationships between consumers, family members and or carers and service providers;
- Acknowledge the role of health consumer/carer advocates and consultants;
- Understand the impact of the mental health service on the consumer’s, family’s and/or carer’s belief system; and
- Acknowledge and encourage the abilities, strengths and contributions of consumers, family members and/or carers.

**Context of Community**

The right and process of self-determination is crucial to ensuring harmony in these inter-relations. Self-determination is both a construct of Aboriginal culture and a globally recognised human right of people - distinct in their culture, territory and history - to their territory, land and resources and their own culturally shaped social, economic and political institutions. Further, as process self-determination can do so much towards lessening the risk for mental ill health.

Culturally valid understandings must shape the provision of services and must guide assessment, care and management of Indigenous people’s health problems generally and mental health problems in particular. These understandings must apply both in services developed by and for Indigenous people in mainstream health and mental health services.

Because our culture is so familiar to us we tend to believe that the way we think, act and judge our world is shared by all others. We sometimes view unfavourably people who do not portray similar values. Our upbringing, education and our own enculturation can make it difficult for us to reflect on and challenge notions that are considered common sense or traditional in our culture. If we are going to work effectively with others, we need to ensure that we reflect on our own beliefs and values, so we can respond effectively in the face of differing values.

How is this done? The following list aims to help you think about the ways that you can ensure that your activities are appropriate and effective in the context of community:

- Acknowledge and promote the positive impact of social, cultural, linguistic, spiritual and/or gender issues on presentation and management of mental health problems and mental disorders;
Maximise engagement and involvement of people from the local community in the overall service structure and in care pathways and processes;
Gain an understanding of kinship structures of local communities;
Promote Aboriginal and Torres Strait Islander models of emotional and social wellbeing and the importance of family and appropriate cultural and linguistic support in assessments, decision-making and care planning;
Use language and communication that is culturally and linguistically sensitive;
Understand the interactions between cultures, notions of mental health and mental health problems or mental disorders and appropriate interventions.

Continuity of Care

People affected by mental health problems and mental disorders require appropriate assessment, treatment and support services provided and/or organised by the mental health professional. Early detection and early intervention may minimise an episode and enable an early return to optimal wellbeing and functioning. Those in need of longer-term interventions receive specialist and integrated mental health services that are linked with primary health care and with other service and support systems. Relapse prevention and promotion of recovery are priorities. Assessment, treatment and support are provided across the lifespan from infancy to old age and delivered in a manner sensitive to the needs and expectations of the individual, the family and groups in the community. Case management systems facilitate continuity of care across service components, according to individual need. Evaluation of the appropriateness and effectiveness of interventions continually occurs.

For consumers with disorders that recur, a recovery framework can help the consumer come to terms with relapses as a part, rather than a failure of their recovery journey. Care across these acute episodes should aim to provide optimal clinical treatment followed by rehabilitation and support services in order to maintain and promote wellness as much as possible. Rehabilitation may focus on vocational, educational, social and cognitive functioning and ideally involves active participation in range of activities such as social and cultural activities, art, music, sports and employment. Ongoing mental health promotion, reduction of risk factors and enhancement of protective factors are very relevant at this end of the spectrum, to facilitate and support recovery and wellbeing.

How is this done? The steps below will help you think about ways to ensure your support of the consumer and carer fits in with opportunities for continuity of care:

- Acknowledge and encourage clinicians, services or advocates who understand the appropriate cultural and linguistic issues to provide assistance and/or care and treatment with the consumer’s consent;
- Understand techniques for developing respectful and empathic working relationships with consumers, family members and/or carers that demonstrate a commitment to cultural appropriateness;
- Find out from the consumer and their family what kinds of activities they enjoy and point out the importance of continuing them as part of recovery;
- Understand early warning signs and risk factors and triggers for relapse;
- Provide services that engage consumers in continual planning and regular review that includes (as appropriate): discharge planning from in-patient facilities; ongoing relapse prevention; crisis plans and support of home care.

Checking for Change

Queensland Health has invested a very large effort into implementing a system for reliable routine outcomes data collection for mental health. This forms part of the
implementation of the National Mental Health Plan and the data collected in the outcomes process are likely to influence many of Queensland Health’s activities and resource allocations in mental health. It is therefore imperative that Indigenous consumers are accurately identified in the system and outcomes assessment is done as reliably, consistently and accurately as possible.

Of first importance in this process is the identification of Indigenous status for every Aboriginal and Torres Strait Islander consumer. If an Indigenous consumer is not properly identified as such in the system, there is no way for Queensland Health to become aware of the needs and outcomes of Indigenous mental health consumers. Please ensure each one of your Indigenous consumers is identified appropriately as Aboriginal, Torres Strait Islander or both in the outcomes database. This should not be determined by observation alone and should have been, but is not always, identified as part of the routine clinical information gathering. The clinician is reminded that while there are times when Indigenous status is incorrectly assigned (for example with South Sea Islanders or PNG nationals); a more common mistake is to assume the consumer is not Indigenous because of their appearance. It is always important to ask if the consumer is Aboriginal, Torres Strait Islander or both if the information is not already available or may not be reliable.

At present, the following tools are in routine use in the Queensland Health Outcomes Collections for Adults: diagnosis (ICD-10-AM) and mental health legal status, focus of care, HoNOS/HoNOS 65+, RUG-ADL, MHI and LSP-16.

It is important that the Indigenous mental health and/or primary health worker provide not only a more detailed picture of how the consumer has been over the assessment period, but also a cultural understanding that often visiting clinicians will not have. This is required for reliable HoNOS and LSP ratings.

When completing the HoNOS and LSP items with Aboriginal and Torres Strait Islander consumers, it is very important that a number of additional considerations are made. These considerations are captured in Four Principles briefly introduced below and further detailed in Chapter Three. These principles were developed in consultation with a range of Indigenous and non-Indigenous stakeholders in mental health and became part of the Extended Outcomes Training package provided to clinicians in the Cairns Network.

**Principle One**: Although the clinician provides the final ratings for HoNOS and LSP, it is extremely important to involve additional Indigenous informants (ideally Indigenous health worker/healer and family/carer) when applying them to Indigenous consumers.

**Principle Two**: Clinicians should objectively reflect the underlying social disadvantage experienced by the consumer in scoring the scales, and thus avoid under-rating issues even when the level of disadvantage is widely experienced in the consumer’s community.

**Principle Three**: Clinicians should objectively reflect non-sanctioned behaviours in scoring the scales, and thus avoid under-rating of socially and culturally unacceptable behaviours even when they are common in the community.

**Principle Four**: Where there is an indication that behaviours (e.g. self-harm), beliefs (e.g. “sung” or “cursed”) and/or experiences (e.g. visions or voices) have a cultural basis, and clinicians must determine whether these are consistent in form, intensity and duration with accepted local norms. If so, DON’T rate them. Only those that are NOT consistent with local norms should be rated. Any concurrent mental health problems or behaviours should always be rated where appropriate.
Here is a checklist for clinicians to ensure they are participating fully in the effort to gain a better understanding of mental health outcomes for Indigenous consumers and checking for change accurately, reliably and usefully:

- Check to make sure that every Aboriginal and/or Torres Strait Islander consumer that you see is marked appropriately on the Indigenous Identifiers question;
- Ensure that you consult at least one carer/family member and a local health worker who knows the consumer when completing the assessment from which you make your ratings;
- Become fully familiar with the HoNOS and LSP items and understand and use the Principles and Additional Guidelines as provided for Indigenous consumers;
- Seek help and advice and inform the Outcomes Coordinator when you experience uncertainty or other problems in completing the outcomes ratings at the specified required times and for informative ad-hoc reviews; and
- Feed back the information to consumers and carers in a manner that supports communication about change and promotes hope and goal setting.

**Considered Clinical Care**

People affected by mental health problems and mental disorders require appropriate assessment, treatment and support services provided and/or organised by the health professional/worker. This principle addresses the concept of clinical expertise and knowledge and how it can be best applied to practice. Promoting employment of evidence-based practice, best practice guidelines and clinical protocols are widely advocated in the health care environment today. While these are very important in the progression of clinical service provision, there are other equally important aspects to be considered. Emphasis should be also placed on a relationship between the health professional/worker and the consumer and family to provide optimal decisions and care for that consumer.

Decision making in clinical practice is crucial in the day-to-day scenarios we encounter and is enhanced with ongoing experience. Our judgment processes should continually be improving as we reflect on what worked and what didn’t work. Judgment is the ability to make logical, rational decisions about whether a given action is likely to help or harm. Clinical judgment is the process by which the health professional/worker listens to the consumer, makes an interpretation of the information, arrives at a diagnosis and identifies appropriate actions. This involves problem solving, decision making and critical thinking. However this critical thinking should incorporate the impact of social, cultural and spiritual ideals of the consumer’s community. Consideration should be given to the fact that we are all different in our own ways, personalities and social circumstances and this can have a major impact on clinical presentation and appropriate helping strategies.

Three basic ingredients contribute to the process of **Considered Clinical Care**.

1. **Experience:**

   Evidence-based practice, clinical protocols and best practice guidelines are important tools that can be used when determining clinical issues in mental health presentations. These tools are more likely to be consciously applied where the health professional/worker has limited practical exposure, becoming second nature with experience. Unfortunately guidelines, while very helpful, mainly provide a
general view and give limited assistance on specific spiritual or cultural issues. Thus mentoring by health professionals/workers with many years of practical life and/or clinical experience, ensuring opportunities to listen to a broad range of informants, being exposed to clinical situations and gaining understanding spiritual and cultural issues contribute significantly towards making holistically-informed, as well as guidelines-informed, decisions.

2. **Knowledge of an individual and their family:**

   The overall knowledge of a health professional/worker specific to mental health issues and to cultural and spiritual sensitivities can have a profound effect on the outcome of a clinical encounter. Attention to detail (thorough history records, regular updates) and knowledge of a consumer’s past and present family support and circumstances offers finer insight into their strengths and care needs.

3. **Knowledge of the broader relationship between consumer and community:**

   Therapeutic relationships with consumers in Primary Health Care should go well beyond developing rapport in the clinical encounter. This requires the health professional and workers to have a superior understanding of, not just the consumer’s history, but also the cultural and community history, along with knowledge on how to access other resources. Holistic outcomes are achieved when emphasis is also placed on accessing community resources (for example, family and carers and their social networks, life promotions officers, sports and recreation, art and music groups, justice groups, spiritual leaders and traditional healers) that enhance the everyday life of the consumer.
CHAPTER FOUR – FRAMEWORK AND PATHWAYS OF CARE

“Big Picture” Framework and Pathways to Support Social and Emotional Wellness and Achieve Continuity of Mental Health Care in Primary Health Care Settings

Introduction

As discussed in Chapter One, Indigenous people define mental health in a broad community sense as “not just the physical wellbeing of an individual, but the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total wellbeing of their community. It is a whole of life view and includes the cyclical concept of life-death-life” (NACCHO 1997).

Thus a loss of wellbeing and mental health is likely to occur when a person becomes overwhelmed by trauma, grief and loss, and stress in their life, when they experience a loss of role, identity, meaning and hope. This can happen through factors interfering with normal development in utero (such as alcohol) or in childhood and adolescence, or through disconnection with core values of culture, heritage, family, land and role models. While these experiences are commonly and deeply felt by Indigenous people, counteracting their impact is a strength often called resilience, which Indigenous people have used to survive despite incredible adversity. Whenever working with Indigenous people, it is always necessary to recognise and respect their strengths and resilience as a means of helping them to address the difficulties they are experiencing and return to a balanced state and regain their wellbeing. The harmful effects of alcohol and drugs on a person’s capacity to maintain this balance can be profound.

All health staff also need to be aware that physical, social and mental health are completely inter-connected. In other words, people with physical health problems are more at risk of social and emotional health problems and people with social and emotional or mental health problems are more at risk of physical health problems.

The degree of ability to cope with life and circumstances, while difficult to define, determines whether a person who is experiencing distress only requires local support to recover their social and emotional wellbeing or if their mental ill health is more severe, possibly a defined mental health disorder that would benefit from more specialist care. Effectively helping a person who is distressed but still generally able to cope can often prevent progression to a mental health disorder, so recognising and giving help early is very important.

Whether people are experiencing a significant loss of wellbeing alone, stress and inability to cope with a physical health problem and/or also serious mental ill health, they need a smooth pathway of care that is appropriate to their needs and minimises risk of further harm.

This chapter first presents an overall “Big Picture” community level framework and then provides a series of specific pathways and tools for the Primary Health Care setting to guide implementation of social and emotional wellbeing approaches alongside mental health care. The aim is to clarify roles, processes and tools that can be used to achieve optimum mental health outcomes.

The steps of the Pathways are designed to:
- provide a broader picture incorporating a holistic approach to wellbeing and mental health that engages the community;
- identify and assist people at risk of or experiencing mental ill health early, not late;
- provide tools to document the decision-making and planning processes;
- deliver appropriate and continuous care across each activity in the pathway;
- ensure that anyone at risk of self harm or suicide receives the best possible care.

The “Big Picture” Framework

The “Big Picture” framework shows how health care pathways need to be embedded in an empowerment and community development framework that fosters individuals and groups to re-establish healthy norms and provide the capacity for change. As highlighted in this document’s Foreword, positive change depends most heavily on things that happen outside the clinical encounter (extra-therapeutic change) and helping relationships that foster the person’s capacity to benefit. These are entirely consistent with the aims of the Cape York Health Reform process now underway.

The following diagram highlights the various potential interfaces between community development and health services that underlie these protocols presented in this manual, and illustrate key challenges that should be achieved for better, sustainable outcomes in mental health.
The orange section defines the aims of the framework in establishing an integrated approach to care across community and health service.

The first blue section of this diagram identifies important community level activities necessary for creating a social environment that is empowered to promote the health of its residents and address the serious issues working against health improvement.

The green section underpins pathways of care presented in this chapter that can assist Primary Health Centres to embed social and emotional wellbeing support, alongside pathways for mental health care, and as an essential part of all services.

The bottom blue section reminds us that the fundamental purpose of health services is to assist people and communities to achieve better health. Services therefore have an obligation to measure changes in health that result from the assistance they provide. The demonstration of better health outcomes resulting from services in relation to the resources they are given and the local context is a driving force for sustainable health service improvement.

**Who Does What? – Responsibilities of the Service Providers**

Below is a table to help clarify the roles and responsibilities of service providers to enable the pathways outlined in this chapter to operate. The table suggests the essential steps in the pathway that need to occur for each client and provides a general example as to who might take responsibility. In preparing for the implementation of these pathways of care into communities, each Primary Health Centre can identify for themselves who is best placed to carry out each activity in their own setting on a daily basis.

<table>
<thead>
<tr>
<th>Suggested Service Provider</th>
<th>Activity</th>
<th>How</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entire staff of the Primary Health Centre supported by Mental Health Educators, Districts &amp; Northern Area Health Service</td>
<td>Raise awareness in community and health centre about importance and roles that everyone can play in promoting social and emotional wellbeing for all</td>
<td>Mental health education &amp; promotion activities, Work together with community groups, put pathways in place to provide good primary mental health care.</td>
<td>Continuous</td>
</tr>
<tr>
<td>Entire health staff especially Indigenous Health Workers</td>
<td>Encouraging people to come to the Health Centre for health checks and when they or their family feel loss of social and emotional wellness.</td>
<td>Everyday talk and yarning in community, with organisations like Men’s, Women’s and Youth groups, CDEP groups, schools</td>
<td>Constantly</td>
</tr>
<tr>
<td>Generalist Primary Health Care Workers</td>
<td>Complete Adult Health Check Screen, yarning about social emotional wellbeing, complete a referral to Identified Indigenous Health/Mental Health Worker if indicated noting level of urgency and enter data onto Ferret system.</td>
<td>See pathway 1 and 3 As per Health Check</td>
<td>Once yearly for AHC screen, when there is concern or any time. Ensure timely or urgent referral to Identified Worker</td>
</tr>
<tr>
<td>Identified Indigenous Health/MH Worker</td>
<td>Engage with client and family to explain follow up process, answer questions, provide ongoing support</td>
<td>See pathway 2 and 3</td>
<td>Immediately upon referral.</td>
</tr>
<tr>
<td>Recommended Service Provider</td>
<td>Activity</td>
<td>How</td>
<td>When</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Clinician with Mental Health experience together with Indigenous Health/ Mental Health Worker</td>
<td>Carry out the second assessment, make decision on referral, complete care plan with the client and family and process referrals, speak to MH clinician urgently for advice and action if needed. Enter data on Ferret.</td>
<td>See pathway 2 and 3</td>
<td>Immediately upon referral and responding with appropriate urgency.</td>
</tr>
<tr>
<td>Mental Health clinician in partnership with Indigenous Health/ Mental Health worker, consumer and family</td>
<td>Complete mental health assessments Case Manager to work with Health Worker and family to prepare for patient’s return to community and implement discharge/ Stay Strong plan Enter data on CESA, Outcomes Info system.</td>
<td>See Pathway 4 and 5</td>
<td>Initially, then followed up with periodic reviews. Outcomes data collected every 3 months or more frequent if required.</td>
</tr>
<tr>
<td>Identified Indigenous Health/ Mental Health Worker.</td>
<td>Follow up with Mental Health clinician to update care plan and Ferret to include any additional therapeutic plans. Discuss with and support the client and family to follow the plans or make adjustments if needed. Assist the Mental Health Clinician in engaging consumer and family in any clinical assessments and outcome ratings. Enter data on Ferret.</td>
<td>See Pathway 4</td>
<td>Ongoing reviews as indicated could include daily contact and frequent support.</td>
</tr>
<tr>
<td>Local Clinician with Indigenous Health/MH Worker.</td>
<td>Regularly review progress of client and care plan and discuss local support. Adjust support as required.</td>
<td>See Pathway 3, 4 and 5</td>
<td>Three monthly to keep Clinician informed.</td>
</tr>
</tbody>
</table>
Specific Care Pathways and Tools

A pathway for each stage of care for social and emotional wellbeing and mental ill health with risk identification, referral and treatment options is outlined below. Please note in every step of the way, social emotional and mental health assessment and care should involve the client, their family, other natural helpers and Indigenous health/mental health workers wherever possible.

OVERALL PATHWAY FOR ALL CLIENTS

This is the overall pathway for care of all clients accessing health services. It aims to provide a blueprint to ensure all appropriate actions are undertaken to support clients to stay strong or recover and facilitate smooth movement between all levels of care.

PATHWAY ONE SIGNALLING SOCIAL AND EMOTIONAL DISTRESS

- **Assessment Tool: Social & Emotional Wellbeing Questions and Instructions**
- **Brief Intervention Tools: Help Sheets**

Pathway 1 demonstrates the activities of the Primary Health Care team to work with the client to identify any social emotional distress they are experiencing through the Adult Health Check screening process, opportunistic presentation or informal referral. These questions form the basis of subsequent support activities. It is an important way to alert health services that someone is having problems coping with a physical illness, such as diabetes or heart disease, or with social circumstances. For those who are only occasionally experiencing negative emotions, a brief intervention tool is provided. Through this pathway, clients who may be experiencing significant distress are identified and given access to Pathway 2 which facilitates more detailed social and emotional support and possibly mental health care.

PATHWAY TWO DETERMINING URGENCY AND LEVEL OF CARE AND SUPPORTING WELLBEING

- **Assessment Tool: Decision Support Tool**
- **Intervention Tool: Stay Safe Plan & Staying Strong Plan**

Pathway 2 demonstrates the care pathway for people who are frequently experiencing social and emotional distress and/or may be at risk of self-harm. The aim of this pathway is to provide a tool, the Decision Support Tool, for determining whether a person is best assisted by the Primary Health Care team or if non-urgent or urgent mental health clinical support should also be provided. At the same time, a Staying Strong Plan tool is completed with the client and family to identify strengths and sources of worry and distress and set simple goals to promote engagement in wellbeing support activities.

The Stay Safe Plan guides discussions and action that must occur if someone, either in screening or in any other context, indicates that they think about harming or killing themselves at a level which merits urgent concern. This pathway, combined with support for other community initiatives, aims to ensure that the health service plays an effective role in reducing the incidence of self-harm or suicide and, once the crisis is addressed, putting in place steps to promote recovery and maintenance of wellbeing of the individual and family.

This pathway also emphasises the need for immediate referral if the person appears to be experiencing a mental health crisis or is at serious risk of suicide.
PATHWAY THREE TOOLS AND PROCESSES FOR MENTAL HEALTH CARE

Guide: Principles of Assessment

Tools: AIMhi NT Care Plan
Stay Strong Family & Clinic Support Care Plan

National, State, Regional and Health Service Specific Tools as relevant to each service can be inserted (for example in Queensland this would include Consumer Care Review Summary, Principles for completing assessments with Indigenous consumers, Outcome Measures – HONOS, LSP, Mental Health Inventory, etc.)

There are many tools and processes developed for mental health care; given their geographical variation and administrative requirements, these are not detailed or provided here. The AIMhi NT developed and trialed Care Plan – renamed the Stay Strong Family and Clinic Support Care Plan – is provided because of the support it has been given from providers on the ground as an essential, straightforward tool.

This pathway focuses on the important role of primary health care practitioners in promoting family involvement, emphasises the need for primary health care staff to implement the wellbeing pathways and tools identified in Pathways 1 and 2.

Part Two of this document provides detailed guidelines for consumers, carers, primary health care workers and specialist clinicians to assist in making individual clinical, home and community support decisions.

PATHWAY FOUR REFERRAL TO TERTIARY MENTAL HEALTH OR OTHER CARE AND RETURN TO PRIMARY HEALTH CARE

Tool: Coming Home Plan

National, State, Regional and Health Service Specific Tools as relevant to each service can be inserted (for example in Queensland this would include Recovery - Relapse Prevention Plan, Consumer End of Episode/Discharge Summary)

This pathway provides assistance to primary care staff to support clients returning from hospital, prison, other care facilities or other places of residence. This focuses on communicating with families and Case Managers and engaging clients in support activities to assist them in meeting basic needs and minimise the stress of reengagement associated with their return home. The tool assists supporting staff to ensure that the person has a place to sleep, food, support for employment or recreational/creative activities, support completion of documentation for entitlements such as Centrelink payments, etc. At the same time, the person is supported to indicate whether they are experiencing significant levels of social or emotional distress and if so, provided access to pathways 1 through 3.
Overall Pathway of Care

Social and Emotional Wellness of Family and Person in Community

Social and Emotional Wellness of Person

Maybe threatened or affected

Routine Adult Health Check

No Concerns
Offer Help Sheets

Support Stay

Strong Plan as needed

Presents for any Health Issue

Concerned Clinician or Community Member

Some Concerns Identified

Pathway 1: Screening through SEWB questions on Adult Health Check or opportunistic Screening

Pathway 2: Decision Support Tool Assessment of SEWB Complete Staying Strong Plan

Concerns Confirmed

SEWB Impairment or Loss does not require secondary or tertiary management Support Stay Strong Plan in Primary Care

SEWB Impairment or Loss/Suspect Mental Health Illness requires secondary or tertiary management Support Stay Strong Plan in Primary Care

No safety concerns Safety concerns

Pathway 3: Referral to Mental Health Specialist

Pathway 2: Implement Stay Safe Plan

Non urgent referral Urgent referral in community Evacuation to hospital

Case Manager & Primary Health Care support recovery and Staying Strong Plan

Pathway 4: Discharge Plan & Coming Home Plan

Community and Health Centre Support for Recovery of Social and Emotional Wellness

Local Protocols and Referral Systems Established

Community and Health Centre Support for Recovery of Social and Emotional Wellness

Social and Emotional Wellness of Person

Maybe threatened or affected

Pathway 1: Screening through SEWB questions on Adult Health Check or opportunistic Screening

No Concerns
Offer Help Sheets

Support Stay

Strong Plan as needed

Presents for any Health Issue

Concerned Clinician or Community Member

Some Concerns Identified

Pathway 2: Decision Support Tool Assessment of SEWB Complete Staying Strong Plan

Concerns Confirmed

SEWB Impairment or Loss does not require secondary or tertiary management Support Stay Strong Plan in Primary Care

SEWB Impairment or Loss/Suspect Mental Health Illness requires secondary or tertiary management Support Stay Strong Plan in Primary Care

No safety concerns Safety concerns

Pathway 3: Referral to Mental Health Specialist

Pathway 2: Implement Stay Safe Plan

Non urgent referral Urgent referral in community Evacuation to hospital

Case Manager & Primary Health Care support recovery and Staying Strong Plan

Pathway 4: Discharge Plan & Coming Home Plan

Community and Health Centre Support for Recovery of Social and Emotional Wellness

Local Protocols and Referral Systems Established

Community and Health Centre Support for Recovery of Social and Emotional Wellness

Social and Emotional Wellness of Person

Maybe threatened or affected

Pathway 1: Screening through SEWB questions on Adult Health Check or opportunistic Screening

No Concerns
Offer Help Sheets

Support Stay

Strong Plan as needed

Presents for any Health Issue

Concerned Clinician or Community Member

Some Concerns Identified

Pathway 2: Decision Support Tool Assessment of SEWB Complete Staying Strong Plan

Concerns Confirmed

SEWB Impairment or Loss does not require secondary or tertiary management Support Stay Strong Plan in Primary Care

SEWB Impairment or Loss/Suspect Mental Health Illness requires secondary or tertiary management Support Stay Strong Plan in Primary Care

No safety concerns Safety concerns

Pathway 3: Referral to Mental Health Specialist

Pathway 2: Implement Stay Safe Plan

Non urgent referral Urgent referral in community Evacuation to hospital

Case Manager & Primary Health Care support recovery and Staying Strong Plan

Pathway 4: Discharge Plan & Coming Home Plan

Community and Health Centre Support for Recovery of Social and Emotional Wellness

Local Protocols and Referral Systems Established
Pathway One: Signalling Social and Emotional Distress

Assessing the Social and Emotional Wellness of Person and Family in Community

Social and Emotional Wellness of Person maybe threatened or affected

Pathway One

Responses from the consumer to the 6 questions of the SEWB screening tool on the Adult Health Check

<table>
<thead>
<tr>
<th>Feeling Sad, Nervous or Angry</th>
<th>Self-Harm / Suicide Thinks about hurting or killing themself</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questions 1 - 5</td>
<td>Question 6</td>
</tr>
<tr>
<td>‘not at all’ and you have no concerns</td>
<td>‘most of the time’ or ‘all of the time’ to any question or you have urgent concerns</td>
</tr>
<tr>
<td>‘a little.’ or ‘some of the time’ or you have some concerns about them</td>
<td>‘a little’ or ‘some of the time’ or you have urgent concerns</td>
</tr>
</tbody>
</table>

Crisis situation, risk of suicide, or relapse of existing mental illness

Assessment
- Risk Assessment
- Primary Clinical Care Manual
- Mental State Exam
- Stay Strong Family & Clinic Support Care Plan
- Other Tool

Offer Support & Information
- Staying Strong Plan

Brief Intervention and tip sheets on Feelings

Urgent Social Emotional Wellbeing follow up and/or Risk Assessment

Refer to:
- Pathway 2 Decision Support Tool
- Staying Strong Plan These Guidelines

Client and carer can be supported at home by Primary Care Worker

Routine Adult Health Check

Presents for any health issue

Concerned Clinician or Community Member

Client and carer can be supported at home by Primary Care Worker

Routine Adult Health Check

Presents for any health issue

Concerned Clinician or Community Member
Social & Emotional Wellbeing Questions & Instructions

Everyone experiences stress in their lives at one time or another. People become “distressed” if levels of “stress” build up on top of each other and cause feelings (like strong anger, deep sadness or too much worry) that affect health and enjoyment of life. People with physical sickness like diabetes, who experience a lot of stress, may have a harder time making changes to protect their health. This is when people may need extra help from families, community members and the Health Mob to manage feelings of mental/emotional stress like depression and anxiety. Without that help, feelings of stress can happen often and get really strong. If someone is feeling this way most or all of the time, they may benefit from further assessment, following initial identification.

Identifying impairment to a person’s social emotional wellbeing usually occurs in one of several ways. A person may present to health centre with acknowledgement of feelings that are not usual, for example, feeling excessively sad, angry or worried. Secondly, a person’s family or friends may identify to the health centre staff that the person is not behaving or presenting themselves as usual. The family or friend may have identified some strange or unusual statements or actions of the person. A third method of identification can occur during health check screening in routine practice. Or, impaired social emotional wellbeing might be identified during a persons routine chronic disease check up, for example, difficulty coping with a diagnosis.

Screening

Health Checks are a tool that is used by the Northern Area Health Services to ensure that every resident of an Indigenous community is checked at least once per year across a basic range of health issues. These include checks for diabetes, heart disease, kidney disease and risk factors that contribute to chronic physical illness, such as obesity, poor nutrition, smoking and alcohol consumption. The health checks also include questions that ask about feelings, for example how often the person feels happy, sad or nervous.

As explained in Chapter One, people’s feelings and mental/emotional wellbeing are very important to their health. Having screening questions for wellbeing alongside those for physical health will remind everyone that helping people with mental/emotional stress is an important part of health care. It is important to remember that these questions are not being asked to decide if a person has a mental illness or not. Instead, they are a tool to let health service providers know when a person might benefit from more talk about the levels of stress they are experiencing in their lives. The questions added to the health check for adults are shown below.

Why these questions?

There are many kinds of screening questions used to measure a person’s emotional and social wellbeing. We have selected questions from a well-known screening tool, the Kessler questionnaire, because:

- It is simple, quick and to the point for screening common emotional problems;
- It has been used successfully around the world, including in the National Aboriginal and Torres Strait Islander Health Survey; and
- Other states and territories are adopting similar questions for health screening.
We have added the first item ‘happy in yourself’ in order to start with positive aspects of emotional wellbeing. Three more questions were added to ask about anger, self-harm and your views as a health worker about the client. They are added because:

- they are needed to meet the specified Medicare requirements; and
- they allow you to provide other information about someone you are concerned about even when their answers don’t suggest they may benefit from help.

Getting the right answer
Two parts of the questions need attention, the questions and the range of answers. Before you begin to ask questions, tell the person: I will be asking you to tell me how many times have you had different feelings in the past month:

- not at all
- a little of the time (less than one week of the month)
- some of the time (one but less than two weeks)
- most of the time (more than two weeks of the month but not all the time)
- all the time.

After you have briefly explained the possible range of answers with the person, you can ask the question for each item. If the person has trouble understanding those words, you may use words that you know will make them feel more comfortable. The following table suggests some words to use for each item.

<table>
<thead>
<tr>
<th>Item on the Health Check form</th>
<th>Suggestions for other ways to explain the item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Happy in your self?</td>
<td>Like your life is going well and you are happy being the person that you are</td>
</tr>
<tr>
<td>So sad that nothing could cheer you up?</td>
<td>Down and depressed and nothing makes you feel better</td>
</tr>
<tr>
<td>Nervous?</td>
<td>Anxious, worried, like something bad is going to happen</td>
</tr>
<tr>
<td>Restless and jumpy?</td>
<td>Like you can’t relax your body or calm down</td>
</tr>
<tr>
<td>That everything was an effort?</td>
<td>Like you can’t be bothered to do even easy things</td>
</tr>
<tr>
<td>Angry at yourself or others?</td>
<td>That ‘hot feeling’ of anger like you might not be able to control yourself</td>
</tr>
<tr>
<td>Like you might hurt yourself?</td>
<td>You feel like cutting, slashing or killing yourself</td>
</tr>
</tbody>
</table>
Steps for recording responses
1. On the form, you can see the possible answers across the top. For each item, you will need to tick the box that matches to the answer they give.
2. There are no response guidelines for the ‘happy in yourself’ question yet because it is being tested for the first time to see if it is useful.
3. If the person is not able to answer the question, tick the box for ‘Don’t know’.
4. If they refuse to answer the question, tick the ‘Refused’ box.
5. If you find you are having trouble with a number of people not understanding or refusing to answer any particular item, email or ring the Chronic Disease Team to let us know about the problem.
6. The Health Worker Item - Sometimes the Health Worker / Health Care Professional might have heard from the person’s friends or a family member, or you may have noticed something that makes you feel concerned about this person, even if they don’t tell it in their answers. This last question gives you an opportunity to record your concern by ticking the appropriate box. You may have an urgent concern (tick ‘Yes, Urgent’), some concern but not urgent (tick ‘Yes, Not Urgent’), no concern (tick ‘No’) or you may feel you don’t know the person well enough to say (tick ‘Don’t Know’).

Responses
There are three levels of response according to the client’s answers. These are
• Referral (shaded in dark orange)
• Brief Intervention (shaded in pale orange)
• Offering Information (shaded in yellow).
These will not be coloured on the Health Check form.

<table>
<thead>
<tr>
<th>In the last 4 weeks, how often did you feel ...</th>
<th>All of the Time</th>
<th>Most of the Time</th>
<th>Some of the Time</th>
<th>Little of the Time</th>
<th>Not at all</th>
<th>Don’t know</th>
<th>Refused to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Happy in yourself?</td>
<td>Response guidelines to be developed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 So sad that nothing could cheer you up?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Nervous?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Restless and jumpy?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 That everything was an effort?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Angry at yourself or others?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Like you might hurt yourself?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Do you think that this person has changed his or her behaviour or is there anything about him/her that makes you concerned about their mental health?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes - Urgent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes - Not Urgent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t Know</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Referral (Answers in the dark orange area)
Refer the person to the designated mental health worker (or medical officer or the director of nursing) if:
- They answer ‘most of the time’ or ‘all of the time’ to one or more of the items (not including the happy question) OR
- They say that they think about harming themselves at any time (little, some, most or all of the time) OR
- You have urgent concerns for them.

Procedure
1. Ask if the person is talking to anyone about the feelings they are having.
2. Let them know having these feelings often can harm health and wellbeing.
3. Tell them there may be ways for the Health Mob to help them deal with the feelings.
4. Ask if they would be willing to meet with the designated mental health worker to talk more about how they are feeling.
5. Arrange for the person to see the worker immediately or as soon as possible.
6. Document your action in the person’s chart.

Brief Intervention (Answers in the pale orange area)
Offer a brief intervention if:
- They answers ‘a little..’ or ‘some of the time’ to one or more of the 5 items (pale orange) OR
- You have some concerns (but not urgent concerns) about them.

Procedure
1. Tell the person that these feelings are part of everyone’s life, but shouldn’t be ignored because they may cause problems if they get worse. Give a Help Sheet that matches the emotion they are feeling.
2. Work with them to complete a Staying Strong Plan that outlines their strengths and sets some small goals to help deal with these feelings.
3. Encourage them to talk to others (family, health worker, pastor, etc) when feeling this way.
4. Suggest the person seek help if the feelings come more often or get stronger.
5. Document your action in the person’s Medical Record (chart).

Offering Information (Answers in the yellow area)
No specific action is required if:
- Their response to all of the items (except ‘happy in yourself’) is ‘not at all’ AND
- You have no concerns.

Thank them for answering and feel free of offer a Help Sheet if they want to read more about emotions and feelings.
TIP SHEET – FEELING SAD

Do you feel sad all the time?
Everyone will feel sad at different times during their life. It is common to experience different “moods” like a “happy” mood or “sad” mood, even a “depressed” mood. Sometimes things happen in your life that causes your mood to change:

- When someone you care for moves away
- Have little or no money
- Being under pressure at work
- Having no job or nothing to do
- Feel lonely and no one to talk to
- When someone you love dies
- After you have a baby

If you are feeling down, there are things you can do to help yourself feel better, like being with people that make you happy and sharing activities like:

<table>
<thead>
<tr>
<th>Fishing and Hunting (going out bush)</th>
<th>Talking to family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Art, music, dance or cultural activities</td>
<td>Talking to someone you trust</td>
</tr>
<tr>
<td>Walking or jogging</td>
<td>Talk to a health worker</td>
</tr>
<tr>
<td>Playing a sport like football or softball</td>
<td>Eating good foods like fresh fruit and veggies</td>
</tr>
<tr>
<td>Doing relaxing things (yarning)</td>
<td></td>
</tr>
<tr>
<td>Going to Men’s or Women’s groups</td>
<td></td>
</tr>
</tbody>
</table>

You might think these things might help you to relax, but really they make things worse:

- Drinking alcohol
- Smoking yarndi
- Smoking cigarettes

Sometimes these sad feelings keep coming and stay with you for a long time. You might feel:

- So sad that nothing could cheer you up or make you feel happy again
- Like you don’t want to talk and laugh with family anymore
- You want to be on your own all the time
- Slack and don’t want to do your favorite activities
- Like you try to do things but it takes a lot of your energy
- Forgetting to do things that you normally would do all the time
- You’re not getting much sleep anymore, or you sleep all the time and don’t want to get out of bed
- Like you are not good enough
- Sick or like you can’t eat or want to vomit a lot of the time
- Like you want to hurt yourself

When these feelings are really strong, they don’t go away and they stop you from being able to normal things that you like to do, then you will benefit from talking to people with professional experience. You can talk about how to get help by talking with your health worker or a nurse at the clinic.
TIP SHEET – FEELING NERVOUS

Feeling nervous a lot of the time?

Everybody feels nervous at different times and this can cause feelings of worry. Sometimes you worry about things that may or may not happen. You might feel:

- Restless or jumpy and not be able to settle down and relax
- Like you have butterflies in your stomach
- Like you are scared
- Like you don’t want to bathe each day or wear washed clothes
- Like your heart is beating faster than normal
- Your mouth is dry and you want to drink a lot of water
- Like your body is trembling or shaking
- You are sweating a lot
- Sick or like you want to vomit

It is normal to have these feelings when you are in a scary, dangerous or unknown situation but they go away when you settle down. It is important to keep an eye on these feelings. If these feelings are really strong all the time and they stop you from being able to normal things that you like to do, then there are some things you can do to help make sure they don’t take over your life or prevent you from doing the normal every day things you like to do.

THERE ARE SOME BREATHING EXERCISES THAT CAN ASSIST YOU TO CALM THOSE FEELINGS DOWN!

Other things you can do to help deal with these feelings and may make you feel calm and relaxed again are:

<table>
<thead>
<tr>
<th>Being with people who you know will support you</th>
<th>Doing relaxing things (yarning)</th>
<th>Fishing and Hunting (going out bush)</th>
<th>Art, music, dance or cultural activities</th>
<th>Walking or jogging</th>
<th>Playing a sport like football or softball</th>
<th>Talk to family</th>
<th>Talk to someone you trust</th>
<th>health worker</th>
<th>Eating good food and drinking water regularly too</th>
</tr>
</thead>
</table>

Sometimes you might be tempted to do these things, but they make things worse:

- Drinking alcohol
- Smoking cigarettes
- Smoking yamdi

If you decided or chose to give them up altogether – That would be GREAT!

If you feel nervous like this often or always and it doesn’t go away, you can:

- Talk to your family or carer
- See your health worker or nurse at the Primary Health Clinic who can give you more information and help you.
- Go along to your Men’s or Women’s group in your Community
- Go along and talk to people at your local church or other groups that support you.
Tool for Pathway One: Emotional Help Sheets

TIP SHEET – FEELING CONFUSED, HEARING VOICES

Confusing thoughts? Jumpy mind? Hearing Voices?

Some times people have thoughts and feelings that don’t make any sense to them or to people around them. It’s a bit like having a dream when you are wide awake. This can be frightening and people might feel that they are all alone. Sometimes these thoughts and feelings can interfere with your normal living or enjoyment of the things that would normally interest you.

