General Practice Liaison Officer Program presents

Connecting The Dots

Navigating Mental Health in Primary Care

SATURDAY 2 AUGUST 2025 | UniSQ

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Acknowledgement

Metro North Hospital and Health Service and Brisbane North PHN respectfully acknowledge the Traditional Owners of the land on which our services and events are located. We pay our respects to all Elders past, present and future and acknowledge Aboriginal and Torres Strait Islander people across the State.

Welcome!

General Practice Liaison Officer Program

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TODAY

8:00am **FIRST SESSION**

- Perinatal mental health
- Child & adolescent psychiatry
- Finding the right care

10:10am **MORNING TEA**

10:40am **MIDDLE SESSION**

- Medicinal cannabis
- Older persons mental health

12:00pm **LUNCH**

12:45pm **FINAL SESSION**

- Eating disorders
- Case studies sessions:
  - Alcohol & depression in primary care
  - Managing acute distress
  - Digital mental health resources
- GP self care & wellness

Slides & resources

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GP and primary care education

Presentations and further resources from past education events

- Caboolture Hospital education
- Cardiology
- Championing Generalism Workshop (updated 2025)
- Diabetes
- Gastroenterology and Hepatology
- Gender Services
- Genetics
- Gynaecology (updated 2024)
- Haematology and Oncology
- Heart Failure
- Immunology & ENT (updated 2024)
- Kidney Health
- Maternity (updated 2025)
- Men's Health (updated 2024)
- Mental Health (updated 2024)
- Neurology
- Orthopaedics (updated 2024)
- Paediatric
- Persistent Pain Management
- Respiratory
- Rheumatology
- Sexual Health
- Skin Cancer (updated 2024)
- Spinal health
- Surgery
- Urology

Contact

Email: MNGPLO@health.qld.gov.au

Refer a patient

Access the referral guidelines to refer a patient.

