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Mental health and substance use

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Introduction: Mental health and substance use

Many Australian Aboriginal people are no longer the proud hunter-gatherers of this land. Instead, we are recognised as one of the most disadvantaged groups in modern Australia. A history of colonisation and disruption has had many negative impacts. Active separation of families has contributed to the disruption of Aboriginal society. A loss of the respected position in a once ordered society has led to disharmony in our communities and degradation of culture. All of these are reflected in and are linked to the development of poor health and mental health in our people.

What this has meant is that generations of our people are at risk and vulnerable to developing mental health problems. This may or may not be related to alcohol or drug use. When this does happen, some individuals or families seek help from Aboriginal health professionals or others. The help that we can offer needs to be well thought out and may rely on both knowledge of cultural understanding in addition to Western approaches. In some more serious cases, we may be called on to help people who are losing touch with reality or becoming depressed or even suicidal.

This is why a chapter on mental health has been included in this handbook. It is not only to provide knowledge to those working in Aboriginal alcohol and drug work, but also as a resource to people who are helping particularly vulnerable members of our communities. This chapter explores some mental health conditions (e.g. depression and suicide; anxiety and stress; and psychosis) in the context of substance use.

Depression and suicide

OVERVIEW

All of us experience grief at some point in our lives. With sickness and deaths and separations, Aboriginal communities can experience grief more often than other Australians. But when a person has a sadness that they cannot shake, or that goes on much longer than normal grief, and stops them moving on with life, then they may be suffering from depression. There are different types of depression, including depression that can occur after a baby is born (postnatal depression). For milder forms of depression, simple measures such as walking outdoors and talking therapies may help. For more severe forms of depression, medicines can be very important. Assessing the risk from depression and from suicidal thinking is very important. All clinicians need to know what professionals in their area can help assess or arrange treatment for a depressed or suicidal patient.

WHAT IS DEPRESSION?

Major depression, also known as clinical depression, is a serious illness. It is a collection of symptoms such as feeling low most of the time, losing interest or motivation to do things, having no energy, and difficulty sleeping and eating.

How common is depression?

Around 1 in 20 Australians will have depression at any one time. Across a lifetime, up to 1 in 4 women and up to 1 in 8 men will experience depression. Overall, younger people have a higher chance of being depressed than the elderly.

Among Aboriginal people, depression is also a widespread problem. It is the most common mental health problem in people seeing their general practitioner (GP). It is hard to know the real number of Aboriginal people who have depression, and many people do not seek help.

WHY DO PEOPLE GET DEPRESSION?

A number of different factors may contribute to a person being depressed. Most often depression occurs because of a combination of these reasons and not just one cause. Personality and life circumstance can also affect why some people become depressed.

Physical or biological reasons

Depression may:

- Run in the family (hereditary)
- Be the result of problems with the body's system for managing stress (the stress-hormone system)
- Be caused by changes to chemicals in the brain. These include changes in the emotional centre (limbic system) to chemicals like serotonin.
- Be caused by other health problems (e.g. anaemia, stroke, heart attack, cancer).

Psychological reasons

Depression may occur because of:

- Bad childhood experiences
- Negative thinking, e.g. if someone always expects the worst or feels like they are a failure or that they are unlovable. This pattern of thinking may come about because of early bad experiences with caregivers.
- Feeling powerless, e.g. where there is domestic violence or loss of control over life
- Certain personality styles, e.g. people who are introverted (who naturally turn inwards and think a lot), who worry a lot, are too dependent on others, or are very sensitive.

Social reasons

- Social factors can make people more likely to develop depression, such as:
 - Not having a close relationship, e.g. with family or partners or being single
 - Being unemployed or doing unpaid work at home only
 - Major life events, which lead to loss, change or other long-term stress.
- In Aboriginal people, depression may be a response to experiencing racism, dispossession and disadvantage.

Cultural reasons for depression and understandings of depression

It is important to consider cultural and spiritual factors when assessing and treating depression.

In traditional communities, people understand depression as something that happens if a person has done something wrong culturally. A person may also become depressed because of 'longing for land'.

HOW TO RECOGNISE IF SOMEONE HAS DEPRESSION

Everyone feels sad or unhappy at times, but these feelings are usually short-lived and gradually go away, and the person can still go on with their life. Clinical (or major) depression is different to these normal changes in mood. People with depression typically feel 'low' in mood most of the time (for at least for two weeks or more), and are unable to enjoy things that would normally give them pleasure. They often have trouble doing things they normally do (e.g. work or looking after their children).

What problems (symptoms) do people report?

- Feel cranky (irritable)
- Sadness
- Not much energy
- Poor memory and concentration, hard to make decisions (indecisive)
- Sleep problems
- Eating less or more than normal
- Weight gain or loss
- Loss of pleasure or interest in things that normally make them happy
- Less interest in sex
- Suicidal ideas, thoughts about death (see Suicide, p. 257).

What might you see in a person with depression (signs)?

- Cries a lot
- Does not look after themselves
- Too much movement (restless, jumpy) or barely moves at all
- Does not speak unless spoken to, or speaks very softly and does not say much
- Cranky (irritable) or sad
- Has negative thoughts about themselves and the future, feels guilty, hopeless or worthless
- Talks about wanting to die and has a plan to hurt themselves
- Seems withdrawn from others and life (e.g. no eye contact, not wanting to talk, or not going out).

Sicknesses often seen in people with depression (comorbidity)

It is very common for people with depression to be facing other health problems at the same time, such as:

- Anxiety disorders
- Medical illnesses (e.g. heart disease, cancer, dementia)
- Substance use problems (especially alcohol – people who are dependent on alcohol have high rates of depression. This may be a result of alcohol being a ‘depressant drug’. However, the person’s depression may also have led to their drinking problem).
- Difficulties relating to other people. These are sometimes described as personality disorders when the way a person interacts with other people is disturbed, unhelpful and does not adapt to different circumstances (‘maladaptive’). These sorts of behaviours can lead to much distress, including depression, and can get in the way of their ability to cope with life, stress, and relationships.

When a client has one sickness (e.g. alcohol problems) at the same time as another sickness (e.g. depression), this is known as comorbidity.