Some of the things that can happen are:
- Losing interest in friends and not wanting to be with other people
- Losing interest in doing things that you like doing
- You might not want to bath each day and wear clean clothes
- Get so worried about things that you can’t sleep
- Restlessness and jumpy
- Not being able to pay attention, concentrate or make any plans
- Your thinking might be jumbled and unclear
- Strange behaviour
- Thoughts and speech jumping around (not making sense when talking)
- Feeling sad

People can also believe that:
- They believe in something that no one else believes is true
- They see or hear things that are not really there
- Someone around you can read your mind or your thoughts
- They feel like they have to do the same thing over and over again

These beliefs can be dangerous sometimes if the voices are telling you to do something that can hurt you or someone else.

These things can be distressing even if they are minor. Sometimes the most distressing part about it is being alone and feeling that no one can help you. In fact there are lots of things you can do yourself and others can do to help you to deal with these feelings.

The first step might be to let someone you trust know how you are feeling and what you are experiencing. It may also help you to stay involved in the things that you enjoy. They might be some of the things listed below.

<table>
<thead>
<tr>
<th>Being with people that make you happy and sharing activities like:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fishing and hunting (going out bush)</td>
</tr>
<tr>
<td>• Art, music, dance, cultural activities</td>
</tr>
<tr>
<td>• Walking or jogging</td>
</tr>
<tr>
<td>• Playing sport, like football or softball</td>
</tr>
<tr>
<td>• Doing relaxing things (yarning)</td>
</tr>
<tr>
<td>• Talk to family</td>
</tr>
<tr>
<td>• Talk to someone you trust</td>
</tr>
<tr>
<td>• Talk to a health worker</td>
</tr>
<tr>
<td>• Eat fresh fruit and vegies regularly</td>
</tr>
<tr>
<td>• Drink water regularly</td>
</tr>
</tbody>
</table>

These things can help you to stay actively involved and contribute in a meaningful way in your family and in your community

IF YOU EXPERIENCE ANY OF THE THINGS LISTED ABOVE, PLEASE SEE THE INDIGENOUS HEALTH WORKER OR A NURSE AT YOUR LOCAL PRIMARY HEALTH CARE CENTRE.
**Tools for Pathway Two**

**Determining Urgency & Level of Care Supporting Wellness**

Pathway 1: There are concerns that the Social and Emotional Wellness of the Person may be threatened or affected

Pathway 2: Team Commences Decision Support Tool (DST)

Complete Parts 1 – 4 and a Staying Strong Plan identifying strengths, supports, difficulties, goals & steps

Complete Part 5: Does Part 5 of DST reveal safety concerns for consumer? (i.e. Is the person feeling hopeless or no good to anybody and having self harm and suicidal thoughts?)

- No safety concerns identified
- Safety concerns identified but no plan
- Urgent Safety Concerns & evidence of plan

Complete & implement Stay Safe Plan

**Part 7: Summary of Referral Decision**

- Person is experiencing social and emotional distress and/or signs of concerning behavioural changes. (Documented in Part 6)
  - Not at all
  - Only a Little
  - Partly Yes
  - Fully Yes

- Person seems to be using drugs or alcohol in a way that may be promoting these emotional difficulties and affecting their mental health.
  - Not at all
  - Only a Little
  - Partly Yes
  - Fully Yes

**THE TEAM RECOMMENDS URGENT MENTAL HEALTH ATTENTION**

Referral Contact MH Service Immediately

Pathway 4: Social Emotional Wellbeing Impairment / Loss / Disorder may require Tertiary Care

Agreement has been reached that the person along with family and/or carer would like continued support from the following:

- Within the Community
- Primary Health Staff
- ATODS
- Mental Health Specialist
Decision Support Tool

Client’s Name ________________  Date ________  Location ________________

Interviewing Team Names  Positions
_________________________________  __________________________
_________________________________  __________________________
_________________________________  __________________________

Fill out the questions below before the client arrives and have a yarn with the team who is present.

1. How well do you know this person? (choose the response matching the Team member with most familiarity with the client)

   Not at all  Only a Little  Quite Well  Very Close

2. How often have you (the Team), seen this person in the community in the past month?

   Daily  Few times a week  Once a Week  Less than once a week

3. Are you aware of other people being concerned/worried about this person’s wellbeing?

   No one is concerned that I know of  People are very concerned
   People are a little concerned  It is not likely that I’d know if people are concerned / worried

4. Did this person complete an Adult Health Check with Social & Emotional Wellbeing Questions?

   Yes  What Date ____________?
   No
What is the Reason for this Referral today *(tick all that apply)*?

i) Health worker is concerned about this person

ii) Community member raised concerns about this person

iii) When asked the SEWB questions in the screening, the client said that most or all the time, he/she are feeling:

| Sad or everything was an effort | Nervous or restless and jumpy | Angry with yourself or others | Feeling like you might hurt yourself | Other ________  
_________________________
_________________________

iv) If the client has been referred because a Health Worker was concerned about him/her, please discuss the reasons for this with that Health Worker to help you *(the team)* know what you might be looking for in this interview.

_________________________
_________________________

6. Besides the interviewing team, who else is present today? *(tick all that apply)*

| Client only | Family member/s | Friends | Health Worker known to client | Other ________  
_________________________
_________________________

Instructions!!!!

There is no right or wrong way to complete this interview – relax, be yourself and let the person do most of the talking if you can – your job is to “open the door”.

You may start by explaining to the client the reason for the referral, tell them that you are not there to do anything fancy – only to give them a chance to talk about how they are feeling and maybe help them to choose some things they’d like to do.

Tell them you’ll ask some guiding questions along the way.

⚠️ Regardless of the reason for referral, you should start the yarning with this question about strengths. Be sure to return to this question at the end to remind the person about the things that make them strong.
**Part 1. Starting from Strengths**

*In the last 4 weeks, how often did you feel…. (Circle their response)*

<table>
<thead>
<tr>
<th>Happy in yourself?</th>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
<th>Don’t know</th>
<th>Refused to answer</th>
</tr>
</thead>
</table>

1. What things made you feel strong and happy in the last month?

- [ ] Family
- [ ] Friends
- [ ] Activities
- [ ] Nothing
- [ ] Other things:
  
  __________________________
  __________________________
  __________________________

2. Can you think back further to a time in your life when you felt stronger and happier?

- [ ] Yes, I can
- [ ] No, I can’t

3. What things made you feel strong and happy at that time?

- [ ] Family
- [ ] Friends
- [ ] Activities
- [ ] Nothing
- [ ] Other things:
  
  __________________________
  __________________________
  __________________________
4. Who are the people who help you feel strong?

5. Are you having any problems now in being with these people?
   - [ ] No
   - [x] Yes

6. Are you having any problems in doing things that you enjoy?
   - [ ] No
   - [x] Yes

7. Are there things you’d like to do to feel happy more often?
   If so, what are they? __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

Look out for lack of people and activities in the person’s life and/or for problems the person may be having with those people or in doing those activities (access or relationship issues).

Remember the person may be struggling with grief and loss (e.g. if the person who used to make them happy has passed away) and may need help to identify things that can be done.
### Part 2. Feeling Sad or Slack, No Energy

Now I want to ask you a couple of questions about feeling sad or slack. Can you tell me how often in the last 4 weeks, did you feel..... (Circle their response)

<table>
<thead>
<tr>
<th>Question</th>
<th>All of the Time</th>
<th>Most of the Time</th>
<th>Some of the Time</th>
<th>Little of the Time</th>
<th>None of the Time</th>
<th>Don’t know</th>
<th>Refused to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>So sad that nothing could cheer you up? (Nothing can make you feel better)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tired out for no good reason</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>That everything was an effort? (felt like you couldn’t be bothered to do anything)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the person is in the amber or red area, help them explore the reasons why they feel sad or tired and how long they have been feeling this way.

You also need to find out what impact this is having on the person – how much distress it is causing and how much it is interfering with their everyday life.

If the person says they feel sad or slack because of alcohol or drugs, see if they are interested in seeing somebody who can help them with that.

### What takes away our strength?

![Image](https://via.placeholder.com/150)

Adapted from AIMHI – Northern Territory materials

Here are some suggested questions to help get you and the client talking about the reasons why he/she is feeling like this:

“\[You said you have been feeling sad or slack, like you have no energy lately. Can we talk about this a little bit more and explore some ways to help with that?\]”

Look out for:
- Loss of something very important to them
- Death in the family. Is this person moving towards coming to terms with the death or do they seem to be unable to see ahead?
- Any concern they have with drug or alcohol use.

Find out if the person is hopeful:
- Can you see that things will change for the better for you?
- What can you do to help yourself feel sad less often?

Is there anything else that you notice about this person's sadness or lack of energy that may be important?

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Social and Emotional Wellbeing and Mental Health Protocols  
Collaborative Research on Empowerment and Wellbeing, University of Queensland & Queensland Health
Part 3. **Anxious or nervousness**

Now I want to ask you a few questions about feeling anxious or nervous. **In the last 4 weeks, how often did you feel………** (Circle their response)

<table>
<thead>
<tr>
<th>Nervous (or Anxious)?</th>
<th>All of the Time</th>
<th>Most of the Time</th>
<th>Some of the Time</th>
<th>Little of the Time</th>
<th>None of the time</th>
<th>Don’t know</th>
<th>Refused to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restless (or jumpy)?</td>
<td>All of the Time</td>
<td>Most of the Time</td>
<td>Some of the Time</td>
<td>Little of the Time</td>
<td>None of the time</td>
<td>Don’t know</td>
<td>Refused to answer</td>
</tr>
<tr>
<td>So nervous that nothing could calm you down?</td>
<td>All of the Time</td>
<td>Most of the Time</td>
<td>Some of the Time</td>
<td>Little of the Time</td>
<td>None of the time</td>
<td>Don’t know</td>
<td>Refused to answer</td>
</tr>
<tr>
<td>So restless that you could not sit still</td>
<td>All of the Time</td>
<td>Most of the Time</td>
<td>Some of the Time</td>
<td>Little of the Time</td>
<td>None of the time</td>
<td>Don’t know</td>
<td>Refused to answer</td>
</tr>
</tbody>
</table>

If the person is in the amber or red area, help them explore the reasons why they feel nervous or restless and how long they have been feeling this way.

You also need to find out what impact this is having on the person – how much distress it is causing and how much it is interfering with their everyday life.

If the person says they feel nervous or restless because of alcohol or drugs, see if they are interested in seeing somebody who can help them with that.

---

What things have made you feel nervous or jumpy?

_________________________________

_________________________________

_________________________________

Do you avoid people and situations in order to feel safe?

☐ No

☐ Yes

Has made you stop doing things you enjoy?

☐ No

☐ Yes

Have you been using alcohol or other drugs to deal the nerves?

☐ No

☐ Yes

Would you like to see somebody who can help you cut down the alcohol or drugs?

☐ No

☐ Yes

---

Here are some suggested questions to help get you and the client talking about the reasons why he/she is feeling like this:

“You said you have been feeling nervous and humpy lately. Can we talk about this a little bit more and explore some ways to help with that?”

Look out for:

- Anxiousness that goes beyond the danger of the situation.
- Inability to calm down through any means.
- Lack of support or isolation from others.
- High levels of distress.
- Any concern they have with their use of drugs or alcohol.

Find out if the person is hopeful:

- Can you see that things will change for the better for you?
- What can you do to help yourself calm down and relax?
Part 4. Anger

Now I want to ask you a few questions about feeling angry.

In the last 4 weeks, how often did you feel... (Circle their response)

<table>
<thead>
<tr>
<th></th>
<th>All of the Time</th>
<th>Most of the Time</th>
<th>Some of the Time</th>
<th>Little of the Time</th>
<th>None of the Time</th>
<th>Don't know</th>
<th>Refused to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angry at yourself or others?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the person is in the amber or red area, help them explore the reasons why they feel angry and how long they have been feeling this way.

You also need to find out what impact this is having on them – how much distress it is causing and how much it is interfering with their everyday life.

If the person says they feel angry because of alcohol or drugs, see if they are interested in seeing somebody who can help them with that.

What things have made you feel angry?

_________________________________

_________________________________

_________________________________

Do you stay away from people or situations to avoid feeling or doing angry things?

☐ No

☐ Yes

Are you worried you might lose control and hurt somebody or do something because of these angry feelings?

☐ No

☐ Yes

Have you stopped doing things you enjoy because of the angry feelings?

☐ No

☐ Yes

Have you been using alcohol or other drugs to deal with your anger?

☐ No

☐ Yes

Would you like to see somebody who can help you cut down the alcohol or drug?

☐ No

☐ Yes

Here are some suggested questions to help get you and the client talking about the reasons why he/she is feeling like this:

“I understand from your Adult Health Check that you said you have been feeling nervous or restless lately. Can we talk about this a little bit more and explore some ways to help with that?”

Look out for:

- Anger that doesn’t go away and causes distress
- Anger that goes beyond the situation (reacting to small things).
- Anger or frustration caused by or made worse by things the person has no control over.
- Lack of support or isolation from others
- A lack of skills to deal with the anger safely.
- Using drugs or alcohol to deal with the angry feelings.

Find out if the person is hopeful:

- Can you see that things will change for the better for you?
- What can you do to help yourself feel less angry or deal better with the angry feelings?
- Are you interested in getting help in learning how to deal with the feelings and become less angry?

Is there anything else that you notice about this person’s anger that may be important?
Part 5. Feeling hopeless or no good to anybody
Having Self-harm or suicidal thoughts

Now I want to ask you a few questions about how you see yourself.

In the last 4 weeks, how often did you feel…. (Circle their response)

<table>
<thead>
<tr>
<th>...Worthless (no good to anybody)</th>
<th>All of the Time</th>
<th>Most of the Time</th>
<th>Some of the Time</th>
<th>Little of the Time</th>
<th>None of the time</th>
<th>Don’t know</th>
<th>Refused to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>...You had no hope for the future</td>
<td>All of the Time</td>
<td>Most of the Time</td>
<td>Some of the Time</td>
<td>Little of the Time</td>
<td>None of the time</td>
<td>Don’t know</td>
<td>Refused to answer</td>
</tr>
</tbody>
</table>

What things have made you feel hopeless or worthless?

___________________________________________________________________________
_________________________________________________________________________

Do you stay away from people or situations when you feel like this?

No
Yes

Have you stopped doing things you enjoy when you have these feelings?

No
Yes

Have you been using alcohol or other drugs to deal with these feelings?

No
Yes

Would you like to see somebody who can help you cut down the alcohol or drugs?

No
Yes

In the last 4 weeks, how often did you feel…. (Circle their response)

<table>
<thead>
<tr>
<th>...Like you might hurt yourself on purpose.</th>
<th>All of the Time</th>
<th>Most of the Time</th>
<th>Some of the Time</th>
<th>Little of the Time</th>
<th>None of the time</th>
<th>Don’t know</th>
<th>Refused to answer</th>
</tr>
</thead>
</table>

If the person’s response is in the amber or red area above, Find out from them the answers to the following questions

☐ no ☐ yes Does he/she have a Plan - do they know what they would do?

☐ no ☐ yes Is the plan serious and likely to result in injury or death?

☐ no ☐ yes Does the person have a way to carry out their plan?

☐ no ☐ yes Does the person have a negative view of themself (worthless)?

☐ no ☐ yes Does the person have a negative view of their future (hopeless)?

IF THE ANSWER TO THESE QUESTIONS IS YES, THEN A STAY SAFE PLAN MUST BE COMPLETED DURING THIS CONSULTATION (PATHWAY 3)
adapted from AIMhi NT Tools
Part 6. Change in Behaviour

Do you think that this person has changed his or her behaviour or is there anything about him/her that makes you concerned about their mental health?

<table>
<thead>
<tr>
<th>No</th>
<th>Don’t Know</th>
<th>Yes, Not Urgent</th>
<th>Yes, Urgent</th>
</tr>
</thead>
</table>

This question is included on the Adult Health Check in order to enable Health Workers to express other concerns about a person’s wellbeing. These might be things that are less obvious than the things explored above.

There might be ways you can explore this with the person in the interview, which would be particularly important if this is the only reason why a referral was made.

The Team should discuss this and write comments below on connection with what the initial assessor indicated and what this in depth interview has found.

Team’s thoughts:

________________________________________________________________________

________________________________________________________________________

The questions on the following page might be helpful when considering whether the change identified by the first health worker, if confirmed in this interview, might be indicating an important mental health difficulty for the client. If they don’t seem to be at all appropriate, do not complete them.
Part 7. Summary of Referral Decision

1. Generally, this person seems to have many positive things in their life that seem to be protecting him/her from becoming overwhelmed with problems.

<table>
<thead>
<tr>
<th>Fully Yes</th>
<th>Partly Yes</th>
<th>Only a Little</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. At this time, this person seems to be at risk of becoming isolated or is already isolated from things that make them happy.

<table>
<thead>
<tr>
<th>Fully Yes</th>
<th>Partly Yes</th>
<th>Only a Little</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. In order to help reconnect with things and people that make them happy, this person has identified some achievable things they would like to do.

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Only a Little</th>
<th>Partly Yes</th>
<th>Fully Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Achieving these things will require help from:

<table>
<thead>
<tr>
<th>Within the Community</th>
<th>Primary Health Staff</th>
<th>ATODS</th>
<th>Mental Health Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. At this time, this person’s life seems to be significantly affected by:

   i. Ongoing Sad Feelings:

      | Not at all | Only a Little | Partly Yes | Fully Yes |
      |------------|---------------|------------|-----------|
      |            |               |            |           |

   ii. Feeling excessively anxious or nervous:

      | Not at all | Only a Little | Partly Yes | Fully Yes |
      |------------|---------------|------------|-----------|
      |            |               |            |           |
iii. Feelings of Anger

iv. Feelings of worthlessness or lack of hope that need to be addressed

v. Thoughts and signs that they might harm themself

6. At this time, this person seems to be experiencing changes in their behaviour or thinking that suggest that something may be happening to their mental health.

7. At this time, this person seems to be using drugs or alcohol in a way that may be promoting these emotional difficulties and affecting their mental health.

8. In order to help this person deal with any of these negative emotions (sadness, lack of energy, anxiousness, nervousness, anger) or unexplained or potentially harmful behaviours, this person has identified some achievable things they would like to do.
9. Achieving these things will require help from:

- Within the Community
- Primary Health Staff
- ATODS
- Mental Health Specialist

Part 8. Referral Check List

As a result of this interview, the team and the client have decided and agreed that:

- A social and emotional wellbeing care plan should be completed.
- The client/family would like support to carry out this plan from:
  - 
  - 
  - 
- The client/family would like to see a Mental Health specialist.
- The client/family would like to see an ATODS person.
- The Team has recommended to the client and family that it would be beneficial to see a mental health clinician.
- The Team has recommended to the client and family that it would be beneficial to see someone to talk to about alcohol or other drugs.
- The client does not want to see a MH specialist at this time but wants to first:
  - 
  - 
  - 
- The client does not want to see ATODS person at this time but wants to first:
  - 
  - 
  - 
- The Team recommends that urgent mental health attention be provided.

- Remember to end the interview with a chat about positive things they say in the interview – working from strengths means helping the person see their own strengths as a way of promoting their social and emotional wellbeing. Sometimes when people are having trouble they forget about these positive influences in their lives.
Pathway 2

Planning Tools for Pathway Two

Stay Safe Plan

For when there are serious concerns about self-harm or suicide but not an immediate crisis.

**MY STAY SAFE PLAN**

☐ **S** Support and supervision -

I will stay at __________________________ (place), and I will help __________________________ (person) keep me safe.

☐ **A** Appointment time given for follow up

I will come to the clinic on ______________________ (day, time)

to see __________________________ (person) to talk about my thoughts.

☐ **F** Follow treatment arranged

I have agreed to __________________________

______________________________ (activities) to keep myself safe.

☐ **E** Engagement with their Stay Safe Plan (they think it is good idea)

I am ___ok ___just a bit ok ___not ok at all with this plan.

☐ **R** Resolution or partial resolution (something has changed for the better)

So far we have been able to keep me safer by __________________________

______________________________

adapted from AIMhi NT Tools
Staying Strong Plan

**STAYING STRONG PLAN**

Take a few minutes and think about the family and important people in your life who can help to keep you strong.

- How can you stay strong for the family and people who need you?
- What can you do to teach others?

---

**What keeps you strong?**

Adapted from AIMHI – Northern Territory materials
Sometimes things can affect your strength; what are the things you want to do in your life?

What do you think will help you Stay Strong in the long run? Write them down.

Big Goal 1.

Big Goal 2.

Little Steps 1.

Little Steps 2.
Pathway Three: Mental Health Care

This pathway depicts care of the client with loss of mental health that has been judged as able to be effectively managed within the local service area with the support of a Mental Health clinician. The tools used to help clients in this setting include care plans, use of brief intervention tools, planned and regular follow up and review, outcome measures and local family support mechanisms – many of which can be implemented by local staff or need local staff input.

Guide: Principles of Assessment (Chapter 2 of this Protocols Document)

Suggested Tools: ALMhi NT Care Plan/ Stay Strong Family & Clinic Support Care Plan

National, State, Regional and Health Service Specific Tools as relevant to each service can be inserted (for example in Queensland this would include Consumer Care Review Summary, Principles for completing assessments with Indigenous consumers, Outcome Measures – HONOS, LSP, Mental Health Inventory, etc.)

Each Service can insert the tools that they are required to use into this Section.
### Stay Strong Family & Clinic Support Care Plan

**Date:** ……/……/……

<table>
<thead>
<tr>
<th>PRINCIPLE NAME (AKA)</th>
<th>OTHER NAMES</th>
<th>DOB: ……/……/……</th>
</tr>
</thead>
</table>

People that help to keep me strong: (family, friends, elders, carers)

I trust this person to give advice about my treatment:

**Things that help to keep me strong:**

<table>
<thead>
<tr>
<th>(tick or circle)</th>
<th>(tick or circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture, language, heritage, spiritual belief</td>
<td>Work</td>
</tr>
<tr>
<td>Art and Craft</td>
<td>Music</td>
</tr>
<tr>
<td>Dance</td>
<td>Teaching Children</td>
</tr>
<tr>
<td>Going to Country</td>
<td>Hunting and Fishing</td>
</tr>
<tr>
<td>Health Centre, Health Worker, Doctor</td>
<td>Knowing about illness and treatment</td>
</tr>
<tr>
<td>Medication</td>
<td>Support</td>
</tr>
<tr>
<td>Good diet</td>
<td>Family</td>
</tr>
<tr>
<td>Exercise</td>
<td>Positive Thinking</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
</tr>
</tbody>
</table>

**Some of the worries I have are:**

<table>
<thead>
<tr>
<th>(tick or circle)</th>
<th>(tick or circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture or spiritual worries</td>
<td>Family or relationship worries</td>
</tr>
<tr>
<td>Not many activities eg. music, hunting fishing, art &amp; craft</td>
<td>Feeling alone – not mixing much with others</td>
</tr>
<tr>
<td>Not enough exercise</td>
<td>Not working or trouble at work</td>
</tr>
<tr>
<td>Not taking medication or treatment</td>
<td>Gambling worries</td>
</tr>
<tr>
<td>Physical illness</td>
<td>Not knowing enough about illness and treatment</td>
</tr>
<tr>
<td>Hearing troubles</td>
<td>Feeling anxious or nervous or jumpy</td>
</tr>
<tr>
<td>Not eating well</td>
<td>Violence or other problem behaviour</td>
</tr>
<tr>
<td>Memory worry</td>
<td>Not caring for self: trouble shopping, cooking, cleaning</td>
</tr>
<tr>
<td>Sleep worry</td>
<td>Feeling sad inside, no interest in doing things</td>
</tr>
<tr>
<td>Marijuana, alcohol, cigarettes, other drugs</td>
<td>Mixed up thoughts, paranoid thinking, silly thoughts</td>
</tr>
<tr>
<td>Side effects of medicine: sleepiness, tight muscles, other</td>
<td>Hearing voices or seeing things</td>
</tr>
<tr>
<td>Too much energy, can't slow down, thinking too fast</td>
<td>Self harm behaviour or thoughts of suicide</td>
</tr>
<tr>
<td>Other worry</td>
<td>Other worry</td>
</tr>
</tbody>
</table>

**Details of worries / current issues**

**Past worries: relevant family, medical, psychiatric and forensic history (trouble with the police or the law)**

**Early warning signs of me getting sick are:**

1.  
2.  
3.  
4.  

**If I know I am getting sick I will do these things to get help quickly:**

1.  
2.  
3.
<table>
<thead>
<tr>
<th>Progress toward previous goals:</th>
<th>Previous care plan completed? ☐ ______</th>
<th>Previous care plan reviewed? ☐ ______</th>
</tr>
</thead>
</table>

### Goals I have today for staying strong and staying well – step by step:

Goals are things that we want to do to stay strong and well. The steps to the goal help us to check how we are going. They should be do-able and measurable. Follow up with review and feedback.

<table>
<thead>
<tr>
<th>Goal: _____________________________</th>
<th>Goal: _____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1.</td>
<td>Step 1.</td>
</tr>
<tr>
<td>Step 2.</td>
<td>Step 2.</td>
</tr>
<tr>
<td>Step 3.</td>
<td>Step 3.</td>
</tr>
</tbody>
</table>

What would be good about making this change:

Think about: What will help? And who? And what has helped before? Change is your own choice. Everyone can make changes. Small steps can lead to big changes.

<table>
<thead>
<tr>
<th>Goal: ______________________________</th>
<th>Goal: ______________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1.</td>
<td>Step 1.</td>
</tr>
<tr>
<td>Step 2.</td>
<td>Step 2.</td>
</tr>
<tr>
<td>Step 3.</td>
<td>Step 3.</td>
</tr>
</tbody>
</table>

What would be good about making this change:

### Treatment goals for other Problems:

<table>
<thead>
<tr>
<th>Other problem (Diagnosis)</th>
<th>Goal and steps</th>
<th>Who will help</th>
</tr>
</thead>
</table>

### Other treatments that I am trying:  

1. Ways to help me take my medication on time (Webster pack, dosette, depot)

2. Living a healthier life (substance use, diet, exercise, smoking, time-out, go bush, job training)

3. Cultural or spiritual activity or treatment (going to country, healer, church)

4. Getting help from others (counselling, other treatments, treatment for physical illness)

### Medication plan (Dose, Frequency and route): see prescription for details

### The name I use for my worries is:
The Diagnosis today is: 

Signed (Client) ___________________________ Signed (Practitioner) ___________________________

The following measure is used in Primary Health Care as a useful social and emotional wellbeing screening tool. The first is an abbreviated version of the Kessler K-10 scale that you can use regularly to check how the client is feeling over time.

<table>
<thead>
<tr>
<th>In the last four weeks how often:</th>
<th>None of the time</th>
<th>Little of the time</th>
<th>Some of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Happy in yourself?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>1. So sad that nothing could cheer you up?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Nervous?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Restless and jumpy?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. That everything was an effort?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. Angry at yourself or others?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. Like you might hurt yourself?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Alternative three item outcome measure and screening tool for depression

1. During the past month have you often been bothered by feeling down, depressed or hopeless?
   
   Yes ☐ No ☐

2. During the past month, have you often been bothered by having little interest or pleasure in doing things?
   
   Yes ☐ No ☐

3. Is this something with which you would like help?
   
   Yes ☐ Yes, but not today ☐ No ☐

If client scores yes to either 1 or 2 AND yes to 3 follow up for possible depression is indicated
(Whooley version of PHQ2) This care plan meets requirements for Medicare items 2710, 2712, 2713 and Team Care arrangements

Mental Health Care Plan – developed by AIMHI NT August 08

Aim to complete a care plan at least every three months
### Mental State Examination

<table>
<thead>
<tr>
<th>Appearance (Dishevelled? Well kept?)</th>
<th>Affect (Happy? Sad?)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behaviour</strong> (Agitated? Relaxed?)</td>
<td>Perception (Voices? Spirits?)</td>
</tr>
<tr>
<td><strong>Conversation</strong> (Sensible? Confused?)</td>
<td>Cognition (Attention? Memory?)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Assessment</th>
<th>1 = No apparent risk</th>
<th>2 = Low Risk</th>
<th>3 = Some Risk</th>
<th>4 = Big Risk</th>
<th>5 = Very Big Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Harm or Suicide Risk</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Harm to Others</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Vulnerability – Cannot look after self</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

Circle the number that matches your assessment of level of risk. Risk issues addressed by following actions:

### Outcome measures scores

<table>
<thead>
<tr>
<th>Concerns raised in SEWB Questions</th>
<th>HoNOS</th>
<th>LSP</th>
<th>Other</th>
<th>Other</th>
</tr>
</thead>
</table>

Tick or circle other care planning interventions:

- [ ] Dosette or Webster pack offered today
- [ ] Carer psycho education given today
- [ ] Adult Health Check in last 12 months (BP, Weight, urine check) OR Adult Health Check arranged today
- [ ] Liver/Renal/Thyroid/BP/Weight/Lipid check in last 6 months OR New test ordered today
- [ ] Mood stabiliser check in last 3 months or circle ‘not applicable’ OR New test ordered today

### Mental Health Care Team

<table>
<thead>
<tr>
<th>Carer or Family member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Mental Health Worker/Health Worker</td>
</tr>
<tr>
<td>General Practitioner</td>
</tr>
<tr>
<td>Registered Nurse</td>
</tr>
<tr>
<td>Allied Health</td>
</tr>
<tr>
<td>Traditional Healer</td>
</tr>
<tr>
<td>Registered Psychiatric Nurse</td>
</tr>
</tbody>
</table>

Care plan complete at Hospital [ ] Health Centre [ ] ______________________ Recorded on recall list [ ]

Date of next review ______________________________. _____/_____/_____.

---

Mental Health Care Plan – developed by AIMHI NT August 08

Aim to complete a care plan at least every three months
Pathway Four: Referral to Tertiary Level Mental Health or other Care and Return to Primary Health Care

Tool: Coming Home Plan

National, State, Regional and Health Service Specific Tools as relevant to each service can be inserted (for example in Queensland this would include Recovery - Relapse Prevention Plan, Consumer End of Episode/Discharge Summary)

This pathway provides assistance to primary care staff to support clients returning from hospital, prison, other care facilities or other places of residence. This focuses on communicating with families and Case Managers and engaging clients in support activities to assist them in meeting basic needs and minimise the stress of reengagement associated with their return home. The tool assists supporting staff to ensure that the person has a place to sleep, food, support for employment or recreational/creative activities, support completion of documentation for entitlements such as Centrelink payments, etc. At the same time, the person is supported to indicate whether they are experiencing significant levels of social or emotional distress and if so, provided access to pathways 1 through 3.

**EACH SERVICE CAN INSERT THE TOOLS THAT THEY ARE REQUIRED TO USE INTO THIS SECTION.**
Pathway Four: Referral to Tertiary Level Mental Health or other Care and Return to Primary Health Care

Social and Emotional Wellness of Person in Community

Person is in crisis: Relapse or Suicidal Crisis

Social Emotional Wellbeing Impairment / Loss / Disorder Requires Tertiary Level Care

Admission

Discharge Summary

Discharge Plan & Coming Home Plan

Pathway 4 Coming Home Plan Completed & Supported

Pathway 2 Stay Strong Plan with local support mechanisms

Pathway 4 Mental Health Care Plan with regular review and update by specialist Case Manager and Local Support Team mechanisms
## Coming Home Plan

Going home is a big relief! Think about what is your **Goal** to **Stay Strong**.

How will I meet my **Needs** and what steps do I need to take when I get home?

Remember, family, friends or important people can also help you to meet those immediate **Needs**.

### Things I need to set in place:

<table>
<thead>
<tr>
<th>Things I need to set in place:</th>
<th>What things do I have to do to meet this need?</th>
<th>Who can give me some help if I need it?</th>
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<td>Things I need to look out for - my &quot;trigger factors&quot;</td>
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<td>Keeping away from things that cause trouble for me</td>
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<td>Doing things I enjoy</td>
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REFERENCES AND KEY READINGS FOR PART ONE

Aboriginal and Torres Strait Islander Queensland Mental Health Policy Statement (1996).


Gulash, A, Saunders, J, White, P & Nolan, T. *Tell the Story: Barriers to Effective Communication in Mental Health Assessments for Aboriginal and Torres Strait Islander Peoples*, Queensland Centre for Schizophrenia Research.


Queensland Mental Health Act (2000).


Tuituia, MH-SMART Initiative, New Zealand.


PART TWO – GUIDELINES FOR SUPPORTING
CONSUMERS WITH SPECIFIC MENTAL HEALTH
DISORDERS

Some Voices from Community

“... sit down and find out their problems, don’t just leave it on their shoulders like
that’s your problem you deal with it you know that type of thing. Have someone there
to sit down and put it back to them and think of ways to help them, themselves, like
you can be there to help but put it back on them - alright what can we do tomorrow,
like don’t you suggest it, ask them to do it.”

“Like a long way I thought I was lost by myself um pointless, worthless but now I’m
starting to like gain confidence and if no-ones willing to listen, well I’m gonna prove it
all by myself and feel like I have the strength to do it.”

“When I was working in health I use to go out with the mental health people who
need to find their family but I never had much to say, but being there hopefully they
would see me as a support person, just being there with the people that need to help
them. And I mean, now I look at, I take a look back and what I reflect on, what use to
happen down at, today I see our people, now, who are suffering from mental illness
and a lot that has been, there are a few been put away. Like to be in an institution is
not the place for them. I reckon to try and untangle their mind and what they’re going
through. They should be treated as normal people which they are some of them, and
some we’ve lost to mental illness by going in, in an institution. Maybe there’s a way
out of that. Ok be on medication, there’s one, but give them something to do.”

"I think [recovery] is very possible cause you can visit counseling, counselors or
whatever, and they reckon they can help quite a bit in mental illness. Managing it
through probably right diets and exercise, just a good happy family environment I
think and no fighting or abusive behaviour round themselves, make it worse I
suppose.”

“... patient is diagnosed as seeing things such as visions or apparitions or whatever
they get classified into certain categories they’re either sane or insane, you know,
depending on what science says about them, but in my culture, we have got words
for these sorts of things, so therefore, a person who is seeing these things is
considered normal because we have a word for spirit of dead people such as
[language word], whereas psychology or whatever does not even take that into
consideration.”
CHAPTER FIVE - DEPRESSION

Helping the Consumer Manage Depression

Aiming to Achieve the Five Cs

Consumer and Carer
During initial contact and assessment, good communication is essential for the health professional/worker in establishing engagement. An ability to listen actively and to communicate empathy (compassion) and caring are particularly important as the consumer may be very vulnerable at this time.

Developing a therapeutic alliance involves the health professional/worker and the consumer reaching a common understanding of the issues, so that they can set goals and agreed strategies and steps to reach the goals. Respect for the consumer and mutual trust is one of the most important elements in developing a sound relationship. True respect enables providers to let consumers make decisions for themselves and to make, and learn from, their own mistakes. The best way to show that respect is to listen and give the consumer all your attention.

While conducting assessments and organising immediate interventions the health professional/worker must ensure that they explain as much as they can to the consumer on a frequent basis and seek their approval. Using words like, “is this clear to you?”, “do you understand?”, “is this what you want to happen?” are just some examples.

Consumers suffering from depression may require constant reassurance due to low mood, feelings of worthlessness and an inability to cope. These are feelings that should be taken seriously and reassurance should be given. It is important not to inflict judgmental views on the consumer as these may cause feelings of and a reluctance to engage in the future. Being non-judgmental also requires service providers to be uncritical of factors affecting many consumers, over which they have little control.

Carer involvement in consumer treatment programs is very important due to their “lived” experience with the consumer, however we do have to recognise the consumer’s right to confidentiality. Therefore it is vital to obtain consent prior to engaging a carer. Consent can be overridden in situations where a consumer or carer may be placed at significant danger due to risk factors relating to mental impairment. A good example of this in relation to depression may be the presence of suicidal ideation (thoughts) or intent (plans), when a consumer is unwell. This situation requires the carer to be informed if the client cannot be immediately transferred to a place of safety (eg) the local hospital or in-patient mental health facility. There may be an increase in the risk of impulsivity if the client has been consuming large amounts of alcohol. Based on the context of the community, (eg communities in crisis) it may be hard to distinguish a reliable carer/family member and emphasis on the importance of seeking an appropriate (suitable/reliable) other is essential.
Hints for consumer involvement:
- Seek clarification from the consumer about the level and degree of involvement permitted for the carer;
- Determine if you are permitted to engage with the carer privately or only in the presence of the consumer;
- Determine if all treatment information can be disclosed and if long-term liaison is permitted;
- Encourage the consumer to engage carers/family in treatment options;
- Avoid over engagement with carers at the expense of the therapeutic relationship with the consumer. This means that building a positive relationship with the consumer is the most important goal. We have to be careful not to sacrifice this when we seek background history from the carer/family. The aim is to empower the consumer in their care while actively involving the carers;
- Provide regular information to the consumer/carer on their treatment and progress, utilising treatment specific material (eg) brochures, handouts, user-friendly materials;
- Provide information on available community resources (eg) mental health nurse/service, life promotions officer, available community services, consumer support group and carer support group; and
- Actively involve the consumer/carer in the development of Care Plans that are specific to their mental health needs and encompasses regular review and updating as the goals change. It is important to regularly review and seek input from the consumer and carer about what the important issues or difficulties are from their perspective.

It is also important to provide emotional and social support to the carer/family. Hints for support include:
- Offer them time to express their feelings and emotions on what they see as the key issues;
- Give reassurance relating to the consumers illness and level of progress;
- Suggest applying some coping strategies to their routine (eg) taking breaks, relaxing and taking time out; and
- Be available to support them and offer education to them as the principal caregiver.

Context of community

There needs to be continuous and effective consultation and collaboration between consumers, carers, service providers, elected leaders and community members, in order to successfully develop culturally-appropriate healing strategies that directly meet the traditional and spiritual needs of Indigenous people. When working in Indigenous settings we must aim to listen and learn from the people we are working with in order to understand about local history, issues and living conditions. The consumer may present in such a way that would in other circumstances indicate symptoms of a depressive episode but due to cultural issues could provide a more logical explanation. Some examples are:

- The consumer presenting with perceived low mood. It may be that the consumer is extremely shy or ashamed because they have to see a health worker;
- Certain questions, or the manner in which they are asked by the health professional/worker, may be seen as inappropriate in cultural terms. Direct questioning may be seen as rude; and
• Where it is necessary to address sensitive issues, (eg women’s business) open the discussion by acknowledging that it might be seen as intrusive and explain why it is necessary to ask such a question.

It is important to respect Indigenous consumers’ cultural/health beliefs, knowledge and practices and to recognise that historical and cultural factors affect people’s health and wellbeing. The health professional/worker should appreciate and utilise the expertise of the local people in the community. Emphasis should be placed on working in partnership with the learning community, while appreciating that effective education for mental health needs to be initiated and driven by the community.

The health professional/worker should avoid imposing their own cultural bias on others and should encourage and support local solutions.

**Continuity of care**

It is vitally important that consumers suffering from depression are followed up on a regular basis due to the need for ongoing assessment for severity of symptoms. Examples would be assessment of ongoing self-harming or suicidal ideation, side effects to medication and compliance with it in the community setting. Health professionals/workers should be aware that consumers who have spent time in an in-patient setting with depression and are discharged back into the community still need intensive follow-up.

In-patient admissions for consumers may deal with reducing risk factors and providing a safe environment while establishing the consumer on anti-depressant medication. This does not mean that other symptoms of the illness are not still present on discharge.

When a consumer is discharged from an in-patient setting, it is important to make contact at the earliest possible opportunity. There are a number of reasons for this:

• The health professional/worker can offer immediate support and reassurance for the consumer. Many consumers suffering from depression remain vulnerable on discharge thus immediate contact is vitally important.

• The health professional/worker can obtain a true picture of the consumer’s mental state and perform a risk assessment. Some risk factors may alter from in-patient to community settings. For example, the consumer may feel isolated and unsupported in a community setting compared to the in-patient setting thus heightening the recurrence of suicidal ideation.