Call the GP hotline for enquiries about referring on **1300 364 938**

Figure 2: Types of serious illness by age and sex, 2009 to 2021

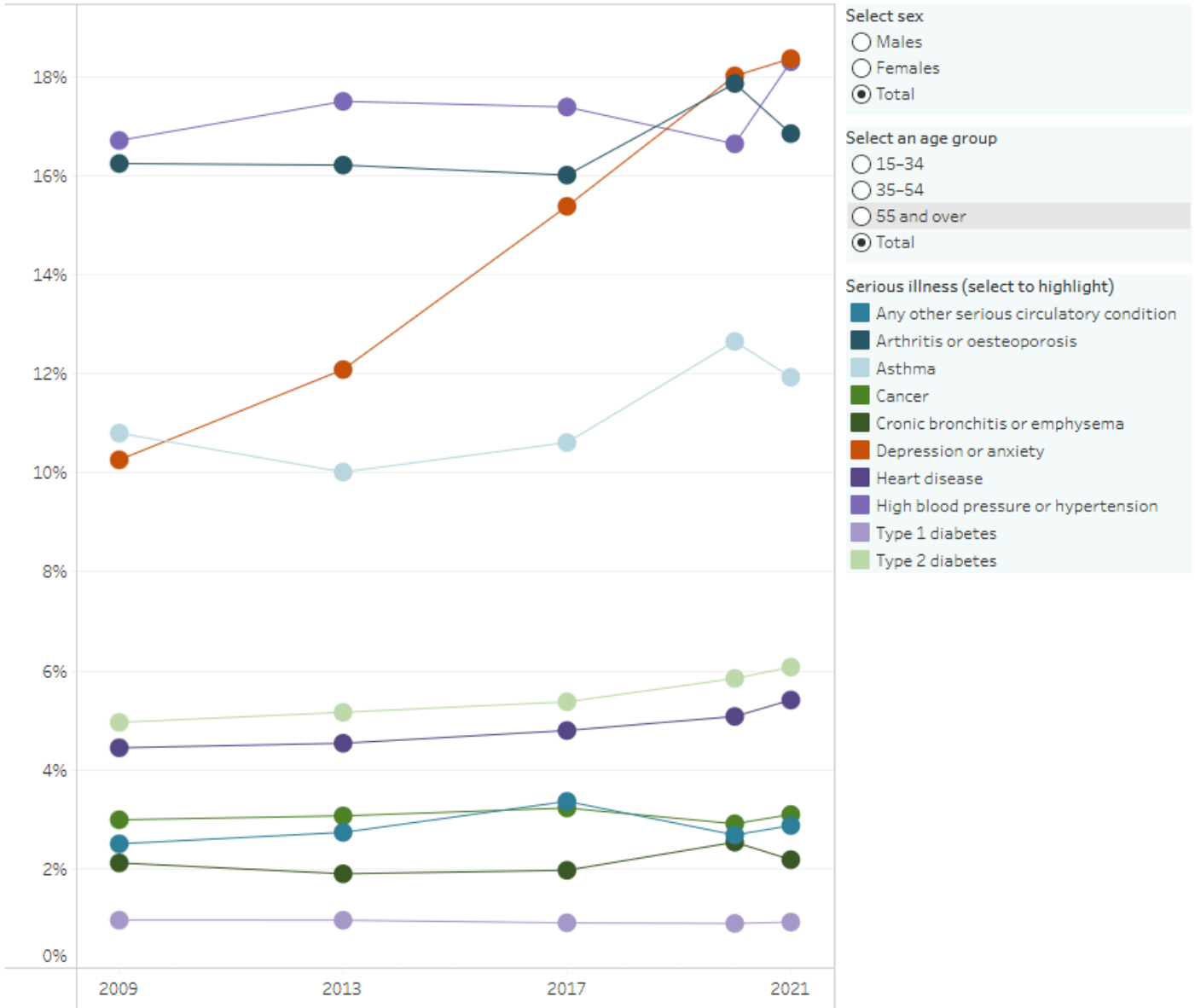

Figure 2: Estimated proportion of Australians reporting serious illnesses, by sex and age group, 2009–2021.

https://www.aihw.gov.au/mental-health

Mental Health in Australia

- 1:5 adults and 1:7 young people experienced a MH disorder in the previous 12m (AIHW)
- 43% of the population had experienced a mental illness during their life – 8.5m people
- Most commonly anxiety disorder (17%, F>M), affective disorder (8%, F>M), substance abuse disorder (3%, M>F)

Disease expenditure

- The Health system spending on disease and injury in Australia 2022–23 report provides estimates of Australia's national health spending. In 2022–23, expenditure on *Mental health conditions and substance use disorders* accounted for almost 7% ($11.9 billion) of total spending by broad disease groups. Of these:
  - over half (52%) of total spending was on public hospitals, totalling $6.1 billion
  - *public hospital admitted patient* has consistently been the highest area of spending, increasing from $2.7 billion in 2013–14 to $4.8 billion in 2022–23 in real terms (AIHW 2024c).
- In 2024, *Mental health conditions and substance use disorders* as a broad disease group accounted for almost 15% of the burden of disease in Australia (AIHW 2024b).

Medicare MH Services (2023-24)

- GP – 78%*
- Psychologist (clinical/other) - 47%
- Psychiatrist – 21%
- Other allied health professionals – 4%

Joint Health Needs Assessment of Brisbane North region - areas outside of normal range for QLD:

- increase in prevalence of people living with MH conditions – 24.5% in 12m (ABS)
- high rates of MH prescription dispensing
- higher rates of MH and psychological distress
- higher rates of MH hospitalisations, particularly in Brisbane inner and Redcliffe SA3s

General Practice Liaison Officer Program presents

Connecting The Dots

Navigating Mental Health in Primary Care

Perinatal mental health

Dr Anastasia Braun | ***Consultant Liaison Psychiatrist & Perinatal Psychiatrist, RBWH***

Liz Bennett | ***Team Leader, Perinatal Wellbeing Team, RBWH***

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Connecting The Dots: Mental Health in Primary Care
GP Education Workshop, 2 August 2025

THE SHADES OF BECOMING A PARENT:
THE UNSEEN LOAD BENEATH THE GLOW

PERINATAL MENTAL HEALTH

Dr Anastasia N Braun, *Consultation Liaison Psychiatrist, Perinatal Psychiatrist, QCPIMH Consultant, RBWH, StVNS, NWPH, PRPH*

Elizabeth Bennett, *Team Leader Perinatal Wellbeing Team, Chair RBWH Staff Council*

The Rainbow Serpent Dhakhan

- Among the **Gubbi Gubbi (Kabi Kabi)** people, who share Country with the neighbouring **Turrbal** people, the Rainbow Serpent is known as **Dhakhan** (*pronounced: DAH-kun*).