Common illnesses that get confused with depression

Sometimes the symptoms of depression are actually being caused by another illness. That illness may be able to be treated so it is important for the depressed client to have a medical assessment. All these illnesses can cause symptoms that can look like depression:

- An underactive thyroid
- Anaemia, kidney failure
- Dementia
- Withdrawal from drugs like alcohol, heroin and other opioids, stimulants and benzos
- Other health problems (e.g. dementia, personality problems and reactions to grief and other stressful events).

HOW TO ASSESS A CLIENT WHO MAY HAVE DEPRESSION

The most useful part of an assessment for depression is to give the client an opportunity to tell their story and explain how they feel. They might talk about what problems they are having and how what they are feeling now is different to how they usually feel.

Questions to ask your client

- What symptoms they are experiencing
 - It may be helpful first to talk a bit and to ask some more general questions to get your client feeling comfortable, such as:
 - “How are you?” or “What have you been doing lately?”
 - If they do not talk much you may then need to ask more specific questions. For example: “Have you been feeling sad or weak?”, “Does it feel like you have lost interest in things you like?” or “Are you having trouble with sleep or eating?”
- If they use drugs or alcohol. If so, how much and how often.
- If they have other mental health problems, now or in the past, and what treatment was provided
- If they have any other health problems and if they take any medicine for these health problems
- If they are feeling suicidal. If they are, find out if they have a plan and what this plan is.
- Ask about other risk factors for depression and suicide (see p. 250, p. 258).

What you observe

Write down some notes about how your client looks, behaves, speaks and relates to you. For example:

- Do they look sad? How do they express their emotional state in their face and body language? (this is called their ‘affect’)
- Do they appear to have trouble concentrating and with short-term memory? (‘cognitive’ problems)
- If the client consents, it is also helpful to speak with their family and any other health professionals who they have seen (e.g. health worker, GP). This gives you the chance to see what behaviour changes people around them have seen.

Consider local culture and views when assessing depression

It is important to work out if cultural reasons may be affecting how the client is feeling. Having an experienced Aboriginal mental health or other Aboriginal health professional (or traditional healer) working with the client's GP or psychiatrist can be important to get the best outcome for the client.

Different types of depression

Many different disorders can cause a depressed mood; for example:

- *Major depression* (also sometimes called clinical depression)
- *Psychotic depression*: the person has beliefs and experiences that are not based in reality (e.g. hallucinations, delusions).
- *'Atypical' depression*: the person sleeps and eats too much. This is the opposite of what usually happens in depression where people often sleep or eat less than usual.
- *Postnatal depression*: this develops during pregnancy or after childbirth.
- *Depression as part of bipolar disorder*: the person may have periods of depression as well as other times when they feel really high (also known as 'mania'; or a manic phase). Each mood swing may last from weeks to months, or longer if not treated.
- *Mood disorders as a result of alcohol or drug use (substance-induced mood disorders)*: some drugs have a depressant effect, such as alcohol and benzos. In other drug use, such as with amphetamines, the person may feel depressed when they first stop using the drug. Usually the person's mood improves when they stop using the substance for a while. This can take about a month after alcohol dependence, for example.
- *Long-term sadness (chronic dysthymia)*: the person feels sad, but only has a few other symptoms of depression, and the low mood is there most of the time for two years or more.

WHEN TO GET HELP IF YOU THINK A CLIENT HAS DEPRESSION

Get help from a GP, psychiatrist or mental health team if:

- You are not confident or trained to assess their level of risk
- You think a client has major depression and may need treatment
- The client is reluctant to talk and has isolated themselves from their family and friends
- The client's families and friends are worried
- You feel that the person may be at risk (e.g. because of community reasons, or lack of resources or experience). This is particularly important if someone has a clear plan to hurt themselves or has already tried to hurt themselves.
- The person is at risk of harming themselves or someone else – they may need treatment for depression, even against their wishes (using the Mental Health Act). Families and carers are typically involved in this process.



If someone needs treatment for depression, even against their wishes

- Usually the clinic nurse or GP can arrange to have the person transferred to a hospital.
- This may mean involving the police to help keep someone safe (and contained) if they do not want to go to hospital.
- Clinic staff sometimes may need to use medicines to help the person calm down, especially if they are angry or aggressive. This may also help keep the client safe while arrangements are made with the hospital and during the transfer.
- The person may feel a little better if they have a trusted relative with them throughout this process.
- The police or clinic staff fill out a schedule (Form 1 of the Mental Health Act), which allows the person with the mental illness to be taken to a mental health hospital for assessment and treatment against their wishes.

WHAT TREATMENTS ARE AVAILABLE FOR DEPRESSION?

For mild to moderate depression, some types of talking therapy (such as CBT – cognitive behavioural therapy – and interpersonal therapy) are just as effective as anti-depressant medicines. They can also have an important role in more severe depression, together with other approaches such as medicines.

Talking therapies

Skilled therapy, with specific treatments such as CBT, is an effective way to treat depression.

In cities or regional areas, psychologists can be accessed through GPs or the local drug and alcohol or mental health service (often paid for by Medicare). In rural and remote settings, they can be harder to find. There are still not many Aboriginal psychologists in Australia. Aboriginal mental health workers may also provide some counselling in your community.

Medicines

In a more severe depression, medicines can have a very important role. Anti-depressants can be used to treat depression together with lifestyle changes (such as exercise and being involved in positive enjoyable activities). There are many different types, each with different doses and side effects. The client's doctor can help them choose the medicine best suited for them. Anti-depressants take a few weeks to work. Most people (around two out of three people) will improve on the first anti-depressant they try. Some people may not want to take tablets or may experience side effects. It is important that they discuss these concerns with their doctor. Anti-depressants must be taken every day to be effective. The GP or psychiatrist can help assess whether an anti-depressant might be helpful for your client.