• An assessment of the overall living environment and the supports in place can be completed. It is a good opportunity to see if the living conditions of the consumer are promoting their mental health and wellbeing.

• Contact with the consumer’s carer/family can be established offering support to carer/family, providing information on illness/diagnosis and determining the issues and concerns that family/carers may have. (For example, are there still risk factors, what does the medication do, what happens if the consumer stops taking medication?)

• It is important to determine the consumer’s degree of insight as this will have a bearing on ongoing care, compliance with treatment and the level of follow-up/intervention. The consumer may decide that because they feel better
following discharge from hospital there is no longer a need to continue taking prescribed medications or that due to side effects (eg over sedation), medications are limiting them in their level of daily functioning.

- Provision of education and monitoring of prescribed medications is important to promote compliance. This is also a good opportunity to observe the client for any side effects relating to the medication. As with most medications there may be side effects with anti-depressants. Some examples are: nausea, difficulty going to sleep, over sedation, headaches and sexual problems. It is important that any side effects are acknowledged immediately to avoid any unnecessary discomfort for the consumer. Some consumers are reluctant to take prescribed medications or are noncompliant with them as a result of experiencing bad side effects.

- Drafting of a community Care Plan must commence at the nearest available opportunity. This should incorporate the consumer’s/carer’s perspective, primary health care staff, the local mental health team and any local organisations that may be involved in the consumer’s care. (Eg ATODs, life promotions officer, sports and recreation officer.) However this will be dependent upon the available resources in the community.

Continuity of Care is essentially an ongoing activity that is performed on a consistent basis for a consumer while there is a need for that consumer to be supported by their Primary Health Care Service relating to their mental health issues. Emphasis should also be placed on continuity of care in relation to preparing and empowering the consumer to aspects of their care. The opportunity for consumers to take control of these aspects of care is vitally important. Sharing responsibility requires a willingness on the part of the health professional/worker to view continuity as a partnership where all parties have shared control.

A Care Planning document is seen as an important part of managing this process and should be completed in consultation with the Multidisciplinary team, the consumer and the family/carer. The Care Plan offers a structured approach for all involved parties and can be updated as goals and treatment issues change.

**What the Care Plan should incorporate for depression**

- Assessment of consumer’s mood and mental state. This can be utilised to determine the stage of treatment/recovery the consumer is at in relation to their illness and can also determine if there are any other underlying symptoms of illness. The presence of depressive symptoms (eg) loss of pleasure or interest, loss of energy, feelings of worthlessness or guilt, insomnia or hypersomnia (oversleeping), agitation, fatigue and the severity of these will be used for determining the immediate focus of care (eg) how distressed they are by the symptoms, how it is impacting on their daily routine, relationships with family members, risk to self and others. (For example, Tanya reports loss of pleasure in her daily activities. She feels worthless and guilty about her lack of motivation. She is also experiencing early morning wakening and reports poor concentration over a four-week period. She declines to answer questions about suicidal thoughts. The immediate focus of care should be to address the existing symptoms. This might suggest commencement on anti-depressant medications but more importantly immediate assessment of the risk factors involved as Tanya declined to answer any questions relating to suicide.)
• It should be developed or altered accordingly relating to risk factors whether that be a consumer's risk to self, others or risk from others. Is there a risk of self-harm? Is the consumer safe in their home environment? Are there enough support mechanisms in place? Is there a responsible carer/family member around at all times? However it should not focus solely on risk factors. Just because there are no risk factors does not mean that there is not an ongoing underlying problem. In Tanya’s case, she has verbalised her symptoms to staff but has been reluctant to disclose if she has suicidal thoughts or intent. There is an immediate risk to Tanya’s safety if she is feeling suicidal or has intent. Are the carer/family members immediately aware of the risk factors? If not they should be informed.

• The Care Plan should incorporate (avoid negative comments) the consumer’s goals or achievements. It should focus on strengths rather than weaknesses. Portray highlighted problems in a positive manner (Tanya has disclosed that she feels worthless and guilty about her lack of motivation. She has talked about this with staff and is encouraged to keep informing them if she continues to feel like this. She is advised to seek further assistance if she is troubled by these feelings.)

• It should be concise and to the point, using simple language that the consumer and carer can understand. Avoid clinical jargon. Instead of: Tanya will use talking therapies when experiencing dysthymia, try: Tanya will talk to a support person when she is feeling sad and hopeless over the next seven days.

• Emphasise achievable goals. Overloading the consumer with too many goals may be overwhelming for their stage of recovery. Take the treatment phase one step at a time, with the most acute issues being addressed first. Avoid overwhelming the consumer with a long list of issues that may need addressing, even if these issues are important in the consumer's overall care.

• Use realistic time frames and ensure the Care Plan is regularly updated emphasising the consumer's achievements (positive reinforcement of these is important so that the consumer is aware of the progress being made). For example, Tanya will aim to be feeling more positive about herself in the next 72 hours. This is not achievable and the consumer is being placed under undue pressure. It is unlikely that these symptoms would disappear or respond so quickly to treatment with medications. Response to anti-depressant medications can take anything up to six weeks and the focus of the Care Plan should centre on strategies to reduce the distress during this period. For example: use of benzodiazepines for agitation and sleep disturbance if necessary, daily contact with the mental health team, coping strategies (relaxation tapes), regular risk assessments and education about the symptoms of the illness.
• Ensure that the consumer/carer/family view is considered and realistic concerns for all parties are included in the document. For example, the consumer’s auntie states that Tanya’s presentation at interview with the mental health nurse is mainly congruent (similar) with how she is at home. Tanya reports loss of pleasure in her daily activities and she feels worthless and guilty about her lack of motivation. She is also experiencing early morning waking and reports poor concentration. She declines to answer questions relating to suicidal ideation. Tanya’s auntie informs the staff that Tanya has disclosed suicidal thoughts to her; however she has guaranteed that she would never harm herself or act on these. She has disclosed being embarrassed about having these thoughts and finds it very hard to talk about them with others. The auntie informs staff that she has a very close bond with Tanya and that Tanya approaches her when she has a problem. This indicates that the consumer’s reason for non-disclosure of suicidal ideation may have been more to do with personal issues than withholding information due to a firm plan or intent to carry through the act. It also indicates that the level and degree of risk is less than may have been previously believed. However it is still important to continue to perform ongoing risk assessments and to check with family members that the risk factors don’t alter.

• Also ensure the Care Plan is split into sections that emphasise the role of each individual involved in the consumer’s care. This gives all involved parties a sense of ownership in the recovery process and gives the consumer a sense of support and safety. It also reinforces to the consumer that they are not alone. For example, the consumer will participate in regular 1:1 sessions with the mental health nurse; the carer will offer the consumer support with daily activities; the health worker will visit the consumer at home every three days for a chat and to provide further medications or the mental health nurse will follow up with the consumer on a weekly basis.

• A copy of each Care Plan should be made available to all involved parties and a copy should be kept in the consumer’s file.

The frequency of visits/supportive follow-up for the consumer (eg daily, weekly, fortnightly, monthly etc) may be determined by a whole range of factors. These factors should indicate either increased or lower occasions of service dependant upon the effect they have on a consumer’s mental health. Some of these factors are:

• Level of chronic and acute issues;
• Increase in risk factors;
• Recent or recurrent admissions to hospital;
• Poor compliance with medications;
• Poor compliance with treatment plan;
• Level of insight on the consumer’s behalf into their condition;
• Continual stresses in the consumer’s activities of daily living. For example, a lack of financial income, poor living conditions, lack of community standing or lack of daily structure;
• Lack of adequate support network from family or friends;
• Poor physical health of a consumer;
• Exacerbation of the consumer’s depressive episode due to dual diagnosis factors (eg self medication with either illicit drugs or alcohol);
• Consumer’s vulnerability to exploitation from others in the community (eg physical or sexual assault, financial exploitation, stigma and shame attached to mental illness);
• Lack of access to mental health, health services due to remote isolation;
• Stage of recovery in the consumer’s care;
• Compulsory follow-up under provisions of the Mental Health Act 2000; and
• History of recurring relapse.

Ideally a consumer should have regular follow-up if any or all of the above factors have been identified as prominent issues in their Care Plan. However where intense follow-up is necessary, care and understanding should be given not to alienate the consumer. Emphasis should be placed on rapport building in a non-intimidating environment with awareness of some consumers' beliefs about shame and stigma attached to mental illness. Just because some clinicians believe in the demystification of the stigmas associated with mental health, this does not mean that the consumer accessing the service has the same view. Rapport building is vitally important to the concept of “continuity of care” as a long-term approach.

Checking for change
Utilisation of outcomes measures can be very beneficial in the ongoing care of the consumer and the direction taken based on the outcomes scores. Ideally a set of outcome measures should be used as the basis for determining the course of care and high scoring areas should be addressed in the care-planning document. However it is important that the consumer/carers have an understanding of the principles surrounding the measurements and that these are used when considering cultural issues relating to Indigenous consumers.

It is important to remember that if a health professional/worker is going to use the measurement tools they must first have formal training in the area to ensure that they have a full understanding of the concepts involved. Clarification should be sought at any point where a health professional/worker has difficulty understanding or scoring a particular item. This can be done by:

• Liaising with another worker whom has outcomes training;
• The local mental health clinician/worker; and
• The Zonal Outcomes Coordinator/Educator.

Whenever completing outcomes measures with Indigenous consumers, it is extremely important to be guided by the four principles identified in Chapter Three. Principle one reminds you to involve additional informants in your assessments that lead to outcomes ratings. Remember that carer/family involvement plays a big part in providing you with greater understanding of the consumer’s experience based on the additional information and insight that they can provide. You are also expected to utilise the expertise of the Indigenous health worker or mental health worker when completing assessments.

When using the outcome measures to assess a consumer possibly suffering from depression, it is always important to keep in mind certain specific issues. Some of these are:

• If the consumer’s self-care appears to be very poor, the health professional/worker should determine how long this has been for and whether it is within acceptable standards for that community. Poor self-care might indicate that the consumer has recently stopped caring for themselves and suggests they may be experiencing some of the symptoms of depression.
- When assessing a consumer's mood, do not confuse shyness or shame with sadness or as evidence of low mood.

- Use simple language and do not assume that everybody's first language is English. A lack of response may be simply because the consumer cannot understand you and rather than evidence of flat affect. Avoid any terminology that might not be fully understood.

- A common belief amongst some Indigenous people is that revealing or showing emotion is a sign of weakness. This also should be considered when assessing flat affect.

- Remember that illicit substances can alter a person's presentation and it is virtually impossible to obtain a clear picture of a consumer's mental state when under the influence of these substances. A consumer presenting with a flattened affect may just be "stoned" from THC use. However it is also good to determine that there are no symptoms of depression when the consumer is drug free. The consumer may be self-medicating with illicit substances as a coping strategy for depression and excessive use could precipitate a depressive episode.

- Excessive alcohol consumption can also alter a consumer's presentation and it is virtually impossible to obtain a clear picture of a consumer's mental state. Alcohol consumption sometimes causes impulsive behaviours or acts, occasionally manifesting themselves in self-harming behaviour and/or suicidal ideation. Where there may be increased risk for the consumer while intoxicated, this usually (though not always) resolves when the consumer is sober. However it is vitally important to ensure that the consumer remains safe while intoxicated or withdrawing, until further assessment can be performed when they are not under the influence. There is every chance that the consumer's frequent alcohol intoxication may be a self-medicating strategy for depression or the alcohol may have exacerbated or precipitated these depressive symptoms.

Any information/data collected from the outcomes measures relating to the consumer's care is confidential and it is important to reassure the consumer that all information obtained is not disclosed or used inappropriately.

**Considered clinical care**

With the Fifth “C” it is important that clinicians should consider, but not be limited to the recommendations. The guidelines are not absolute and should not necessarily be interpreted as standards of practice. Mental health professionals' care for patients with depression in many different settings, some of which are isolated and highly challenging, where it may not be feasible to apply all of the recommendations.
Depression

What is Depression?

People who are depressed are people who are feeling very sad inside.

They might

- Not each much
- Feel guilty
- Walk round all night
- Think of dying
- Cry for no reason
- Sit down alone

Why am I depressed?

These things can cause depression

- Poor physical health
- Loss or bereavement
- Too much stress
- Too much Alcohol or Gunja or other drugs
- Family History (someone else in the family has the illness)
- Stopping usual treatments
- Breaking Law
What change helps if you are depressed or very sad inside?

OUTSIDE CHANGES
Family support
Elders
Traditional Healer
Clinic Mob
Mental Health Mob
Antipsychotic tablets with
dosette or Webster pack
Hunting, fishing, dance
Going to country
Stopping gunja, alcohol or
Other drugs

INSIDE CHANGES
Know about treatment
Remember totems, family, elders
Think with your head not
with your heart

How do you make change?

• Everyone can make change – when they are ready
• There are lots of different ways to change
• Telling people they SHOULD change doesn’t help
• Letting them know you think they CAN change does help
• Everyone changes in his or her own time
• Small steps can lead to big changes

This information sheets is produce by AIMHI NT – 2005. We invite your feedback and comments. (08) 89227943
Depression: a Guide for Primary Care Workers, Consumers and Carers

These guidelines are an adaptation of the “Guide to Treatment for Consumers and Carers” by Suzy Stevens, Don Smith and Pete Ellis for the Royal Australian and New Zealand College of Psychiatrists. It is intended as a general guide only and not as a substitute for clinical advice.

1. What is Depression?
Depression is characterised by significantly lowered mood and loss of pleasure or interest in things that are normally enjoyable. Most people feel miserable or “down in the dumps” at times. Usually these feelings fade over time, especially when people have other good things happening in their lives or found a way to cope with the change or loss.

However, when these feelings are intense and persistent, stopping us from doing the things we would usually do over a period of weeks or longer, it is possible that the depressed feeling has become an actual illness. Depressive illness can vary from just interfering with usual activities and relationships (mild to moderate depression), to being very debilitating (severe or “major depression”). Severe depression can make it seem impossible for the person to relate and communicate with others, or to do day-to-day tasks. This can even lead to psychotic experiences, where the person may believe, see or hear things that don’t seem to be real. In these situations, a mental health clinician, working with local family and health worker informants, can assist in understanding the situation and providing helpful assistance to the client and their family.

One very important aspect of depression is that it may cause a person to think about harming or even taking their own life. These thoughts can be distressing and the person may become fearful that they will act on them. Anyone who has thoughts of harming themselves should be urged to talk with trusted family members or friends and seek help at the health centre immediately. Talking with others often helps people to deal with those feelings and seek the help they need to ensure their safety.

There is seldom just one specific cause of depression. Sometimes depression happens without any apparent cause at all; at other times it occurs when people are coping with stressful events or experiencing prolonged stress. Examples of life events that can promote depression include:-

- the loss or death of someone you love
- having a baby
- being under pressure at work or unemployed
- trying to make ends meet on a low income
- feeling lonely
- having a chronic illness that takes away energy and demands major lifestyle change

More than one family member may experience depression. This is related to genetics (the physical make-up we are born with) or environmental factors that surround us, such as an unhappy childhood or relationship. Some factors protect us against depression, such as having supportive and close relationships.
Importance of depression
The prevalence of depression in the general population is 5.8% of adults, or about one in 25 people at any given time[1]. The rate is similar across age groups but reduced in persons 65 years and over. Depression is more common among females (lifetime prevalence of 10-26%) than males (lifetime prevalence of 5-12%). Mental and behavioural conditions (of which depression is a subset) are significantly more common in disadvantaged areas[1].

Depression in Aboriginal and Torres Strait Islander people
Information on levels of depression in Aboriginal and Torres Strait Islander populations is limited; however, it is at least as common, and probably more common, in this group. The terms people use to describe depression varies across cultures. In Aboriginal and Torres Strait Islander communities, people who are depressed may say:
- “I feel depressed”, “I’m sad”, “I’m blue” or
- “I’m slack”, “I feel all washed up”, “I’m no good – all washed up”

Health practitioners need to be attentive to local ways of communicating and be mindful when assessing an Aboriginal and / or Torres Strait Islander person’s mood:
- not to confuse shyness or shame with sadness or as evidence of low mood
- to use simple language and do not assume that English is the first language
- to be aware that a lack of response may be because the person cannot understand you, rather than evidence of flat affect

On the other hand, it is also important:-
- to be aware that a common belief among some Indigenous people is that revealing or showing emotion is a sign of weakness, so they may hide the way they really feel
- that the person may not know that constant sadness can be a sign of illness

Non-Indigenous clinicians are always advised to involve local health workers and family (as appropriate) in assessments when there is some concern that a person may be depressed.

2. Diagnosis
Diagnosis of depression is made by confirmation of symptoms listed which must be present for at least 2 weeks. There is no experience of mania or hypo-mania evident and substance misuse or physical disorders (e.g. hypothyroidism) have been ruled out.

Diagnostic criteria [2] include presence of a minimum number of symptoms:-
- restlessness or slowness observed by others
- inability to make decisions and can’t concentrate
- not sleeping OR sleeping too much
- self blame and feelings of worthlessness
- fatigue or loss of energy nearly every day
- feeling down all day
- thinking about death frequently
- no longer interested in favourite activities, and
- significant changes in weight or appetite.
3. Management Aims
Research (Hubble et al., 1999) has shown that the greatest contributions to positive outcomes in helping a person manage depression come from:-

- maximising the cooperation of the person and building a trusting relationship between client and health professional
- identifying and working on factors that appear to have contributed to the depression
- continuing with treatment for as long as is necessary to allow the person to become stable and then deal with the issues contributing to the depression
- ensuring functional alliances with family/friends, primary care providers, other mental health professionals to enhance the engagement of and support for the consumer in daily activities and health care
- maintaining cultural awareness and sensitivity and accessing cultural and primary language services that meet the traditional and spiritual needs of the client
- establishing local networks, practices and protocols for care of someone with a depressive illness
- identifying and addressing known risk factors for relapse

Management plans will vary with each person however the overall plan will include:-

- mental and physical health assessment
- actions that aim to remove the person's depressed mood such as
  - providing culturally safe and appropriate education and support
  - attention to addressing accompanying problems i.e. sleep, appetite, low activity level, social isolation, unfavourable relationships
  - recognising the signs and taking steps to prevent relapse.
- Actions that aim to enhance wellness and facilitate positive change
  - promoting the person's ability to see and enhance their strengths
  - assisting the person to identify goals and steps toward achieving them
  - recognise healing and foster realistic hope

4. Relationship with other conditions / diseases
Depression often accompanies other physical health problems (such as diabetes and cardiovascular disease) and substance misuse problems (Burns and Teeson 2002). When other health problems exist together with and compound a mental disorder, this is called co-morbidity.

It is now known that depression can be a cause, a consequence and an aggravating factor in some chronic physical diseases. Most research has focused on depression and cardiovascular disease. For example, men with depression have a 71% increased risk of developing heart disease and are 2.3 times more likely to die of heart disease than non-depressed men [4,5].

History of depression is a common risk factor for self-harm and suicide[3], however it should not be considered a necessary prerequisite for suicidal behaviour. This is especially relevant for young Indigenous people for whom suicide is thought to result from a complex array of risks, including mental health status, alcohol use, impulsivity and the perceived ‘meaning’ of suicide within the social and cultural context (Hunter and Harvey, 2002).

The use of alcohol and other psychoactive drugs in depression is common, as people may turn to these drugs to help them “deal with” depressive feelings. However, this is often harmful, making the depression worse and the combination of alcohol/other drugs and depression increases the chances of self-harming behaviour.
5. Planning Care
When planning client care the following points should be considered:

- assessment of consumer’s mood and mental state to benchmark the client’s stage of treatment and recovery
- inclusion of risk factors i.e. risk to self, others or risk from others including ongoing monitoring of suicide risk throughout treatment
- education of the client on what depression is, how they became depressed and the likely length of time their treatment may require
- details of support mechanisms
- incorporate goals or achievements - focusing on strengths. Limit goal setting to small achievable steps
- use realistic time frames and ensure the plan is regularly updated
- ensure that the consumer / carer / family view is considered
- split the care plan into sections that emphasise the role of each person involved
- consider previous experience with medication, physical health, living conditions and history of relapse
- consider ongoing relapse prevention and early intervention in any recurrence
- provision of a copy of the care plan to all involved parties

6. Treatment
Emerging evidence (Hubble et al., 1999; Grossman et al., 2004) shows the equal value of non-pharmacological approaches (cognitive behaviour therapy (CBT), interpersonal psychotherapy (IPT) and mindfulness-based meditation (MM) provided by suitably trained practitioners) to pharmacological treatments for some depression.

While there is increasing evidence that CBT, IPT and MM are as effective as antidepressants in many depressive illnesses, they should only be considered where an experienced practitioner is available. In communities where such expertise is not available the importance of a supportive relationship that encourages service access should not be underestimated. Addressing specific social and interpersonal difficulties should always be an integral part of counselling approaches.

Initiation of treatment will usually be for mild or moderate depressive disorders, which may occur with a physical or substance misuse problem. The level of depression governs the treatment options for the client and can range from mild depression without complications to severe and psychotic depression with the risk of suicide.

More general approaches to assisting people with depression, such as addressing drug and alcohol consumption, improving diet and increasing physical activity, should be universally applied (Hubble et al., 1999; Dunn et al., 2005). However, it is important to help the client set their own goals, make feasible plans to achieve them and gain support from others so there is not a risk of feeling a failure to meet unrealistic expectations.
6.1 Medication treatment for depression

<table>
<thead>
<tr>
<th>Class</th>
<th>Recommended drug</th>
<th>Dose range</th>
<th>Tips</th>
</tr>
</thead>
</table>
| Serotonin Selective Reuptake Inhibitors (SSRI's) | fluoxetine fluvoxamine paroxetine sertraline citalopram | according to individual and level of depression experienced | • A small number of people feel agitated on SSRI's and clients should be educated to tell their health professional immediately if this happens  
• Concerns that they may prompt suicidal feelings have not been proven |
| Tricyclic anti-depressants (TCA)           | imipramine nortriptyline                      |                                         | • These are more likely to be used if the depression is severe and/or another treatment has not worked sufficiently.  
• Side effects are more common than SSRI's, especially early in treatment.  
• Not suitable when some medical conditions are present (such as)  
• Dangerous in overdose |
| Serotonin & Noradrenaline Reuptake Inhibitor (SNRI) | Venlafaxine                                  |                                         | • Particularly useful when other treatments have been unsuccessful or for severe depression.  
• Side effects more similar to tricyclic anti-depressants |

6.2 Mild and Moderate Depressive Disorders
This section outlines treatment strategies that are usually initiated through primary care settings. Specialist input should always be sought and decisions about community-based care versus hospitalisation must consider factors including existing health and social resources in communities.

6.2.1 Mild depression without any complications
Treatment should be provided within primary care and include:
• education about depression
• discussion and consideration of lifestyle changes
• helping the person develop problem-solving skills
• exploring with the person their relationships with significant others
• offering specific assistance as required
• providing supportive monitoring

There is no evidence supporting the use of pharmacological or psychological treatments for this group unless the symptoms persist beyond 8 weeks – then brief treatment with CBT and IPT or a Selective Serotonin Reuptake Inhibitor (SSRI), in addition to supportive management may assist.
6.2.2 Moderately Severe Depression  (including co-morbid anxiety & dysthymia)
- treatment consists of an antidepressant and one of the brief psychological therapies (8–12 sessions of CBT or IPT) is indicated.
- monitoring should be weekly and include:-
  o review of side effects
  o assessing treatment benefits
  o identifying changes in stresses and circumstances
  o encouragement of compliance with treatment

At the end of a reasonable trial period, for example 4 to 6 weeks, treatment should be reviewed and revised as indicated. It is expected that input from specialist services will be limited to the initial phases, with primary service follow-up

6.3 Severe Depressive Disorders
This section discusses severe depressive disorders where specialist input should be obtained and hospitalisation considered. A care coordinator is recommended to manage the clients care in collaboration with other services particularly if substance misuse is also present.

6.3.1 Moderately severe depression with co-morbid substance abuse
Use interventions to reduce alcohol consumption and then treat as if moderate or severe depression. This will require explicit coordination of alcohol and drug, secondary mental health and primary care services.

6.3.2 Moderate to severe depression with physical disorders
Concurrent treatment of the physical disorder and depression in both secondary and primary care services is critical.

6.3.3 Severe depression with melancholia
Generally, initiate an antidepressant and once there has been a response, consider adding a psychological therapy (to either achieve a full response and/or reduce the risk of relapse).

6.3.4. Psychotic depression
Care should be provided by specialist mental health services (usually this will mean hospitalisation) until stabilised, and then continuing consultation/liaison with primary care services. Psychotic depression may require complex medication regimes and, at times, electro convulsive therapy (ECT).

6.3.5 Severe depression with risk of suicide
Assessment suicide risk in an acute presentation is achieved by asking a series of questions as set out in Primary Clinical Care Manual edition 5 – Depression. Care should be provided by specialist mental health services (this often involves hospitalisation) until stabilised, then continuing consultation/liaison with primary care services. In severe depression it is often necessary to proceed to second and third-line treatments at an earlier stage. For example, ECT is an effective treatment in depression that may have a place earlier or later in treatment depending on its nature and severity. In this situation, treatment in a hospital setting will be required.

Treatment away (hospital) from the depressed person’s home may be necessary to ensure greater supervision or specialised treatment is required, eg. ECT. The setting will need to be selected based on the client’s needs, level of expertise and support required. This may include friends/family, respite accommodation or inpatient hospital
care. Good communication between primary and secondary or tertiary services and the family is very important. A care coordinator will assist in this communication.

### Summary of non-drug options for treatment of depression

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Considerations &amp; Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cognitive Behaviour Therapy (CBT)</strong></td>
<td>As effective as anti-depressants for mild to moderate depression, may provide skills that reduce risk of relapse. Can be difficult to find an expert therapist. Requires considerable commitment by person with depression.</td>
</tr>
<tr>
<td><strong>Mindfulness Meditation</strong></td>
<td>As effective as anti-depressants for mild to moderate depression, may provide skills that reduce risk of relapse. Required experienced teacher or psychologist and commitment from person with depression, but gives long term benefit.</td>
</tr>
<tr>
<td><strong>Interpersonal Psychotherapy (IPT)</strong></td>
<td>As effective as anti-depressants for mild to moderate depression. Can be difficult to find an expert therapist. Requires considerable commitment by person with depression.</td>
</tr>
<tr>
<td><strong>Problem Solving Therapy (PST)</strong></td>
<td>May be available in general practice as part of the support for mild and moderate depression. Not all doctors are trained in this treatment.</td>
</tr>
<tr>
<td><strong>Physical Activity</strong></td>
<td>Levels of physical activity consistent with general public health recommendations is effective in treating major depressive disorder.</td>
</tr>
</tbody>
</table>

#### 6.4 Relapse

Even when treated properly, depression sometimes returns. Sixty per cent of those who have an episode of depressive illness remain well over the next year; others can relapse during this time.

Some important points to keep in mind:

- those who have had three episodes of depression have a higher rate of recurrence
- of this group, 20% remain free of depression over three years
- the pattern of relapse varies between different people
- for some people, depression is more common at a particular time of year, for instance during the wet season, or at the time of the year when a significant event occurred in the past, such as the death of a loved one

**6.4.1 Recurrent depression / failure to respond to first-line treatment**

- check whether the client is taking prescribed medication regularly, discuss any problems they are having and possible solutions
- check adequacy of dose and adequacy of treatment period
- check diagnosis: consider second opinion and
- consider second line treatments

If first-line treatment was an SSRI or a psychological therapy, consider a switch to Venlafaxine or another antidepressant; or combine a course of one of the brief psychological therapies and an antidepressant.
The most important factor in the management of depression is to maintain the clients understanding of and their participation in their treatment regime for at least one year for a first episode and three years duration for a recurrent depression. Addition of a psychological therapy, such as CBT, MM or IPT, to the continuing and maintenance phases has been associated with lower relapse rates after 2-3 years. (Teasdale et al., 2000).

However, since depression is often recurrent, most presentations, even to primary care providers, will be for a second or subsequent episode of depression. The key intervention should be continuing with effective, acceptable treatment.

### 6.5 What to do at a depression check –up

<table>
<thead>
<tr>
<th>Goals</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical cause of depression is ruled out</td>
<td>Perform full physical examination – blood pressure, weight, respiratory rate, at initial visit including – pathology for thyroid function test (TFT), ? what other pathology (eg FBP, LFTs etc) Monitor weight and blood pressure</td>
</tr>
<tr>
<td>Identify current or past life problems or social stressors which may have contributed to depression</td>
<td>MSE is conducted to assist in gathering baseline assessment and benchmarking the client’s progress. It assists the client, family and clinician to understand how these problems and stressors have led to illness and to discuss ways to develop skills and strategies to deal with future challenges. Obtain a history or past depressive episodes and rule out psychosis</td>
</tr>
<tr>
<td>The client understands what depression is, treatment options available and what steps they can take to improve wellbeing</td>
<td>Education occurs on what depression is – see above. It also needs to be explained that it may have taken many years for them to get to this stage and that it may take a long time to deal with the depression. Discussion occurs about treatment options – medication and other things</td>
</tr>
<tr>
<td>Clients understand their medication</td>
<td>Consumer medication information is given about the clients medication and an explanation is given on how long they maybe required to take the medication. Side effects are explained (need to spell these out) Interaction with other medications and alcohol and other drugs such as beta-blockers, anti-hypertensives, oral contraceptives and corticosteroids</td>
</tr>
<tr>
<td>There is a trusting relationship between client and health professional</td>
<td>Counselling is offered to the client, and they participate in their care planning. They have one person who they can contact at the health centre who coordinates their care.</td>
</tr>
<tr>
<td>The client knows who and where to seek help if they feel suicidal</td>
<td>The client is assessed for suicidal risk by asking questions such as: Do they have any ideas about suicide? Have they thought about death or dying? Do they have a plan about suicide? Also ask about risk to others and if they have access to weapons. Clients are given contact name and details for support services such as Life Promotion Officers, Crisis Counselling</td>
</tr>
<tr>
<td>The client has a short term plan on activities which may improve their enjoyment in life</td>
<td>The client is assisted to problem solve stressors in their life as they present which adversely affect their mental health. They are encouraged to resist negative thoughts and replace them with more realistic thoughts, resist pessimism and self-criticism</td>
</tr>
<tr>
<td>The client is able to sleep at night</td>
<td>Education is given on “sleep hygiene” practices which assist in getting a good night’s sleep. Such as cutting down alcohol or caffeine drinks before bedtime, personal hygiene practices, lack of interruptions and disruptive noise (if possible) during the night, comfortable bedding</td>
</tr>
<tr>
<td>The client knows about lifestyle choices that can help improve their health</td>
<td>Education is given about safe drinking levels, healthy nutrition, physical activity levels (exercise, where possible, is very important) and cessation of smoking</td>
</tr>
<tr>
<td>Steps are in place to address substance misuse (if appropriate)</td>
<td>Referral to alcohol, tobacco and other substance (ATODS) services occur to help client if dual diagnosis of substance misuse exists. Care coordinator is given feedback about consultations.</td>
</tr>
</tbody>
</table>
### 7. Care plan summary

<table>
<thead>
<tr>
<th>Action</th>
<th>Frequency</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dx</strong></td>
<td><strong>6 weeks</strong></td>
<td><strong>monthly</strong></td>
</tr>
<tr>
<td>Full physical health check</td>
<td>Dx</td>
<td>12 mthly</td>
</tr>
<tr>
<td>TFT, what other pathology?</td>
<td>Dx</td>
<td></td>
</tr>
<tr>
<td>MSE</td>
<td>Dx</td>
<td>at 6 weeks</td>
</tr>
<tr>
<td>Medication review</td>
<td>Dx</td>
<td>at 6 weeks</td>
</tr>
<tr>
<td><strong>Education</strong> on Physical symptoms</td>
<td>Dx</td>
<td>at 6 weeks</td>
</tr>
<tr>
<td>Support systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling safe and secure – having worries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coping strategies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifestyle issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ATODS service Review</td>
<td>As needed</td>
<td>As required</td>
</tr>
<tr>
<td><strong>Dx</strong></td>
<td><strong>6 weeks</strong></td>
<td><strong>monthly</strong></td>
</tr>
<tr>
<td>Education on nutrition, physical activity, smoking cessation and alcohol</td>
<td>Dx</td>
<td>At 6 weeks</td>
</tr>
<tr>
<td>Weight</td>
<td>Dx</td>
<td>At 6 weeks</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>Dx</td>
<td>At 6 weeks</td>
</tr>
<tr>
<td>MO Review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Further Information and Support

Useful websites for depression include:
- [www.bluepages.anu.edu.au](http://www.bluepages.anu.edu.au)
- [www.beyondblue.org.au](http://www.beyondblue.org.au)
- [www.blackdoginstitute.org.au](http://www.blackdoginstitute.org.au)

Information about the location of mental health services is available through the local primary care centre or hospital.

Information is also in the Emergency Health and Help section of the local White Pages. Alternatively Lifeline’s “Just Ask” information line can be accessed on 1300 131 114.

Urgent telephone assistance is also available through: Lifeline 1300 131 114 (local call)

Kids Helpline 1800 55 1800 (free call)
Treatment for Depression: a Guide for Clinicians

These guidelines are an adaptation of the “Summary Australian and New Zealand Clinical Practice Guidelines for the Treatment of Depression” published in Australasian Psychiatry by Pete Ellis, Ian Hickie and Don Smith for the RANZCP Clinical Practice Guideline Team for Depression (Ellis, Hickie et al 2003) which are themselves based on the RANZCP full guidelines (Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Depression 2004). NH&MRC-defined levels of evidence for each suggestion are recorded in the text and information regarding these is published elsewhere (Boyce, Ellis et al 2003; Boyce, Ellis et al 2003) and includes a description of the guideline development process. Consumer guidelines have also been developed. While the levels of evidence are retained in this document the reader is referred to the original documents for full referencing.

Overview
Depression is common, serious and treatable. The Australian and New Zealand Clinical Practice Guideline provides evidence-based treatment guidance across the spectrum of depressive disorders and delineates where specialist treatment and primary care management are indicated. This version covers the key contents of the guideline. It includes assessment, treatment and general management issues by category type and severity of depressive disorder. In Indigenous primary care settings initiation of treatment will usually be for mild or moderate depressive disorders which may be complicated by comorbid physical or substance misuse problems. These include:

- Mild depression without complications;
- Moderately severe depression (including with comorbid anxiety) and dysthymia;
- Uncomplicated, melancholic or atypical depression;
- Moderately severe depression with comorbid substance abuse; and
- Moderate to severe depression with physical disorders.

More severe depressive disorders will usually require prompt specialist assessment and intervention, at times hospitalisation. These include:

- Severe depression with melancholia;
- Recurrent depression or failure to respond to a preferred first-line treatment; and
- Psychotic depression, and severe depression with risk of suicide.

Continuing and maintenance treatments for recurrent depression are discussed. Emerging evidence of the equal value of cognitive behaviour therapy (CBT) and interpersonal psychotherapy (IPT) to pharmacological treatments for some depression is discussed, and the need to ensure that they are provided by suitably trained practitioners. Indications for hospitalisation and electroconvulsive therapy (ECT) are also provided.
Introduction

The diagnosis of depression
Two diagnostic frameworks are commonly used by mental health professionals, the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-IV) and the Mental Health Manual (10th Revision) of the International Statistical Classification of Diseases and Related Health Problems (ICD-10AM). The latter is now standard in Queensland Health. A comparison of the diagnostic guidelines for depression are presented in Appendix 1.

The prevalence of depression
Depression is common, serious and treatable. It affects 1 in 25 people in any one month. Information on levels of depression in Indigenous populations is limited. However, data from the Australian Institute of Health and Welfare reveal (AIHW) that for 1998-1999, the Indigenous:non-Indigenous standardised morbidity ratio for mood and neurotic disorders was 1.3 for Indigenous males and 1.2 for Indigenous females. For 2002 to 2003 the AIHW databases show that only 5.4% of Indigenous psychiatric hospital care days were attributed to depressive disorders (ICD-10). The real burden of depressive disorders is clearly much greater than these figures suggest and likely to be particularly so in remote and rural settings where access to community-based and hospital care is limited. This is supported by the much higher rates of completed suicide, particularly in the young adult Indigenous population.

Assessment
In addition to establishing rapport, assessment should include full evaluation and formulation, take into account social and cultural issues and include particularly:

- Risk assessment;
- Subtype, severity and duration of depression;
- Comorbidity (with medical and or other psychiatric and or alcohol and drug problems);
- Current stresses, strengths and supports; and
- Relevant personal and family history and past history of any mental illness.

Summary of treatment evidence
The evidence supports the following treatments provided as part of an overall clinical management plan. Every person with depression is an individual facing uniquely different circumstances. Their treating clinician should consider the extent to which the available evidence is pertinent to the treatment of this individual.

Components of an effective treatment plan include:

- A therapeutic relationship, which is essential to maximise benefits of treatment;
- Treatment alliances with patient, family/friends, primary care providers, other mental health professionals; and
- Access to cultural and primary language services.

The greatest contribution to a positive treatment outcome comes from:

- Maximising cooperation of the person with the selected treatment;
- Identifying and addressing known risk factors for relapse; and
- Maintaining a treatment regime for as long as is necessary to allow the person to stabilise (ie at least 1 year, and where there is a history or significant risk of recurrence at least monitor and treat proactively for three years).
These considerations considerably outweigh the limited advantages of one treatment over another. Figures 1 and 2 outline the stages generally indicated in the process of assessment and treatment. The research evidence on which these recommendations are involves carefully selected subjects in controlled clinical trials. The extent to which this reflects the complex circumstances of Indigenous settings and patients needs to be considered carefully in terms of considered clinical care.

**For all depressed people**
Provide education about depression and lifestyle changes that will assist recovery, mindful of identified stresses and supports. This should be ongoing to maintain changes achieved, and repeated if life circumstances change. Suicide risk needs to be monitored throughout treatment.

**Mild and moderate depressive disorders**
The following sections outline treatment strategies for depressive disorders that will usually be initiated and monitored through primary care settings. Specialist input should always be sought and decisions about community-based care vs hospitalisation often must take into account a range of other factors including existing health and social resources in Indigenous communities.

**Mild depression without any complications**
Treatment should be provided within primary care. It should include education about depression; examine the need for lifestyle changes; consider teaching problem-solving techniques; consider relationships with significant others and offer specific assistance as required; and provide supportive monitoring. There is no evidence for the use of pharmacological or psychological treatments for this group unless the symptoms persist beyond 8 weeks – then brief treatment with Cognitive Behaviour Therapy (CBT) or Interpersonal Psychotherapy (IPT) or a Selective Serotonin Reuptake Inhibitor (SSRI) in addition to supportive management may assist.

**Moderately severe depression (including with comorbid anxiety) and dysthymia**
Either an antidepressant and if possible, one of the brief psychological therapies (8–12 sessions of CBT or IPT) is indicated. Monitoring should be regular and include review of side effects, treatment benefits, changes in stresses and circumstances and encourage compliance. Monitoring should be at a frequency appropriate to the severity of the illness (at least weekly is suggested). At the end of a reasonable trial period, for example 4 to 6 weeks, treatment should be reviewed and changed/revised as indicated. It is expected that input from specialist services will be limited to the initial phases and thereafter will be consultative to primary services, which will manage long-term care.

**Severe depressive disorders**
The following sections deal with severe depressive disorders where specialist input should be obtained as soon as possible and where hospitalisation should be considered.