- In Gubbi Gubbi creation Lore, Dhakhan is a powerful ancestral being who travels between waterholes, shaping the land and leaving behind sources of life. His presence is felt in the rivers, in the rain, and in the sacred places where fertility and spirit converge.

- Dhakhan is more than a myth — he is memory made into land, protector of water, and guardian of the child-spirit returning to Country.

I would like to start my acknowledgement with a story.

Long before time had shape, the Rainbow Serpent moved through sky and earth, carving rivers through mountains and singing life into the land. Her body shaped waterholes, birthing places, and sacred flows. She is still present—in the still water, the bend of gum trees, the silence before the storm.

This story reminds us that birth, water, and sacred law are deeply connected. Life begins in water, and when its flow is interrupted, something sacred is disturbed. So too in our care—when the natural flow of the body, spirit, or relationship is blocked, there are consequences.

Nowhere is this flow more sacred than in pregnancy and birth. When a woman feels safe, seen, and supported, her bond with her baby is empowered—and that connection flows into future generations.

Our care, like a river, must remain fluid, grounded, and uninterrupted. Here on Turrbal Country, near the Nudgee Waterholes where our team is based, we offer our work with respect, hoping our intentions are felt by the Ancestors and shape the care we provide.

We honor and pay respects to the Aboriginal and Torres Strait Islander Elders, Ancestors, and LORE who continue to guide this land and its people.

Case 1 "Echoes in the Waiting Room"

- Mikayla is a 24-year-old Gooreng Gooreng woman who recently relocated from rural Victoria to Brisbane's northern corridor, where she now lives with her current partner in a Department of Housing property. The couple is expecting a baby, and Mikayla is approximately 20 weeks pregnant. This is her fourth pregnancy.
- Her first child, a 3-year-old daughter, lives in kinship care with Mikayla's aunt in regional Queensland. The child was removed shortly after birth due to concerns primarily related to Mikayla's previous partner's substance use and volatile behaviour, although there were also questions raised at the time about Mikayla's capacity to provide safe care. Mikayla is currently engaged in family court proceedings to regain access. She describes herself as "trying to get everything back on track."
- Mikayla's second pregnancy ended in a missed miscarriage at 13 weeks. She required two dilation and curettage (D&C) procedures due to retained products of conception. She later shared that the hospital experience was "cold" and that no one checked in on how she was feeling emotionally. Her third pregnancy also ended in early loss, though she is vague about details.
- Mikayla's current pregnancy is complicated by ambivalence. She has attended her initial antenatal appointments but missed the last two. Her GP notes that she is often quiet and withdrawn in consultations, with flat affect and poor eye contact. At times, she is accompanied by her current partner, who tends to answer questions on her behalf. There is no history of diagnosed mental illness, though the GP is concerned about her level of disengagement.
- Mikayla describes the birth of her first daughter as "scary." Records indicate a premature delivery at 34 weeks, following placental abruption and postpartum haemorrhage that required transfusion. She was discharged home within 48 hours of birth, and no follow-up maternal mental health review was recorded.
- When gently asked about her current relationship, Mikayla shrugs. There is no disclosed violence, but she becomes visibly tense when asked directly. Her partner works intermittently and has a history of incarceration, including a previous domestic violence order with another partner. He has not been seen alone.
- Mikayla shares that she sometimes feels the baby move and "tries not to think too much." She avoids talking about the future. She expresses that she doesn't like hospitals and often gets "bad dreams" before appointments. She says her housing is "okay, a bit crowded," but doesn't elaborate.
- At the most recent GP visit, Mikayla mentioned she "just wants things to be different this time," but couldn't explain further.