Electroconvulsive therapy (ECT)

Shock treatment (electroconvulsive therapy, ECT) has got a bad name from movies and because of the way it was used in past times, but these days ECT is an effective, safe and life-saving treatment in severe cases of depression. ECT is a painless procedure that is performed by a medical team while the client is under anaesthetic (i.e. is kept asleep by strong medicines). Some side effects, such as confusion and headaches, only last a few hours. Others such as problems with short-term memory may last 3–6 months. ECT does not cause brain damage. It is used in severe cases of depression where it would be dangerous or cruel to leave the client suffering while waiting for medicines to start working. It can also be useful if the person cannot take anti-depressant medicines.

SELF-HARM

When a person has depression or other problems (e.g. health, family, money worries), they may want to physically harm themselves ('self-harm').

Some common reasons for why people self-harm are:

- To block out emotional distress
- To release tension and stress
- Because they want to 'feel' something, as they feel so out of touch with reality.

Clients who harm themselves may also later attempt suicide so it is important to assess the client each time they are seen. Clients who self-harm can be challenging to care for. Seek advice from their psychiatrist on the best way to respond if they harm themselves. If a client tells you they feel like hurting themselves or have already harmed themselves, it is important to have them assessed (e.g. by a GP, clinic nurse or mental health worker).

For some traditional communities, ritual self-harm may be part of a ceremony. This should not be misinterpreted as a suicidal gesture. If you are not sure if this is appropriate cultural behaviour, seek advice from an experienced local Aboriginal health worker or community member.

Suicide

Some people who have depression wish that they were dead and think about killing themselves ('suicidal ideation'). It is important that risk of suicide be assessed properly.

How common is attempted suicide and suicide?

We do not know enough about suicide in Aboriginal people, but we do know that it is common. In some studies, up to 1 in 6 people have attempted suicide (15%), and in any one year, 1 in 50 (2%). The suicide rate in Aboriginal communities is double that of other Australians. Suicide is often impulsive and young Aboriginal men have the highest rates of suicide. Most deaths occur between ages 15–30 and from violent methods (e.g. hanging, gunshot wounds).

What makes some people more likely to attempt suicide? (risk factors)

- Experience of grief and loss (deaths, loss of culture)
- Experience of trauma
- Having a mental illness (half of all people who commit suicide have depression)
- Using alcohol and other drugs
- Being single, divorced, separated or widowed
- Having a medical illness
- Family history of suicide
- Being sexually abused as a child
- Someone who worries, has low self-esteem or takes lots of risks
- Problems connecting with others
- Poor achievement at school.

HOW TO ASSESS A CLIENT WHO MAY BE AT RISK OF SELF-HARM OR SUICIDE

Risk is assessed in a number of ways:

- Taking a history from the person and their relatives
- Talking with health staff who have helped the client in the past
- Asking the client directly whether they have been thinking about suicide or self-harm.

Find out about any factors that may place a client at risk of self-harm or suicide

Do not be afraid to ask lots of questions; for example:

- Have you thought about hurting yourself?
 - If you have, do you have a plan?
 - Have you acted on this plan in any way?
- How often do you think about suicide or self-harm?
- Do you have access to things to harm yourself with (e.g. medicines to overdose on, a weapon to harm themselves with)?
- Have you tried to hurt yourself in the past?
- What situations make you think about hurting yourself (e.g. when drinking)?
- Have you decided when you will hurt yourself?
- What stops you from hurting yourself?

Also, try to work out:

- Has the client been looking after themselves and their family as usual?
- Has the client been aggressive, violent or neglectful? If so, in which circumstances?

Think about any factors that may help protect the person

- Supportive family
- Their spiritual beliefs
- An important role (such as being a parent).

Work out what practical help or supervision can be provided

It may not be possible to care for the person at home. The person may have to be cared for by relatives/friends, be seen at a health clinic or admitted to hospital.



Who should you refer the client to?

If you have a client who you think might be at risk of harming themselves or harming someone else, tell their local doctor, nurse, mental health service or the police. It may be that your client needs urgent protection, even if they do not want help. They need an assessment and may need to talk to someone and have treatment. They could also call Lifeline (131 114) or Kids Helpline (1800 55 1800). These services are free from landlines, payphones and mobiles across Australia, although people with a Telstra mobile cannot access Kids Helpline for free. Kids Helpline also offers web counselling and email counselling (www.kidshelp.com.au).

HOW TO PREVENT DEPRESSION AND SUICIDE FROM HAPPENING

Finding ways to improve a person's social and emotional wellbeing may help to prevent depression and suicide. Exercise and good experiences (e.g. going fishing, going to the movies) can help, as well as connecting with family and culture.

Where to get more information

- Beyondblue: www.beyondblue.org.au or www.youthbeyondblue.org.au
- Lifeline: www.lifeline.org.au or 131 114
- Kids Helpline: www.kidshelp.com.au or 1800 55 1800
- Sane Australia: www.sane.org
- Reach Out: www.reachout.com

FURTHER READING

See more information on the Beyondblue website: www.beyondblue.org.au.

See the Indigenous Risk Impact Screen (IRIS; p. 427).

See a resource for Indigenous Social and Emotional Wellbeing work:
www.healthinfonet.ecu.edu.au/sewworkers.

Anxiety and stress

OVERVIEW

We all experience anxiety at some point in life when coping with stressful events. But the word ‘anxiety’ is also used to describe a mental disorder in which the experience is too severe, it goes on for too long, or where there is no obvious cause. This chapter will look at what is anxiety, what causes it, when does it become a ‘disorder’, and what kinds of anxiety disorders are there. It will also talk about how to help someone with anxiety.

WHAT IS ANXIETY?

Anxiety is a condition that may be serious and affects behaviour, emotions and thoughts (i.e. it is both physical and psychological). We can think of the physical elements as ‘tension’ (or agitation) and the psychological elements as ‘apprehension’ (an unpleasant feeling that something is wrong or something bad may happen).

What is happening in anxiety?

The physical parts of anxiety, i.e. tension, are like the ‘fight, flight or freeze’ response that most animals (including humans) have in dangerous situations. As the brain signals ‘danger’, the body gets ready to respond. The body sets itself to ‘high alert’ with increased activity of the nervous system and the body produces ‘stress hormones’ (steroids and adrenaline-like substances) that prime us for action. In response, heart and breathing speed up, muscles tense, arms and legs may become shaky (tremulous), mouth becomes dry, sweating may increase, and there may be ‘a knot’ (discomfort) in the stomach as the body gets ready for ‘action’. In anxiety, these changes may be minor and brief, or they may be intense and/or long lasting.