**Moderately severe depression with comorbid substance abuse**
Use interventions to reduce alcohol consumption and then treat as if moderate or severe depression. This will require explicit coordination of alcohol and drug, secondary mental health and primary care services.
Moderate to severe depression with physical disorders
Concurrent treatment of the physical disorder and depression in both secondary and primary care services is critical.

Severe depression with melancholia
Generally, initiate an antidepressant and once there has been a response, consider adding a psychological therapy (to either achieve a full response and/or reduce the risk of relapse).

Psychotic depression
Care should be provided by specialist mental health services (usually this will mean hospitalisation) until stabilised, and then continuing consultation/liaison with primary care services. Psychotic depression may require complex medication regimes and, at times, ECT.

Severe depression with risk of suicide
Care should be provided by specialist mental health services (as above, this will usually involve hospitalisation) until stabilised, and then continuing consultation/liaison with primary care services.

Recurrent depression or failure to respond to a preferred first-line treatment
- Check compliance;
- Check adequacy of dose and adequacy of treatment period;
- Check diagnosis: consider second opinion; and
- Consider second line treatments: if first-line treatment was an SSRI or a psychological therapy, consider a switch to Venlafaxine or another antidepressant; or combine a course of one of the brief psychological therapies and an antidepressant.

Continuing treatment
The most important factor in the management of depression is to maintain compliance with an effective treatment for at least one year for a first episode and three years duration for a recurrent depression. Addition of a psychological therapy to continuing and maintenance phases has been associated with lower relapse rates.

Maintenance treatment for recurrent depression
Depression is often a relapsing condition, so once the person has responded to treatment, ongoing relapse prevention and early intervention in any recurrence is essential. Indeed, most presentations, even to primary care providers, will be for a second or subsequent episode of depression and the treatments offered should acknowledge this. In this respect depression is similar to many medical conditions such as congestive heart failure or basal cell carcinoma, where risk of relapse is significant and ongoing monitoring is indicated. The key intervention should be continuing with an effective and acceptable treatment. The uses of CBT or IPT where there are residual symptoms or inadequate response have been associated with lower rates of relapse after 2 or 3 years.

Maintenance and relapse prevention should include:
- Arrangement of social support;
- Educate to recognise symptoms and reduce risk factors for relapse; and
- Proactive follow-up.
General management issues

Severe depression
In severe depression it is often necessary to proceed to second- and third-line treatments at an earlier stage. For example, ECT is an effective treatment in depression, which may have a place earlier or later in treatment depending on the nature and severity of depression. In this situation, treatment in a hospital setting that provides this treatment will be required.

While there is increasing evidence that CBT and IPT are as effective as antidepressants in many depressive illnesses, not all therapists are equally experienced or effective. Research studies of these therapies adhere strictly to versions of these therapies that follow treatment manuals and may not reflect usual practice. CBT and IPT should be considered where an experienced practitioner is available. In Indigenous communities where such expertise is often not available the importance of a supportive relationship that encourages service access should not be underestimated. Addressing specific social and interpersonal difficulties should always be an integral part of counselling approaches.

Hospitalisation
Treatment away from the depressed person’s usual home may be necessary to ensure greater supervision if they are:

- Suicidal;
- Unable to look after themselves;
- In a setting that is considered to be exacerbating their illness;
- In need of otherwise unavailable psychological support in severe distress; and
- If further specialised treatment is required eg. Electroconvulsive Therapy (ECT).

The setting for this will need to be selected on the basis of the depressed person’s needs, the extent and level of expertise or support required and the range of options available. This may include friends and family, respite accommodation, or inpatient hospital care.
Figure 1: Assessment and treatment of depression in specialist care

Establish rapport and then assessment of:
- Cultural issues
- Suicidality
- Comorbidity (i.e., anxiety, substance abuse)
- Determine: duration, severity, melancholic/atypical/psychotic features

Ensure appropriate access to cultural and primary language services or support for the whole course of using available resources

Assess risk, implement management plan and treat depression

If co-morbidity:
- Alcohol and drug: treat first then depression
- Anxiety, treat in parallel or concurrent with depression

Ensure appropriate access to cultural and primary language services or support for the whole course of using available resources

Mild Moderate Severe and/or melancholic Atypical Psychotic

Refer back to GP - ongoing treatment (see figure 2 for treatment) if:
- Inadequate response by 12 weeks
- More severe or psychotic
- Suicidal or likely to harm others then refer for further specialist assessment, treatment and/or support

First line treatments (as per algorithms)
- Check compliance and adequacy of dose
- Consider obtaining a second opinion
- Consider Second line treatments

Worse/suicidal Inadequate response Response

- Consider a second opinion
- Implement second/third/fourth line treatments (as per algorithms)

Continuation of an effective treatment (for at least 1 year for first episode and 3 years for recurrent)

Remission Relapse

Maintenance and relapse prevention:
- Treat residual psychological issues
- Arrange social support
- Education to recognise symptoms and reduce risk factors for relapse
- Proactive follow-up for recurrent depression

Inadequate response Response

Recurrence
Figure 2: Selection of evidence-based treatment for uncomplicated, melancholic or atypical depression

First Line: Mono-therapy:
- Adjustment disorder of Mild - lifestyle, problem solving and monitor
- Dysphoria or Moderate - CBT/IPT or SSRI
- Severe uncomplicated - TCA, Venlafaxine, Nefazadone, SSRI or CBT/IPT
- Sever with melancholic - TCA or Venlafaxine
- Atypical (not necessarily severe) - Phenelzine or CBT/IPT

AND

Monitor 2 - 3 times weekly for compliance and side effects. If suicidal or otherwise at risk and not responding to current treatment consider augmented or combine treatments.

Partial response or non response

Second Line:
- If monitoring only add CBT/IPT or SSRI
- If TCA or Venlafaxine, review and increase dose
- If SSRI or Nefazadone switch to TCA or Venlafaxine (mild/mod add CBT)
- If TCA or Venlafaxine consider adding CBT/IPT
- If CBT/IPT then add TCA or Venlafaxine (mild/mod add SSRI)
- If atypical: Add other therapy (CBT/IPT or Phenelzine)

Partial response or non response

Augmented or Combined:
- Add lithium
- Consider high dose Venlafaxine

Partial response or non response

Right unilateral ECT and an effective antidepressant (preferably during, certainly following, ECT)

Response

Continuation until remission.
If residual negative cognitions or relationship issues consider adding CBT or IPT (6 - 8 sessions).
Continue antidepressant.
If no remission by 3 months seek a second opinion and continue active treatment

Remission

Maintenance: At remission -
- Continue anti-depressant and/or CBT booster:
  - First episode for at least 1 year
  - Recurrent: ongoing & monitor 3 monthly for up to 3 years or when risk reduced
- If only prior drug therapy, add 6 - 8 sessions of CBT or IPT with one 3 monthly booster session for 2 - 3 years:
  Consider Social work assistance for accommodation, befriending and employment. Teach problem solving.

Notes:
1. If at any stage suicidal or otherwise at serious risk and not responding to current treatment, then consider ECT.
2. CBT or IPT should only be used if a practitioner of similar competence to that used in the research studies is available.

LEGEND
Levels of Evidence (NHMRC):
- Level I: Systematic Review of RCTS
- Level II: At least one adequate RCT
- Level III: Non-RCT study
- Level IV: Case series
- Level V: Expert opinion
### Figure 3. ICD 10 and DSM IV Criteria

<table>
<thead>
<tr>
<th>ICD 10 Criteria for Depressive Episode</th>
<th>DSM IV Criteria for Depressive Episode</th>
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<tbody>
<tr>
<td>In typical mild, moderate, or severe depressive episodes, the patient suffers from lowering of the mood, reduction of energy, and decrease in activity. Capacity for enjoyment, interest, and concentration is reduced, and marked tiredness after even minimum effort is common. Sleep is usually disturbed and appetite diminished. Self-esteem and self-confidence are almost always reduced and, even in the mild form, some ideas of guilt or worthlessness are often present. The lowered mood varies little from day to day, is unresponsive to circumstances and may be accompanied by so called “somatic” symptoms, such as loss of interest and pleasurable feelings, waking in the morning several hours before the usual time, depression worst in the morning, marked psychomotor retardation, agitation, loss of appetite, weight loss, and loss of libido. Depending upon the number and severity of the symptoms, a depressive episode may be specific as mild, moderate, or severe. Includes single episodes of</td>
<td></td>
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<tr>
<td>- depressive reaction</td>
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<tr>
<td>- psychogenic depression</td>
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<td>- reactive depression</td>
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<tr>
<td>Excludes: adjustment disorder (F43.2) Recurrent depressive disorder (F33.-) When associated with conduct disorders in F91.- (F92.0) The following fifth-character subdivision is for use with category F32: 0 = not specified as arising in the postnatal period 1 = arising in the postnatal period</td>
<td>Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.</td>
</tr>
<tr>
<td>1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (eg, feels sad or empty) or observation made by others (eg, appears tearful). Note: in children and adolescents, can be irritable mood.</td>
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<tr>
<td>2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation made by others)</td>
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<tr>
<td>3. Significant weight loss when not dieting or weight gain (eg, a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: in children, consider failure to make expected weight gains.</td>
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<tr>
<td>4. Insomnia or hypersomnia nearly every day</td>
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<tr>
<td>5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)</td>
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<td>6. Fatigue or loss of energy nearly every day</td>
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<tr>
<td>7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)</td>
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<tr>
<td>8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)</td>
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<tr>
<td>9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide</td>
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<tr>
<td>B. The symptoms do not meet criteria for a mixed episode. C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.</td>
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<tr>
<td>D. The symptoms are not due to the direct physiological effects of a substance (eg, a drug of abuse, a medication) or a general medical condition (eg, hypothyroidism).</td>
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<tr>
<td>E. The symptoms are not better accounted for by bereavement, ie, after the loss of a loved one, the symptoms persist for longer than 2 months or are characterised by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.</td>
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CHAPTER SIX – ANXIETY DISORDERS

Helping the Consumer to Manage Anxiety

Aiming to Achieve the Five Cs

**Consumer and carer**

During initial contact and assessment good communication is essential for the health professional/worker in establishing engagement. An ability to listen actively and to communicate empathy (compassion) and caring are particularly important.

Everyone experiences anxiety at different times. It is normal and appropriate to become anxious in some situations. The body has a system that responds in a certain way to potential danger situations to make the consumer more able to fight or flee. This type of anxiety is normal. It is not a cause for concern and can help in many situations, for example in interviews, meetings and exams.

Anxiety disorders are diagnosed when the level of anxiety is out of proportion to the situation. The consumer with anxiety disorder becomes anxious when there is no real danger (for example: the consumer refuses to speak in large groups for fear of making a mistake or the fact that they might be judged).

Carer involvement in consumer treatment programs is also vitally important with anxiety due to their “lived” experience with the consumer. However we do have to recognise the consumer’s right to confidentiality and obtaining consent prior to engaging a carer is vital. Encourage the consumer to engage carers/family in treatment plans and options. Avoid over engagement with carers at the expense of the therapeutic relationship with the consumer. This means that building a positive relationship with the consumer is the most important goal and we have to be careful not to sacrifice this when we seek background history from the carer/family. The aim is to empower the consumer in their care while actively involving the carers. For a detailed discussion on health professional/consumer communication, please refer to Chapter 4.

Living with a consumer who is anxious can be difficult at times. It may restrict the activities of other family members in important ways. For instance, a consumer who is anxious about going to unfamiliar places may unknowingly force the family/carer not take a holiday.

The key to supporting a consumer who is anxious is to be encouraging and understanding. It will be important not to reinforce the person’s fears by reassuring the person with panic disorder that their fears are realistic. Provide regular information to the consumer and carer/family on their treatment and progress, utilising treatment specific material (eg, user-friendly brochures on anxiety, what it is and helpful ways of coping with it). Hints for carer/family include:

- Encourage the consumer to talk about what’s happening (feeling and thoughts);
- Try to focus on their strengths rather than their weaknesses;
- Try to create a calm and non-demanding environment at least for a little while;
- Make an effort to include pleasant or recreational activities;
- Don’t get involved in arguments in the short-term. The consumer may be likely to overreact and have particularly strong emotions. Look to de-escalate rather than escalate conflict for a while.
Provide information on available community resources (for example, mental health nurse/service, life promotions officer, available community services, consumer support group, and carer support group). Actively involve the consumer/carer in the development of Care Plans that are specific to their anxiety needs and include regular review and updating as the goals change. It is important to regularly review and seek input from the consumer and carer about what the important issues or difficulties are from their perspective.

It is also important to provide emotional and social support to the carer/family. Hints for support include:

- Offer them time to express their feelings and emotions on what they see as the key issues;
- Give reassurance relating to the consumer’s illness and level of progress;
- Suggest applying some coping strategies to their routine (for example, taking breaks, relaxing, taking time out); and
- Be available to support them and offer education to them as the principal caregiver.

**Context of Community**

As we discussed in the previous section, continuous and effective consultation and collaboration is necessary between consumers, carers, service providers, elected leaders and community members. This is vital in developing culturally appropriate healing strategies that directly meet the traditional and spiritual needs of Indigenous people.

When working in Indigenous settings, we must aim to listen and learn from the people we are working with to understand about local history, issues and living conditions. The consumer may present in such a way that would in other circumstances indicate symptoms of a depressive episode but due to cultural issues could have a more logical explanation. Some examples are:

- The consumer presenting with perceived low mood or symptoms of anxiety. It may be that the consumer is extremely shy, ashamed or just nervous because they have to see a health worker;
- Certain questions or the manner in which they are asked by the health professional/worker may be seen as inappropriate in cultural terms. Direct questioning may be seen as rude and may actually be anxiety provoking.
- Where it is necessary to address sensitive issues (for example, men’s business) open the discussion by acknowledging that it might be seen as intrusive and explain why it is necessary to ask such a question. Sensitive issues can also be anxiety provoking.

Remember to respect cultural and health beliefs and recognise the historical and cultural factors that affect people’s health and wellbeing. Acknowledge and utilise the local community’s expertise and work in partnership. The health professional/worker should avoid imposing their own cultural bias on others and should encourage and support local solutions.


Continuity of care
It is vitally important that consumers suffering from anxiety are followed up on a regular basis due to the need for ongoing support, management and assessment of severity of symptoms. Anxiety is frequently comorbid with other mental disorders. Anxiety symptoms commonly occur in combination with depression, so it is important to follow up on self-harming or suicidal ideation, side effects to medication (if used as a treatment option) and compliance with same in the community setting.

More often than not consumers suffering from an anxiety disorder will be managed in the community setting. However this can be dependent on the severity of their symptoms, availability of supports and access to community services. In-patient admissions for consumers may deal with reducing risk factors and providing a safe environment while establishing the consumer on an appropriate treatment program. This does not mean that other symptoms of the illness are not still present on discharge.

When it is determined that the consumer is suffering from an anxiety disorder, it is important to make contact at the earliest possible opportunity. There are a number of reasons for this:

- Health professional/worker can offer immediate support and reassurance for the consumer.
- Health professional/worker can obtain a true picture of the consumer’s mental state and perform a risk assessment. Some risk factors may alter in different settings and environments.
- An assessment of the overall living environment and supports in place can be completed.
- Contact with the consumer’s carer/family can be established offering support to carer/family, providing information on illness/diagnosis and determining the issues and concerns that family/carers may have.
- It is important to determine the consumer’s degree of insight as this will have a bearing on ongoing care, compliance and level of follow-up/intervention.
- Provision of education and monitoring of prescribed medications is important to promote compliance. This is also a good opportunity to observe the client for any side effects relating to the medication.
- Drafting of a community Care Plan must commence at the nearest available opportunity. This should incorporate the consumer’s/carers perspective, primary health care staff, the local mental health team and any local organisations that may be involved in the consumer’s care. (For example, ATODs, life promotions officer, sports and recreation officer.) However this will be dependent upon the available resources in the community.

Continuity of Care is essentially an ongoing activity. It is performed on a consistent basis while there is a need for the consumer to be supported by their primary health care service for their mental health issues. Emphasis should also be placed on continuity of care in relation to preparing and empowering the consumer in aspects of their care. The opportunity for consumers to take control of these aspects of care is vitally important. Sharing responsibility requires willingness on the part of the health professional/worker to view continuity as a partnership where all parties have shared control.

A Care Planning document is seen as an important part of managing this process and should be completed in consultation with the multidisciplinary team, the consumer and the family/carer. The Care Plan offers a structured approach for all involved parties and can be updated as goals and treatment issues change.
What the Care Plan should incorporate for anxiety disorders:

- Assessment of consumer's mood and mental state. This can then be utilised to determine the stage of treatment/recovery the consumer is at in relation to their illness. For example, the presence of intense feelings of anxiety with frequent panic attacks indicates that the immediate focus of care should be around safety and decreasing the level of severity of attacks. This can be done by focusing on relaxation techniques like deep breathing or muscle relaxation exercises.

- It should be developed or altered accordingly relating to risk factors whether that be a consumer's risk to self, others or risk from others. For example: is there a risk of self-harm; is the consumer safe in their home environment; are there enough support mechanisms in place; is there a responsible carer/family member around at all times; does the client require in-patient treatment?

- The Care Plan should incorporate positively (avoid negative comments) the consumer’s goals or achievements. Focus on strengths rather than weaknesses. Portray highlighted problems in a positive manner. Encourage the consumer to first identify the problem. This may give them a sense of achievement or empowerment.

- It should be concise and to the point using simple language that the consumer and carer can understand. Avoid clinical jargon. For example instead of: the consumer will engage in breathing activities to alleviate the onset of panic attacks; try: Tom will use deep breathing exercises to help overcome his panic attacks.

- Place emphasis on achievable goals as overloading the consumer with too many goals may be overwhelming for their stage of recovery. Take the treatment phase one step at a time, with the most acute issues being addressed first. Avoid overwhelming the consumer with a long list of issues that may need addressing. (Cognitive Behavioural Therapy [CBT] may be a treatment option after the acute issues of anxiety have been addressed.)

- Use realistic timeframes and ensure the Care Plan is regularly updated emphasising the consumer’s achievements (positive reinforcement of these is important so that the consumer and carer/family is aware of the progress being made). For example, “Tom will aim to reduce the severity of his panic attacks with deep breathing exercises over the next 24 hours”, is not achievable and would probably put even more pressure on the client.

- Ensure that the consumer/carer/family view is considered and realistic concerns for all parties are included in the document. For example, the consumer’s mother states that the consumer’s presentation at interview with the mental health nurse is incongruent (different) with how he is at home.

- Also ensure the Care Plan is split into sections emphasising the role of each person involved in the consumer’s care. This gives all involved parties a sense of ownership in the care process and gives the consumer a sense of support and safety. It reinforces to the consumer that they are not alone. For example: the consumer will participate in regular 1:1 sessions with the mental health nurse; the carer will offer support with daily activities; the health worker will visit the consumer at home every three days for a chat and to provide further medications; the mental health nurse will follow up with the consumer weekly.

- A copy of each Care Plan should be made available to all involved parties and a copy should be kept in the consumer’s file.
The frequency of visits/supportive follow-up for the consumer (daily weekly, fortnightly, monthly etc) may be determined by a whole range of factors. These factors should indicate either increased or lower occasions of service dependant upon the effect they have on a consumer's mental health. Please refer to Chapter 5 for a list of these factors.

Ideally a consumer should have regular follow-up if any or all of these factors have been identified as prominent issues in their Care Plan. However where intense follow-up is necessary, care should be taken not to alienate the consumer. The emphasis should be on rapport building in a non-intimidating environment with awareness of some consumers’ beliefs about shame and stigma attached to mental illness. Clinicians should be careful not to assume they understand the consumer’s feelings about stigma and mental illness. Rapport building is vitally important to the concept of “continuity of care” as a long-term approach.

Checking for change
Utilisation of outcomes measures can be very beneficial in the ongoing care of the consumer and the direction taken based on the outcomes scores. Ideally a set of outcome measures should be used as the basis for determining the course of care and high scoring areas should be addressed in the Care Planning document. However it is important that the consumer/carers have an understanding of the principles surrounding the measurements and that these are used taking into consideration cultural issues relating to Indigenous consumers. It is important to remember that if a health professional/worker is going to use the measurement tools they must first have formal training in the area to ensure that they have a full understanding of the concepts involved. Clarification should be sought at any point where a health professional/worker has difficulty understanding or scoring a particular item. This can be done by:

- Liaising with another worker who has outcomes training;
- The local mental health clinician/worker; and
- The Outcomes Coordinator/Educator.

Whenever completing outcomes measures with Indigenous consumers, it is extremely important to be guided by the four principles identified in Chapter Three. Principle one reminds you to involve additional informants in your assessments that lead to outcomes ratings. Remember that carer/family involvement plays a big part in providing you with greater understanding of the consumer’s experience based on the additional information and insight that they can provide. You are also expected to utilise the expertise of the Indigenous health worker or mental health worker when completing assessments.

When using the outcome measures to assess a consumer possibly suffering from anxiety it is always important to keep in mind issues that are similar to those for someone possible suffering from depression. For a list of these issues and a discussion of their impact on item rating, please refer to Chapter 5.

Considered clinical care
With the Fifth “C” it is important that clinicians consider, but not be limited to, the recommendations. The guidelines should not necessarily be interpreted as absolute standards of practice. Mental health professionals care for patients with anxiety in many different settings, some are isolated and challenging, where it isn’t feasible to apply all of the recommendations.
Anxiety

What is Anxiety?

People who feel edgy and nervous and restless – and who worry about things a lot of the time – might have an anxiety disorder.

THEY MIGHT

Feel afraid for no good reason
Walk round all night instead of sleeping
Worry about things a lot of the time

Get angry too quickly
Not concentrate well and not be able to work
Feel short of wind and shaky and sweaty

What makes me anxious?

These things can cause anxiety

Poor physical health
Loss or bereavement
Too much stress
Too much Alcohol or Gunja or other drugs
Stopping usual treatments
Breaking Law
Family History (someone else in the family has the illness)
What change helps if you are anxious?

OUTSIDE CHANGES
Family support
Elders
Traditional Healer
Clinic Mob
Mental Health Mob
Anti anxiety and antidepressant tablets with dosette or Webster pack
Hunting, fishing, dance
Going to country
Stopping gunja, alcohol or Other drugs

INSIDE CHANGES
Know about treatment
Remember totems, family, elders
Remember what keeps you strong – spiritually and emotionally
Make changes so that you are doing what keeps you strong – spiritually, physically, socially and emotionally
Relax more
Think positive

How do you make change?

• Everyone can make change – when they are ready
• There are lots of different ways to change
• Telling people they SHOULD change doesn’t help
• Letting them know you think they CAN change does help
• Everyone changes in his or her own time
• Small steps can lead to big changes

This information sheet is produce by AIMHI NT – 2005. We invite your feedback and comments. (08) 89227943
Treatment for Anxiety: Guidelines for Clinicians


OVERVIEW
These guidelines are an adaptation of the “Summary Australian and New Zealand Clinical Practice Guidelines for the Management of Panic Disorder and Agoraphobia”, (2003) published in Australasian Psychiatry by Gavin Andrews, Mark Oakley-Browne, David Castle, Fiona Judd and Andrew Baillie for the RANZCP Clinical Practice Guideline Team for the Treatment of Panic Disorder and Agoraphobia (Andrews, Oakley-Browne et al 2003). NH&MRC-defined levels of evidence for each suggestion are recorded in the text and information regarding these is published elsewhere (Boyce, Ellis et al 2003; Boyce, Ellis et al 2003) and includes a description of the guideline development process. Consumer guidelines have also been developed. While the levels of evidence are retained in this document, the reader is referred to the original documents for full referencing. Also incorporated in this adaptation is material from the “Treatment Guide for Consumers and Carers on Panic Disorder and Agoraphobia” written by Professor Gavin Andrews, Louise Shepherd, Andrew Page and Andrew Baillie (Andrews, Shepherd et al 2003).

Introduction

Anxiety is:

The apprehensive anticipation of future danger or misfortune accompanied by a feeling of dysphoria or somatic symptoms of tension. The focus of anticipated danger may be internal or external. (American Psychiatric Association 1994)

Anxiety is a normal and unavoidable part of life. In fact it sensible to become anxious in some situations. For instance, in a situation of danger a manageable degree of apprehension can help prepare for immediate action (also called the “fight or flight” response). This type of anxiety is useful and normal and is not a cause for concern.

Panic disorder and agoraphobia
Anxiety becomes a real concern when it is either excessive and/or cannot be switched off. When this is the case the person may have an anxiety disorder. There are many types of anxiety disorders. Some involve a background of elevated worry, regardless of circumstances. Some result in sudden and frightening physical experiences – so real that the person experiencing them may feel they are having a heart attack (panic attacks). Some can result in significant behaviour and lifestyle changes in an attempt to avoid situations that are thought to bring on anxiety or panic. These last two are features of panic disorder and agoraphobia respectively.

What is panic disorder?
Panic disorder is very different to everyday anxiety. Panic disorder is a condition that affects 1-2% of the Australian and New Zealand populations each year. It usually begins during the teens or early twenties and women are twice as likely as men to experience it.

The exact causes of panic disorder are still unclear but there is some evidence of a family tendency to nervousness and a link with major life events and stresses. Panic disorder involves recurrent, unexpected panic attacks. A panic attack is a sudden
period of intense fear or discomfort, in which four or more of the following symptoms reach a peak within 10 minutes:

- Palpitations, pounding heart, or accelerated heart rate;
- Sweating;
- Trembling or shaking;
- Sensations of shortness of breath or smothering;
- Feeling of choking;
- Chest pain or discomfort;
- Nausea or abdominal distress;
- Feeling dizzy, unsteady, light-headed, or faint;
- Derealisation (feeling “unreal”) or depersonalisation (feeling detached from yourself);
- Fear of losing control or going crazy;
- Fear of dying;
- Numbness or tingling sensations; and
- Chills or hot flushes.

At least one of these attacks is followed by one month (or more) of one (or more) of the following:

- Worry about having more attacks;
- Worry about what the attacks “mean” (eg, losing control, heart attack, or “going crazy”); and
- A significant change in behaviour related to the attacks (especially one that allows avoiding a situation that causes anxiety).

Research suggests that people who suffer from panic disorder:

- Report that they feel disabled by their problem and this often interferes with work and other life responsibilities;
- May lead restricted lives: eg not driving far from home, missing special occasions due to their fear of panic attacks;
- Use more alcohol and other drugs, possibly as a way to deal with their distress;
- Think about suicide more often and have greater risk of attempting suicide;
- Spend less time on interests, sports and other satisfying activities;
- Are often financially dependent on others; and
- Spend more time seeking medical advice because they are afraid they have a life threatening illness.

What is agoraphobia?

Agoraphobia is often thought to mean that people are afraid of “open spaces”. This is partly true, however agoraphobia also refers to anxiety associated with being in places or situations from which escape might be difficult or where help is not available in the event of a panic attack.

For this reason people with agoraphobia often avoid busy public places or only enter these situations with a trusted friend or relative. People may also avoid exercise, sexual relations, going out in hot weather or experiencing strong emotions such as anger. These forms of avoidance, also known as “safety behaviours” will also need to be addressed for treatment to be successful. Obviously this can be extremely disabling and limits opportunities in work, social or other activities.
Managing anxiety symptoms
There are several ways that people can manage their anxiety symptoms themselves. Here are some simple techniques.

**Slow breathing techniques**
Part of the “fight or flight” response is increasing the rate of breathing. An increase in breathing can be triggered as part of the automatic “fight or flight” response. Common sensations of over breathing include feeling light-headed, dizzy or things feeling unreal and feeling breathless. If a person experiences these sensations when anxious, over breathing may be playing a role.

Some people with panic disorder may be more anxious in general and may over breathe in other situations, whereas other people with panic disorder only tend to over breathe in association with certain situations. It is possible to demonstrate how an increase in breathing can affect feelings by deliberately over breathing until sensations such as feeling dizzy and light-headed are experienced.

It is much easier to prevent a panic attack than to stop one. The slow-breathing technique is a skill that is easy to learn and can be used at times when symptoms of the “fight or flight” response are experienced. The best approach is to start slowing breathing at the first signs of anxiety. It is best to breathe using the diaphragm (lower stomach), not the chest. Below is a set of typical instructions to help someone with their breathing.

**Slow-breathing technique**
Take a regular breath (through your nose) and hold it for six seconds (use a watch). When you get to six, breathe out and say the word “relax” to yourself in a calm and soothing manner. Breathe in and out in a six second cycle (in for three, out for three). Continue breathing in this way until the anxiety symptoms of over breathing have gone. There are a number of good tapes and CDs available. It is not so important which one you choose – the important thing is taking time to relax.

The person who is being instructed about breathing should be encouraged to practise this technique until she or he is able to automatically start slowing her or his breathing in response to anxiety-provoking thoughts and/or situations. They should be told that over the next few weeks it would be helpful to monitor their breathing rate at different times throughout the day and to practice the technique.

**Relaxation training**
Relaxation is the voluntary letting go of tension. This tension can be physical tension in the muscles or it can be mental (or psychological) tension. When we physically relax, the impulses arising in the various nerves in the muscles change the nature of the signals that are sent to the brain. This change brings about a general feeling of calm, both physically and mentally. Muscle relaxation has psychological benefits as well as physical. Through relaxation training you will learn how to recognise tension and achieve deep relaxation.

When someone is in a continual high state of tension, it’s easier for a panic attack to occur because the body is already highly activated. A minor event, such as getting stuck in traffic, can trigger further tension, which in turn can lead to hyperventilation (over-breathing) and panic. By learning to relax, it is possible to reduce general levels of arousal and tension, and gain control over these feelings of anxiety.
Meditation
There are many different types of relaxation that can achieve similar benefits. Possible types of relaxation are meditation, yoga, or tai chi. Any of these may be useful if they reduce tension and people under stress or experiencing anxiety should be encouraged to find time each day to relax.

Guided imagery
For many people who feel anxious about doing something hard it may be useful to encourage them to practice it in their mind first. They should think about doing whatever they are worried about in a successful, calm way – even if it is hard. Help them to imagine that they are coping.

Exercise
Many people with panic disorder avoid doing aerobic exercise as the increase in heart rate and faster breathing may remind them of panic symptoms. However, in the long-term exercise is a very important way of dealing with anxiety and is an important part of stress management. Recommend at least three sessions of exercise per week, choosing activities that are enjoyable and varied and encourage setting and maintaining a routine.

Exposure
When anxiety causes people to avoid everyday places and activities they should be encouraged to gradually reintroduce these into their life. First, they should write a list of things that are avoided because of anxiety and then start to gradually reintroduce these activities. Achievable goals are important and anyone trying to overcome their anxieties in this way should be encouraged and helped to reward themselves, even if their attempts had not been entirely successful. They should be told that it is important to feel some anxiety during the exposure exercises and to "stay with" the anxiety until it reduces. They may need to be reassured that it will reduce and supported to keep up their efforts. However, if after using these recommendations for several weeks panic attacks or avoidance behaviours are still present, specialist referral should be sought. Facing fears can be hard work. Support and advice from a professional may be vital.

Effective treatments for panic disorder
Panic disorder is a condition that we know a lot about. There has been a great deal of research to find out which treatments are effective. That is: which treatments will significantly help someone with panic disorder. The aims of treatment for panic disorder are:

- To help that person cope with and stop panic attacks;
- To help them become aware of and stop fear-driven avoidance; and
- To help them reduce their vulnerability to future panics.

It is important to remember though that even if treatment is helpful, most people still experience symptoms of anxiety during their recovery. The major treatments for panic disorder are:

- Cognitive Behavioural Therapy; (CBT)
- Antidepressant medication; and
- Benzodiazepine medication.

Each of these treatments with potential advantages and disadvantages are described below.
Psychological treatments

**Cognitive behavioural therapy (CBT)**

CBT for panic disorder involves identifying and changing both anxiety provoking thoughts and their associated behaviours. There is evidence that CBT is more effective than medication in both the short and long-term.

The **cognitive therapy** part of the treatment involves identifying triggers for panic attacks and understanding the fears that a person suffering from this disorder has about the symptoms of panic. Triggers might be a thought or situation or a slight physical change such as faster heartbeat. People are taught to be more realistic in their interpretation of panic symptoms and feared situations.

The **behaviour therapy** part of the treatment looks at techniques to modify behaviours. There are several types of behaviour therapy.

**Relaxation and breathing techniques**

Panic can be made worse by over-breathing. Slowing one’s breathing rate can be effective for some people to help deal with a panic attack and also to prevent a full-blown attack from occurring. Relaxation is probably more useful as a general strategy for dealing with anxiety but has been shown to be somewhat helpful for some people with panic disorder. Relaxation and slow breathing alone have not generally been shown to effectively treat panic disorder, although there is some evidence that a form of relaxation called “applied relaxation” can be helpful.

**Interoceptive and in-vivo exposure**

Another type, exposure therapy, involves becoming less frightened of the symptoms of panic in a controlled manner, by becoming used to them in a controlled way. For instance, it might involve jogging on the spot in the therapist's office to become more familiar with the meaning of certain symptoms such as rapid heartbeat and shortness of breath. For those who avoid situations for fear of having a panic attack it will be important to face feared places. This type of exposure involves breaking a fearful situation down into achievable steps and doing them one at a time until the most difficult step is achieved.

**Education about the disorder**

Understanding about anxiety in general and panic disorder specifically is helpful to dispel fears that commonly held about this disorder, such as, that they are going crazy or will die as a result of the symptoms.

**Medications for panic disorder**

**Anti-depressants**

There are many different types of anti-depressant medications that have been found to be effective in treating panic disorder. Each type works slightly differently. The doctor and patient should discuss the different medications and the patient’s circumstances to decide which will works best while causing the least amount of side effects.

Most medications will be started at a low dose and increased to an effective level over several weeks. Some people will experience side effects, and it is important to discuss these with your doctor. Currently there is no evidence that the benefits of medications will continue once the medication is stopped. Classes of medications commonly prescribed are:
Selective Serotonin Re-uptake Inhibitors (SSRIs)
The most well known of these medications is probably Prozac (fluoxetine) but now there others including Luvox (fluvoxamine), Efexor (venlafaxine), Aropax (paroxetine), and Zoloft (sertraline). Side effects include headaches, nausea, insomnia and difficulties with sexual intercourse. Symptoms can also occur when the patient stops the medication suddenly.

Benzodiazepines
These drugs are designed to reduce tension and increase relaxation without causing sleep. Benzodiazepines such as alprazolam (Xanax) have been found to be effective in treating panic disorder. Disadvantages of this class of medication include their addictive quality and problems with withdrawal when the medication is stopped. Long-term use is associated with dependence, increased risk of motor accidents and memory problems. Other medications have been studied for panic disorder but there is not sufficient information at this stage to recommend their use.

“How long until I feel better?”
Improvements will not be seen instantly with any type of treatment so it is important to encourage patience and to support the patient in continuing to work towards recovery. All treatments require the patient to be actively involved.

Generally with most anti-depressant medications results will take three to four weeks to be seen. If after six weeks on a certain medication there has been little or no improvement the mental health specialist will consider other options.

With CBT improvement will often be gradual and the patient needs to be encouraged to give the treatment a chance. Treatment often involves eight to 12 sessions of 60-90 minutes. With CBT patients need to be active participants in treatment. They need to practice the techniques and complete homework between sessions. If there has not been any improvement after six to eight sessions, other treatments will have to be considered.

Questions about treatment
- What is the diagnosis?
- What can I expect if I do not get treatment? What happens if I do nothing?
- What are the treatment options?
- What are the benefits and harms (costs) of the treatment options?
- How long will it take?
- What results can I expect?
- How much time and/or effort will it take me?
- What will it cost me?
- Is there anything that would complicate treatment? (Other problems such as depression or substance misuse may make treatment more difficult and take longer to see benefits.)
- Can we make a time to review progress and if necessary revise our treatment plan?
- Are these the latest treatment guidelines for my condition? Can you recommend any reading material including self-help books?
- How do the benefits and harms weigh up for me?
- Can I speak to someone who has been through treatment with you?
- Or to someone who has been through this procedure with other therapists?
Common questions to ask about medication

- Name of medicine:
- Dose / instructions:
- When and how often do I take the medicine?
- What are the side effects? Will I be tired, hungry, thirsty etc?
- Are there any foods I should not eat while taking it?
- Can I have beer, wine or other alcoholic drinks?
- Can I take the medicine with other medicines I am taking?
- What do I do if I forget to take the medicine?
- How long will I have to take the medicine?
- What are the chances of getting better with this treatment?
- How will I know if the medicine is working or not?
- What is the cost of the medicine?
- Any other questions?

Readers can also check out a website which includes a checklist of issues to consider (www.voyager.co.nz/~rational/).

Carer Issues
What About the carers?
Living with someone who is anxious can be difficult at times. It may restrict the activities of other family members in important ways.

The decision to get help for panic disorder can be a difficult one to make. There will often be a lot of fear associated with seeking treatment and for those with agoraphobia getting to treatment will often involve facing one’s fears. For some, past treatment may have been disappointing and they may be sceptical about the benefits of seeking help.

The key to supporting a relative or friend who is anxious will be to be encouraging and understanding. It will be important not to reinforce the person’s fears by reassuring the person with panic disorder that their fears are realistic. The organisations and reading suggested below will also be helpful for family members and friends of people experiencing panic disorder and agoraphobia.

Information and support
There is a range of options for support while you are experiencing panic disorder or agoraphobia. It is important to accept support when it is offered as facing fears can be hard work if done on your own. Friends and family are an important source of support as well as your local GP, Primary Health Clinic doctor, other health professionals and mutual support organisations (see below).

Queensland organisations
The organisations below are mostly voluntary, non-government agencies. They do not replace the need for formal treatment but are an adjunct to it and can provide further information.

QLD Obsessive Compulsive Disorder Support Group
Mental Health Association (QLD) Inc
Orford Drive, Wacol QLD
PO Box 475 Summer Hill QLD 4074
Ph: 07 3271 5544 Fax: 02 3271 6815
Email: association@mentalhealth.org.au
Website: www.mentalhealth.org.au
Suggested reading

**Panic disorder and agoraphobia**


Page, A (2002), *Don't Panic! Overcoming Anxiety, Phobias and Tension.* Sydney, ACP/Media21


**Cognitive therapy**


**Stress management**


Burrows, GD, Stanely, RO & Norman, TR (1999), *Stress, Anxiety and Depression:* Adis International Pty Ltd.


**WEBSITES**

American Psychological Association (APA) [www.psych.org/main.html](http://www.psych.org/main.html)

Anxiety Disorders Foundation of Australia (NSW) [www.ocs.mq.edu.au/~abaillie/adfa.html](http://www.ocs.mq.edu.au/~abaillie/adfa.html)

Australian Association for Cognitive Behavioural Therapy (AACBT) - [www.psyc.uwa.edu.au/aacbt](http://www.psyc.uwa.edu.au/aacbt)


Beck Institute – [www.beckinstitute.org](http://www.beckinstitute.org)

Behaviour Online - [www.behaviour.net - cognitive therapy](http://www.behaviour.net - cognitive therapy)


Center for Cognitive Therapy - [www.med.upenn.edu/~psyct/](http://www.med.upenn.edu/~psyct/)

Clinical Research Unit for Anxiety Disorders, Sydney – [www.AforAnxiety.com](http://www.AforAnxiety.com)

Internet mental health – [www.mentalhealth.com](http://www.mentalhealth.com)

Royal Australian and New Zealand College of Psychiatrists – [www.ranzcp.org/](http://www.ranzcp.org/)

The CBT Website – [www.cognitivetherapy.com](http://www.cognitivetherapy.com)

CHAPTER SEVEN – SELF HARMING BEHAVIOURS

Helping the Consumer to Prevent Self-Harm

Aiming to Achieve the Five Cs

*Consumer and carer*
Self-harm is a behaviour and not an illness. People sometimes self-harm to deal with distress or to let people know they are in distress. This can sometimes be described as “a cry for help”. There is no one cause for self-harming behaviour. Some people think that self-harming is just “an attention seeking” behaviour. This belief is unfounded and makes little of self-harm and the distress the consumer is feeling at the time. During initial contact and assessment good communication is essential for the health professional/worker in establishing engagement. Consumers exhibiting self-harming behaviours may require constant reassurance due to low mood, feelings of worthlessness and an inability to cope.