Case 1 "Echoes in the Waiting Room"

- *A 24-year-old Aboriginal woman presents to GP at 20 weeks pregnant (G4P1).*
- One living child in **kinship care** after child protection removal
- Circumstances of the current pregnancy
- Two prior **pregnancy losses**, including missed miscarriage with complications
- Traumatic birth history with **postpartum haemorrhage** and prematurity
- **Quiet, flat affect**, missed antenatal appointments
- Attends with **partner who answers for her**
- Partner has a history of **DV order and incarceration**
- No disclosed current violence, but **tension noted in interactions**
- Mikayla expresses ambivalence, **vague connection to baby**, poor future planning
- GP notes growing concern but **no formal mental health diagnosis**

Case 1 “Echoes in the Waiting Room”

What are the red flags in this scenario that may point to perinatal mental health risk?

- Disengagement (missed appointments, flat affect)
- Birth trauma and unresolved grief from pregnancy losses
- Custody loss and current **family court stress**
- Partner answering for her (possible **coercive control**)
- Tension during relationship discussions
- Vague or avoidant talk about baby and future
- Poor engagement with health system / past negative experiences

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Case 1 "Echoes in the Waiting Room"

How would you begin a mental health assessment that is safe, culturally sensitive, and trauma-informed?

What cultural or contextual tools or questions can help deepen your understanding?

- Use **yarning** techniques to create narrative space
- Avoid rapid questioning; allow for silence and trust-building
- Normalize discussion of stress, parenting and sleep
- Ask about **emotional safety** and who supports her day-to-day
- Consider starting with:
  - "*Many women I see at this point in pregnancy are carrying a lot-not just physically, but in their hearts. I wonder what that's been like for you.*"
- Check identification of community or **Country connection** (Gooreng Gooreng)
- Reflect on local **kinship structures** and implications of child removal
- Use reflective prompts like:
  - "*Are there people you feel more yourself with?*"
  - "*What's helped you feel steady, even when things got tough before?*"
- Be aware of **intergenerational grief**, loss of parenting role, shame

Demographics

NAME I RECLAIM

N – Name
Full legal name and preferred name, if different

- *Alexandra (prefers Alex)*
- *Legal name Jonathan, uses Jono socially*

A – Age
Current chronological age

- *36 years old*

M - Marital/relationship Status
Current relationship status or structure, including complex or fluid configurations

- *Separated; co-parenting with ex-partner*
- *In polyamorous relationship; not legally partnered*
- *Widowed, lives alone*
- *Partner currently incarcerated*
- *On-and-off de facto relationship*

E - Ethnicity, Cultural Identity & Ancestry
Self-defined cultural, ethnic, or spiritual identity, including Aboriginal or Torres Strait Islander background, and any migrant/refugee experience

- *Identifies as Aboriginal (Wakka Wakka) and Torres Strait Islander*
- *Refugee from Afghanistan, arrived in 2015*
- *Filipino-Australian, raised Catholic*
- *No specific cultural affiliation, Anglo background*
- *Mixed heritage – Aboriginal and Italian descent*
- *Second-generation migrant from Lebanon*

I – Identified Gender & Identity
Affirmed gender identity, Pronouns, and other aspects of personal identity the individual considers core to how they are seen and respected

- *Trans woman, uses she/her pronouns*
- *Non-binary, uses they/them*
- *Cisgender male*
- *Genderfluid with varying pronoun use*

R - Residence & Living Situation
Current living arrangement, housing stability, and who the person lives with

- *Private rental with partner and baby*
- *Lives in DoH property alone*
- *Refuge accommodation after DV incident*
- *Temporary hotel stay organised by homelessness service*
- *Lives in FIFO arrangement, partner away fortnightly*
- *Couch-surfing between relatives*
- *Boarding with elderly parent in overcrowded house*
- *Living with extended family; 4 adults, 6 children in 2-bedroom flat*
- *On waiting list for public housing*
- *Sleeping rough with child*

E - Employment & Income
Occupational status and financial supports, including entitlements or pending claims

- *On DSP*
- *Workers' compensation following workplace injury*
- *Receives income protection payments*
- *Unpaid maternity leave*
- *Supported by partner's income only*
- *Student, dependent on scholarship income*
- *Awaiting DSP outcome*
- *Casually employed, no sick leave*
- *Single parent on Centrelink*
- *Visa-restricted work rights*
- *Recently terminated employment; appealing decision*