The psychological element of anxiety, i.e. apprehension, is a sense of foreboding (that something bad is going to happen). This feeling can vary from feeling emotionally ‘keyed up’ and ready to react (excited expectation) or crippling dread. The causes of this thinking may be obvious to the person (e.g. many past bad experiences) or the person may not understand why they feel this way.

These experiences of tension and apprehension are usually present to some extent when people talk of being anxious or stressed.

How common is anxiety?

Anxiety disorders are common and affect around one in 10 Australians. Anxiety is more often seen in women than men. Aboriginal Australians are more at risk of developing an anxiety disorder than many other Australian groups because of greater exposure to 'risk factors' throughout life, i.e. experiences that can occur while the baby is developing in pregnancy, in childhood or in later life.

WHY DO PEOPLE GET ANXIETY?

Most often anxiety occurs because of a combination of factors and not just from one cause. Both personality and life circumstances can affect why some people have anxiety.

Physical or biological reasons

A range of physical or biological reasons can make a person more at risk of developing anxiety:

- *Family history:* anxiety is linked with the natural level of activity in the brain. While levels of anxiety can be positively or negatively affected by past experience, there are enormous differences in how people respond to stress and how they experience anxiety. Our genes (inherited factors) can influence our brain's make-up.
- *Changes to chemicals in the brain:* the brain can be 'short circuited', for example, by alcohol or drugs or by an illness such as an overactive thyroid gland.
- *Problems during pregnancy can make a person at risk of later anxiety:* this can happen, for example, from stress in the mother, alcohol, tobacco and other drug use, or poor nutrition.

Social and psychological reasons

How likely a person is to get anxiety is influenced by their family and community setting. These may have a positive effect or a negative effect:

- *Problems during infancy*: e.g. illness, separations from parents, poor growth, and unstable homes can place a person at risk of problems with anxiety.
- *How safe and adequate the family environment is*: this influences emotional development of the infant and child.
 - A good environment helps a person develop trust in others and a sense that the future will turn out well (optimism). It also can offer healthy lifestyle options.
 - Experience of major life difficulties like traumas (e.g. deaths, or abuse as a child) can increase the risk of later anxiety. Sometimes, after childhood traumas, distress linked to those traumas may be triggered again by quite minor events, e.g. people who were removed as children from their families may suffer from severe anxiety if they face an event or situation that triggers the bad memories.
 - A sense of control over their environment and confidence as they grow up that they can get along with people and play a part in society: if the infant or growing child develops this sense of control and ability, they are less likely to develop anxiety disorders.
- *Experience of trauma and stress throughout life*: Aboriginal Australians are more likely to experience situations and events that are stressful (such as death, loss, separation, unemployment, money worries, poor health, poor living conditions) and are less likely to have access to resources and services to help them during times of need. All these traumas and stresses may place people at risk of anxiety disorders.
- *Experience of racism, dispossession and other disadvantage*: these can put a person at greater risk of anxiety.
- *How stable the community is*: even if a person does not use any drug, if the community around them is unstable, or uses a lot of alcohol or cannabis, they can face constant demands for money, and sometimes have violence around them. This creates stress, which puts them at risk of anxiety.

The difference between just feeling anxious and an anxiety disorder

Understanding anxiety as a ‘normal’ reaction helps us to understand when anxiety becomes a problem in someone’s life. Performing in front of an audience is an example of a situation where it is normal to feel anxious. If you are well prepared, you may feel very alert and your body may feel slightly on edge. These sensations usually disappear once the performance is over and you feel a sense of relief.

You get less anxious before a performance once you have done it many times before (i.e. you have repeated that sort of performance). Also you feel less stressed if you have practiced (rehearsed) the performance successfully, either out loud or in your mind. The repeated success gives you a sense that you are ‘in control’ and of ‘mastery’. This is because each time a stressful experience is successfully completed (resolved), your brain adjusts, to help you deal with the next stressful situation.

In life, as children grow up they repeatedly end up practising how to cope with stressful events. A supportive, stable family or community can help children get through stress successfully (i.e. to resolve this stress). The young person learns that they can cope with stress and their brain learns ‘success’.

Other people never get the sense that stress can be managed or that things will settle down. They may have experienced so many pressures and traumas that stress seems overwhelming. They never get that feeling that stress can successfully settle down (be resolved). The brain still adapts and learns from past experiences, but in this case the brain learns ‘failure’ instead of success. Instead of imagining successfully coping with stress, without planning to, the individual begins to repeatedly ‘rehearse’ in their mind the experience of failure or stress, along with all the uncomfortable feelings that go with it. Expecting a bad outcome, the anxiety becomes dread and the brain signals ‘flight or freeze’.

HOW TO RECOGNISE IF SOMEONE HAS ANXIETY

Sometimes there are clear signs a person is anxious (e.g. trembling, restlessness or fidgety, or the person looks like they are worrying about something). But other times, there may be no outward signs that the person is feeling anxious. Their anxiety may come out in things they say, or you may need to ask some questions to find out if they are anxious.

Anxiety is considered a disorder when responses to stressful events are either:

- Excessive (too much)
- Persistent (too long)
- Disabling (the response to stress interferes with the person socially, emotionally and with their ability to do the work or other activities they normally would do).

These responses to stress may be physical and/or psychological (i.e. of the body or of the mind).

HOW TO ASSESS A CLIENT WHO MAY HAVE ANXIETY

There are questions you can ask to find out if your client has anxiety, and how severe that anxiety is. Whether you assess a client yourself, or whether you refer them to a mental health team will depend on how severe their anxiety is, and on your training.

If a client has experienced major traumas in the past, and finds it very difficult to talk about these events, you should respect this. It is not a good idea to push a person to talk about these events when they are not ready. It can be very distressing, and sometimes can put them at risk of self-harm. Such a client can be offered specialist mental health support.

For most clients with anxiety, getting a better understanding of what they are experiencing now can help you find ways to support them.

What problems (symptoms) do people report?