It is important not to inflict judgmental views on the consumer due to possible issues of shame and guilt and the threat of future reluctance to engage. Being non-judgmental also requires that service providers be uncritical of factors affecting many consumers over which they have little control. For example: in the case of a consumer with a long standing history of sexual abuse as a child, superficial cutting may be a learned behaviour as a means of coping as a result of poor support or treatment of the traumas they experienced in their childhood.

As discussed in previous sections, carer involvement is important. However we do have to recognise the consumer’s right to confidentiality and obtaining consent prior to engaging a carer is vital. Consent can be overridden in situations where a consumer or carer may be placed at significant danger due to risk factors relating to mental impairment. For example: a consumer in crisis, engaging in self-harming behaviours, may not meet the criteria for an in-patient setting/admission however ongoing continuance of this behaviour could increase the risk of death by accident. Therefore in some situations, it is vitally important that there is carer/family involvement to ensure the consumer is safe and to remove potential items of harm. Based on context of the community (eg communities in crisis) it may be hard to distinguish a reliable carer/family member and emphasis to the importance of seeking an appropriate (suitable/reliable) other is essential.

*Context of community*
As discussed in previous sections, there needs to be continuous and effective consultation and collaboration between consumers, carers, service providers, elected leaders and community members. This is vital in developing culturally appropriate healing strategies that meet the traditional and spiritual needs of Indigenous people.

When working in Indigenous settings, we must aim to listen and learn from the people we are working with to understand about local history, issues and living conditions. The consumer may present in such a way that would in other circumstances indicate symptoms of self-harming behaviour but due to cultural issues could provide a more logical explanation.
Examples are:

- consumer presents with superficial lacerations (cuts) to their forearms following the death of a family member. It is not uncommon in some Indigenous communities for people to express their grieving through self-injury in the form of “sorry cuts”.
- Certain questions or the manner in which they are asked by the health professional/worker may be seen as inappropriate in cultural terms. Direct questioning may be seen as rude.
- Where it is necessary to address sensitive issues (eg women’s business) open the discussion by acknowledging that it might be seen as intrusive and explain why it is necessary to ask such a question.

Remember to respect cultural and health beliefs and recognise the historical and cultural factors that affect people’s health and wellbeing. Acknowledge and utilise the local community’s expertise and work in partnership. The health professional/worker should not impose their own cultural bias on others and should encourage and support local solutions.

**Continuity of care**

It is vitally important that consumers presenting with self-harming behaviours are followed up on a regular basis due to the need for ongoing assessment for severity of symptoms. Examples would be assessment of ongoing self-harming or suicidal ideation, ongoing support with behavioural treatments (medication treatments are not usually used) in the community.

Health professionals/workers should be aware that consumers who have spent time in an in-patient setting with self-harming behaviour and are discharged back into the community still need intensive follow-up.

In-patient admissions for consumers may deal with reducing risk factors and provide a safe environment while establishing the consumer on an appropriate form of treatment. This does not mean that other symptoms of the behaviour are not still present on discharge. These behaviours may be triggered for the consumer by being back in the environment that represents the original trauma.

When a consumer is discharged from an in-patient setting it is important to make contact at the earliest possible opportunity. There are a number of reasons for this:

- The health professional/worker can offer immediate support and reassurance to the consumer. Some people who self-harm often have problem-solving difficulties and they find it hard to ask for help. They may have particular problems remembering how they solved a similar problem before. This may lead to feeling a loss of control and trigger further self-harming behaviour. Thus immediate contact is vitally important to prevent this from occurring.
- The health professional/worker can obtain a true picture of the consumer’s mental state and perform a risk assessment. Some risk factors may alter from in-patient to community settings. For example, the consumer may feel isolated and unsupported in a community setting compared to the in-patient setting thus heightening the re-occurrence of self-harming behaviours.
- It allows an assessment of the living environment and supports in place.
- Contact with the consumer’s carer/family can be established offering support to carer/family, providing information on the behaviours and determining the issues and concerns that family/carers may have.
- It is important to determine the consumer’s degree of insight as this has a bearing on ongoing care, treatment and level of follow-up/intervention.
• Drafting of a community Care Plan must commence at the earliest opportunity. This should incorporate the consumer/carer’s perspective, primary health care staff, the local mental health team and local organisations that may be involved in the consumer’s care (eg ATODs, Life Promotions Officer, Sports and Recreation Officer.) However this will depend on available resources.

Continuity of care is essentially an ongoing activity that is performed on a consistent basis for a consumer while there is a need for support. Emphasis should also be placed on continuity of care in relation to preparing and empowering the consumer in aspects of their care. The opportunity for consumers to take control of these aspects of care is vitally important. Sharing responsibility requires a willingness on the part of the health professional(worker to view continuity as a partnership where all parties share control.

A Care Planning document is seen as an important part of managing this process and should be completed in consultation with the Multidisciplinary team, the consumer and the carer/family. The Care Plan offers a structured approach for all involved parties and can be updated as goals and treatment issues change.

**What the Care Plan should incorporate for self-harm:**

• Assessment of consumer's mood and mental state. This can be used to determine the stage of treatment/recovery the consumer is at and can also determine if there are any underlying symptoms of mental illness (e.g. depression or schizophrenia). The presence of self-harming ideas indicates that the immediate focus of care should be around safety and employing strategies that will help the consumer cope. (e.g. When the consumer feels like harming themselves, they agree to will seek out a family member to talk about their problem, ring the health centre and/or look at the list of problem solving solutions in their notepad).

• It should be developed or altered accordingly relating to risk factors: whether that be a consumer's risk to self, others or risk from others. Is there a risk of self-harm? Is the consumer safe in their home environment? Are there enough support mechanisms in place? Is there a responsible carer/family member around at all times? However it should not focus solely on risk factors and just because there are no risk factors does not mean that there is not an ongoing underlying problem.

• The Care Plan should incorporate positively (avoid negative comments) the consumer’s goals or achievements. Focus on strengths rather than weaknesses. Portray highlighted problems in a positive manner (For example: Sally has contacted the health centre when feeling like self-harming and has talked about her problems with staff; she is encouraged to continue doing this over the next one month period).

• It should be concise and to the point using simple language that the consumer and carer can understand. Avoid clinical jargon (Instead of: Sally will attempt to engage in alternative coping strategies prior to resorting to self mutilation, try: Sally will speak to a support person if she feels like self-harming).

• Place emphasis on achievable goals as overloading the consumer with too many goals may be overwhelming for their stage of recovery. Take the treatment phase one step at a time, with the most acute issues being addressed first. Avoid overwhelming the consumer with a long list of issues that may need addressing even if these issues are important in the consumers overall care. With self-harming behaviour it is important to address the acute crisis issues first - self-poisoning, overdosing and cutting - as some of these can be potentially dangerous or life threatening.
• Use realistic time frames and ensure the Care Plan is regularly updated emphasising the consumer's achievements (positive reinforcement of these is important so that the consumer is aware of the progress being made). For example: Sally will aim to stop her bad feelings of self-harming behaviours over the next two days. This is not achievable and the consumer who is likely to have problem solving difficulties is being placed under undue pressure.

• Ensure that the consumer/carer/family view is considered and realistic concerns for all parties are included in the document. For example: the consumer’s mother states that Sally’s presentation at interview with the mental health nurse is incongruent (different) with how she is at home. Sally informs us that there are no issues currently; she denies self-harming behaviours and suicidal ideation. Sally’s mother informs that she threatens to harm herself on a daily basis at home; she made superficial cuts to her forearms yesterday and has threatened to take an overdose of tablets recently.

• Also ensure the Care Plan is split into sections emphasising the role of each individual involved in the consumer’s care. This gives all involved parties a sense of ownership in the recovery process, gives the consumer a sense of support and safety and reinforces to the consumer that they are not alone. For example: the consumer will participate in regular 1:1 sessions with the mental health nurse. The carer will offer the consumer support with daily activities. The health worker will visit the consumer at home every three days for a chat and to provide further medications. The mental health nurse will follow up with the consumer on a weekly basis.

• A copy of each Care Plan should be made available to all involved parties and a copy should be kept in the consumer's file.

The frequency of visits/supportive follow-up for the consumer (daily weekly, fortnightly, monthly etc) may be determined by a whole range of factors. These factors should indicate either increased or lower occasions of service dependant upon the effect they have on a consumer’s mental health. Please refer to Chapter 5 for a list of these factors.

Ideally a consumer should have regular follow-up if any or all of these factors have been identified as prominent issues in their Care Plan. However where intense follow-up is necessary care and understanding should be given not to alienate the consumer. The emphasis should be on rapport building in a non-intimidating environment with awareness of some consumers’ beliefs about shame and stigma attached to mental illness.

**Checking for change**

Utilisation of outcomes measures can be very beneficial in the ongoing care of the consumer and the direction taken based on the outcomes scores. The outcome measures should be used as the basis for determining the course of care and high scoring areas should be addressed in the Care Planning document. It is also important that the consumer/carers understand the principles surrounding the measurements and that these are used, taking into consideration cultural issues relating to Indigenous consumers. It is also important to remember that health professionals-workers who use the measurement tools must first have formal training in the area to ensure that they have a full understanding of the concepts involved. Clarification should be sought at any point where a health professional/worker has difficulty understanding or scoring a particular item.
This can be done by:

• Liaising with another worker who has outcomes training;
• The local mental health clinician/worker; and
• The Zonal Outcomes Coordinator/Educator.

Whenever completing outcomes measures with Indigenous consumers, it is extremely important to be guided by the four principles identified in Chapter Three. Principle one reminds you to involve additional informants in your assessments that lead to outcomes ratings. Remember that carer/family involvement plays a big part in providing you with greater understanding of the consumer's experience based on the additional information and insight that they can provide. You are also expected to utilise the expertise of the Indigenous health worker or mental health worker when completing assessments.

When using the outcome measures to assess a consumer presenting with self-harming behaviour it is always important to keep in mind certain specific issues. Some of these are:

• Self-harm.
• Excessive alcohol consumption can also alter a consumer’s presentation and it is virtually impossible to obtain a clear picture of a consumer’s mental state. Alcohol consumption can cause impulsive behaviours or acts, sometimes manifesting themselves in self-harming behaviour and/or suicidal ideation. Where there may be increased risk for the consumer while intoxicated, this usually (not always though) resolves when the consumer is sober. However it is vitally important to ensure that the consumer remains safe while intoxicated or withdrawing until further assessment can be performed when the consumer is not under the influence. There is every chance that the consumer’s frequent alcohol intoxication may be a self medicating strategy for an underlying mental health problem or a previous traumatic event.
• A consumer presents with superficial lacerations (cuts) to their forearms following the death of a family member. It is not uncommon in some Indigenous communities for people to express their grieving through self-injury in the form of “sorry cuts”. It is important that the health professional/worker determines whether this act was one of non-accidental self-injury as part of a mourning ritual or an act of self-harm relating to personal issues. Carer/family members and an Indigenous health/mental health worker must be consulted to determine if this behaviour is consistent in form, intensity and duration with socially and culturally acceptable behaviours of that community.

Any information/data collected from the outcomes measures relating to the consumer’s care is confidential and it is important to reassure the consumer that all information obtained is not disclosed or used inappropriately.

**Considered clinical care**

With the Fifth “C” it is important that clinicians should consider, but not be limited to, the recommendations. The guidelines are not absolute and should not necessarily be interpreted as standards of practice. Mental health professionals care for patients with self-harming behaviour in many different settings, some of which are isolated and highly challenging, where it may not be feasible to apply all of the recommendations.
Self-harm: a Guide for Primary Care Workers, Consumers and Carers

These guidelines are an adaptation of the “Guide to Treatment for Consumers and Carers” by Jonine Penrose-Wall, Zoe Farris and Priscilla Berkery for the Royal Australian and New Zealand College of Psychiatrists. It was written in association with people recovered from self-harm and those working with them. It is intended as a general guide only and is not as a substitute for clinician advice.

About self-harm
Self-harm is a behaviour and not an illness. People self-harm to cope with distress or to communicate that they are distressed. It includes self-poisoning and overdoses, minor injury, as well as potentially dangerous and life threatening forms of injury. It does not mean body piercing, getting a tattoo, unusual sex or the recreational use of drugs and alcohol. Some people who self-harm are suicidal at the time. Others report never feeling suicidal. This guide is for and about adults who have engaged in self-harm. It aims to inform them of the best possible assessment, treatment and support and what to expect of services intended to reduce self-harm and its related suffering.

Self-harm is more common among younger people. In any year, more than 25,000 people are admitted to hospitals in Australia as a result of self-harm. Thousands more are treated in emergency departments but these cases are not included in the statistic above. Self-harm accounts for approximately 10% of all hospitalisations of young people aged 15 – 19 in New Zealand, 92% of them being due to self-poisoning. Usually, more women than men self-harm. Women more commonly take overdoses than men. Overdose is the most common form of self-harm in both Australia and New Zealand.

Indigenous people in Australia are twice as likely to die by suicide as non-Indigenous people and young Aboriginal men are at the highest risk – over three times more likely than young non-Indigenous men. Hanging is by far the most common means of suicide for both Indigenous men and women and often occurs as an impulsive act associated with intoxication and/or interpersonal conflict. While death from suicide is ten times more common among Indigenous men than Indigenous women, non-fatal self-harm is more common among women – as it is in the wider society.

Self-harm is always serious. It can cause disability and death. It is also serious because it means that a person is seriously emotionally distressed at the time of the injury.

What causes self-harm?
There is no one cause for self-harm. However, research suggests that some people seem to be more at risk than others are. These include:

- Those under stress or in crisis, and those who have self-harmed before;
- Those with mental disorders (eg anxiety, depression or schizophrenia);
- Those who misuse alcohol or other substances or have these addictions;
- Those who have experienced childhood trauma or abuse; and
- Those who have debilitating or chronic illness.
Is it just attention seeking?
Some people think that self-harm is “just attention seeking”. This attitude is unhelpful and it trivialises self-harm and the distress the person is feeling at the time.

This attitude does not take into account that people who self-harm have genuine difficulties coping. People who self-harm often have problem-solving difficulties and they find it hard to ask for help. They tend to have memories that over-generalise from experience and forget how they solved a similar problem in the past. They get stuck when trying to solve a current problem. This can lead to frustration and to feeling out of control. For other people, self-harm may indicate that they are experiencing symptoms of mental illness (eg major depression or schizophrenia).

Why should I get help for self-harm?
Of those who present to a hospital after self-harm, about half will never attend with the problem again. Others attend hospital again after repeating self-harm. This increases the chance of the behaviour becoming a habit as a response to distress.

Research shows that 1% of those who self-harm die by suicide within the first year of going to hospital with the problem. Some people die by accident after self-harm because of the seriousness of their injuries or the substance they took.

About half of all people who attend hospital after self-harm do so only once. Treatment teaches you new coping skills.

How do I get professional help?
It is important to get help whenever you have thoughts of self-harm. The primary care centre of the hospital is often the first place to get help. You do not have to be physically sick to get help. It is OK to talk to clinic staff about your feelings, problems, lifestyle and your overall wellbeing.

You can ask the primary care staff to arrange for you to meet with a mental health professional trained in providing treatments to reduce self-harm. The clinic staff can also work jointly with you and a mental health professional in the longer term.

In towns and cities you can also contact mental health services directly – free public mental health services are listed in the front pages of the phone book. They have “crisis teams” or “crisis and assessment teams”. Many also have workers who specialise in helping young people. Often, they will come to you and some are contactable 24 hours a day, at least by telephone. You can also call a help-line. These are also listed in the phone book and in many public phone boxes. They can’t provide “therapy” over the phone, but can help you over the initial crisis of feeling out of control, alone and unsafe. Their purpose is support and referral.

What will happen if I go to the hospital?
If you have already injured yourself, it is likely you will end up in the hospital emergency room. Here, staff will treat any injuries, assess you physically and mentally, make sure the parts of your body are working as they should, and will organise for you to get specialist help.

Can the hospital or clinic help me find mental health care?
It is an important job of the hospital or clinic to link you with a mental health worker for assessment and treatment after self-harm and find other support. For example:
- Staff may talk to a family member or friend to decide whether or not you will be safe to go home - this is to see what support you have if you leave hospital;
• They may contact your local doctor to discuss the idea of you seeing him or her for counselling after you leave hospital; and
• They may introduce you to, or give you the name of a mental health professional who can work through the problems that led you to harm yourself.

Some people are admitted to hospital after self-harm. Usually this is to treat a mental illness where the person cannot be treated at home. However most mental health care is provided on an outpatient basis in your community.

Can I help myself?
About one-half to two-thirds of people who self-harm do not keep appointments with health professionals. The steps toward helping yourself include:
• Decide to keep appointments;
• Work with the health and mental health staff;
• Find out about their training and skills so that you can have confidence in the treatment they offer; and
• Always remind yourself of the positive skills you have and build on these.

Keeping the first appointment is a step toward helping yourself.

How effective are treatments for self-harm?
It is difficult to prove that treatments work and research has not shown any approach to be clearly successful in specifically reducing self-harm. However, the main focus of treatment should be to deal with any underlying mental health problems.

Treatment Goals
• Treat associated mental illness;
• Prevent future self-harm;
• Improve coping skills;
• Reduce distress;
• Prevent suicide;
• Extend the time between self-harm;
• Reduce injury severity; and
• Help your family to help you.

Treating depression
Antidepressant medication should only be used by people if actually depressed and should be taken exactly as prescribed. SSRIs are a class of anti-depressant medication that are effective for treating depression. Some people can feel agitated on SSRIs and should report this to their doctor. It was once thought that SSRIs prompt suicidal feelings. However it has been shown not to increase suicidal behaviour.

Treating bipolar disorder
Lithium is a mood stabilising medication for bipolar disorder - a kind of mood disorder. It has side effects and can become toxic over time. A doctor must monitor it regularly. It has been shown to reduce self-harm in those with bipolar disorder and some people diagnosed with some sorts of personality disorder. It should only be taken if prescribed.

Psychological treatments
Cognitive behaviour therapy (CBT), Problem Solving Therapy (PST), Dialectical Behaviour Therapy (DBT) and Interpersonal Therapy (IPT) are all forms of psychological treatment with proven effectiveness for helping people with depression, anxiety disorders and other mental health problems. There are no side effects. There
is some research to show they may help people reduce risk for self-harm. Health professionals need special training to use these treatments.

**What other things may help?**  
Coupled with looking after yourself and your relationships, and thinking positively about the future, most agree it is possible to overcome self-harm in time. It is recommended that you use the recommended research-based treatments for any mental disorder you might be experiencing and get help to cope with stress.

Some people have found the following to sometimes be helpful:

- Attending support groups for people with similar problems;
- Reading books about other people’s recovery;
- Continuing activities that are positive in your life and to be hopeful about the future;
- Continuing positive relationships and observing the coping styles of other people; and
- Reading information on the internet that advises on how to get the most out of mental health care.

**Help Lines and Referral Services**  
If you wish to talk to someone about deliberate self-harm the most useful contact is your primary care service.

- To find out what mental health services are available in your area look in the “Emergency Health and Help” section of your local White Pages.
- If you need to talk to someone urgently please call:
  - Lifeline Australia 13 11 14
  - Just Ask Mental Health Information and Referral Service 1300 131 114
  - Kids Help Line 1800 55 1800
  - Your state or territory association or foundation for mental health. Contact details can be found in the phone book.
Adult Deliberate Self-Harm: a Guide for Clinicians

These guidelines are an adaptation of the “Summary Australian and New Zealand Clinical Practice Guidelines for the Management of Adult Deliberate Self—Harm”, published in Australasian Psychiatry by Philip Boyce, Greg Carter, Jonine Penrose-Wall, Kay Wilhelm and Robert Goldney for the RANZCP Clinical Practice Guideline Team for Deliberate Self-Harm (Boyce, Carter et al 2003) which are themselves based on the RANZCP full guidelines (Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Deliberate Self-harm 2004). NH&MRC-defined levels of evidence for each suggestion are recorded in the text and information regarding these is published elsewhere (Boyce, Ellis et al 2003; Boyce, Ellis et al 2003) and includes a description of the guideline development process. Consumer guidelines have also been developed. While the levels of evidence are retained in this document the reader is referred to the original documents for full referencing.

Overview
This guideline covers self-harm regardless of intent. It is an evidence-based guideline developed from a systematic review of epidemiological, treatment and medico-legal literature. All patients presenting after deliberate self-harm should be comprehensively assessed to detect and treat mental disorders, alcohol and other drug problems and personality disorders. Immediate management aims to ensure safety from further self-harm, assess and treat injuries, prevent disablement and death as a result of injuries or poisoning, and manage suicide risk by ensuring prompt psychiatric referral and mobilising social supports. Psychological management aims to detect and treat underlying mental disorders, reduce distress and enhance coping skills and thereby, reduce repeat episodes and habituation of self-harm. Managing suicide risk is a continuous responsibility and suicide vulnerability may persist long-term in some patients. There is little firm guidance from the literature on treatment efficacy to guide ongoing psychiatric management. The mainstay of psychological care remains the treatment of underlying mental health disorders. Cognitive–oriented therapies and problem-orientated approaches appear promising for reducing repeated self-harm for most patient groups but no single treatment has confirmed superiority. There is no one recommended pharmacological treatment specifically to reduce self-harming behaviours.

Introduction
Deliberate self-harm (including self-injury and self-poisoning with or without suicidal intent) is a common and serious health problem. Engaging patients in treatment and providing effective services are challenges, particularly in light of the need to screen for and manage suicide risk in this diverse patient group. This summary is intended for use by clinicians. Research shows [III-2] that improved service organisation, if sustained with staff education and supportive management, can reduce barriers to accessing specialist mental health care by these patients. International reviews and existing clinical and service development guidelines on deliberate self-harm (see comprehensive version) report that clinician and patient attitudinal barriers, fragmentation in the organisation of mental health services, and less than optimal links between specialist and primary care pose barriers to effective care.
Definitions
Deliberate self-harm is defined as an act of intentional self-poisoning or self-injury, irrespective of the apparent purpose of the act. Self-injury includes a wide variety of behaviours: self-mutilation; cutting; jumping from heights; attempted hanging; car crashes that are deliberate; and burning. Self-poisoning refers to an overdose of medications or the ingestion of other substances. Self-mutilation usually refers to self-harm where non-suicidal intent at the time of the injury is clear. This does not include culturally informed and socially sanctioned behaviours involving self-injury as occurs in some tradition-oriented societies in association with mourning and other rituals.

Overview of deliberate self-harm
Although it evokes strong negative feelings in some health professionals, repeat deliberate self-harm is a relatively infrequent problem with a low base rate of presentations. Furthermore, between 41 and 70% of adolescents and adults who present with an index episode of deliberate self-harm do not attend follow-up treatment. This hampers the further development of an evidence base for individualised treatment approaches. The mainstay of treatment is the detection and management of underlying mental disorders and the prevention of further episodes. Most current knowledge about the patient population is based on non-Indigenous hospital studies and little is known about deliberate self-harm in the wider Australian or Indigenous populations. In hospital samples, psychiatric disorders are present in >50%. Drug and alcohol abuse, personality disorders and physical illness are all over-represented. Elevated rates of suicide attempts have been demonstrated among those with childhood sexual abuse histories. Intoxication with alcohol and other substances is common prior to self-harm and may confound diagnosis and complicate assessment and management. Patients may be difficult to engage in a therapeutic alliance. Although the majority harm themselves only once, management requires providing assessment to the large numbers of persons presenting with varied needs. Services must determine management approaches that are feasible to deliver. Mental health teams must be able to direct long-term effort toward those at most risk of repeat episodes. Public health approaches are used in combination with clinical service delivery approaches.

Overview of the clinical epidemiology: rates of deliberate self-harm
Notwithstanding the lack of comparable definitions and outcomes, hospital registration studies in Australia and New Zealand in 1997/1998 and in 1998/1999, report the rate for self-harm between 73 and 159 per 100 000. This is likely to be an underestimate. The most common form of deliberate self-harm is self-poisoning, which accounts for between 73 and 84% of all hospitalised cases. Deliberate self-harm is more common among women and the highest rate is among men aged 25–34 and women aged 15–24. Risk of repeat is highest in the first 3–6 months and declines slightly after, but remains high for a significant proportion of patients in the long-term, with a cumulative rate of approximately 10% at 10 years. Patients presenting with deliberate self-harm experience higher death rates from other causes.

The completed suicide rate is twice as high in the Indigenous compared to the non-Indigenous population with the highest rate being for males aged 25 to 34 (83 per 100,000, 3.5 times higher than for non-Indigenous males). The highest rate for females is for those aged 15–24, being 20 per 100,000 (6 times the rate for non-Indigenous females in this age group). Hanging is by far the most common means of suicide, accounting for two thirds of both Indigenous male and female deaths compared to 30% and 21% for non-Indigenous males and females. Suicide has increased dramatically over the last three decades from rates that were very low.
This increase was initially in urban and town settings but suicide now occurs across urban, rural and remote communities. Indigenous self-harm tends to be impulsive (often associated with intoxication and interpersonal conflict) and public. Whereas completed suicide is much more common among Indigenous males compared to females (rates some ten times greater), as in the wider community non-fatal self-harm is more common among Indigenous females (Hunter 2005 [in press]). A study based on interviews with 183 youth in Western Australia found 30% at high to very high risk of depression, 40% at risk of suicide, and 40% at risk of impulsive behaviour (Westerman 2003).

**Assessment**

**Initial acute management**

Hospital management involves treating the effects of the injury or poisoning through coordinated multidisciplinary care. Once stabilised, the patient must have a comprehensive mental health assessment including information from relatives, primary care practitioners, or those attending with the patient collected and documented. Acute management involves:

1. engaging and establishing a therapeutic alliance with the patient and relatives;
2. identifying and treating underlying mental disorders where present;
3. comprehensive assessment of risk of harm to self and others;
4. psychosocial assessment;
5. initiating treatment planning with patient, family and other health services;
6. documenting the assessment status of the person’s safety between transitions of care and at discharge from the hospital; and,
7. including longer-term goals such as enhancing resilience and promoting adaptive coping strategies. It is essential that every patient has a complete assessment and mental health services should be organised to make this possible. There is evidence that patients not assessed have higher rates of repetition and completed suicide [III].

**Conducting the comprehensive assessment**

A comprehensive assessment will not be complete until the patient’s cognitive function has returned to normal; in particular, following an overdose of medications that can impair cognition. The patient interview should be conducted in a safe and secure environment and there is a need to balance privacy, dignity and security considerations [V]. As a minimum, it should include initial and ongoing assessment of mental state, detection of mental disorders; and assessment of risk of harm to self and others. This should include:

1. eliciting any thoughts and plans about further self-harm;
2. the detailed review of current and past episodes of self-harm behaviour;
3. assessment of the patient’s current social circumstances, and any alternative means of dealing with ongoing stressors; and
4. assessment of current psychosocial stressors and available support from others.

Clinicians should also follow policy and procedures advised by their employing organisation where these policies are current and appropriate. Numerous risk assessment protocols for measuring suicidal risk have been evaluated. These facilitate clinician recall of the domains of risk to cover and those recommended by local hospital policy should be completed clearly in the patient’s file. Even with validated risk assessment tools, no single tool is sufficient and assessment efficacy remains a problem.
All patients presenting after deliberate self-harm should be given a comprehensive psychiatric assessment. Mental health services should be involved as soon as possible. The key management approach includes coordination between the medical and mental health teams. Acute management should include risk assessment, mental health assessment, psychosocial assessment as well as an assessment of the availability of local services. Regardless of whether their role is short-term or long-term, health professionals should aim to form a therapeutical relationship, respecting the patient's predicament and seeking to understand the problems they have. Eliciting guarantees of safety from the patient or developing “no self-harm contracts” are not sufficient as sole management strategies and are not recommended. Clinicians should not rely upon one risk assessment protocol as a sole management strategy. Clinical judgement and effectively engaging the patient is the mainstay of providing quality care to a highly distressed person. Any documented risk assessment form completed should, however, be placed in the patient’s notes.

Issues

**Acute management**

Key medico-legal considerations include:

1. assessing “competence” of the patient for providing informed consent to treatment;
2. facilitating informed consent;
3. ensuring clinician knowledge about appropriate mental health legislation;
4. ensuring “duty of care” for patient safety during episodes of care and during transfer to other settings; and
5. attending to concerns about confidentiality (risks to safety mean that confidentiality cannot be preserved, but the patient should be consulted wherever possible regarding what is said and to whom). Protocols should specify lines of responsibility and how to access senior medical clinicians for assessment, second opinions and treatment planning. These protocols should ensure that support is provided to family members.

**Ongoing care**

Identifying and treating underlying mental disorders where present is the mainstay of preventing or reducing the severity of future self-harm. Patients may appear to reject help from health professionals and may be difficult to engage. Many will not return for appointments. Dysfunctional coping styles and chaotic help-seeking by some of these patients can compromise therapeutic efforts and require a work environment supporting clinician reflection and awareness and thereby enabling sustained engagement.

Clinicians need to develop appropriate strategies for support that could include supervision, peer discussion and training specific to the management of patients who self-harm. Clinicians should assess the extent to which family members and significant others, where appropriate, can act as treatment allies particularly where there is a risk for suicide. A high index of suspicion for suicide is always prudent and helping carers manage this risk is essential. Treatment should be delivered in an atmosphere of optimism for recovery from any present mental disorder, and of optimism that change toward positive problem-solving and coping styles can be achieved.
Current treatment evidence
The goals of services provided to patients following self-harm are to increase the patient’s resourcefulness and positive coping, to prevent repeat episodes or habituation, to reduce distress to patients and relatives, and to prevent suicide. For those few patients with habitual self-harm, it aims to prolong the period between episodes of self-harm and reduce injury severity. Any present mental disorders should be treated according to recognised evidence-based treatment guidelines. Treatment planning should be collaborative with the patient and take into account patient preferences. Both psychological and pharmacological treatments have been evaluated. The following is an evidence summary concerning treatments evaluated to reduce self-harm specifically and are synthesised into six key practice recommendations.

1. **Ensure prompt access to emergency care**
The key issue is service management within primary care and hospital settings for prioritising the medical and mental health assessment of patients presenting with deliberate self-harm.

2. **Ensure prompt access to mental health assessment**
All patients presenting for emergency care following an episode of deliberate self-harm should have a comprehensive mental health assessment. A properly trained health professional, ideally a mental health professional, should conduct this assessment. The minimum requirements for the assessment have been described in the section on conducting the comprehensive assessment.

3. **Encourage treatment engagement and follow-up attendance**
It is essential to engage the patient for assessment of risk and to detect potential mental health problems, psychosocial disadvantage or distress that is amenable to change.

4. **Teach new coping and problem-solving skills**
When compared to standard after-care, certain cognitive oriented therapies have been found promising in reducing morbidity associated with deliberate self-harm.

5. **Treat underlying mental disorders in those who self-harm**

*Patients with mood disorders*
Limited evidence is available on the role of antidepressants and antipsychotics, and there is reported caution about the role of anxiolytic medications for reducing self-harm specifically. Tricyclic antidepressants are not recommended for patients at risk for self-harm due to safety in overdose concerns. Selective serotonin reuptake inhibitors (SSRIs) are thereby recommended for most patients. The SSRIs are indicated only if the patient is currently depressed. In general, treat depression assertively and exercise caution about the potential lethality of any prescribed medications. Considerable evidence indicates that lithium, other mood stabilisers and anticonvulsants are effective in the treatment of depression among patients with bipolar disorder. Thus these drugs play a key role in the management of the disorder and probably in the reduction of the very high risk (15–20% die by suicide) of suicide among these patients.

*Patients with schizophrenia and other psychotic disorders*
A multicentre, randomised international trial comparing atypical antipsychotics recently reported that clozapine reduced repeat self-harm in hospitalised patients with past self-harm histories when compared with olanzapine.
Patients with personality traits and disorders
Dialectical behaviour therapy has been shown to reduce self-harm in patients with borderline personality disorder and histories of multiple self-harm episodes.

Patients with alcohol and substance misuse
Coexisting alcohol and/or other substance misuse should be addressed and where appropriate specific dual diagnosis interventions utilised.

Avoid approaches where there is evidence of harmful effects
There is caution in the literature about contracting people not to self-harm because this approach may be applied unskilfully, or it may be over-relied upon as a sole management strategy. There is some evidence that certain approaches (such as recovered memory treatment with people who have a history of childhood trauma [III-3]) can increase the risk of self-harm

A general management principle is to assist entry of the patient to mental health services in a streamlined and well-organized intake process that is known to all medical and non-medical disciplines within the health service. Clinicians should take into account usual standards for culturally sensitive engagement with patients after self-harm from Maori, Pacific Islander, Aboriginal and Torres Strait Islander and other cultural or age groups. The management of comorbidity underpins much clinical management of deliberate self-harm. Comprehensive assessment includes the assessment of substance misuse and/or addiction, and treatment planning should ensure management or referral for management of substance misuse issues.

Conclusion
Our review confirms previous findings that there are promising but no proven superior therapies for reducing deliberate self-harm in all patient groups. However, this is a highly diverse population and further research on specific subgroups is needed. An evidence base is emerging for reducing risk in some clinical subgroups and in how to engage patients in treatment and reduce their distress by better service organisation and responsiveness.
CHAPTER EIGHT – SCHIZOPHRENIA AND BIPOLAR DISORDERS

Helping the Consumer Manage Schizophrenia and Bipolar Disorder

Key Definitions

Definition - Psychoses
The term psychosis refers to when an affected individual experiences a loss of touch with reality, characterised by delusions (false beliefs) and/or hallucinations (false or distorted perceptions) of objects or events, including sensations of sight, sound, taste, touch and smell, typically with a powerful sense of their reality. Psychosis is most commonly associated with the mental illness schizophrenia, but can be experienced as part of mania (bipolar disorder), as part of psychotic depression (see Chapter Five), or in association with certain organic brain syndromes (such as arising from drug or alcohol abuse). Although the symptoms of psychosis in these conditions may appear similar on initial presentation, careful history and examination will usually clarify the primary condition. This is very important as treatment approaches differ. In this chapter schizophrenia is taken as the ‘model’ of a psychotic disorder. General approaches to care (the Five Cs) are relevant to all psychotic disorders. In addition, the guide for clinicians includes a section on managing acute emergencies in schizophrenia (p. 131) the principles of which are also appropriate for emergency management of acute psychotic symptoms associated with bipolar disorder. However, there are unique features to the clinical management of bipolar disorder which are addressed in a guide to clinicians which follows the sections on schizophrenia. These two conditions are the major contributors to the burden of disorder from psychotic conditions.

Definition - Schizophrenia
Schizophrenia is a psychotic disorder with the presence of both positive and negative symptoms. It is a poorly understood illness and affects approximately one in every 100 people across the world. During initial contact and assessment good communication is essential for the health professional/worker in establishing engagement. However initially it may be harder to engage the consumer due to symptoms relating to the illness (eg) suspiciousness, paranoia and blunted affect. An ability to listen actively and to communicate empathy (compassion) and caring are particularly important.

Definition – Bipolar Disorder
Bipolar disorder is a mood disorder and may present with depression. As noted in the sections on that condition (see Chapter five), serious depressive illness may have psychotic features – psychotic depression (see p 76). However, in bipolar disorder patients also experience episodes of hypomania or mania (see below). Untreated, mania often is associated with psychotic symptoms and presents unique challenges in terms of rapport building, treatment and long-term management.
Aiming to Achieve the Five Cs

Consumer and carer
Schizophrenia is a psychotic disorder with the presence of both positive and negative symptoms. It is a poorly understood illness and affects one in every 100 people across the world. During initial contact and assessment good communication is essential for the health professional/worker in establishing engagement. However initially it may be harder to engage the consumer due to symptoms relating to the illness (eg) suspiciousness, paranoia and blunted affect. An ability to listen actively and to communicate empathy (compassion) and caring are particularly important.

Developing a therapeutic alliance involves the health professional/worker and the consumer gaining a common understanding of issues so that they can set goals and agree strategies. Respect and trust are key ingredients. Respect for the consumer is one of the most important ingredients for developing a sound relationship. True respect enables providers to let consumers make decisions for themselves and to make, and learn from, their own mistakes.

While conducting assessments and organising immediate interventions the health professional/worker must ensure that they explain as much as they can to the consumer on a frequent basis and seek approval from the consumer. Using words like “is this clear to you?”, “do you understand?”, “is this what you want to happen?” are just some examples.

Consumers may require constant reassurance due to experiencing derogatory auditory hallucinations (hearing unkind voices), visual hallucinations (seeing things), delusions, feeling tense/agitated. It is important not to inflict judgmental views on the consumer due to possible issues of shame and guilt and the threat of future reluctance to engage. Being non-judgmental also requires that service providers be uncritical of factors affecting many consumers over which they have little control.

Carer involvement in consumer treatment programs is vitally important due to their “lived” experience with the consumer but we still have to recognise the consumer’s right to confidentiality and obtaining consent prior to engaging a carer is vital. However when a consumer develops symptoms of psychosis, they may not want their carer/family involved. This may be due to a paranoid delusion (unfounded belief) that their care/family wants to hurt them or suspiciousness that their carer/family does not have their best interests at heart. Consent can be overridden in situations where a consumer or carer may be placed at significant danger due to risk factors relating to mental impairment. For example: the consumer expresses homicidal intent towards a carer/family member because they have a delusional belief that that person wants to poison them; or the consumer is experiencing command hallucinations (voices ordering them to carry out an action) telling them to kill somebody. It is in these types of situations that consent can be overridden to protect the consumer and others. However we must remember that this does not mean that all aspects of the patients care should be disclosed. Based on context of the community (eg communities in crisis) it may be hard to distinguish a reliable carer/family member and emphasis to the importance of seeking an appropriate (suitable/reliable) other is essential.

Consumers suffering from schizophrenia are sometimes more likely to express reluctance at carer/family involvement in their care. However, as we have discussed, this is more likely due to reasons related to their symptoms (eg suspiciousness,
paranoia, delusions, auditory/command hallucinations) rather than a genuine reasoning for the same. This request for total confidentiality usually alters as the consumer receives treatment for the symptoms and their mental state improves. A health professional/worker should also clarify at regular intervals if the consumer wants others involved in their care. It is sometimes good to get written consent from the consumer.

Hints for consumer involvement include:

- Seek clarification from the consumer about the level and degree of involvement permitted for the carer. Determine if you are permitted to engage with the carer privately or only in the presence of the consumer.
- Determine if all treatment information can be disclosed and if long-term liaison is permitted.
- Encourage the consumer to engage carers/family in treatment plans and options.
- Avoid over engagement with carers at the expense of the therapeutic relationship with the consumer. This means that building a positive relationship with the consumer is the most important goal and we have to be careful not to sacrifice this when we seek background history from the carer/family. The aim is to empower the consumer in their care while actively involving the carers.
- Provide regular information to the consumer/carer on their treatment and progress, utilising treatment specific material (eg) brochures, handouts, user friendly materials.
- Provide information on available community resources (eg) mental health nurse/service, life promotions officer, available community services, consumer support group, and carer support group.
- Actively involve the consumer/carer in the development of Care Plans that are specific to their mental health needs and encompasses regular review and updating as the goals change. It is important to regularly review and seek input from the consumer and carer about what the important issues or difficulties are from their perspective.