C - Communication, Language & Cognitive Needs
Primary language, interpreter needs, literacy challenges, and neurodivergent communication considerations

- *Requires Vietnamese interpreter*
- *Autistic; prefers visual communication and written follow-up*
- *Uses AAC device*
- *Limited reading comprehension*
- *Speaks fluent Spanish, prefers information in native language*
- *Sensory sensitivity – avoids group meetings*
- *Diagnosed ADHD, difficulty following long instructions*
- *Requires simplified information due to intellectual disability*

L - Legal Entanglements
Involvement with legal systems including child protection, court matters, incarceration, and culturally relevant systemic issues

- *Primary carer for 2 children under 5, one with GDD*
- *Supports elderly mother with mobility issues*
- *Shared custody of 6-year-old son*
- *Responsible for emotional support dog*
- *Lives with adult child with intellectual disability*
- *Carer for two nieces due to sibling's incarceration*
- *Main caregiver for disabled partner*
- *Looks after newborn plus two children from previous relationship*
- *Has custody of grandchild due to parental neglect*

A – Active Care Responsibilities
Current caring responsibilities, including children (biological, step, foster, or kin), elderly family members, individuals with disability, pets or other dependents. These roles can shape a person's available time, emotional load, access to treatment, mobility, or capacity for decision-making

It also reflects cultural and extended care obligations, common in Aboriginal and Torres Strait Islander families and communities, where care is often shared across kinship networks and responsibilities may not be legally formalized but are culturally embedded.

- *Sole parent of two children*
- *Caring for elderly parent with dementia*
- *Co-parenting with shared custody*
- *Caring for a child with special needs*
- *Living with and supporting a partner with chronic illness*
- *Responsible for large dog with separation anxiety that limits absences from home*
- *Has multiple pets and no alternate carer, limiting hospital admission or travel*
- *Kinship carer for nieces/nephews across multiple households*
- *Young person supporting younger siblings and grandmother due to loss of parental figure*
- *Woman fulfilling cultural obligations to care for non-biological children in extended family*
- *Man providing daily food and shelter for community dogs*
- *Grandmother raising grandchildren due to family incarceration or systemic removal*

I - Informal & Emotional Supports
Available social/emotional support from friends, family, community, or groups

- *E.g.: Supported by sister and mother's group*
- *No contact with family; two close friends nearby*
- *Partner emotionally supportive but works away FIFO*
- *Isolated, avoids social situations due to anxiety*
- *Participates in weekly church and community group*
- *Strong support from neighbour and peer mentor*
- *Involved in cultural men's group*

M - Mental Health Act Status
Current or previous status under the Mental Health Act, including involuntary treatment, forensic orders, or community treatment

- *Currently on Treatment Authority; case managed, reviewed monthly*
- *Voluntary admission; previously involuntary during manic episode*
- *On Community Treatment Order with follow-up from mental health team*
- *Previously under Forensic Order post-hospitalisation*

Obstetric History

O - Obstetric history

Current pregnancy details
Gravida/Para status, gestation, pregnancy intention

- G6 P1-1 M1 T1 E1 32/40
- (gender)
  planned/unplanned/mistimed/wanted/unwanted

- *G3P1 at 34+2 weeks, unplanned but wanted*
- *IVF pregnancy after multiple unsuccessful cycles; high emotional significance*
- *Planned pregnancy, partner not involved; reports emotional disconnection*
- *Mistimed pregnancy; conflicted about continuing*
- *G1P0, 28 weeks; first time mother; limited antenatal engagement*

Reproductive & Birth History (previous Obstetrics, Trauma & Fertility)
Combines previous pregnancies, birth complications, losses, obstetric and psychological trauma, and fertility experiences

- Traumatic birth/PPH/perianal tear 3rd degree/LSCS/Forceps
- IVF
- TOP & M : year/gestation/coercion/coping
- Psychological trauma, Cultural aspects of birthing /cultural displacement, ancestral connection, and trauma related to birthday outside traditional lands