- Stress
- Cannot relax
- Cannot eat
- Cannot stay still
- Feeling tense
- Heart beats fast
- Trouble getting to sleep.

Questions to ask your client

You can check for anxiety by asking your client:

- Do you feel 'keyed up' or on edge?
- Do you worry a lot?
- Have you been irritable or cranky?
- Do you have trouble relaxing?
- Do you have trouble sleeping? (i.e. trouble falling or staying asleep, waking up early, or have vivid dreams or nightmares)
- Have you had any headaches or neck aches?
- Have you experienced any of the following: trembling, tingling, dizzy spells, sweating, going to the toilet a lot to 'wee' (i.e. pass urine), diarrhoea?
- Have you been worried about your health?
- Do they describe anxiety-related behaviours (e.g. trying to avoid certain activities or places, doing things in very particular and unusual ways)?
- Ask about their substance use, general mental health and physical health:
 - Do they use drugs or alcohol? If so, how much and how often, and has their use changed recently?
 - Do they have other mental health problems, now or in the past, and, if so, what treatment was provided and/or how did they cope or make it better?
 - Do they have other health problems, and, if so, do they take any medicine for these health problems?
 - Do they worry about recent health problems, and, if so, what are the symptoms of these (e.g. feeling tense, heart beating fast, poor sleep)?

What might you look for in a person with anxiety (signs)?

- Breathing fast
- Being cranky or irritable
- Being sad
- Sweating
- Fidgeting behaviour
- Pacing
- Being 'jumpy'
- Trembling (tremor).

Sicknesses often seen in people with anxiety (comorbidity)

It is very common for people with anxiety to be facing other health problems at the same time, such as:

- Depressive disorders
- Medical illnesses
- Substance use issues.

Other conditions where anxiety can be just one symptom

As well as being a disorder of its own, anxiety can be a symptom of a wide range of other physical and mental illnesses:

- Depression
- Conditions where the client believes what they are feeling is part of a serious medical illness but there is no evidence of this. The most common example is hypochondriasis (the person is sometimes described as a ‘hypochondriac’).
- Some personality disorders (e.g. borderline personality disorder): there is usually a lifelong history of problems with relationships and with self-image. Clients may have impulsive and self-defeating behaviours such as self-harm and substance misuse.
- Substance misuse is commonly linked with anxiety:
 - Intoxication: stimulants like amphetamines can cause all the symptoms of anxiety (and, if used repeatedly, can cause paranoia with intense fearfulness about imagined harm).
 - Withdrawal: anxiety can be part of withdrawal symptoms when the drug is not available (e.g. for alcohol, cannabis, opioids, petrol sniffing).
- Physical illnesses: such as an overactive thyroid or as a side effect of a medicine (e.g. some anti-depressants).

Tools to help screen for anxiety or to assess it

Many questionnaires have been developed as tools to identify anxiety. Some are 'screening tools' that are used to pick up people with possible anxiety disorders (e.g. in a general health clinic). The others are 'diagnostic tools' to confirm that the person who is anxious really does have an anxiety disorder. Examples can be found in Mental Health First Aid.

Consider local culture and views when assessing anxiety

It is important to work out if cultural reasons may be affecting how the client is feeling. Having an experienced Aboriginal health professional (or traditional healer) working with the client's GP or psychiatrist can be important to get the best outcome.

Individuals from traditional areas may more easily talk about physical anxiety experiences than about their emotions. Also, there may be issues that they will not mention unless asked about, especially if the person asking is not from that community. For example:

- Beliefs in sorcery are very common.
- Fears may also be associated with worry about payback, sometimes without any idea about why.
- 'Jealousing' needs to be asked about – for men and women, both for the jealous person and the person exposed to it.

DIFFERENT MENTAL DISORDERS WHERE ANXIETY IS A CORE FEATURE

Anxiety is the core symptom for many different mental disorders, including:

- *Generalised anxiety disorder*: the person has long-standing and excessive worries about issues such as money, family, work, with many of the physical experiences described earlier.
- *Social phobia*: the person is fearful of and tries to avoid social situations. This is more commonly seen in people who were obviously shy as children.
- *Panic disorder*: the person has repeated, intense but short-lived 'attacks' of acute anxiety with such strong physical symptoms that the person fears for their life.
- *Agoraphobia*: the person is worried about experiencing repeat panic attacks and this leads to increasing social withdrawal until they feel unable to leave their house.
- *Post-traumatic stress disorder (PTSD)*: the person has experienced intense trauma(s) that leads to intense and often long lasting anxiety symptoms. They have particular psychological and behavioural reactions that relate to the trauma, and PTSD is often associated with depression and substance use.
- *Obsessive compulsive disorder*: the person experiences repeating and worrying thoughts (obsessions) and feels pressure to perform particular behaviours or rituals that they recognise as unnecessary or 'silly' but cannot resist (compulsions).
- *Reactive or adjustment disorders*: the person experiences marked anxiety or distress for a period of time, often after a life event. They may find their own ways to deal with this and their anxiety settles. If it does not, support and simple measures are usually enough to help them feel back in control of their life.

HOW TO HELP SOMEONE WITH ANXIETY

Helping someone who is experiencing anxiety is an important role for all health and alcohol and drug workers. With awareness and understanding you can help someone be better able to cope with the symptoms of anxiety. You can also help them find approaches to tackle the causes of anxiety. Finally, you can help a distressed person to consult a doctor or mental health professional if the problem gets worse or keeps going on.

The first step in helping someone with anxiety is to show concern and to develop a trusting relationship with them to find what is going on.