It is also important to provide emotional and social support to the carer/family. This is especially important where consumers’ symptoms may negatively effect or place undue strain on the household or the overall family environment. Carer/family members are better equipped to help the consumer when they have a better knowledge of the consumer’s illness and the reason why it can affect them in different ways:

- Give information on schizophrenia explaining signs and symptoms (eg differences between positive and negative symptoms, how they affect the consumer’s presentation.
- Provide information on treatments explaining what the medication does and if there are any side effects.
- Give reassurance about concerns they may have about ongoing symptoms and management issues.
- Be available to support them and offer education to them as the principal caregiver.

**Context of community**

When working in Indigenous settings, we must aim to listen and learn from the people we are working with to understand about local history, issues and living conditions. The consumer may present in such a way that would in other circumstances indicate symptoms of psychosis but due to cultural issues could provide a more logical explanation. Examples include:
• The consumer reports seeing visual hallucinations (seeing things) of a dead relative on a regular basis. It is important to determine from a culturally appropriate person in the community to what extent the presentation is seen as acceptable in the community.

• Certain questions or the manner in which they are asked by the health professional/worker may be seen as inappropriate in cultural terms. Direct questioning may be seen as rude. The consumer has almost no eye contact with the health professional/worker with little warmth and is not willing to communicate. Are they paranoid/suspicious of your questioning because of delusional beliefs, cultural issues or because of shyness or shame? Again it is important to determine from a culturally appropriate person if this is acceptable behaviour in this community.

• Where it is necessary to address sensitive issues (eg women’s business) open the discussion by acknowledging that it might be seen as intrusive and explain why it is necessary to ask such a question.

Remember to respect cultural and health beliefs and recognise the historical and cultural factors that affect people’s health and wellbeing. Acknowledge and utilise the local community’s expertise and work in partnership.

**Continuity of care**

It is vitally important that consumers presenting with schizophrenia are followed up on a regular basis due to the need for ongoing assessment for severity of symptoms. Examples would be assessment of ongoing positive or negative symptoms, self-harming or suicidal ideation, and side effects to medication and compliance with it in the community setting.

Health professionals/workers should be aware that consumers who have spent time in an in-patient setting with schizophrenia and discharged back into the community still need intensive follow-up.

In-patient admissions for consumers may deal with reducing risk factors and providing a safe environment while establishing the consumer on an appropriate form of treatment, mainly stabilisation on medication. This does not mean that other symptoms of the illness are not still present on discharge (these symptoms may be triggered for the consumer by being removed from a controlled in-patient setting back into the environment where the illness began).

When a consumer is discharged from an in-patient setting it is important to make contact at the earliest possible opportunity. There are a number of reasons for this:

• The health professional/worker can offer immediate support and reassurance for the consumer. Many consumers suffering from schizophrenia remain vulnerable to relapse thus immediate contact is vitally important to prevent this from occurring.

• The health professional/worker can obtain a true picture of the consumer’s mental state and perform a risk assessment. Some risk factors may alter from in-patient to community settings. For example, the consumer may initially feel isolated, unsupported and more vulnerable on discharge from the in-patient setting to the community thus heightening the recurrence of symptoms of the illness.

• Allows an assessment of the overall living environment and supports in place.

• Contact with the consumer’s carer/family can be established offering support to carer/family, providing information on the illness/diagnosis and determining the issues and concerns that family/carers may have. For example, are there...
still risk factors; what does the medication do and what happens if the consumer stops taking medication?

- It is important to determine the consumer’s degree of insight as this will have a bearing on ongoing care, compliance with treatment and level of follow-up/intervention. The consumer may decide that because they feel better following discharge from hospital that there is no longer a need to continue taking prescribed medications or that due to side effects (eg over sedation) medications are limiting them in their level of daily functioning.

- Provision of education and monitoring of prescribed medications is important to promote compliance. This is also a good opportunity to observe the client for any side effects relating to the medication. As with most medications, there may be side effects with antipsychotics. Some examples are: sedation, muscle stiffness, tremor, drooling and sexual problems. It is important that any side effects are acknowledged immediately to avoid any unnecessary discomfort for the consumer. Some consumers express reluctance in taking prescribed medications or are non-compliant with them as a result of experiencing bad side effects.

- Drafting of a community Care Plan must commence at the nearest available opportunity. This should incorporate the consumer’s/carer’s perspective, primary health care staff, the local mental health team and any local organisations that may be involved in the consumers care (eg ATODs, life promotions officer, sports and recreation officer). However this depends on available resources in the community.

Continuity of Care is essentially an ongoing activity that is performed on a consistent basis for a consumer while there is a need for that consumer to be supported by their Primary Health Care Service relating to their mental health issues. However some emphasis should be placed on continuity of care in relation to preparing and empowering the consumer in aspects of their care, the opportunity for consumers to take control of these aspects of care are vitally important. Sharing responsibility requires a willingness on the part of the health professional/worker to view continuity as a partnership where all parties have shared control.

A Care Planning document is seen as an important part of managing this process and should be completed in consultation with the Multidisciplinary team, the consumer and the family/carer. The Care Plan offers a structured approach for all involved parties and can be updated as goals and treatment issues change.

**What the Care Plan should incorporate for schizophrenia**

- Assessment of consumer’s mood and mental state. This can be utilised to determine the stage of treatment/recovery the consumer is at in relation to their illness and can also determine if there are any other underlying symptoms of illness. The presence of positive symptoms (eg hearing voices or paranoid delusions) may indicate that the immediate focus of care should be around the level of acuity of the consumer. That is: how distressed they are by the symptoms; how it is impacting on their daily routine, relationships with family members or risk to self or others. For example: Bob has reported that he sometimes still experiences auditory hallucinations telling him to harm others. The voices are distressing him but he feels that he would not act on these voices’ instructions. The immediate focus of care should be to address the existing positive symptoms. This would suggest an increase in medications and an immediate assessment of the risk factors involved.

- It should be developed or altered accordingly relating to risk factors whether that be a consumer’s risk to self, others or risk from others. Is there a risk of
self-harm? Is the consumer safe in their home environment? Are there enough support mechanisms in place? Is there a responsible carer/family member around at all times? However it should not focus solely on risk factors and just because there are no risk factors does not mean that there is not an ongoing underlying problem. In Bob’s case, he is experiencing voices that are telling him to harm people, however he feels that he would not act on these. There is an immediate risk to Bob’s own reputation if he were to act on the instructions and a risk to other people when he is experiencing these voices. Are carer/family members aware of the immediate risk to themselves and others? If not they should be informed. Sometimes a short stay in hospital is required even though this may not be what the consumer wants.

- The Care Plan should incorporate positively (avoid negative comments) the consumer’s goals or achievements. Focus on strengths rather than weaknesses. Portray highlighted problems in a positive manner. (Bob has disclosed that he is hearing voices telling him to harm other people. He has talked about this with staff and he is encouraged to continue informing them when he experiences these voices. He is advised to seek help if he is having trouble coping with these voices.)

- It should be concise and to the point, using simple language that the consumer and carer can understand. Avoid clinical jargon. For example, instead of: Bob will utilise talking therapies when experiencing derogatory auditory hallucinations; try: Bob will talk to a support person when he hears bad voices over the next seven days.

- Place emphasis on achievable goals, as overloading the consumer with too many goals may be overwhelming for their stage of recovery. Take the treatment phase one step at a time, with the most acute issues being addressed first. Avoid overwhelming the consumer with a long list of issues that may need addressing even if these issues are important in the consumer’s overall care. With psychosis it is important to address the acute crisis issues first. In Bob’s case we would look at the risk factors and ensure that Bob and others were safe. We also look at the auditory hallucinations and the distress they are causing Bob.

- Use realistic timeframes and ensure the Care Plan is regularly updated emphasising the consumer’s achievements. Positive reinforcement of these is important so that the consumer is aware of the progress being made. (For example, Bob will aim to control his bad voices over the next 48 hours. This is not achievable and the consumer is being placed under undue pressure. It is highly unlikely that positive symptoms would respond so quickly to treatment with medications. Response to antipsychotic medications can take up to six weeks so the Care Plan should focus on strategies to reduce distress during this period. For example, use of benzodiazepines for agitation and sleep disturbance if necessary; daily contact with the mental health team; coping strategies [listening to music], regular risk assessments and education about the symptoms of the illness.)

- Ensure that the consumer/carer/family view is considered and realistic concerns for all parties are included in the document. For example, the consumer’s mother states that Bob’s presentation at interview with the mental health nurse is incongruent (different) with how he is at home. Bob informs us that he is experiencing voices telling him to harm others but he would not act on these and would not harm anybody. However Bob’s mother informs that Bob becomes extremely agitated when at home. He has become violent and damaged furnishings and on one occasion has locked himself in a room with a knife. When he is agitated, he screams at people to stay away or he will harm them. The consumer may not recall these episodes of agitation due to mental
impairment at that time. It also indicates that the level and degree of risk is far
greater than may have previously been believed.

• Also ensure the Care Plan is split into sections emphasising the role of each
individual involved in the consumer’s care. This gives all involved parties a
sense of ownership in the recovery process, gives the consumer a sense of
support and safety and reinforces to the consumer that they are not alone. For
example, the consumer will participate in regular 1:1 sessions with the mental
health nurse. The carer will offer the consumer support with daily activities.
The health worker will visit the consumer at home every three days for a chat
and provide further medications. The mental health nurse will provide weekly
follow-up.

• A copy of each Care Plan should be made available to all involved parties and
a copy should be kept in the consumer’s file.

The frequency of visits/supportive follow-up for the consumer (daily, weekly,
fortnightly, monthly etc) may be determined by a whole range of factors. These
factors should indicate either increased or lower occasions of service dependant
upon the effect they have on a consumer’s mental health. Please refer to Chapter 5
for a list of these factors.

Ideally a consumer should have regular follow-up if any or all of these factors have
been identified as prominent issues in their Care Plan. However where intense
follow-up is necessary, care and understanding should be given not to alienate
the consumer. The emphasis should be on rapport building in a non-intimidating
environment with awareness of some consumers’ belief about shame and stigma
attached to mental illness.

Checking for change

Utilisation of outcomes measures can be very beneficial in the ongoing care of the
consumer and the direction taken based on the outcomes scores. Ideally a set of
outcome measures should be used as the basis for determining the course of care
and high scoring areas should be addressed in the Care Planning document.
However it is important that the consumer/carers have an understanding of the
principles surrounding the measurements and that these are used taking into
consideration cultural issues relating to Indigenous consumers.

It is important to remember that if a health professional/worker is going to use the
measurement tools they must first have formal training to ensure that they have a full
understanding of the concepts involved. Clarification should be sought at any point
where a health professional/worker has difficulty understanding or scoring an item.

This can be done by:

• Liaising with another worker who has outcomes training
• The local mental health clinician/worker
• The Zonal Outcomes Coordinator/Educator.

Whenever completing outcomes measures with Indigenous consumers, it is
extremely important to be guided by the four principles identified in Chapter three.
Principle one reminds you to involve additional informants in your assessments that
lead to outcomes ratings. Remember that carer/family involvement plays a big part in
providing you with greater understanding of the consumer’s experience based on the
additional information and insight that they can provide. You are also expected to
utilise the expertise of the Indigenous health worker or mental health worker when
completing assessments. When using the outcome measures to assess a consumer
presenting with schizophrenia, it is always important to keep in mind certain specific issues. Some of these are:

- Application of the fourth principle guiding outcomes ratings with Indigenous people who may have schizophrenia or who may be experiencing socially and culturally acceptable experiences associated with funerals, religious or traditional activities that could be mistaken for psychotic experiences, is extremely important. The principle guides you to consult with a family member/carer and a local Indigenous health or mental health worker to determine consistency in form, intensity and duration with accepted beliefs, experiences and behaviours.
- Principle four also guides you to rate significant distress or potential danger associated with behaviours, beliefs and experiences, regardless of whether the cause is deemed to be a psychotic episode or an experience consistent with accepted cultural experience.
- If the consumer’s self-care appears to be very poor the health professional/worker should determine its duration (how long) and whether it is within acceptable standards for that community. Poor self-care might indicate that the consumer has stopped caring for themselves and they may be experiencing some negative symptoms of schizophrenia.
- When assessing a consumer’s mood do not confuse shyness or shame with sadness or as evidence of blunted affect.
- Use simple language and do not assume that everybody’s first language is English. A lack of response may be simply because the consumer cannot understand you and not evidence of slow or impaired cognitive functioning or refusal to engage.
- Remember that illicit substances can alter a person’s presentation and they can also induce psychosis. It is virtually impossible to obtain a clear picture of a consumer’s mental state when under the influence of these substances. A consumer presenting with blunted affect may just be “stoned” from THC use, however it is vitally important to determine that there are no symptoms of psychosis when the consumer is drug free. The consumer may be self-medicating with illicit substances as a coping strategy for other mental health problems and excessive use could precipitate a psychotic episode.
- Excessive alcohol consumption can also alter a consumer’s presentation and it is virtually impossible to obtain a clear picture of a consumer’s mental state. Alcohol consumption sometimes causes impulsive behaviours or acts sometimes manifesting themselves in self-harming behaviour and/or suicidal ideation. Where there may be increased risk for the consumer while intoxicated this usually (not always though) resolves when the consumer is sober. However it is vitally important to ensure that the consumer remains safe while intoxicated or withdrawing until further assessment can be performed when the consumer is not under the influence. There is every chance that the consumer’s frequent alcohol intoxication may be a self-medicating strategy for symptoms of schizophrenia. Excessive alcohol intake can sometimes have a negative impact on antipsychotic medications and the symptoms that they are used to treat.

Any information/data collected from the outcomes measures relating to the consumers care is confidential and it is important to reassure the consumer that all information obtained is not disclosed or used inappropriately.

**Considered Clinical Care**

With the Fifth “C” it is important that clinicians should consider, but not be limited to, the recommendations. The guidelines should not necessarily be interpreted as absolute standards of practice. Mental health professionals care for patients with schizophrenia in different settings, including isolated and challenging settings, where it isn’t feasible to apply all recommendations.
**Psychosis**

What is Psychosis?

People who are hearing voices, and who have jumbled thoughts may have an illness called psychosis.

They might:

- Act strangely
- Feel afraid
- Walk round all night
- Think of dying
- See things not there
- Sit down alone

What makes me psychotic?

These things can cause psychosis:

- Poor physical health
- Loss or bereavement
- Too much stress
- Too much Alcohol or Gunja or other drugs
- Family History (someone else in the family has the illness)
- Stopping usual treatments
- Breaking Law
What change helps if you are hearing voices or have jumbled thoughts inside?

**OUTSIDE CHANGES**
- Family support
- Elders
- Traditional Healer
- Clinic Mob
- Mental Health Mob
- Antipsychotic tablets with dosette or Webster pack
- Hunting, fishing, dance
- Going to country
- Stopping gunja, alcohol or other drugs

**INSIDE CHANGES**
- Know about treatment
- Remember totems, family, elders
- Think with your head not with your heart

How do you make change?

- Everyone can make change – when they are ready
- There are lots of different ways to change
- Telling people they SHOULD change doesn’t help
- Letting them know you think they CAN change does help
- Everyone changes in his or her own time
- Small steps can lead to big changes

This information sheet is produce by AIMHI NT – 2005. We invite your feedback and comments. (08) 89227943
Schizophrenia: a Guide for Primary Care Workers, Consumers and Carers

These guidelines are an adaptation of the “Guide to Treatment for Consumers and Carers” by Eoin Killackey, Patrick McGorry and Kathryn Elkins, for the Royal Australian and New Zealand College of Psychiatrists. It is intended as a general guide only and is not as a substitute for clinician advice.

Introduction
This document is an adaptation of the RANZCP guidelines developed for adults and young people with or suspecting they have schizophrenia, and is intended for the use of primary care workers as well as consumers and carers. It has been written to provide information about schizophrenia and its treatment, based on the best research evidence to March 2003.

There have been many advances in treatment recently. Research into effective therapies for schizophrenia is booming. There is already excellent knowledge about treatment but unfortunately, a lot of this knowledge is not being fully utilised. It is the responsibility of health professionals to ensure that they are up to date with current best practice approaches for the illnesses their clients have.

The current treatments for schizophrenia are the most effective yet and should provide hope that a comprehensive treatment approach will reduce the suffering that schizophrenia can bring.

What is schizophrenia?
Schizophrenia is a poorly understood illness in the general community. There is much misinformation and stigma associated with it. For instance, it is NOT true that a person suffering from schizophrenia has “multiple personalities”. It is also NOT true that people with schizophrenia will be violent. If they receive appropriate treatment they are no more likely than people in the general population to commit crimes.

Schizophrenia is one of a group of mental disorders known as psychosis. A person experiencing psychosis has a loss of contact with reality. These disorders are characterised by difficulties with the thinking process. This can include seeing or hearing things which other people cannot see or hear. Such experiences are called hallucinations.

Psychosis can also include holding beliefs that are very odd or not true. These beliefs are called delusions. People with psychosis often feel that they want to withdraw from the outside world. Their energy and emotions are affected. They may feel a loss of vitality. They may also feel depressed or irritable.

Who gets schizophrenia?
Anyone can get schizophrenia. Schizophrenia affects one in 100 people across all countries, social classes and cultures. Schizophrenia usually begins when people are aged between 15 and 25, although it can also emerge later in life. Men and women are affected equally, although men tend to have an earlier onset.

What are the first signs something is wrong?
Most people experience changes in behaviour and perception. When these occur together they are called a “prodrome”. The prodromal symptoms include:
• Changes from normal behaviour, e.g. worsening of usual work or school performance;
• Social withdrawal;
• Emerging unusual beliefs; and
• Changes in perception such as experiencing brief instances of hearing sounds not heard by others.

The prodromal period lasts approximately two years on average. After this time clearer symptoms of psychosis become evident. The prodrome is best thought of as a warning but it does not mean that the person experiencing a prodrome is necessarily going to develop a psychosis.

What are the symptoms of schizophrenia?
Health professionals talk about two main types of symptoms in relation to schizophrenia. These are positive symptoms and negative symptoms. Positive symptoms are experiences that happen in addition to normal experience. These include symptoms such as hallucinations (positive because they are additional perceptions). Negative symptoms incorporate a loss or decrease in normal functioning. They include experiences such as loss of pleasure or interest in normal activities, loss of motivation and loss of interest in socialisation. Symptoms vary from person to person, but commonly include:

**Negative symptoms**
- Feeling unmotivated
- Not feeling social
- Feeling apathetic
- Not feeling any emotions

**Mood**
- Irritability
- Suicidality
- Depression
- Elevated mood

**Positive symptoms**
- Delusions
- Hallucinations
- Disorganised thoughts
- Feeling tense and agitated

Schizophrenia appears cyclical, worsening in periods known as relapse, but improving or disappearing completely during remission. People with schizophrenia can have periods of stable emotional health. However, during the acute or psychotic phase, when delusions and hallucinations may occur or worsen, many have trouble with everyday tasks like thinking clearly, managing feelings, solving problems, making decisions or relating to family, friends or professionals.

What causes schizophrenia?
It is now accepted that schizophrenia is a syndrome (cluster of symptoms) produced by a complex change in brain functioning. This change interferes with intellectual processes and produces unusual experiences and emotional changes.

The causes of schizophrenia are multiple. They involve a combination of genetic risk factors and other contributors such as complications during pregnancy and early life,
and almost certainly other problems with brain development during adolescence. It is probable that a different mix of causes can occur from person to person. While in some people it is possible to show subtle changes in brain structure using tests such as magnetic resonance imaging scans (MRI), in most people these changes seem to reflect the way the brain is functioning when that person is unwell. This is why treatment with anti-psychotic drugs seems to restore normal central nervous system/brain functioning. However, a great deal still needs to be learned about this complex disorder of the central nervous system.

What other problems do people with schizophrenia face?
People with schizophrenia may also face other problems. Anxiety and depression are very common. The rates of substance use (cigarettes, alcohol and cannabis especially) can be up to ten times higher than in the general community. Because symptoms, if left untreated, affect relationships, many people with schizophrenia are single and unemployment can be a problem. People can also have accommodation problems and may withdraw from family and friends. Isolation and loneliness can be common. Thus people with schizophrenia may need assistance for several problems when seeking professional help. They should be assured that it is OK to ask for help for any of these problems to improve the chance of recovery.

How is schizophrenia diagnosed?
While there is currently no test for schizophrenia, some other medical tests may be necessary to rule out other possible illnesses, both physical and mental, which have symptoms similar to those of schizophrenia. Getting a correct diagnosis can be difficult because psychiatric diagnoses are still based on descriptions of behaviour. Sometimes there are difficulties in getting timely help because the person may be fearful and feel reluctant to describe their symptoms or see a health professional. However, it is advised that a psychiatrist who is qualified and experienced in confirming the diagnosis and planning treatment be consulted.

Is there a cure?
There is currently no cure for schizophrenia. However, many treatments that aid recovery have been developed. Although some people who are diagnosed as having schizophrenia will recover completely, most will remain vulnerable to relapse and may have sustained disability. Despite this, good quality of life is possible, and with improvements in the quality of treatment and support, the goal of treatment should be recovery – return to leading a full life.

Prevention: can the prodrome be treated?
The prodrome is the period before an acute episode of psychosis that indicates that a psychotic episode may be about to occur. People showing signs of a prodrome who have never had an episode of psychosis, are encouraged to develop a relationship with a mental health professional or a doctor with a knowledge of this prodromal period.

Individuals with a parent or sibling with psychosis have more risk of developing schizophrenia. If there is any change in level of functioning at school or work, or if symptoms of depression or strange thinking occur, it is a good idea for these individuals to go to their local health care centre to be thoroughly assessed. By being monitored in this manner, if clear psychotic symptoms emerge (and there is no guarantee that they will), early specific treatment is readily available. This can avoid the need for hospitalisation and minimise the impact of a potential psychotic episode.

Evidence from research indicates that assessment and provision of low levels of medication in the prodromal period may reduce the risk of eventual psychotic symptoms in some people.
Treatment: what to expect

When should treatment begin?
The sooner a person with schizophrenia gets help for their symptoms the better chance they have of receiving effective treatment. Research shows it is important to get help early for the first and for all subsequent episodes. In most cities a specialist “early intervention team” provides care during the first episode and offer follow-up for the one or two years. In towns and remote areas this is probably not available, but getting help early is still possible and important.

The first task is to undertake a thorough assessment to understand more about the young person’s life, like accommodation, finances, symptoms and physical health. A thorough investigation is required to make sure that there is no underlying physical condition that may better account for the symptoms. Once a medical check has been completed, a referral can be made to an appropriate mental health service. There may be significant social, cultural or religious issues that need to be considered in treatment and these should be identified.

How is care organised?
When receiving care through a public mental health service, it is usual practice to be allocated a case manager (sometimes called a key worker) and a doctor. The case manager organises the assessment, treatment plan and ongoing treatment. This includes information and education for the family or partner, or carers. They also arrange links to other services such as community agencies, employment services, social security and accommodation agencies. The case manager also prepares the treatment plan that encompasses all aspects of care: medication, psychotherapy, education, support and other treatment or services required.

How to advocate for improving care?
People being treated for schizophrenia should be confident they are receiving the level of care they need. They should be informed about this and encouraged to speak out if they are dissatisfied. They should be encouraged to talk to their case manager, or the clinic manager.

Location
A range of treatment settings is available and the choice of which one to use is made on the basis of severity of illness. Where possible people with schizophrenia are treated in the community to reduce the distress and disruption to their lives. The case manager should do home visits and provide support in crisis situations.

Consumers in recovery or remission can be treated with regular outpatient appointments. However, if there is a risk of harm to self or others, or if the patient is extremely distressed, the best option may be a short stay in hospital. Sometimes this may be necessary even though it may not be what the person wants at the time.

When the consumer is well, arrangements for what will happen in the event of a relapse can be put in place in advance. This gives her or him more control and an ability to have a say in treatment planning.

How is schizophrenia treated?
Treatment should include medication, psychological treatment and community support. The combination of treatments is crucial.
Medication
Medication is essential for effective treatment of schizophrenia for most people. However, it works best when integrated with good quality psychosocial treatment.

It is necessary to find the right type and dosage of medication to treat symptoms with the least side effects. Generally, a single medication will be used. However, in some cases it may be helpful to combine drug therapies. The main type of medicines used to treat schizophrenia are called **antipsychotics**. There are two groups of antipsychotics. The older group, “typical” antipsychotics, include drugs such as chlorpromazine and haloperidol. The newer group are called “atypical” antipsychotics. These include olanzapine, risperidone, clozapine, and quetiapine. Older medications work, but often have more side effects, especially if used in excessive doses.

Safe dose range information can be found in drug product information, or in standard manuals of medication such as MIMS or the *Therapeutic Guidelines*. Both of these are also available on the Queensland Health website through the Clinician’s Knowledge Network under “Drug Information”. The choice of medication should be carefully explained and the patient given written information on the drugs prescribed, including any side effects that may occur.

Does the medication work?
All of the drugs used have gone through rigorous international testing and have been shown to reduce the symptoms of psychosis. They are not addictive. There are several types of medication and the psychiatrist or medical officer should choose the one to best address each particular patient’s symptoms. Patients should be encouraged to ask about the reasons a specific medication was chosen and about benefits and risks. In recommended doses, anti-psychotic medication is safe. However, excessive doses can result in a range of disturbing side effects.

What symptoms are helped by medication?
The positive symptoms of psychosis, such as hallucinations and delusions have been the main focus of medication treatment. Newer antipsychotic medication may also be helpful in treating negative symptoms, particularly problems with mood, thinking and socialising. Feelings of anxiety and agitation are also helped by anti-psychotic medication.

Does the medication work for everyone?
A small number of people do not respond well to initial treatment and may need to try several antipsychotics as well as other therapies to gain control over their symptoms. A drug such as clozapine has been found to be effective for people whose symptoms are resistant to initial atypical anti-psychotic medications.

Relapse prevention and medication
Individuals who have experienced a psychosis previously should consult their mental health team to prevent a further episode. This may include restarting or increasing medication, adding a different medication in combination with psychosocial treatment and regular monitoring.

What are the side effects from medication?
As with most medications, there may be side effects when taking antipsychotics. It is very important to communicate any changes or new symptoms to your doctor, as these may be side effects of your medication. A table of drugs and side effects is in Appendix 2 of the guide for clinicians which follows.
Movement disorders
Common side effects include movement disorders, in particular dystonia (muscle spasm); Parkinsonism (tremor, slow movements); and akathisia (restlessness). These side effects may be more prevalent on the older typical antipsychotics.

No one should have to experience these side effects these days! Doctors can treat these side effects by using low doses of antipsychotics or prescribing medicines to reduce these movement symptoms. The newer or atypical antipsychotics have been found in studies to be effective at treating symptoms, and to cause fewer movement disorders. While newer drugs in general have fewer effects on muscle tone and movement, they are more likely to cause weight gain, loss of libido (sex drive), and hormonal side effects.

Tardive dyskinesia
Another effect often seen with anti-psychotic medication is tardive dyskinesia (TD). This involves uncontrollable muscle spasms resulting in a twisting of the body or neck. TD will occur in 5% of patients who take typical antipsychotics. Studies have found that risperidone and clozapine (two of the atypical antipsychotics) have much lower rates of TD. Evidence is not yet available for the newest atypical antipsychotics (olanzapine and quetiapine), however it is expected that the risk for TD will be quite low.

Patients should be encouraged to ask for and obtain as much information as possible about symptoms, side effects and other problems. Patients have a right to expect the best treatment possible. They should be instructed carefully and encouraged to take all medications as prescribed. In general, if a drug works well - stick with it - don't chop and change. These drugs take a little while to start working and should not be stopped unless under good medical supervision.

Other side effects
Other side effects include sedation, galactorrhea (stimulation of milk secretions in females), sexual problems in males, and rarely, liver disorder.

Clozapine has been associated with a small chance (less than 1%) of agranulocytosis (loss of production of white blood cells that are involved in defending the body from infection). This can lead to an increased chance of experiencing life-threatening infections. To prevent this, assessment of white cells is conducted weekly which aims to prevent the mortality risk.

Clozapine has been associated with seizures, sedation, drooling and increased heart rate. However, with careful monitoring, and encouragement to report any difficulties or side effects, these symptoms can usually be managed.

Risperidone in low doses has very few non-movement disorder side effects. In higher doses some movement disorder side effects have been noted. Users have also reported some gastric distress and mild sedation.

Olanzapine has few movement disorder side effects, but has been associated with non-movement disorder side effects such as sexual dysfunction, weight gain, and possible mild liver dysfunction. Quetiapine has been associated with side effects such as drowsiness, dizziness, and headaches but there is a significantly lower incidence of distressing symptoms such as movement disorder symptoms and less restlessness.
Amisulpride may cause side effects including weight gain and drowsiness. Amisulpride may be more likely to cause changes in the breast, such as increased milk flow and changes in males than other antipsychotics although these are very rare, but may be less likely to cause sedation and movement disorder side effects. Patients should be encouraged to talk to the doctor about the advantages and disadvantages of using these new medications, particularly the possible impact of side effects.

**What is the treatment for side effects?**
Psychiatrists often use a medication called an anticholinergic such as benzotropine (Cogentin) to treat movement disorders caused by older antipsychotics.

Anticholinergic medications may lead to dry mouth, constipation, or impaired memory skills. Many side effects, such as sedation, improve with time, or by changing the dose, changing the type of anticholinergic, or adding another medication. Some non-medication strategies may also be helpful. For example reviewing diet and exercise habits may assist with minimisation of weight gain. Depot medication can be a useful strategy for a small number of individuals, at least as a time-limited strategy.

Anyone receiving these medications should be told that if they experience anything which may be a side effect, the doctor should be informed as soon as possible. It may be that the symptom is not a side effect, but it is better to be sure.

**What is depot medication?**
Depot medication is a form of anti-psychotic medication given by injection, which slowly releases the drug over one to four weeks (depending on which drug is given). A doctor or nurse will usually give the injection. Some people prefer depot medication as they find remembering to take pills every day difficult. However, depot medication can cause the same side effects as mentioned above for the forms of these drugs taken orally.

Sometimes people with schizophrenia are ordered to take medication under government laws such as the *Mental Health Act*. In this situation, depot medication is often used. An order to be treated (often called a Community Treatment Order or CTO) and to take medication made under mental health legislation must be reviewed at regular intervals and patients may appeal against the CTO.

**Patients who have been put on an order to receive treatment under the Mental Health Act should be given appropriate information regarding their rights and how to represent their interests.**

**What about other medications?**
There are several groups of medications often used with anti-psychotic drugs. The doctor or psychiatrist may consider prescribing other medications along with an anti-psychotic medication to treat the symptoms of schizophrenia or other problems. There are many medications that may be used in conjunction with antipsychotic medication. They include:

- Anti-anxiety agents which are used to treat distress or agitation;
- Mood stabilising agents to treat mood symptoms when they occur in psychosis (Lithium, Tegretol (Carbamazapine) and Sodium Valproate);
- Sleeping tablets (hypnotics) to help insomnia;
- Side effect medication (anticholinergics, or anti-parkinsonian drugs) used to reduce movement disorders; and
- Anti-depressants used to treat depression.
There are a number of points to consider. Accepting the need for regular medication is a challenge for anyone. Taking medications long-term requires some lifestyle change. Just as with arthritis and diabetes, having a psychotic condition also requires this approach. Making lifestyle and mindset changes is not easy. Furthermore, drugs are often seen as mind altering rather than mind restoring. This view is especially so when taking the drugs includes unpleasant experiences such as sedation, “numbing” or slowed down thinking, movement or body problems or sexual side effects.

However, medications are a very powerful protector against a second or further breakdown. Taking medication as it is prescribed makes it five times less likely that a relapse will occur. Sometimes it takes more than one episode for people to accept that medication is necessary.

How much is needed?
Anti-psychotic medications are administered at the dose that proves most appropriate for each individual patient. For many medications, the doctor will start with a low dose and increase very slowly to reach the level where symptoms stop, before side effects start to be present. Doses differ according to the potency of the medication used and cannot easily be compared against one another.

For example:

<table>
<thead>
<tr>
<th>100 milligrams (mg) of chlorpromazine is approximately equal to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2mg of Haloperidol, OR 2mg of Risperidone, OR 7.5-10mg of Olanzapine</td>
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</tbody>
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How long should medication be taken?
Some people will require anti-psychotic medication for long periods. Usually the medication is continued for one to two years after the person has achieved excellent recovery from their first episode, and is stable in life with regard to relationships, work or accommodation.

In the early years there is a high risk of relapse and if the person experiences another episode they may need anti-psychotic medication for two to five years before ceasing use. For those who have multiple episodes, they may need to use medication for much of their life.

What if the medications don’t work?
If one or two anti-psychosis medications have been tried and symptoms have not improved a thorough review is necessary. First, the health practitioner will need to check that the medication was taken as prescribed and that the dose was correct, and that there are not other factors involved such as a medical problem or using cannabis or other drugs.

The mental health team may suggest that psychological therapy, described below, be offered to help cope with the symptoms and that other medicines be added to help. A third atypical medication may be tried. Clozapine, a medication showing good results when other treatments are not successful may be offered. However, clozapine requires a considerable side effect monitoring scheme.

What about pregnancy and breastfeeding?
Many anti-psychotic medications have not been tested on pregnant women. Unborn babies are very sensitive to drugs and it is very important to check if a patient who is prescribed these medications is pregnant. They should be warned carefully (particularly if they are taking anticonvulsant drugs which are sometimes used to treat mental health disorders and which are known to harm the developing foetus) and told
to inform the health team immediately if they become pregnant or plan to do so. They should be encouraged to talk to their doctor about the safest choices to use during pregnancy and/or breastfeeding.

**Psychosocial treatment**
Psychosocial treatments should be tailored to the needs of the individual. Medications aim to reduce symptoms, while psychosocial treatment helps adapt to psychosis and helps the patient strive for good quality of life, despite the illness. One important feature of all psychosocial treatment is developing a relationship with the health professional that is trusting and optimistic. Preferably, they should extend this relationship to include family, partner or carer. There are several kinds of psychosocial treatment that may benefit recovery.

**Psychoeducation**
This therapy provides education to individuals and their carers about their illness, either individually or in a group. It works by increasing understanding of symptoms and treatment options, services available and recovery patterns. Information and education may be given via videos, pamphlets, websites, meetings or discussions with the case manager or doctor.

**Family therapy**
Not all patients want their family involved in their care. That is their right and it should be respected (as long as they are 18 years or older). However, there are good reasons why the family, partner or some other key individual might be involved in planning and providing care. For a majority of people, their family is the primary source of long-term support. Secondly, even if the patient doesn’t initially want their family directly involved, the family may wish to talk to a professional about their experience of the patient’s illness and how they might help. It can be very distressing to see a loved one become unwell. Thirdly, the family can be an important source of information to help in clarifying the diagnosis, and in supporting treatment. However, the patient should be heard out and unless there are very clear reasons not to do so, their wishes should be respected.

Research shows that recovery is aided if treatment of schizophrenia is a collaboration between the patient, family, doctor and case manager. The purpose of this collaboration is to work together towards recovery. Good communication exists when they talk about the choice of treatments so that everyone learns the same information and can move towards the same goal.

Clinicians should offer family members or carers frequent support when the patient is acutely unwell, and on an ongoing basis as needed. Ideally, printed or other information on medications, therapy or group activities should be made available for the patient’s family members or partner.

Support groups are designed for patients and families where experiences with services or treatment are shared. Sometimes the family may be able to help in other ways: identification of early warning signs; keeping records of the effectiveness of medication at treating symptoms in the past; and in assisting in accessing care. They also play an important role in encouraging and supporting return to social, academic and vocational activities.

**Cognitive Behavioural Therapy**
One form of psychotherapy, which has been found to be effective in psychosis is, called Cognitive Behavioural Therapy or CBT. It may be recommended depending on needs and phase of illness. Research suggests that CBT can improve coping
strategies, help the patient learn new ways to manage stressful situations, improve thinking and memory skills, learn to socialise, reduce the level of positive symptoms, and to manage ongoing symptoms. Research has also shown that CBT is a treatment of choice for depressive and anxiety symptoms. It may also be effective in reducing drug abuse. These are very common experiences for people going through a psychotic episode. It is also more common for people experiencing psychosis to have suicidal thoughts and feelings. They are at a greater risk than the general community for self-harm and suicide. This risk can be reduced through supportive psychotherapy and use of expertly conducted CBT. It works by reducing depressive thoughts and severity and hopelessness, which can be experienced by some people with schizophrenia.

Vocational and social rehabilitation
Rehabilitation focuses on social and occupational skills that may be absent or underdeveloped due to illness. Depending on needs, rehabilitation can be undertaken in a group or individually. It’s about getting life back on track and not just the management of symptoms.

Group activities
People with schizophrenia may benefit from participating in groups with other people who also have schizophrenia. The focus of these groups can vary. They may provide information; teach coping skills for dealing with mental illness; provide opportunities for formal or informal exercise; help to develop relationships; help to learn to become independent again; improve confidence; enhance study or work skills; or just be fun.

Self-help groups
Self-help groups are not really considered “treatment”. Rather, they are there for support and information. They may be beneficial because they provide support, facilitate information exchange and provide resources. Often self-help provides opportunities for new friendships. Self-help groups may also work to foster understanding of people with schizophrenia by the wider community. They can also give the chance to help people recovering benefit from hearing of each other’s experiences.

Advocacy is important. There is much known about the optimal treatments for psychosis, however, access to these optimal treatments is not as easy as it should be. Through self-help groups patients and families can lobby for better services or more research.

Crisis support
A system of mobile clinical support is available in most cities 24 hours a day. Public mental health crisis assessment teams (often called “CAT”) are trained mental health professionals linked with a local service who can speak with patients over the phone about their situation, current treatment and symptoms and when necessary visit or arrange follow-up. This may not be available in small towns and communities. However, the local primary care centre should be able to make contact with a psychiatrist or the CAT team at any time and should have those details available for after-hours staff. Consumers and their families should be encouraged to contact the primary care team early if they believe there is a problem.

Counselling
Talking to someone is an important part of treatment. Your case manager and mental health team will provide general counselling and support during and after an episode of psychosis.
Isolation and loneliness are related to poorer and slower recovery. Group activities counteract these problems.

Coping with bad times
Suicide is one of the main causes of death for people with schizophrenia, most likely due to the depressive symptoms especially early on in people’s experiences of psychosis. Here are some messages for patients to help them deal with “bad times”:

- If you are feeling down, depressed, demoralised or thinking about suicide it is VITAL that you talk to someone about it;
- Suicidal thinking is temporary, but it is dangerous to try to cope with on your own;
- Depression can be overcome. Most people have a good recovery even if things have been a bit rocky for a while. Tell the patient that the key steps to surviving depression and suicidal thoughts in schizophrenia are:
  - Tell someone - your doctor, case manager, relatives, friends
  - Seek help - your doctor or case manager can help you manage your low feelings
  - Don’t remain alone – keep company around you and perform some positive activity.

Research shows that combined treatments work best, rather than choosing only one treatment. It is important to choose both medication and psychosocial treatments together to progress recovery.

Other treatments and treatment issues

What is the role of hospitalisation?
A range of treatment settings should be available to people with schizophrenia. Treatment should occur in the least restrictive environment possible and hospitals used only when absolutely necessary. This may be when patients need a place away from major stresses, when medications need major review or when treatments are needed that can only be delivered in hospital.

Going to hospital can be distressing. Everybody has ideas about what a psychiatric ward will be like. Most of these ideas are based on outdated stereotypes, and fiction. Patients have a right to be treated with respect and to have things explained in a way and language that they understand. Sometimes it is necessary for family or friends to stay with the patient while she or he is admitted and getting settled in. Hospitalisation should also offer access to non-medication treatment options such as those discussed previously.