The word 'ANXIETY' can help you remember how to assess and manage a client's anxiety

| | | |
|----------|------------|--|
| A | <i>Ask</i> | About physical and psychological symptoms. |
|----------|------------|--|

| | | |
|----------|-------------|---------------------------|
| N | <i>Note</i> | Appearance and behaviour. |
|----------|-------------|---------------------------|

| | | |
|----------|------------------|---|
| X | <i>(e)Xplore</i> | Stressful life situations – e.g. relationships, money, legal. |
|----------|------------------|---|

| | | |
|----------|------------------------|---|
| I | <i>Intake of drugs</i> | Alcohol, tobacco, cannabis, caffeine, others. |
|----------|------------------------|---|

| | | |
|----------|-----------------|--|
| E | <i>Everyday</i> | Approaches to managing stress – e.g. exercise, talking, music. |
|----------|-----------------|--|

| | | |
|----------|---------------------------|--|
| T | <i>Traditional issues</i> | Think about sorcery, payback, jealousy, and traditional practices. |
|----------|---------------------------|--|

| | | |
|----------|-------------------|---|
| Y | <i>Yesteryear</i> | Be alert to the person's past and issues such as health, trauma, childhood. |
|----------|-------------------|---|

Choosing the right time, place and approach to talk about anxiety

Helping usually starts with communication. An anxious person will often begin to experience relief when they start talking. You can help this process by being tuned in to that person's preferences:

- Where: they may be keen to talk but there may be a better place (i.e. where they can be more relaxed or away from someone who is causing them stress).
- When: they may be keen to talk but not able to right now (i.e. they may start to feel more settled when they know that you will be available later).
- How: they may also need:
 - Assurance (e.g. about confidentiality, which can be a tricky issue, for instance, when there is concern about abuse)
 - A support person (e.g. family member) with them
 - Simple things that show them that you care (e.g. getting them a glass of water or cup of tea; avoid giving lots of coffee to people who are acutely anxious; offering something simple to eat can also help as some people develop symptoms that look like anxiety if they have not eaten and their blood sugar falls).



Dealing with acute anxiety or panic

If the person looks tense and is breathing rapidly it can be useful to take some time to focus on their physical symptoms. Do this by:

- Trying to get them into an appropriate space (where they feel safe and there are not too many distractions), and into a comfortable position (usually sitting in a relaxing armchair)
- Helping them clear their mind of thoughts that are tormenting them by focusing on their breathing, i.e. help them to breath slowly and calmly
- Relaxation exercises – you can learn effective relaxation exercises (see Relaxation exercise, p. 272).

If someone is so distressed that they are confused (i.e. they do not know where they are or what is going on), agitated (i.e. they are unpredictable and potentially harmful to themselves or others) or they have severe physical symptoms (such as breathing difficulties or chest pain), then the first thing to do is to make sure they are seen by a doctor or nurse.

When the acute situation has settled, then you can look at lifestyle and other coping strategies.

A relaxation exercise (PMR – progressive muscular relaxation)

- First explain what you are going to do (“I’m just going to show you something simple that will help you relax your body”).
- Give clear instructions (“I want you to listen to me and to breath slowly, I am going to count to four slowly and I want you to breathe in, and then I’ll count to four again as you breath out – you just keep in time with me”).
- Talk in a reassuring way (let them know that they are doing well, that their breathing is settling).
- Sometimes people find this easier with their eyes closed – but that should be left up to that person to decide.
- When breathing is regular you can stop counting and just talk reassuringly for a few minutes, encouraging them to continue; then point out that they have been able to do something that has helped make a difference, i.e. to get back in control.

Key steps

After choosing the right time, place and approach, these three steps will often be enough to help someone feel that they are beginning to get things under control:

- Simply talking things through: allow people to express their distress and the issues behind it (a chance to ‘vent’).
- Let them know that help is available (reassure the person).
- Begin to discuss options and strategies (problem solving).

Everyday strategies to manage stress

You can help a client develop lifestyle strategies to reduce stress. The basics can be discussed straight away, but it is helpful to follow up on this through a number of meetings.

The word ‘STRESS’ can help you remember strategies that your client can use to reduce stress in their life

| | |
|---|--|
| <p>S <i>Substance use (alcohol and drugs)</i></p> | <p>Can be part of the problem, not the solution; reducing caffeine, e.g. less coffee, tea and soft drinks (particularly Coke) can help; reducing stimulant use (e.g. ice), and reducing alcohol and benzos, as withdrawal can cause anxiety.</p> |
| <p>T <i>Talking with others</i></p> | <p>Developing social relationships.</p> |
| <p>R <i>Relaxation exercises, meditation or other mindfulness approaches can also be effective</i></p> | <p>These approaches have been successfully used in Aboriginal populations (e.g. with children from primary school in the Townsville region). It is worth learning some basic relaxation exercises (such as the exercise described in the box above).</p> |
| <p>E <i>Exercise</i></p> | <p>Exercise (regular, aerobic, low intensity), such as walking, effectively reduces stress.</p> |
| <p>S <i>Sleep routine and ways to improve sleep</i></p> | <p>For example, avoid coffee or Coke after 4pm, and have a calming routine before bed, and avoid daytime naps.</p> |
| <p>S <i>Sensible diet and possibly supplements like fish oil</i></p> | <p>There is now evidence that fish oil supplements are useful in preventing a number of mental and physical health problems. They are natural, harmless and cheap. For people who are vegetarian or allergic to fish, linseed oil may help.</p> |

Getting someone to think about these issues can offer them a sense of direction and of regaining control in their life.

There are tools available for health workers to provide information about exercise, tips for good sleep habits and nutrition, and most clinics have brochures that are useful to give to clients.

When to refer?

Health workers and alcohol and drug workers can do a lot to help people who are experiencing anxiety. However, it is important to be aware of your limits and to know when to seek help. There are now effective treatments for anxiety disorders, and helping the client get a referral to a qualified mental health practitioner is an important intervention in itself. In general, talking therapies are better than drug use. Occasionally, if talking therapies fail, then a doctor can recommend a non-addictive medicine to help, e.g. an anti-depressant that also works on anxiety.



Note: some clients will be using benzos to deal with long-term anxiety. This is a very risky solution for anyone with an alcohol or drug problem as benzos are addictive. Also the person becomes tolerant to their effects if used regularly, so they work less well.

HOW TO PREVENT ANXIETY FROM HAPPENING

The strategies listed on p. 273 are also useful to prevent anxiety. Exercise and good experiences (e.g. going fishing, going to the movies) are also important, as is connecting with family and culture. As a health professional, you can also help others through the example you provide. So, the messages about managing stress and living a healthy lifestyle are as relevant for the health professionals as they are well for the patient. Take care of yourself so you can better help others.

Where to get more information

- *Beyondblue:* www.beyondblue.org.au or www.youthbeyondblue.org.au
- *Lifeline:* www.lifeline.org.au or 131 114
- *Kids Helpline:* www.kidshelp.org.au or 1800 55 1800
- *Sane Australia:* www.sane.org
- *Reach Out:* www.reachout.com
- *Mental Health First Aid:* www.mhfa.com.au/cms/

FURTHER READING

See the Indigenous HealthInfoNet website and type *anxiety* in the search box: www.healthinonet.ecu.edu.au.

See a resource for Indigenous Social and Emotional Wellbeing workers: www.healthinonet.ecu.edu.au/sewbworkers.

Psychosis

OVERVIEW

Sometimes a person may become out of touch with reality; for example, hearing voices or thinking people are ‘out to get them’ or are controlling them. This state of mind is known as psychosis. Psychosis may occur as part of schizophrenia, bipolar disorder or severe depression occurring after childbirth. In some people, the use of alcohol or certain drugs may cause psychosis (e.g. ‘drug-induced psychosis’). On the other hand, people with psychosis may turn to alcohol or other drugs to relieve the symptoms of psychosis.

When psychosis occurs, it is usually distressing to the client, their family and the community. Treatment for psychosis usually involves anti-psychotic medicines, counselling and relapse prevention for substance misuse.

How common is it?

We do not know how common psychosis is among Aboriginal people. In some parts of Australia with high levels of cannabis use, health professionals report that many Aboriginal people are admitted to hospital with drug-induced psychosis.

HOW DO YOU KNOW IF SOMEONE HAS PSYCHOSIS?

What problems people report (symptoms)

When a person develops psychosis there is a change in their thinking and behaviour that involves:

- A set of beliefs that is not true and not based in reality (delusions). These beliefs cannot be shaken, even when you talk to the person. Examples include: the false belief that someone is wanting to hurt you, or believing that someone is able to control your thoughts.
- Hearing voices that other people do not hear (auditory hallucinations). Sometimes people may see things that are not there, or experience changes in smell, taste or touch that are not real (these are also hallucinations).

It is important to look at any client in the context of their culture. For example, if a client says they are seeing a person who has recently died, check with a local person (if you are not from the client's country) whether these experiences are considered culturally 'normal'.

What you might see in a person with psychosis (signs)

- What they say does not make sense (disturbed thought process)
- Lack of expression on their face (flattened affect)
- Disorganised or unusual behaviour – this may include unusual rituals such as holding their body in an unusual position (posture) for no reason and for long periods
- Not talking much or not starting conversations, when they normally would (lack of spontaneous speech)
- Lack of motivation or the ability to start things (apathy)
- Not able to do their usual tasks at home, work or school. For example, cannot look after themselves, isolates themselves from friends or family, do not want to engage with people (emotionally detached).
- May be suspicious of other people even when there is no real reason for this (paranoid).

It is important to try to help a person to get treatment early and to prevent relapse – as the more times a person experiences psychosis the more problems can grow.

WHAT TYPES OF PSYCHOSIS ARE THERE?

Psychosis may only last a short period of time like hours or days (transient psychosis), or it may continue for six months or more (sustained or chronic psychosis). Short-term psychosis often happens because of drug use. Short-term psychosis can also happen in someone with a personality disorder who is in crisis (e.g. when going through a relationship breakup they may develop paranoid ideas like everyone is looking at them and laughing about them, or they might hear voices saying things like: ‘you are a bad person’, ‘you are ugly’, ‘who would want you?’). Longer-term psychosis is often part of a mental illness like schizophrenia.

There are several different types of psychosis, and they can be hard to tell apart:

- *Drug-induced psychosis*: happens after using amphetamines, cocaine or cannabis.
- *Schizophrenia*: this is one of the most common illnesses that cause chronic psychosis. A doctor (where possible a psychiatrist) makes the diagnosis of schizophrenia. Before making a diagnosis of schizophrenia, the doctor will check if the client has other medical problems that could be their psychotic symptoms, e.g. head injury or thyroid problems. The doctor will usually wait until the client has stopped using drugs like cannabis or stimulants before making a diagnosis.
- *Bipolar disorder*: in this illness, a person typically has a history of ‘manic’ episodes or depressive episodes. In the manic episodes people sleep very little, may feel really happy, have far too much energy, and make bad decisions, such as spending very large amounts of money in a way that is not normal for them. The highs and the lows of bipolar disorder typically last weeks to months (longer if not untreated). Of course, it is normal for healthy people to experience a variety of mood changes throughout the day depending on their circumstances and thoughts.
- *Schizoaffective disorder*: where a person has problems with their mood (mania or depression) and also psychotic symptoms.

Common health problems associated with psychosis (comorbidity)

- Drug and alcohol problems, including tobacco
- Greater chance of developing other mental health problems such as:
 - Depression
 - Suicide
 - Anxiety (e.g. feeling worried, loss of self-confidence and difficulties returning to social situations).

WHY DOES PSYCHOSIS DEVELOP?

Many different factors may put a person at risk of developing psychosis.

Their 'make-up' (or biological reasons)

- Psychosis may be caused by changes to chemicals in the brain. We do not know exactly why this happens, but brain chemicals like dopamine and serotonin are involved.
- The chance of developing schizophrenia is greater if a close relative has it (i.e. schizophrenia is carried in their 'genes'); schizophrenia is also more common if the client had problems with how their brain developed when they were young.

Psychological and social reasons

- Psychosis is more likely to develop in people who experience stressful events in their life (e.g. separation or divorce from a partner, death of a partner, loss of employment). Stressful life events may increase the risk of relapse of psychosis, but may or may not be a cause of schizophrenia.

Drugs such as cannabis and amphetamines can cause psychosis

- *Cannabis and psychosis*: if a person uses cannabis when they are young (especially under the age of 15) they are more likely to develop psychosis later in life than if they had never used it. The more cannabis they use, the greater the chance of developing psychosis. If someone has a family history of psychosis, cannabis use can increase their chance of getting psychosis.
- *Stimulants and psychosis*: after taking large doses of amphetamines or other stimulants, people can develop a psychosis with confusion, which goes away quickly as the drug leaves the body. Long-term (chronic) stimulant use can cause a long-term psychosis (similar to schizophrenia) in some people, even after use of the drug has stopped.