Other issues
Patients may want to know: what can I do to help myself? They should be told that they can contribute to their wellbeing by staying informed about schizophrenia and its treatments. Tips for patients for good health practices include:

- Following a sensible diet;
- Having regular exercise;
- Avoid all illicit drugs as they have a strong negative impact on recovery;
- Tobacco, as for all individuals, is discouraged, as it acts on the liver and may mean higher doses of medication are required;
- Moderate use of alcohol and caffeine is advised;
- Developing good sleep habits;
- Learning and using stress management techniques;
- Try and build an honest and open relationship with professionals involved in care. It will make it easier for them to understand the situation and provide appropriate help;
- Pay attention to changes in your body and in your thinking and report them as soon as practical to your treating team. This includes collaborating with your doctor to find a medication that gives you the most benefit and use it as recommended;
- It is wise to develop a plan to monitor early signs of relapse. You may want to ask close friends or family to help; and
- Finally, it is important to nurture all the positive relationships you have in your life to ensure you have support throughout treatment and a positive outlook for the future.

Encourage optimism in the future. It is possible to live well with, and after having had, schizophrenia!
Schizophrenia: a Guide for Clinicians

These guidelines are an adaptation of the “Summary Australian and New Zealand Clinical Practice Guidelines for the Management of Schizophrenia” (2003) published in Australasian Psychiatry by Patrick McGorry, Eoin Killackey, Kathryn Elkins, Martin Lanbert and Tim Lambert for the RANZCP Clinical Practice Guideline Team for the Treatment of Schizophrenia (McGorry, Killackey et al 2003). These are, in turn, an abbreviated form of the full guidelines review published in the Australian and New Zealand Journal of Psychiatry (Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for the Treatment of Schizophrenia and Related Disorders 2005). NH&MRC-defined levels of evidence for each suggestion are recorded in the text and information regarding these is published elsewhere (Boyce, Ellis et al 2003; Boyce, Ellis et al 2003) and includes a description of the guideline development process. Consumer guidelines have also been developed. While the levels of evidence are retained in this document the reader is referred to the original documents for full referencing.

Introduction

Schizophrenia is a complex and misunderstood illness with a poor public image. It usually emerges during the critical period of transition to adulthood. Recognition and treatment is often suboptimal, yet over the past decade schizophrenia has become more treatable than ever. A new generation of drug therapies, a renaissance of psychological and psychosocial interventions and a first generation of reform within Australia’s and New Zealand’s specialist mental health systems have combined to create an evidence-based climate of realistic optimism. Neuroscientific advances hold out the strong possibility of more definitive biological treatments in the near future. This potential for greatly improved outcomes and quality of life contrasts starkly with the day-to-day reality for many people with schizophrenia. There is a large gap between the proven efficacy of treatments for schizophrenia and the effectiveness achieved in the “real world”.

Clinicians should consider, but not be limited to, the recommendations. The guidelines are not absolute and should not necessarily be interpreted as standards of practice. Mental health professionals care for patients with schizophrenia in many different settings, some of which are isolated and highly challenging, where it may not be feasible to apply all of the recommendations.
TABLE 1: KEY RECOMMENDATIONS... Foundations for effective care include:

**General**
- Optimism and partnership;
- A stable and secure social environment, including a pleasant home environment, family and peer support, financial security and a meaningful social role; and
- Therapeutic engagement and continuity of care.

**Specific**
- Early detection and comprehensive treatment of first episodes of schizophrenia is a priority because it can minimise the psychosocial – and possibly biological – impact of illness and may improve long-term outcomes.
- Comprehensive and sustained intervention should be provided during the initial years following diagnosis because the course of illness is strongly influenced by what occurs during this “critical period”. Patients should not have to “prove chronicity” before they gain consistent access to specialist mental health services.
- Antipsychotic medication is the cornerstone of treatment but there is great scope for further improvement in the expert use of these medications. The treatment of choice for most patients is the atypical antipsychotic medications because of their superior tolerability, probable greater efficacy in relapse prevention and, in particular, reduced risk of tardive dyskinesia. In first-episode psychosis atypical agents should be used as first-line therapy.
- Conventional antipsychotic medications in low dosage may still have a role to play in a small proportion of patients, where there has been full remission and good tolerability, where atypicals are poorly tolerated, or where depot medication is unavoidable. However, the indications are shrinking progressively.
- Clozapine should be prescribed early, if there is incomplete remission of positive symptoms following treatment with at least two other antipsychotic medications (this should be done by a psychiatrist).
- Clozapine may also be considered where there are pervasive negative symptoms or a significant and persistent risk of suicide.
- Psychosocial interventions should be available routinely for all patients within an integrated hospital and community service, and provided by appropriately trained mental health professionals. Appropriate interventions include family interventions, CBT, vocational rehabilitation and therapy for comorbid conditions, particularly substance use disorders.
- Interventions should be tailored to the phase and stage of illness, and to the gender and cultural background of the person.
- Consumers and relatives should be closely involved in their own care.
- Maintenance of good physical health and the prevention and early treatment of medical illness in people with schizophrenia has been neglected.
- Actively focus on general medical care for people with schizophrenia.
- General practitioners should be closely involved in the care of people with schizophrenia in a “shared care” model. Sole care by a GP with minimal or no specialist involvement is not an acceptable standard of practice, despite the challenges of Australia’s geography.

(CBT, cognitive behavioural therapy; GP, general practitioner)

An overview of schizophrenia

**What is schizophrenia?**
Schizophrenia is a psychotic disorder that is defined in terms of a variable confluence of positive and negative symptoms without the sustained presence of major mood disturbance. Cognitive impairment and disability are common additional concomitants. The boundaries and validity of the concept, especially in the onset phase, remain problematic. Schizophrenia overlaps with other psychotic disorders phenotypically and in terms of underlying risk factors.
**The diagnosis of schizophrenia**

Two diagnostic frameworks are commonly used by mental health professionals: the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association (DSM-IV) and the *Mental Health Manual* of the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10AM). The latter is now standard within Queensland Health and the diagnostic guidelines for schizophrenia are presented in Appendix 1.

Diagnosis is complicated in cross-cultural settings. For instance, in Aboriginal and Torres Strait Islander populations positive symptoms must be carefully differentiated from certain culturally informed experiences. These may be accompanied by negative symptoms from the baneful effects of unrelenting social disadvantage that is common in many Indigenous settings and which is often complicated by substance use. These difficulties are compounded by clinical contexts in which communication may be fraught with uncertainty and miscommunication, emphasising the importance of informed Indigenous collateral informants (Hunter 2004).

**Aetiological basis of schizophrenia**

Schizophrenia arises from a combination of risk factors, mainly in genetically vulnerable people. The genetic vulnerability is complex and is now regarded as involving a variable combination of multiple genes of small effect. Environmental risk factors are also necessary and some operate early in life, creating a neurodevelopmental vulnerability state. Other contributory risk factors include gender, socioeconomic disadvantage and urban birth. Recently it has become clearer that risk factors and pathophysiological processes operating closer to the onset of the syndrome are also required. This second set of factors is believed to involve either endogenous central nervous system (CNS) processes such as increased neuronal dysfunction with reduced connectivity, or extrinsic candidates such as substance abuse, viral infections and developmental stress. How specific these risk factors are for schizophrenia is not clear. There is now extensive evidence of mild structural and significant functional abnormalities in the CNS of people with schizophrenia, although none of these are specific and there is still no laboratory test to confirm the diagnosis of schizophrenia.

**Impact of schizophrenia**

The lifetime prevalence is approximately 1% and it occurs in all known cultures. The course of illness is highly variable, although despite much better recovery rates than generally appreciated, significant disability does occur in a large subgroup and life expectancy is substantially reduced by suicide and chronic medical diseases.

Psychotic disorders appear to be more common in Aboriginal and Torres Strait Islander populations. The standardised mortality ratio for deaths due to mental and behavioural disorders for the period 1999 to 2001 for Queensland, South Australia, Western Australia and the Northern Territory was 4.1 and 1.9 for Indigenous males and females compared to non-Indigenous males and females respectively. Hospital separation rate ratios for 2000 to 2001 for schizophrenia, schizotypal and delusional disorders was 2.3 and 2.1 for Indigenous males and females compared to non-Indigenous males and females. While these elevated rates are influenced by a wide range of factors substance use is clearly important. From the same data the hospital separation rate ratios for mental disorders due to psychoactive substance use for Indigenous vs non-Indigenous males and females was 4.8 and 3.6 respectively (McLennan and Madden 2003).
Current treatment evidence
The management of schizophrenia is best considered in stages or phases: the prepsychotic or prodromal phase, first-episode psychosis, recurrent or persistent schizophrenia (including prevention and treatment of relapse), maintenance therapies, and treatment-resistant schizophrenia.

Prepsychotic or prodromal phase

Background
In most patients a prolonged period of symptoms and increasing disability, commonly termed the “prodrome”, occurs before the onset of severe and persistent positive psychotic symptoms that are sufficient to allow the diagnosis of schizophrenia or first-episode psychosis. Such psychosocial damage is always difficult to reverse. Recently it has also been shown that active neurobiological change may occur during this period. While more evidence is required before definitive guidelines can be developed the following recommendations are offered.

Recommendations
1) The possibility of psychotic disorder should be considered in any young person who is becoming more socially withdrawn, performing more poorly for a sustained period of time at school or at work, behaving in an unusual manner for them, or becoming more distressed or agitated yet unable to explain why [V-1].
2) Subthreshold psychotic features combined with the onset of disability, especially if there is a family history, indicate very high risk. The young person and the family should be actively engaged in assessment and regular monitoring of mental state and safety. This should be carried out in a home, primary care or office-based setting if possible, to reduce stigma [V-1].
3) Concurrent syndromes such as depression and substance abuse, and problem areas such as interpersonal, vocational and family stress, should be appropriately managed [III-3].
4) Information about the level of risk should be carefully provided, conveying a sense of therapeutic optimism. It should emphasise that current problems can be alleviated, that progression to psychosis is not inevitable, and if psychosis does occur then effective and well-tolerated treatments are readily available. Engagement at this early stage will help to reduce any subsequent delay in accessing treatment for first-episode psychosis [III-3].
5) The use of antipsychotic medication during the prodrome is the subject of research. At present it should be reserved for patients who are clearly psychotic [V-1].

First-episode psychosis

Background
Two key issues in first-episode psychosis (FEP) are the timing of intervention (and thus the duration of untreated psychosis (DUP)) and its quality (the sustained provision of comprehensive phase-specific treatment). There are often prolonged delays in initiating effective treatment for first-episode psychosis. Prolonged DUP is associated with poorer response and outcome. Early identification of people in the earliest phases of psychotic disorders combined with optimal treatment is very likely to reduce the burden of disease while it is active. Any improvements in long-term outcome should be seen as a bonus, rather than as a prerequisite for improving clinical standards during early illness. First-episode psychosis tends to be more responsive to treatment than subsequent episodes and later phases of illness but it can be more demanding because of the range of clinical issues to be addressed. Syndromes, and hence diagnoses, tend to be unstable and may evolve over time. The umbrella term “psychosis” allows this syndromal flux and comorbidity to be
accommodated, and treatment commenced for all prominent syndromes, before a stable diagnosis such as schizophrenia needs to be applied. Whether or not core "schizophrenia" can be diagnosed or not is not crucial for effective treatment in FEP. Treatment-relevant syndromes are positive psychosis, mania, depression, substance abuse and the negative syndrome. Cannabis use in particular is common in FEP and can cause confusion and delay in treating the psychotic episode. Significant cannabis use appears to be a risk factor for onset of schizophrenia as well as an aggravating factor for subsequent course.

**Recommendations**

1) Strategies to improve the treatment of FEP include better mental health literacy, more informed primary care, and greater responsiveness of public and private psychiatry to possible cases. Community-wide education systems should be developed to improve understanding of how psychotic disorders emerge in a hitherto healthy person and how to seek and obtain effective advice, treatment and support [III-1].

2) A high index of suspicion and a low threshold for expert assessment should be set for FEP [V-1].

3) Entry and retention within specialist mental health services is often based on a reactive crisis-orientated model in which individuals must reach a threshold of behavioural disturbance, risk, disability or chronicity. This creates unnecessary trauma, demoralisation and therapeutic nihilism in-patients, families and clinicians. Instead, services should aim for proactive retention of patients throughout the first 3–5 years of illness, combining developmental (youth) and phase-specific perspectives [III-3].

4) Initial treatment should be provided in an outpatient or home setting if possible. Such an approach can minimise trauma, disruption and anxiety for the patient and family, who are usually poorly informed about mental illness and have fears and prejudices about in-patient psychiatric care. In-patient care is required if there is a significant risk of self-harm or aggression, if the level of support in the community is insufficient, or if the crisis is too great for the family to manage, even with home-based support [IV-1].

5) In-patient care should be provided in the least restrictive environment.

6) Pharmacological treatments should be introduced with great care in medication-naive patients, to do the least harm while aiming for the maximum benefit. Appropriate strategies include graded introduction, with careful explanation, of low dose antipsychotic medication plus antimanic or antidepressant medication where indicated. Skilled nursing care, a safe and supportive environment, and regular and liberal doses of benzodiazepines are essential to relieve distress, insomnia and behavioural disturbances secondary to psychosis, while antipsychotic medication takes effect [III-3, V-1].

7) The first-line use of atypical antipsychotic medication is recommended on the basis of better tolerability and reduced risk of tardive dyskinesia. In the longer term, the risk–benefit ratio may change for some patients, for example if weight gain or sexual side effects associated with the atypical agents develop. Typical antipsychotic medications may then be one of the options considered [I]. Appendix 2 lists the characteristics of currently available antipsychotics.

8) A baseline physical examination, electrocardiogram (ECG), weight (body mass index; BMI) and fasting serum glucose should be included in the initial assessment [V-1]. Where possible a neurological examination including a neurocognitive screen for movement disorder should be undertaken and if the patient is hospitalised a baseline CT scan is recommended.
9) Psychosocial interventions, especially cognitive behavioural therapy (CBT), are an important component of early treatment, providing a humane basis for continuing care, preventing and resolving secondary consequences of the illness, and promoting recovery. Cognitive behavioural therapy may also be helpful for comorbid substance use, mood and anxiety disorders and improving treatment adherence [II-3].

10) Families and, whenever possible and appropriate, other members of the person’s social network should be actively supported and progressively educated about the nature of the problem, the treatment and the expected outcomes. If there are frequent relapses or slow early recovery, a more intensive and prolonged supportive intervention for families is required [I].

11) If recovery is slow and remission does not occur despite sustained adherence to two antipsychotic medications (at least one of which is an atypical medication) for 6 weeks each, early use of clozapine and intensive CBT should be seriously considered [I].

12) Early use of clozapine should also be considered if suicide risk is prominent or persistent [II].

Recommended interventions in FEP are summarised in Table 2. Appendix 2 lists the characteristics of currently available antipsychotics.
TABLE 2: RECOMMENDED INTERVENTIONS IN FIRST-EPISODE PSYCHOSIS

**Pharmacological interventions: First-episode non-affective psychosis**

- **24–48 h observation (no antipsychotics, but use benzodiazepines for anxiety and sleep disturbance) [V-1].**
- **Start low dose atypical [II] Increase within 7 days to initial target dose (risperidone 2 mg, olanzapine 10 mg, quetiapine 300 mg, amisulpride 400 mg) and hold for next 3 weeks [III-2, V-1].**
- **If no response increase dose slowly over next 4 weeks (8 weeks in total) to 4 mg, 20 mg, 800 mg and 800 mg respectively [III-2, V-1].**
- **If response occurs, continue for 12 months, and if remitted stop gradually over a few months with close follow-up.**
- **Side effects (eg weight gain) may be grounds to consider switch to typical agent.**
- **If no response, assess reason. For poor adherence, discuss, analyse reasons, optimise dose, try compliance therapy [V-2].**
- **Non-response: switch to another atypical and assess over 6–8 weeks [V-1].**
- **If no response or poor adherence, or persistent suicide risk, positively recommend clozapine, informing patient and family of benefits and risks. If reluctant, further trials of atypicals or typicals may be justified. An injectable atypical preparation, namely risperidone, has recently become available [V-2].**
- **If no response or poor adherence with frequent relapse, try low dose typical depot trial for 3–6 months. Currently, unless specifically preferred by the patient, this is a last resort option because of reduced tolerability, greater restrictiveness and associated stigma. This recommendation may partially change with the availability of atypical injectables [V-2].**

**Pharmacological interventions: First-episode schizoaffective psychosis**

- **24–48 h observation (no antipsychotics, but use benzodiazepines for anxiety and sleep disturbance) [V-1].**
- **If manic type: start with mood stabiliser plus low-dose atypical antipsychotic (add benzodiazepine if sedation required) [V-1].**
- **If no response switch to another atypical [V-1].**
- **If depressed type: Start with low dose atypical and SSRI [V-1].**
- **If response, continue for 12 months and discontinue gradually [V-1].**
- **If cyclothymic or family history of bipolar add mood stabiliser [V-1].**
- **If no response switch to another atypical. If no response to SSRI try SNRI [V-1].**
- **If still no response try tricyclic antidepressant then consider ECT [V-1].**

**Psychosocial interventions**

**Prepsychotic period**

- Engagement.
- CBT [V-1].
- Stress management [V-1].
- Vocational rehabilitation [V-1].
- Family intervention [V-1].
- NB – SSRIs where indicated.

**First episode acute phase**

- CBT [II]
- Psychoeducation and emotional support for both the patient and family/carers [V-1].
- Debriefing for patient and carers (especially where the admission involved traumatic events) [V-2].
- Address comorbidity (eg substance use, mood and anxiety disorders, trauma) [V-1].
- Case management aimed at coordinating care, reversing downward social drift, vocational repair, reduction in environmental stressors, engagement in and acceptance of treatment, lifestyle and social environment [V-1].

**CBT -** cognitive behavioural therapy; **SNRI-** selective noradrenaline re-uptake inhibitor; **SSRI -** selective serotonin re-uptake inhibitor.
Recovery and relapse: treating schizophrenia in the critical period

**Background**
Relapses are common during the first 5 years after a first episode of psychosis, a phase that has been termed the “critical period”. Young people naturally find it difficult to accept the lifestyle change of taking daily medication, especially if they have substantially recovered. Poor adherence often contributes to one or more relapses, which are risky, disruptive and may confer an increased chance of treatment resistance. Secondary consequences such as worsening substance abuse, vocational failure, family stress and homelessness are common during this phase, as the social fabric of the young person’s life is put under severe strain. It is essential that high quality and intensive biopsychosocial care be provided continuously and assertively during this critical period. In practice, though, patients are rapidly discharged to primary care and may experience acute relapse, a suicide attempt or manifest severe disability and collateral psychosocial damage. This minimalist model is highly inappropriate for the needs of patients during this often-stormy critical period of illness.

**Recommendations: recovery from first-episode psychosis**

1) In fully remitted patients, antipsychotic medication should be continued for at least 12 months and then an attempt made to withdraw the medication over a period of at least several weeks. Close follow-up should be continued with specialist review for a further period of at least 12 months, and any relapse rapidly identified and treated [V-1].

2) Approximately 10–20% of patients fail to fully remit after a trial of two antipsychotic medications. They should be considered as manifesting treatment resistance (see specific guidelines following [III-3]).

3) Even in fully remitted patients, a range of psychological, family and vocational issues need to be addressed. Comorbidity, especially substance abuse, depression, posttraumatic stress disorder (PTSD) and social anxiety, is common and should be treated [V-1].

4) Every patient has the right to a safe, secure and agreeable home environment [V-1].

5) Family support and intervention should be consistently provided during this phase [I].

6) Suicide risk must be actively monitored and addressed [II].

7) Vocational recovery interventions should be offered once a stable clinical state has been achieved [II].

8) Most patients should be closely monitored by a specialist mental health team throughout the early years of illness [V-2].

**Recommendations: managing acute relapse**

Table 3 summarises strategies for acute relapse. A solid therapeutic relationship and a staged approach are essential. Good adherence to antipsychotic medication and specific psychosocial interventions, particularly family interventions, can reduce the risk of relapse. A significant advantage of an atypical antipsychotic over a typical agent in the prevention of relapse has recently been demonstrated. Poorly engaged, frequently relapsing patients benefit most from intensive case management or assertive community treatment (ACT) models of care. Comorbid substance abuse commonly contributes to relapse, and interventions based on CBT and motivational interviewing show early promise, although this is likely to remain a challenging issue. Appendix 2 lists the characteristics of currently available antipsychotics.
TABLE 3: RECOMMEND INTERVENTIONS IN ACUTE RELAPSE
Pharmacological interventions: Oral
- CBT: cognitive behavioural therapy. Ascertain reason for relapse. Distinguish between relapse linked to poor adherence and relapse despite good adherence [V-1].
- Optimise medication dose and review polypharmacy [V-1].
- Re-start medication if relapse due to non-adherence after understanding the reasons [I].
- If on typical antipsychotic, switch to atypical if response not optimal or if there are tolerability problems. If relapse has occurred despite good adherence, switch to an atypical medication. If patient has been in remission with good quality of life and has no tolerability problems with typical agent, re-start or continue the typical medication. If tolerability problems with the atypical, especially weight gain, offer switch to another atypical or typical [II].
- If on depot, consider relapse as a learning experience and an opportunity to review need for depot within a psychoeducational framework [V-1].
- Consider depot as a last resort only, unless patient prefers this. Atypical depot may offer distinct advantages [V-2].
- If treatment resistance is evident, and two antipsychotic agents (at least one an atypical) have been tried, consider psychiatric evaluation for trial of clozapine [I].

Pharmacological interventions: Depot
- Prior to starting or continuing depot consider potential reversible factors in current relapse (eg extrapyramidal side effects) [V-1].
- Where possible consider use of atypical depot preparations and obtain psychiatric consultation before switching from typical to atypical preparations.
- If a depot is considered essential, consider using the lowest dose possible and maximum dosing interval.
- Depot should be used in conjunction with psychosocial interventions [I].
- Short-term benzodiazepine or oral neuroleptic supplementation may be required [II].

Psychosocial interventions
- Support and counselling for consumer and carers about relapse, especially for a second episode [I].
- Structured family interventions [I].
- Address comorbidities using CBT [II].
- Psychoeducation [III-1].
- Compliance therapy [II].
- Case management [V-1].
- Assertive community treatment [I].
- Vocational rehabilitation [I].
- Relapse prevention [I].
- Harm minimisation for substance use disorders [II].
Prolonged schizophrenia: maintenance treatment and care

Background
Long-term issues in schizophrenia include lifestyle problems and the physical and mental consequences of chronic illness, such as poverty, poor housing, a strained relationship with family members, social isolation and unemployment. Clinical issues include ongoing relapse prevention, reducing the demoralising effects of persistent psychotic symptoms, depression and suicide, substance abuse, smoking, family relationships and vocational rehabilitation. The personal relationship with the patient is critical and a staged approach to recovery essential. Hence psychosocial intervention is always an essential element in addition to pharmacotherapy. Monotherapy with atypical antipsychotic medication, following consultation with the patient and family, is the treatment of choice, unless there has been full remission and good tolerability with a typical agent, or the atypical medications have produced unacceptable side-effects. Physical morbidity must not be neglected. The emergence of obesity, impaired glucose tolerance, tardive dyskinesia, hypertension and cardiovascular disorders should be regularly considered. Although the risk of tardive dyskinesia has been reduced with the atypical antipsychotics, the risk of obesity, diabetes mellitus and sexual side effects has increased and is of particular relevance with Indigenous patients. Preventive health care should be offered early and consistently. No conclusive evidence could be found at this stage to support more widespread introduction of cognitive remediation or social skills training programs.

Recommendations [all V-1]
1) Actively maintain and enhance the patient’s social environment and social capital within a case management framework, addressing issues such as access to paid work or pension support, housing, social relationships. Attend to clinical issues such as active personal and family support, medication adherence, depression, monitoring suicide risk and substance use.
2) In conjunction with general practitioners, ensure full annual physical check-ups that cover weight, blood pressure, lipid profile, ECG and fasting blood glucose, and usual preventive medicine activities such as appropriate screening for cervical, breast, bowel, skin and prostate cancer.
3) Encourage smoking cessation and reduction or cessation of substance misuse, and promote exercise and a healthy diet.
4) Regularly review sexual function.
5) Regularly (6-monthly) examine for signs of tardive dyskinesia.
6) Check for signs of late remission and review the need for continuing antipsychotic medication.
7) Actively encourage and facilitate meaningful social role development and maintenance, especially through “in vivo” vocational rehabilitation.

Treatment-resistant schizophrenia

Background
Symptoms persist in a substantial minority of people with schizophrenia despite apparently adequate treatment. It is important for clinicians to remain hopeful of positive change rather than becoming nihilistic, and recognize that late remissions can occur despite treatment resistance. Treatment resistance can be defined narrowly in terms of persistent positive symptoms, or more broadly to include the persistence of negative symptoms and disability. Complacency, therapeutic nihilism and service gaps have meant that many such patients have not been exposed to clozapine, CBT or active psychosocial interventions. Conditions that may resemble “treatment resistance” include marked but subtle extrapyramidal symptoms, unrecognised depression, inadequate psychosocial rehabilitation, poor adherence, substance abuse, drug interactions and inappropriate drug therapy.
**Recommendations**

1. Identify and address contributing factors such as poor adherence, extrapyramidal side effects, depression, substance abuse, polypharmacy, or poor social environment and support [V-2].

2. Ensure that the patient has received two adequate trials (at least 6 weeks of maximum well-tolerated dose) of antipsychotics, of which at least one should be atypical [V-1].

3. Clozapine is the treatment of choice for clearly defined treatment resistance [I].

4. Depot antipsychotics can be considered if there has been poor adherence and atypicals are the preparations of choice (clozapine should be considered because the required monitoring often enhances adherence) [V-1].

5. Cognitive behavioural therapy should be offered either in conjunction with clozapine or as an interim alternative to it if the patient is unwilling to consent to clozapine. In this situation every effort should be made to inform the patient and family of the disabling consequences of the illness if symptoms do not remit, restate the risks and benefits of clozapine and evidence for its use, and enable them to reach an informed choice.

6. If treatment resistance persists despite treatment with clozapine, reinstate the best previous antipsychotic and try an appropriate adjunctive therapy, such as lithium. Cognitive behavioural therapy should always be provided should clozapine fail. There is no firm evidence that combining antipsychotics in such patients is useful and tends to increase the side-effect burden [V-2].

7. Personal, family and social support, vocational rehabilitation and a safe and fulfilling lifestyle are critical for this group of patients, who are at risk of being marginalised and demoralised [I].

**Managing acute emergencies in schizophrenia**

**Background**

Key goals in managing emergencies involving patients with schizophrenia are summarised in Table 4.

**Key recommendations**

1. A range of preventive strategies aimed at reducing the likelihood, severity and sequelae of acute emergencies should be actively promoted.

2. Use typical antipsychotics only as a last resort in emergency tranquillisation because of the extremely high risk of extrapyramidal side effects. Even in multiphasic patients, the doses of typical neuroleptics required for tranquillisation greatly exceeds the threshold for extrapyramidal side effects (EPS).

3. If the patient is non-combative, try oral therapy with benzodiazepines (diazepam 5–10 mg stat with second dose after 1 hr if required to a max. of 20 mg in 24 hours) followed by oral olanzapine, preferably wafers, but if not available, tablet form (5–10 mg stat, after consultation with MO may repeat in 2 – 4 hours according to clinical response up -20 mg in 24 hours) as the next option. High doses of benzodiazepines may be required for some patients, especially those with severe substance dependence. The use of haloperidol is very difficult to justify because it is non-sedative and is associated with severe EPS and dysphoria in most cases.

4. If the patient is openly combative, remains aggressive while consistently refusing oral medication, if the initial response to oral medication is inadequate, or if rapid tranquillisation is required because of escalating aggression, then parenteral medication will be necessary. Start with clonazepam 1-2mg stat, this should be repeated only under MO supervision to a maximum of 4mg in 24 hours. Under the direct and continuing on-site supervision of a medical officer midazolam 5mg
i.m. may be considered (this should only be used when there is access to the benzodiazepine reversal agent, flumazenil. As when any parenteral medication is administered, resuscitation facilities must be available and the patient must be directly observed for at least 2 hours).

5. If the aforementioned steps have been ineffective, consider the following:
   - after an oral benzodiazepine and atypical antipsychotic, try haloperidol 5-10mg orally or chlorpromazine 25–100 mg orally;
   - after i.m. therapy, consider haloperidol 5-10mg IM. Access to cardiopulmonary resuscitation (CPR) and defibrillation must be assured;
   - further sedation should be under psychiatric supervision. Consideration may be given in District hospital settings to zuclopenthixol acetate (use low doses, especially in patients not previously treated with antipsychotics, because EPS are very common);
   - after parenteral tranquilization, monitor temperature, pulse, blood pressure and respiratory rate every 5–10 min for 1 hour, then half-hourly until the patient is ambulatory.

6. After remission of symptoms, the patient should normally be maintained on the lowest effective dose of an atypical antipsychotic. Debriefing for patients, staff, family members or other caregivers should always be provided.

Table 4: Key goals in managing emergencies
   - Primary prevention of emergency situations and the need for restraint.
   - Prevention of physical harm to the patient, other patients or staff.
   - Prevention of psychological trauma to patients and staff arising from the management of emergencies.
   - Prevention of adverse events from physical or pharmacological restraint during emergencies.
   - Prevention of sequelae of emergency restraint.

Conclusion
These guidelines are inevitably a “work in progress”. The evidence base continues to grow steadily and, despite gaps and the lack of uniform level I evidence, is relatively clear as judged by the degree of consensus between these guidelines and those from other countries that have produced similar documents. Treating schizophrenia inadequately is already a costly exercise.
# Diagnostic Criteria for Schizophrenia in ICD-10 and DSM-IV

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<th>ICD-10</th>
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| **Characteristic Symptomatology:** | **A.**
| 1. One month or more, in which a significant portion of time is taken up one very clear symptom or 2 less clear: | **1.** Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):
   - Delusions;
   - Hallucinations;
   - Disorganised speech (frequent derailment or incoherence);
   - Grossly disorganised or catatonic behaviour;
   - Negative symptoms, ie, affective flattening, alogia or avolition.
|   - A. Passivity phenomena | **Note:** Only one criterion A symptom required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person’s behaviour or thoughts, or two or more voices conversing with each other.
   - B. Delusions of control, influence, or passivity, clearly referred to body or limb movements or specific thoughts, actions, or sensations; delusional perception;
   - C. Voices commenting or other types of hallucinatory voices coming from some part of the body;
   - D. Persistent bizarre delusions.
| Or | **B. Social/Occupational functioning**
| 2. At least two of the following: | For significant portion of time, since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to onset (or when the onset is in childhood or adolescence, the failure to achieve expected level of interpersonal, academic, or occupational achievement).
|   - E. Persistent hallucinations every day for 1 month when accompanied either by fleeting or half-formed delusions without clear affective content; | **C.** Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least one month of symptoms (or less if successfully treated) that meet Criterion A (ie, active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (eg, odd beliefs, unusual perceptual experiences).
   - F. Thought stopping/blocking AND incoherence or irrelevant speech, or neologisms;
   - G. Catatonic behaviour;
   - H. Negative symptoms;
   - I. A significant and consistent change in the overall quality of some aspects of personal behaviour, manifest as loss of interest, aimlessness, idleness, a self-absorbed attitude, and social withdrawal.
| **Duration:** | **DSM-IV**
| One of 1 or two of 2 present for one month | **C.** Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least one month of symptoms (or less if successfully treated) that meet Criterion A (ie, active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (eg, odd beliefs, unusual perceptual experiences).
<table>
<thead>
<tr>
<th>Exclusion:</th>
<th>ICD-10</th>
<th>DSM-IV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The diagnosis is not made in presence of extensive depressive or manic symptoms unless it is clear that schizophrenic symptoms antedated the affective disturbance. The disturbance is not due to substance intoxication, dependence or withdrawal, or overt brain disease.</strong></td>
<td></td>
<td><strong>D. Schizoaffective and Mood Disorder exclusion:</strong> Schizoaffective Disorder and Mood Disorder with Psychotic features have been ruled out because either (1) no Major depressive, Manic, or Mixed episodes have occurred concurrently with the active phase symptoms; or (2) if mood episodes have occurred during active phase symptoms, their total duration has been brief relative to the duration of the active and residual periods. <strong>E. Substance/general medical condition exclusion:</strong> The disturbance is not due to the direct physiological effects of a substance (eg, a drug of abuse, a medication) or a general medical condition. <strong>F. Relationship to a pervasive developmental disorder:</strong> If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).</td>
</tr>
</tbody>
</table>
### APPENDIX 2 MEDICATION GUIDE

Usual therapeutic doses and intensity of common side effects of antipsychotic medications (Based on and adapted from Therapeutic Guidelines (Psychotropic) Version 4)

<table>
<thead>
<tr>
<th>Drug Newer Oral Agents</th>
<th>Dose Range (mg)</th>
<th>IM Dose interval</th>
<th>Sedation</th>
<th>Postural Hypotension</th>
<th>ACh</th>
<th>EPS</th>
<th>Weight Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clozapine</td>
<td>100-600</td>
<td></td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+[1]</td>
<td>+++</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>5-20</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>+[1]</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Quetiapine</td>
<td>300-700</td>
<td>+</td>
<td>++</td>
<td>+</td>
<td>+[1]</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Risperidone</td>
<td>0.5-6.0</td>
<td>+</td>
<td>++(initially)</td>
<td>0</td>
<td>+[1]</td>
<td>+</td>
<td></td>
</tr>
</tbody>
</table>

**Older Oral Agents**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose Range (mg)</th>
<th>IM Dose interval</th>
<th>Sedation</th>
<th>Postural Hypotension</th>
<th>ACh</th>
<th>EPS</th>
<th>Weight Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlorpromazine</td>
<td>50-600</td>
<td></td>
<td>+++</td>
<td>+++</td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>0.5-12</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+++</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Pericyazine</td>
<td>25-75</td>
<td>+++</td>
<td>++</td>
<td>+++</td>
<td>++</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Pimozide</td>
<td>2-12</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>++</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Trifluoperazine</td>
<td>10-50</td>
<td>+</td>
<td>+++</td>
<td>+</td>
<td>+++</td>
<td>+</td>
<td></td>
</tr>
</tbody>
</table>

**Acute Parenteral Agents**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose Range (mg)</th>
<th>IM Dose interval</th>
<th>Sedation</th>
<th>Postural Hypotension</th>
<th>ACh</th>
<th>EPS</th>
<th>Weight Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haloperidol</td>
<td>2-10</td>
<td></td>
<td>++(?)</td>
<td>NA</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlorpromazine</td>
<td>25-50</td>
<td>++(?)</td>
<td>+++(?)</td>
<td>NA</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Olanzapine</td>
<td>(?)</td>
<td></td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zuclopenthixol acetate</td>
<td>50-150</td>
<td>2-3d [2]</td>
<td>+++</td>
<td>+</td>
<td>++</td>
<td>+++</td>
<td>+</td>
</tr>
</tbody>
</table>

**Depot Agents**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose Range (mg)</th>
<th>IM Dose interval</th>
<th>Sedation</th>
<th>Postural Hypotension</th>
<th>ACh</th>
<th>EPS</th>
<th>Weight Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risperidone Consta</td>
<td>25-50</td>
<td>2</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>Flupentixol decanoate</td>
<td>12.5-50</td>
<td>2-4</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>Fluphenazine decanoate</td>
<td>20-40</td>
<td>2-4</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>Haloperidol decanoate</td>
<td>50-200</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>Zuclopenthixol decanoate</td>
<td>200-400</td>
<td>2-4</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+++</td>
<td>+</td>
</tr>
</tbody>
</table>

Ach = anticholinergic effects; EPS = extrapyramidal effects; 0 = Negligible or absent; + = Mild; ++ = Moderate; +++ = Marked; NA = not applicable

[1] Rarely a problem at usual therapeutic doses; [2] single dose, not to be repeated for 2 or 3 days; [3] An initial test dose recommended for depot agents especially if not previously exposed to this type of agent (but not if switching from zuclopenthixol acetate to decanoat)
**Mania**

**What is mania?**

People who are full of energy, are acting strangely happy, and who have very fast thoughts and speech may have an illness called mania.

**They might**

- Think they are the best or special in some way
- Walk round all night – no sleep
- Have strange or silly or very happy behaviour
- Get angry too quickly
- Talk too much and too fast and jumbled up
- Have so much energy that they can’t stop

**What makes me manic?**

These things can cause mania

- Poor physical health
- Loss or bereavement
- Too much stress
- Stopping usual treatments
- Breaking Law
- Family History (someone else in the family has the illness)

People with mania or depression can also have psychosis as well – and will usually need treatment for both problems – see the psychosis pamphlet
What change helps if you are hearing voices or have jumbled thoughts inside?

**OUTSIDE CHANGES**
- Family support
- Elders
- Traditional Healer
- Clinic Mob
- Mental Health Mob
- Antipsychotic tablets with dosette or Webster pack
- Hunting, fishing, dance
- Going to country
- Stopping gunja, alcohol or Other drugs

**INSIDE CHANGES**
- Know about treatment
- Remember totems, family, elders
- Think with your head not with your heart

How do you make change?

- Everyone can make change – when they are ready
- There are lots of different ways to change
- Telling people they SHOULD change doesn’t help
- Letting them know you think they CAN change does help
- Everyone changes in his or her own time
- Small steps can lead to big changes

This information sheets is produce by AIMHI NT – 2005. We invite your feedback and comments. (08) 89227943
Bipolar Disorder: a Guide for Primary Care Workers, Consumers and Carers

Please refer to the definitions and discussion on achieving the 5 Cs for schizophrenia when working with someone with bipolar disorder:

- Consumer and carer centred approach;
- Context of community;
- Continuity of care;
- Checking for change; and
- Considered clinical care.

These guidelines are an adaptation of the “Guide to Treatment for Consumers and Carers”, by Phillip Mitchell, Gin Malhi, Bernette Redwood and Jillian Ball for the Royal Australian and New Zealand College of Psychiatrists. It is intended as a general guide only and is not as a substitute for clinician advice.

Introduction

Aim and purpose of the guide

This document is an adaptation of the RANZCP Bipolar Disorder Treatment Guide for Consumers and Carers released in May 2003 and is a research summary of what is known about bipolar disorder and its treatment. It is also a plain English version of the Australian and New Zealand Clinical Practice Guideline for the Treatment of Bipolar Disorder written for mental health professionals by the same authors for the RANZCP Clinical Practice Guideline Treatment Team for Bipolar Disorder (Mitchell, Malhi et al 2003). Information relating to the NH&MRC-defined levels of evidence on which the clinical guidelines were based is published (Boyce, Ellis et al 2003; Boyce, Ellis et al 2003) and includes a description of the guideline development process.

What this guide covers

Its purpose is to provide information on best practice in the assessment, diagnosis and treatment of bipolar disorder. It is important that its recommendations are not taken as absolute. First, we cover why comprehensive assessment and diagnosis is so important. We then outline treatments by each phase of the illness:

- Acute treatment of mania and mixed episodes
- Acute treatment of depression
- Preventative continuing treatment of mania and depression

What is bipolar disorder?