Culture and psychosis

Some Aboriginal people may also believe a serious sickness like psychosis happens for cultural reasons; for example, because the person did something wrong.

How long does psychosis last?

A period of psychosis can affect a person once, or may come back again and again throughout their life, like in bipolar disorder or schizophrenia.

Does schizophrenia get better?

If a client has schizophrenia:

- Up to 1 in 3 will completely recover
- Up to 1 in 3 will continue to have moderate symptoms
- About half will continue to be significantly affected
- Up to 4 in 10 may try to hurt themselves (attempt suicide).

Clients may experience less problems with schizophrenia if:

- Psychosis develops very quickly (not slowly over many months)
- There is an obvious trigger for the psychosis (e.g. a period of cannabis use)
- Schizophrenia develops at a later age (e.g. after age 25, because by this time many people will have finished school, met a partner, started work, which are all things that reduce the chance of developing schizophrenia).

A drug-induced psychosis tends to gradually disappear within days to months after a person stops using the drug. If it is still present after more than three months of abstinence, the doctor will usually review the diagnosis and there could be something else going on.

HOW TO HELP SOMEONE WHO EXPERIENCES PSYCHOSIS

A person with psychosis usually needs medical treatment. It can sometimes be difficult and frustrating trying to convince them to access a doctor. Occasionally, if they are a risk to themselves or others, they can be forced to have treatment. For any psychosis, stopping using drugs such as cannabis and amphetamines is important. This is particularly important for drug-induced psychosis.

Medicines

Anti-psychotic medicines, such as olanzapine (Zyprexa) or quetiapine (Seroquel), can relieve symptoms of psychosis such as paranoia and thought disorder. They usually start to work after 10 days, but may take a couple of weeks. Some people do not like taking this medicine because of the side effects. There are many different anti-psychotic drugs, each with different side effects.

Some common side effects are:

- Putting on weight
- Diabetes
- Drowsiness
- A drop in blood pressure when standing up, which can cause dizziness (postural hypotension)
- Stiffness or trembling in muscles
- Feeling restless inside ('akathisia').

Because of these side effects, people on anti-psychotics should have regular check-ups with their doctor to make sure they do not have any problems with their weight, heart, body movement, and cholesterol. Also, they should be checked for diabetes.

If your client is experiencing side effects, you can support them to talk to their GP or psychiatrist. Their doctor may know another medicine that could work better for them. Some people with psychosis also experience depression. A GP or psychiatrist can assess whether the person may also need an anti-depressant medicine.

Psychological treatments

There are a number of 'talking' therapies (psychological therapies) used to help treat psychosis. These are not enough on their own, but may increase the effectiveness of medicines. These psychological treatments may also help a client cope with any symptoms that cannot be fixed by medicines.

The types of therapies used are:

- *Cognitive behavioural therapy (CBT)*: where the client is taught to understand how their thoughts affect their feelings and actions, and to learn new ways of thinking
- *Social skills training*: where the client is taught social skills such as how to start and hold conversations, how to develop friendships, find a job, and find some hobbies
- *Family therapy*: where the client and their family are provided with information and education about psychosis and learn problem-solving skills. This can help to improve communication, reduce stress and reduce feeling socially isolated.

Other coping strategies

- For hearing voices: encourage the client to keep busy (walk, exercise, play music), spend more time with family or friends and keep busy (TV, music, humming, earplugs, any other activity they enjoy).
- For delusions: the client can learn to test the reality of their thoughts (this also can be part of CBT).
- For drug and alcohol problems: it may be helpful for the client to talk with a mentor, e.g. an older person in the community who has successfully ceased using drugs or alcohol; they can try to avoid particularly stressful situations or situations where they will be very tempted to use alcohol or drugs.
- Check that your client knows where to get help if they are at risk of hurting themselves. This may be through the local mental health team, the clinic, a helpline or a responsible community member.
- For sleeping problems: you can teach the client ways to try to sleep better (see Further reading, p. 282).

Helplines to provide information and support to your client

Lifeline (24 hours, 7 days)

Ph: 131 114

www.lifeline.org.au

Kids Helpline (24 hours, 7 days)

Ph: 1800 55 1800

www.kidshelp.com.au

Sane Australia (9am to 5pm weekdays)

Ph: 1800 18 7263

www.sane.org

Relapse prevention

Trying to prevent relapse of psychotic episodes is an important part of treatment. Along with the mental health team, you can help your client by doing these things:

- Establish and maintain a good relationship with the client.
- Help them find out more about psychosis.
- Look out for the early warning signs that your client may be getting unwell (e.g. signs that they are staying in their room or withdrawing from family or friends, feeling nervous or cranky, and finding it hard to concentrate). The client's family may also be able to help look out for the early warning signs of psychosis.
- Encourage them to seek help early if they become unwell.

- Support them to have more contact with their mental health worker or GP, who will monitor their symptoms and review their medicines. Talk with the client about how to cope with stress better. For example:
 - Relaxation techniques like controlled breathing, meditation and progressive muscle relaxation may be helpful.
 - ‘Step by step’ problem solving may also help. This is a way of working through a problem one step at a time, which can make people more aware of lots of possible solutions and feel more in control of their problem (see Further reading, p. 282).

HOW TO PREVENT PSYCHOSIS FROM EVER HAPPENING

Avoiding cannabis and amphetamine use can reduce the risk of psychosis. This is particularly important if a person has a family history of psychosis.

FURTHER READING

Sleep habits: www.cci.health.wa.gov.au/docs/Info-sleep%20hygiene.pdf.

Relaxation techniques: www.gpcare.org/evidence%20based%20psychological/relaxationstrategies.htm.

Problem solving: www.reachout.com/find/articles/problem-solving.

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Hunter E (1993). Aboriginal mental health awareness. An overview: Mental status examination. *Aboriginal and Islander Health Worker Journal*. 17, 14-20.

See a resource for Indigenous Social and Emotional Wellbeing workers: www.healthinfonet.ecu.edu.au/sewbworkers.