Bipolar disorder is a mood disorder. Figure 1 on the following page shows the criteria for diagnosing Bipolar Disorder according to the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV). Queensland Health uses the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM). A comparison of these two diagnostic frameworks is provided in Appendix 4. Bipolar Disorder is characterised by periods of mania or hypomania, depression, and “mixed episodes” (or “dysphoric mania” — a mixture of manic and depressed symptoms). According to DSM-IV, the illness is commonly subdivided into:

- Bipolar I disorder — at least one lifetime manic episode or at least one mixed episode
- Bipolar II disorder — only periods of a major depression accompanied by at least one hypomanic (not manic) episode.
Most people experience multiple episodes at an average of one episode each two to three years, with each phase lasting about three to six months. If a person has four or more episodes in a 12-month period, their condition is termed “rapid cycling” bipolar disorder.

**Treatment of mania and mixed episodes**
This section discusses the initial clinical assessment, how bipolar disorder presents when people first experience it and the main treatment approaches, mood stabilising and antidepressant medications.

**Initial diagnosis**
When people with bipolar disorder experience acute mania, immediate referral to a specialist psychiatric service is usually necessary.

Diagnosing bipolar disorder can be very complex and the first assessment may not provide a definitive diagnosis. To confirm the diagnosis, a mental health professional (usually a psychiatrist) should undertake a comprehensive assessment. This should include information from relatives and other local informants.

It is necessary to conduct a full psychiatric history, mental state assessment and physical examination to confirm the diagnosis, to exclude any underlying organic cause (such as a prescription drug or substance-induced manic state) and identify any physical complications (such as dehydration). Assessment should also include determining if there is any risk to the person’s safety or to others, a key consideration in deciding how best to manage the condition.

Mania refers to elevated mood that is characterised by high-risk behaviour of either: aggression, excessive spending, or engaging in what is called, “disinhibited behaviour”. This is behaviour that is likely to severely damage the patient’s reputation, such as sexual indiscretions. Insight and judgment are usually impaired early in the episode of illness. Some people may develop delusions, or fixed false beliefs. These are symptoms of psychosis. The presence or absence of psychosis will be taken into account in treating bipolar disorder.
FIGURE 1: THE CRITERIA FOR DIAGNOSIS BIPOLAR DISORDER

The Diagnostic and Statistical Manual (DSM-IV) criteria are:

**Bipolar 1:** Occurrence over a lifetime of at least one manic episode or at least one mixed episode.

**Bipolar 2:** One or more major depressive episodes accompanied by at least one hypomanic episode (not manic episodes).

**Hypomania and Mania (DSM-IV Criteria)**
A distinct period of abnormally and persistently elevated, expansive or irritable mood. Mania lasts at least one week (or any duration if hospitalisation is necessary). Hypomania lasts at least four days. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

- Inflated self-esteem or grandiosity
- Decreased need for sleep (eg feels rested after only three hours of sleep)
- More talkative than usual, or pressure to keep talking
- “Flight of ideas” or subjective experience that thoughts are racing
- Distractibility (ie attention too easily drawn to unimportant or irrelevant external stimuli)
- Increase in goal-directed activity (either socially, at work or school, or sexually, or a mental and physical restlessness) and
- Excessive involvement in pleasurable activities that have a high potential for painful consequences (eg engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

**Major Depression (DSM-IV Criteria)**
Five or more of the following symptoms have been present during the same two week period and represent a change from previous functioning; at least one of the symptoms is either depressed mood or loss of interest or pleasure.

- Depressed mood as indicated by either subjective report (eg feels sad or empty) or observation made by others (eg appears tearful)
- Markedly diminished interest or pleasure in activities
- Significant weight loss when not dieting, or weight gain or decrease or increase in appetite
- Insomnia or excessive sleep
- Mental and physical slowing or restlessness
- Fatigue or loss of energy
- Feelings of worthlessness, or excessive or inappropriate guilt
- Diminished ability to think or concentrate, or indecisiveness
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt, or a specific plan for committing suicide.

**Mixed Episodes (DSM-IV Criteria)**
The criteria are met both for mania and a major depressive episode nearly every day during at least one week period.
**Initial management**

Figure 2 shows the approach mental health professionals usually take in the initial management of a person when they present with acute mania. Although community or outpatient treatment is always preferable, and admission with the patient’s consent is sometimes possible, involuntary hospitalisation under the relevant health legislation is often needed. Going to hospital can protect the person and their family from the damage that may result from the impaired judgment associated with the illness. The decision to go to hospital is often traumatic for the person with bipolar disorder and their family.

**FIGURE 2: INITIAL CLINICAL ASSESSMENT - HYPOMANIC/MANIC EPISODE**

**INITIAL SCREENING ASSESSMENT**

- Severity of symptoms;
- Level of functional impairment;
- Degree of insight;
- Presence/absence of psychosis;
- Risk to self (financial, sexual, reputation) or others (violence); and
- Amount/quality of family support and/or community services.

Assessment may lead to:

- Outpatient treatment, OR
- Voluntary hospitalisation, OR
- Involuntary hospitalisation.

**Comprehensive clinical assessment**

Clinical assessment requires patient cooperation. This may not be possible if the patient is irritable or aggressive as a result of acute mania. The comprehensive assessment is carried out after the person is more settled.

A full medical history and a mental state assessment should be performed. This includes a “risk assessment”, which assesses a person’s potential for experiencing harms associated with mania. These may include aggression, financial harm, risky sexual behaviour or vulnerability to exploitation and the possibility of contracting communicable diseases (such as HIV, Herpes or Hepatitis C) due to sexual behaviour.

The medical history should include past episodes of psychiatric problems and compliance with recommended treatment. Physical examination should exclude organic causes of the manic behaviour, such as neurological disorder, systemic disease, the misuse of alcohol or drugs or other substances, or the use of prescription medication, as well as assessing any physical consequences of mania (eg dehydration, emaciation or injuries).

Routine laboratory investigations include urea and electrolytes, full blood count, liver function tests, thyroid function tests and therapeutic drug monitoring of mood stabiliser serum concentrations. Other investigations should be carried out if needed. For example, these may include a brain scan, cognitive/dementia screen, and an EEG.
**Acute treatment of manic episodes**
Medications are the main way of managing an acute manic episode. The aim of the medications is to stabilise mood (Figure 3 on the following page).

There are two components to the drug management of acute mania. The first is the commencement of a mood stabiliser (lithium, sodium valproate, carbamazepine or olanzapine). Mood stabilisers act on the elevated mood but take about one week to start working for most people.

The second component is the concurrent use of an antipsychotic or benzodiazepine (or a combination of these). These medications calm or sedate the person with mania as a temporary procedure, until the mood stabiliser starts to help the person to feel better.

The research evidence that has evaluated the effectiveness of lithium when compared to placebo is strong. Studies show that carbamazepine and valproate are of similar value to lithium, although there have been few trials, particularly for carbamazepine.

Olanzapine has also been studied and has been demonstrated in controlled trials to be more effective than placebo. It is possibly more effective to valproate.

For lithium and sodium valproate, therapeutic blood concentration levels for acute mania are reasonably well established. For carbamazepine however, the plasma therapeutic range used is that applied for epilepsy. However, dosage is mainly determined by the assessment of individual response to the medication.

**Management of mixed episodes of bipolar disorder**
The treatment of mixed episodes involves the choice of any of these medications.

- Valproate
- Carbamazepine
- Lithium
- Olanzapine

The best evidence for the treatment of mixed states of bipolar disorder is for valproate. However, this finding is based on only one study of valproate and lithium in mania. The evidence for carbamazepine is weak and, although there are no specific studies of lithium in mixed episodes, some doctors recommend its use if anticonvulsants have not worked. Olanzapine, an antipsychotic medication, has been shown to be effective in studies that included people with both mania and mixed episodes.

**If the episode does not respond to first line treatment**
The timing of the decision to change treatment will depend on both clinical urgency and the degree of response, which varies from person to person. There are several options when a person does not respond to the initial medication chosen:

- Increase the dose and/or blood levels of the mood stabiliser;
- Switch mood stabilisers;
- Combine mood stabilisers; or
- Add an additional antipsychotic such as risperidone, olanzapine or haloperidol.
FIGURE 3: TREATMENT OF A MANIC EPISODE

MOOD STABILISER WITH OR WITHOUT ADDITIONAL TREATMENTS FOR OTHER SYMPTOMS

1) MOOD STABILISER

LITHIUM
Commence with 750 to 1000 mg daily.
Determine serum level after 5-7 days of steady-dose treatment
[Aim for serum concentration of 0.8-1.2 mmol/L]

OR

VALPROATE
Commence with 400 to 800 mg daily.
Determine serum level after 5 days of steady-dose treatment OR
Use loading dose strategy commencing at 20 to 30 mg/kg
[Aim for serum concentration of 300-800 µmol/L]

OR

CARBAMAZEPINE
Commence with 200-400 mg daily.
Determine serum levels after 5 to 7 days of treatment.
[Aim for serum concentration of 17 to 50µmol/L].

OR

OLANZAPINE
5 to 20 mg daily

WITH OR WITHOUT

2) ADDITIONAL TREATMENTS FOR OTHER SYMPTOMS

AIMS

• Contain aggressive / overactive / disturbed behaviour
  • Treat psychosis
  • Manage sleeping difficulties

OPTIONS

i) Taken orally
  • Benzodiazepines (diazepam, clonazepam, lorazepam)
  • Antipsychotics (risperidone, olanzapine, chlorpromazine, thioridazine, haloperidol)

ii) Taken by injection (only use if oral administration is not possible or ineffective)
  • Benzodiazepines (midazolam IM, diazepam IV)
  • Antipsychotics (droperidol IM, haloperidol IM, zuclopenthixol IM)
  • Cease adjunctive treatments prior to discharge.
If there is continuing failure to respond
- Re-evaluate the diagnosis – consider alternate causes (other psychoses, organic disorders)
- Electroconvulsive therapy (ECT)

Electroconvulsive Therapy (ECT)
ECT is administered on an inpatient or day treatment basis by psychiatrists especially trained to administer it. It is a physical treatment and is only able to be conducted after ensuring no physical complications could arise from its use in a particular patient’s case. ECT involves the use of electricity to stimulate the brain. It is a safe and painless procedure and can be life-saving for severe depression. It is now administered to very specific target areas of the brain so that side effects (such as short-term memory loss) are limited and/or of very short duration. Informed consent is mandatory.

Continuation treatment
Following remission of an initial episode of mania, the mood stabiliser should be continued for at least six months. This is because experience with most patients shows that this is the best way to prevent another episode. The benzodiazepine or antipsychotic should be withdrawn once the acute episode has resolved but the mood stabiliser is continued.

For those people with a well-established history of bipolar disorder, there are several recommended criteria for deciding if the person is likely to benefit from ongoing medication treatment. Most of these guidelines are based on medical consensus opinions and clinical wisdom, taking into account how often illness happens, its severity and the level of disability that it causes.

Criteria for continuation and maintenance treatment
First manic episode
- Continue treatment for at least six months

Manic episode in established bipolar illness
Various criteria for long-term treatment – however serious consideration should be given to long-term treatment whenever a patient has experienced two episodes of mania and/or depression. This is particularly relevant in remote settings where there are greater difficulties with follow-up monitoring. The practitioner should also consider past suicide attempts, psychotic episodes and functional disability associated with episodes.

Treatment of bipolar depression
Assessment of bipolar depression
The treatment for bipolar depression is sometimes different to how people with depression, but without bipolar disorder, are treated for depressive symptoms. This chapter discusses assessment and management of these episodes in relation to bipolar disorder depression. In established bipolar disorder, depression arises:
- In the absence of ongoing medication – a new depression
- During ongoing treatment – called “breakthrough depression”.

As shown below, a full psychiatric history, mental state and physical examination should be conducted to:
- Confirm diagnosis;
- Exclude underlying complications (such as the presence of any other illness);
- Identify physical complications; and
- Assess any risk of self-harm.
The reason for the latter is that people with bipolar disorder have much higher rates of self-harm and suicide than the general population. This is usually due to depression, sometimes due to impulsivity, and at other times can result from accidents during periods of manic behaviour. Stopping medications too soon is a common cause of depressive relapse, so the assessment will involve a full medication history and review.

INITIAL CLINICAL ASSESSMENT OF BIPOLAR DEPRESSIVE EPISODE

INITIAL SCREENING ASSESSMENT

- Severity of symptoms
- Level of functional and cognitive impairment
- Presence/absence of psychosis
- Risk to self (suicide)
- Extent of family support and/or community services

TREATMENT CONSIDERATIONS

Legal aspects (eg informed consent, mental capacity)
Care in least restrictive environment ensuring safety (risk of self-harm)
This may lead to:

- Outpatient care OR
- In-patient care EITHER
- Voluntary hospitalisation OR
- Involuntary hospitalisation

COMPREHENSIVE CLINICAL ASSESSMENT OF BIPOLAR DEPRESSIVE EPISODE

Clinical assessment requires patient cooperation and may not be possible if the patient is severely slowed physically and mentally. It is essential to obtain corroborative information especially in cases with suspected cognitive impairment.

- Suicide risk assessment
- Exclude organic causes (neurological disorder, systemic disease, substance misuse, drug induced)
- Sophisticated appraisal of possible psychotic symptoms – especially pathological/delusional guilt and hallucinations
- Check compliance with mood stabilisers
- Conduct routine haematological and biochemical investigations (urea and electrolytes, full blood count, thyroid function tests, therapeutic drug monitoring)
- Additional investigations if indicated (eg brain scan, cognitive/dementia screen).
New depressive episode
The first step in managing a new depressive episode is for appropriate antidepressant treatment to be started. There are two options that work for most people: using a mood stabiliser alone or mood stabiliser and antidepressant combined.

Mood stabiliser alone
Lithium is recommended as the first-line treatment unless it has been unsuccessful in the past or is poorly tolerated. If it has not worked before, lamotrigine (an antiepileptic drug) or valproate should be tried. The administration of a mood stabiliser minimises the risk of switching (from depression into mania). For patients who are not psychotic, suicidal or hospitalised, this may be sufficient.

Mood stabiliser medication is tailored to each individual by monitoring blood levels to ensure that the dosage of medication is adequate. Lithium is the preferred choice because it has been shown by research to be very effective. However, it has a slow onset of action and it is not as effective an antidepressant as lamotrigine. Therefore, both lithium and lamotrigine should be considered as first-line options. Valproate should be considered in rapid cycling bipolar disorder.

Mood stabiliser and antidepressant combined
Because the antidepressant effect of mood stabilisers can take several weeks to work, where there is a risk of self-harm, simultaneous antidepressant use is advisable.

The concurrent use of a mood stabiliser and antidepressant may enhance and accelerate antidepressant effectiveness and reduce the likelihood of switching moods.

Breakthrough depression on a single mood stabiliser
If there is “breakthrough depression” the dose and/or blood levels of the mood stabiliser should be optimised. If this is unsuccessful the addition of (i) an antidepressant; or (ii) a second mood stabiliser should be considered.

Add an antidepressant
Antidepressant therapy on its own may induce mania or rapid cycling, and should therefore be avoided. Selective serotonin reuptake inhibitors (SSRIs) and venlafaxine form the medications of choice (tricyclic and monoamine oxidase medications may be used but must be under close psychiatric supervision).

Upon remission or recovery of the episode, antidepressants should be tapered so as to minimise the risk of switching moods while the mood stabiliser is continued.

Add second mood stabiliser
Adding a second mood stabiliser is as effective as adding an antidepressant, but can have significant side effects in some people.

Lithium, valproate and carbamazepine combinations are used routinely but convincing research is only available to suggest that the combining of lithium and carbamazepine is the better option. Lamotrigine is the preferred choice when considering a second mood stabiliser. However, its dose should be reduced in combination with valproate because of the risk of serious rash. Therefore, overall, the addition of an antidepressant is the preferred choice but a second mood stabiliser can be tried, especially if combination therapy is likely to continue long-term.
Choice of antidepressant
The SSRIs are the antidepressants of choice in the treatment of bipolar depression because research shows they are superior and they seldom cause mood switching. Venlafaxine is a suitable alternative.

Choice of mood stabiliser
The choice of mood stabiliser is made on the basis of clinical indications. However, the research evidence clearly shows that lithium and lamotrigine are superior.

- Lithium
- Lamotrigine
- Olanzapine/SSRI combination

Failure of depressive episode to respond to treatment
If the depressive episode does not respond to initial treatment it is important to be sure that treatment is at the right dosage and that it is being taken as prescribed. If there is still no improvement, either or both mood stabilisers and antidepressants can be tried instead or another mood stabiliser added. By this stage, lithium should have been tried.

Any number of mood stabiliser combinations can be attempted in conjunction with antidepressants. However, if despite all reasonable efforts the patient remains depressed or only partially responds, it is important to re-evaluate the diagnosis and review therapy. Organic causes need to be ruled out. Furthermore, the impact of any additional medical or psychiatric conditions should be thoroughly re-assessed.

Finally, consideration needs to be given to psychosocial factors, such as how much support the person has, and whether or not their living circumstances are such that recovery will be promoted. Following remission of the depressive episode it is appropriate to withdraw antidepressant treatment after two to three months to avoid causing mania and/or rapid cycling. However, in every individual, it is necessary to balance the need to treat bipolar depression versus the risk of precipitating mania. It is usual to withdraw antidepressant treatment after two to three months to avoid precipitating mania / rapid cycling. If the person has recurrent depressive episodes, the antidepressant can be continued if administered with a mood stabiliser.

Most experts agree that electroconvulsive therapy is the most effective antidepressant therapy for bipolar depression. It should therefore be used when indicated and especially if it has been previously effective or there are psychotic symptoms.
FIGURE 4: SUMMARY PHARMACOLOGICAL INTERVENTION – DEPRESSIVE EPISODE

NEW DEPRESSIVE EPISODE
Initiate and optimise mood stabiliser
OR
Initiate and optimise mood stabiliser and antidepressant concurrently

BREAKTHROUGH DEPRESSIVE EPISODE ON SINGLE MOOD STABILISER
Check blood levels
IF Inadequate blood levels – THEN optimise mood stabiliser to adequate blood levels

WHEN adequate blood levels
Add antidepressant
OR
Add second mood stabiliser

SUMMARY: FAILURE OF DEPRESSIVE EPISODE TO RESPOND TO TREATMENT
FAILURE TO RESPOND
Switch/substitute antidepressants
OR
Switch/substitute mood stabilisers
OR
Electroconvulsive therapy

CONTINUING FAILURE TO RESPOND
- Confirm correct diagnosis
- Re-evaluate psychological/social factors responsible for maintaining depression
- Consider adjunctive psychological therapies

Prevention of further episodes
Everyone with bipolar disorder has different patterns of illness. Because the illness is episodic, it can be hard to judge when to stop or when to continue treatment. If the patient ceases medication and relapses, the experience should be used to educate the patient and reinforce compliance.

Attitude to medication and coping with side effects
Adverse side effects are not the only cause of non-acceptance of medication. The lack of feelings of general health and wellbeing, successful social interaction and intellectual activity are important considerations. People who manage to live well with bipolar disorder tend to agree that even when treatment is seemingly effective, all other life issues must be taken into account.

Weight gain is often a significant problem for people taking medication for bipolar disorder. This is especially so for lithium, sodium valproate or antipsychotics. Diet and exercise help lift depression and may assist with weight gain.

Not taking medication properly is the most common cause of relapse. A good mental health professional discuss how the patient manages their medication and their attitude and response to it, to try to prevent the possibility of relapsing. These approaches may include:
• Providing you with education about the recurrent and disabling nature of this condition and potential side effects of medications;
• Addressing the fear people with bipolar disorder often have about the potential sudden loss of control of their behaviour and the embarrassing consequences (it is sometimes only after several episodes that many individuals come to accept the diagnosis and need for ongoing medication or treatment); and
• Helping you to locate support (see Appendix 3).

Barriers to Taking Medication

- Doubt about the diagnosis and willingness to risk another episode to confirm it;
- Possible side effects;
- Possible enjoyment of the experience of mania and a wish to experience it again;
- Not realising that mania and depression may involve negative consequences for them or for others;
- Concerns over pregnancy or interactions with medications used for other health problems; and
- All medications cause side effects. These cause many people to stop taking medications. It is important to discuss all side effects you experience with your doctor.

Continuity of care
An under-acknowledged issue in the long-term management of bipolar disorder is that of continuity of care. Ongoing contact with the same mental health professional increases the likelihood of early identification of recurrences, and facilitates awareness of the impact of the illness. Unfortunately, mental health professionals change often. Research suggests that the best outcomes are achieved if there is continuity of care in terms of case management.

How to tell if longer-term treatment is needed?
Long-term treatment is called the “maintenance” phase of treatment or “relapse prevention”. The goal of long-term treatment for bipolar disorder is to maintain stable mood and to prevent a relapse of mania or a depressive episode. The mental health professional should discuss with the patient their pattern of illness and should suggest the appropriate maintenance strategy.

Non rapid cycling

There is strong evidence from clinical trials of the long-term effectiveness of lithium for bipolar disorder. While there have been studies indicating that carbamazepine works to about the same extent as lithium, there have been no long-term studies of either carbamazapine or valproate confirming their superiority over placebo.

For individuals on lithium, kidney function, serum creatinine and electrolytes should be monitored every three to six months. Thyroid function (including thyroid-stimulating hormone (TSH)) should be monitored every six to twelve months, in addition to clinical assessment.

Abrupt stopping of lithium leads to relapse of mania (or, less likely, depression) in many people with bipolar disorder within the next few months. Therefore, if lithium is to be stopped, this should be undertaken slowly over at least one to two months.
For carbamazepine and valproate, haematological and hepatic function should be monitored at least each three to six months after treatment has begun.

**Rapid cycling**
There is no convincing evidence from randomised controlled trials that any of the mood stabilisers are robustly effective in the treatment of rapid cycling bipolar disorder. Valproate has been reported to be effective in some studies but this finding is yet to be confirmed by further research. Lamotrigine was found to have mood stabilising properties in one rigorous study of a mixed group of people who had unipolar and rapid-cycling forms of bipolar disorder.

**Failure to prevent recurrences of bipolar disorder**

**Non-rapid cycling**
There is some evidence that adding a second mood stabiliser (particularly using the combination of lithium and valproate) enhances long-term mood stability.

**Rapid cycling**
First, potential causes of rapid-cycling bipolar disorder should be excluded and managed. These may include substance misuse, antidepressant medications, and possible physical conditions such as hypothyroidism.

**FIGURE 5: MEDICATIONS FOR LONG-TERM TREATMENT OF BIPOLAR DISORDER**

1) **NON-RAPID CYCLING**
- **LITHIUM**
  (Aim for serum concentration of 0.6 to 0.8 mmol/L)
- **OR**
  **VALPROATE**
  (Usual dose range 1000 to 2500 mg; serum concentration 350-700 µmol/L)
- **OR**
  **CARBAMAZEPINE**
  (Usual dose range 600 to 1200 mg; serum concentration 17 to 50 µmol/L)
- **OR**
  **LAMOTRIGINE**
  (Usual dose range 50 to 300 mg; serum concentration not useful)

2) **RAPID CYCLING**
- **VALPROATE**
  (Usual dose range 1000 to 2500 mg; serum concentration 350-700 µmol/L)
- **OR**
  **LAMOTRIGINE**
  (Usual dose range 50 to 300 mg; serum concentration not useful)
- **OR**
  **CARBAMAZEPINE**
  (Usual dose range 600 to 1200 mg; serum concentration 17 to 50 µmol/L)
- **OR**
  **LITHIUM**
  (Aim for serum concentration of 0.6 to 0.8 mmol/L)
FAILURE TO PREVENT RECURRENCES OF BIPOLAR DISORDER

NON-RAPID CYCLING
- Exclude non-compliance
- Treat any comorbid substance misuse
- Trial alternative mood stabiliser alone or in combination with current mood stabiliser (strongest evidence is for lithium+valproate)

RAPID CYCLING
- Exclude non-compliance
- Treat any comorbid substance misuse
- Exclude antidepressant-induced affective instability
- Exclude subclinical hypothyroidism
- Trial alternative mood stabiliser alone or in combination with current mood stabiliser (strongest evidence is for lithium+valproate).

Further treatment choices

Psychosocial treatments
So far we have reported the research evidence for the effectiveness of medications. There are further treatment choices, such as psychological and psychosocial approaches, which may also improve health outcomes. These may be used at all phases of illness along with medication. Here we discuss the role of these approaches in relation to medications, and other treatment issues.

Learning to live with a continuous illness that is episodic is a major issue for people with bipolar disorder and their families. Repeated episodes of mania and depression tend to lead to increased rates of divorce, family breakdown, unemployment, a break in social networks and education, and financial difficulties. Therefore suffering can be reduced if other steps, over and above medication, are taken to manage the condition.

While in other psychiatric illnesses, there is often an “either/or” choice between taking a medication OR using a psychological treatment, in bipolar disorder, medication remains essential rather than optional. The psychological treatments here are called, “adjunctive”, which means that they can be used in addition to medications.

Psychological treatments
People with bipolar disorder often express embarrassment because of the inappropriate behaviour, or sexual indiscretions, which might have happened when they were manic. Education about the illness and cognitive therapy can help to deal with the psychological and social stresses that the illness can cause.

These strategies therefore play an important role in any treatment plan. Cognitive therapy appears to not only help people with bipolar disorder to understand the disorder and improve coping strategies, but might also improve self-esteem. The main psychological treatments that are used are:
- Psychoeducation (education about the illness provided in groups, individually, or with family members);
- Cognitive Behaviour Therapy (CBT);
- Interpersonal and Social Rhythm Therapy (IPSRT).
Coping strategies
Consumers tend to agree that there are several strategies that can help patients improve how you cope with their illness. These are:

- Being educated about how to identify the early signs and symptoms of either mania or depression;
- Encouraging family and friends to also be able to identify such early signs;
- Staying in treatment and being aware of anything that risks not taking medication;
- Remembering to focus upon the achievement of goals, rather than letting the illness take over the patient’s life;
- Keeping a mood diary to help keep track of you treatment progress and any side effects of any medications the patient is taking; and
- Keeping support around you from family and friends.

However, support from family and friends, does not always shield the patient from the effects of life stresses. Increased levels of support may be necessary when people are required to cope with the death of family or close friends, loss or interruption to careers, or psychological and social distress of other kinds.

Complementary (non-prescribed) medications
Herbal remedies and other natural supplements have not been well studied and their effects on bipolar disorder are not fully understood. Omega-3 fatty acids (found in fish oil) are being studied to determine their usefulness for long-term treatment of bipolar disorder. St John’s Wort (hypericum perforatum) is being studied in regard to depression, but there is some evidence that it can reduce the effectiveness of some medications, can react with some prescribed antidepressants, or may cause a switch into mania.

Pregnancy and breast feeding
The period following childbirth for all women is an extremely emotional period but for women with bipolar disorder the risk of mania, depression or psychosis is particularly high. About 30% of women with pre-existing bipolar disorder will experience a manic or depressive episode following childbirth.

During pregnancy and breast-feeding the goal of treatment is to use the minimum effective dosage of medications and to limit the total number of medications while sustaining the mother’s mental health. Ensuring adequate social, emotional and psychological support is critical.

Support groups
While types of support groups vary widely, here we discuss groups run by people who themselves have experienced bipolar disorder and its treatments.

There is now a growing awareness of the benefits of support groups for people with a bipolar disorder. They have been found to influence positively: the person’s recognition of a need for practical and experiential information about the illness; the awareness of need for medications; and they have been found to assist with the interpersonal difficulties associated with this condition.

Such groups may also help people to cope with hospitalisation, understanding mental health legislation and finding other important mental health information. Some provide support over the telephone and professional referral services. Some groups also enable partners, relatives and friends to attend groups with the person experiencing bipolar disorder.
Standards Of Care
People with any kind of mental illness should expect to be treated with courtesy and compassion by health professionals. There are published National Standards for Mental Health Services available in both Australia and New Zealand which are a guide to what to expect from services. Currently, all public mental health services are aiming to achieve these standards over time. There are some key ideas to keep in mind:

- Evidence-based treatments have the best chance of working if delivered by skilled staff who have up-to-date training;
- Patients have a right to quality care and you also have a responsibility to work with your health professionals to get the best care outcomes; and
- There are complaints processes in mental health services and patients should be informed about how to use these processes should they have concerns regarding the quality of treatment.

Conclusion
This guide has covered what the latest research and expert and consumer opinion tell us about living with bipolar disorder and its treatments according to each phase of illness.

People who manage their bipolar disorder well provide assurance and hope that living with it and achieving a good lifestyle is possible. The wider community is now more aware and understanding of bipolar disorder, there is support and there are highly effective treatments now available.

While there remains no cure, there is no reason to think that treatments will not improve even further in the future. This guide has also discussed where research is limited or remains uncertain. Future research will aim to reduce the side effects of existing treatments and to develop better ones.
Diagnostic Criteria for Bipolar Disorder in ICD-10-AM and DSM-IV

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<tr>
<th>ICD-10-AM Characteristic Symptomatology</th>
<th>DSM-IV</th>
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<td><strong>Bipolar affective disorder</strong> A disorder characterised by two or more episodes in which the patient’s mood and activity levels are significantly disturbed, this disturbance consisting on some occasions of an elevation of mood and increased energy and activity (hypomania or mania) and on others of a lowering of mood and decreased energy and activity (depression). Repeated episodes of hypomania or mania only are classed as bipolar. Although the most typical form of bipolar disorder consists of alternating manic and depressive episodes separated by periods of normal mood, it is not uncommon for depressive mood to be accompanied for days or weeks on end by overactivity and pressure of speech, or for a manic mood and grandiosity to be accompanied by agitation and loss of energy and libido. Depressive symptoms and symptoms of hypomania or mania may also alternate rapidly, from day to day or even from hour to hour. A diagnosis of mixed bipolar affective disorder should be made only if the two sets of symptoms are both prominent for the greater part of the current episode of illness, and if that episode has lasted for at least 2 weeks.</td>
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<td><strong>Hypomania</strong> A disorder characterised by persistent mild elevation of mood, increased energy and activity, usually feelings of well-being and both physical and mental efficiency. Increased sociability, talkativeness, over-familiarity and sexual energy and a decreased need for sleep are often present but not to the extent that they lead to severe disruption of work or result in social rejection. Irritability, conceit, and boorish behaviour may take the place of the most usual euphoric sociability. Disturbance of mood and behaviour are not accompanied by hallucinations or delusions. Several of these features should be present for at least several days on end, to a degree and with a persistence greater than described for cyclothymia. Considerable interference with work or social activity is consistent with a diagnosis of hypomania, but if disruption of these is severe or complete, mania should be diagnosed.</td>
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<td><strong>Mania</strong> Mood is elevated out of keeping with the patient’s circumstances and may vary from carefree joviality to almost uncontrollable excitement. Elation is accompanied by increased energy, resulting in overactivity, pressure of speech, and a decreased need for sleep. Attention cannot be sustained, and there is often marked distractibility. Self-esteem is often inflated with grandiose ideas and overconfidence. Loss of normal social inhibitions may result in behaviour that is reckless, foolhardy, or inappropriate to the circumstances, and out of character. The episode should last for at least 1 week and should be severe enough to disrupt ordinary work and social activities more or less completely. The mood change should be accompanied by increased energy and several of the symptoms referred to above (particularly pressure of speech, decreased need for sleep, grandiosity, excessive optimism).</td>
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<td><strong>Bipolar 1:</strong> Occurrence over a lifetime of at least one manic episode or at least one mixed episode. <strong>Bipolar 2:</strong> One or more major depressive episodes accompanied by at least one hypomanic episode (not manic episodes).</td>
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<td><strong>Hypomania and Mania</strong> A distinct period of abnormally and persistently elevated, expansive or irritable mood. Mania lasts at least one week (or any duration if hospitalisation is necessary). Hypomania lasts at least four days. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:</td>
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<td><strong>Inflated self-esteem or grandiosity</strong></td>
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<td><strong>Decreased need for sleep (eg feels rested after only three hours of sleep)</strong></td>
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<td><strong>More talkative than usual, or pressure to keep talking</strong></td>
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<td><strong>“Flight of ideas” or subjective experience that thoughts are racing</strong></td>
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<td><strong>Distractibility (ie attention too easily drawn to unimportant or irrelevant external stimuli)</strong></td>
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<td><strong>Increase in goal-directed activity (either socially, at work or school, or sexually, or a mental and physical restlessness)</strong></td>
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<td><strong>Excessive involvement in pleasurable activities that have a high potential for painful consequences (eg engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).</strong></td>
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<td><strong>Major Depression</strong> Five or more of the following symptoms have been present during the same two week period and represent a change from previous functioning; at least one of the symptoms is either depressed mood or loss of interest or pleasure.</td>
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<td><strong>Depressed mood as indicated by either subjective report (eg feels sad or empty) or observation made by others (eg appears tearful)</strong></td>
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<td><strong>Markedly diminished interest or pleasure in activities</strong></td>
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<td><strong>Significant weight loss when not dieting, or weight gain or decrease or increase in appetite</strong></td>
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<td><strong>Insomnia or excessive sleep</strong></td>
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<td><strong>Mental and physical slowing or restlessness</strong></td>
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<td><strong>Fatigue or loss of energy</strong></td>
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<td><strong>Feelings of worthlessness, or excessive or inappropriate guilt</strong></td>
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<td><strong>Diminished ability to think or concentrate, or indecisiveness</strong></td>
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<td><strong>Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt, or a specific plan for committing suicide.</strong></td>
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<td><strong>Mixed Episodes</strong> The criteria are met both for mania and a major depressive episode nearly every day during at least a one week period.</td>
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## APPENDICES

### GENERIC AND BRAND NAMES OF MEDICATION CLASSES

#### ANTIDEPRESSANTS
- CITALOPRAM Cipramil/Celepram/Talohexal
- CLOMIPRAMINE Anafranil/Placil/Clomipramine-BC/ Clopram/Genrx Clomipramine
- FLUOXETINE Prozac/Zactin/Lovan/Auscap/ Fluohexal-BC
- FLUVOXAMINE Luvox/Faverin/Movox/Fluoxetine- BC/Genrx Fluoxetine
- MIRTAZAPINE Avanza/Remeron/Mirtazapine
- MOCLOBEMIDE Aurorix/Arima/Mohexa/Clomipramine/ DBL Moclobemide/Genrx Moclobemide/Moclobemide-BC
- NEFAZODONE Serzone
- PAROXETINE Aropax/Genrx Paroxetine/Oxetine/ Paxtine
- REBOXETINE Edronax
- SERTRALINE Zoloft
- VENLAFAXINE Efexor/Efexor-XR

#### MOOD STABILISERS
- CARBAMAZEPINE Tegreto/Teril/Carbamazapine-BC
- LAMOTRIGINE Lamictal
- LITHIUM CARBONATE Lithicarb/Quilonum SR
- SODIUM VALPROATE Epilim/Valpro

#### ANTIPSYCHOTICS
- CHLORPROMAZINE Largactil
- Clopixol Clopixol
- CLOZAPINE Clopine/Clozaril/Clozapine Synthon
- DROPERIDOL Droleptan
- FLUPENTHIXOL Fluanxol Depot
- FLUPHENAZINE Modecate/Anatensol/Fluphenazine DBL
- HALOPERIDOL Serenace/Haldol Decanoate/ Haloperidol
- OLANZAPINE Zyprexa
- PERICYAZINE Neulactil
- QUETIAPINE Seroquel
- RISPERIDONE Risperdal
- THIOTHIXENE Navane
- TRIFLUOPERAZINE Stelazine
Can you explain that term?

Some of the words or expressions that describe symptoms or treatment processes may require further explanation. The symptoms of mania and depression are particularly hard to describe and they have been further explained here so that you may see if they relate to you, or, if you are a carer, to the person you are concerned about. We also explain the different mental health professionals and their roles.

Deliberate self-harm – an act intended to cause injury or self-poisoning, to relieve distress, and sometimes to cause death. It can be used to try to cope with a mental illness or stress of some kind but is considered maladaptive coping. Two RANZCP guidelines exist for consumers who have self-harmed: Coping without self-harm – treatment guide for young people and Coping without self-harm, treatment guide for consumers and carers.

Depression – A mood disorder ranging from passing sad moods to a serious disabling illness requiring medical and psychological treatment. Major depression is a “whole body” disorder impacting on emotions (feelings of guilt and hopelessness or loss of pleasure in once enjoyed activities), thinking (persistent thoughts of death or suicide, difficulty concentrating or making decisions), behaviour (changes in sleep patterns, appetite, or weight), and even physical wellbeing (persistent symptoms such as headaches or digestive disorders that do not respond to treatment).

Flight of ideas – this refers to the experience of ideas entering the mind at a very rapid pace. The thoughts may be positive or negative, but their pace is such that few make much sense or can be reasonably acted upon.

Hypomania – periods of pathologically elevated mood without delusions. This is quite different to normal enthusiasm.

Inflated self esteem or “grandiose ideas” – during mania, a person may experience or think of him or her self as being more capable, energetic and competent in activities than they do normally, or competent or superior in areas which they consider themselves not to be particularly skilled at when they are well. Others would not see them as being this capable in a particular area, so the inflated self-esteem is out of proportion to reality and is potentially socially embarrassing.

Mania – periods of pathologically elevated mood with transient psychotic periods.

Pressure of speech or to keep talking – this refers to a compulsion where the person may, or may not be aware they are talking too much, but feels unable to slow or stop speaking, even though it is not socially appropriate to be so outspoken.

Psychosis – This is a loss of touch with reality, characterised by delusions (false beliefs) and/or hallucinations (a false or distorted perception) of objects or events, including sensations of sight, sound, taste, touch and smell, typically with a powerful sense of their reality. Psychosis can be experienced as part of mania or as part of psychotic depression and is treatable with antipsychotic medications.

Psychotherapy/Psychological intervention – A form of treatment for mental disorders based primarily on verbal communication between the patient and a mental health professional, often combined with prescribed medications. Psychotherapy can be conducted in individual sessions or in a group.

Symptom – A feeling or specific sign of discomfort or indication of illness.
Information and Support
Many organisations are community-managed non-profit associations. They provide mutual support, information, and referral services for clinical, housing, rehabilitation, employment, legal or advocacy services. They may also assist partners, relatives and friends of people with bipolar disorder over the telephone, or in mutual support groups.

Mental Health Association (QLD) Inc
Oxford Drive, Walcol QLD
PO Box 475 Summer Hill QLD 4074
Ph: 07 3271 5544
Fax: 02 3271 6815
Email: association@mentalhealth.org.au
Website: www.mentalhealth.org.au

SANE Australia
PO Box 226 South Melbourne VIC 3205
Ph: 03 9682 5944
Fax: 03 9682 5944
Email: sane@sane.org
Web: www.sane.org

Support for Carers
 Associations for the Relatives and Friends of the Mentally Ill (ARAFMI)
ARAFMI (Qld) Inc
PO Box 248 Newfarm QLD 4005
884 Brunswick St Newfarm QLD 4005
Ph: 07 3254 1881
Fax: 07 3254 1736
Email: arafmi@irvnet.au

Carers Australia
Deakin West ACT 2600
Ph: 02 6282 7886
Fax: 02 6282 7885
Carers’ Resource Centre
Free Call: 1800 242 636
Email: caa@carersaustralia.com.au
Web: www.carersaustralia.com.au

Also look in the front pages of the telephone book for a mental health information and referral service. Also:

Lifeline Australia (13 11 14) conducts a referral service for rural Australia combining the databases of Mental Health Associations, Lifeline Centres, Kids Help Lines, and the State Mental Health Branch

Just Ask Mental Health – Information and Referral Service 1300 1311 14
KEY REFERENCES AND FURTHER READINGS FOR PART TWO:


Page, A (2002), Don’t Panic! Overcoming Anxiety, Phobias and Tension. Sydney, ACP/Media 21


Tanner, S & Ball, J (1989), Beating the Blues. Sydney, Australia: Double Day.