- *Previous birth via emergency LSCS following non-reassuring CTG*
- *G3P1M1 – one early miscarriage, one term birth with vacuum assistance*
- *TOP at 12 weeks (2021) following coercion from abusive partner; unresolved grief*
- *History of 3rd degree tear and PPH during second delivery*
- *Stillbirth at 39 weeks; avoids talking about it; trauma unprocessed*
- *Birth in 2019 under general anaesthetic; described as "traumatic and powerless"*
- *History of IVF: 4 unsuccessful attempts, 1 successful cycle leading to current pregnancy*
- *Fertility struggles over 5 years contributed to depressive symptoms and relationship strain*
- *NICU admission after premature birth; feelings of abandonment and failure*
- *Has refused antenatal care this pregnancy due to previous birth trauma and mistreatment*
- *Aboriginal woman expressed sadness and disconnection, sharing that she was not able to give birth on her ancestral land as her grandmother did; felt "the spirit of the baby wouldn't be properly welcomed"*
- *Torres Strait Islander mother relocated to urban centre for birth; reported feeling "cut off" and "shamed", stating that birthing away from her island home disrupted cultural traditions and spiritual continuity*

Bonding
Bonding with baby in utero and past children

- *Describes the foetus as "foreign" and avoids touching her abdomen*
- *Refers to the baby by name; anticipatory bonding evident*
- *Bonding with the first child delayed for 6 months due to postnatal depression*
- *Actively avoids conversations about the baby; feels "numb"*
- *Strong emotional engagement; decorated nursery and daily journaling about the baby*
- *Aboriginal mother avoids bonding activities due to fear of baby being removed by child protection given family history*
- *Torres Strait Islander woman reports emotional detachment; "women in my family don't show feelings about babies in case they're taken"*

Contraception
Current or intended contraception use; historical or cultural context

- *No contraception; believes contraception is "unnatural"*
- *Previous IUD expelled spontaneously; has avoided further contraception since*
- *Partner against hormonal contraception; relies on withdrawal*
- *Plans postpartum tubal ligation due to medical complexity*
- *Past experience of severe side effects with oral contraceptives; reluctant to restart*

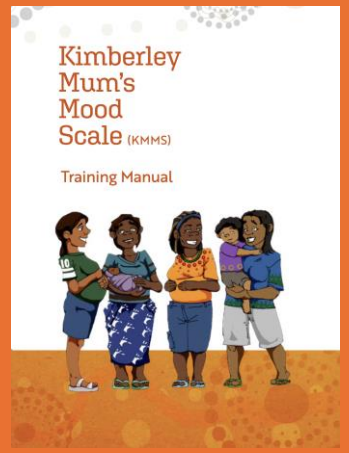
Breastfeeding
Intention, history, challenges, or trauma related to breastfeeding

- *Breastfed previous child for 2 years; positive experience*
- *Severe mastitis with first child; stopped after 2 weeks, fearful to try again*
- *Cultural expectation to breastfeed, but feels no desire to do so*
- *Plans to formula feed due to history of sexual trauma*
- *Unable to establish supply with previous baby due to NICU separation; determined to breastfeed this time*
- *Previously felt ashamed when breastfeeding didn't go as planned; currently ambivalent*

Mother – Baby Unit (MBU) Mental Health Experience
Previous admissions or care in perinatal psychiatric settings.

- *Admitted to MBU in 2021 for postpartum psychosis; positive experience with strong clinician connection*
- *Admitted for bonding issues after traumatic birth; discharged with ongoing ACT support*
- *Declined previous MBU admission due to fear of being separated from baby*
- *Reported feeling stigmatised by MBU staff during past stay; reluctance to re-engage*
- *Aboriginal woman declined referral to MBU due to cultural mistrust and prior trauma of institutional separation from family*
- *Torres Strait Islander mother accepted MBU stay but only after community Elder advocated and remained involved in care*

Kimberley Mum's Mood Scale



The Edinburgh Postnatal Depression Scale

Today's Date: __/__/____ Weeks pregnant: _____ or week postnatal: _____

Surname: _____ Given Name:_____ Total Score: _____

INSTRUCTIONS:

Please select one option for each question that is the closest to how you have felt in the PAST SEVEN DAYS.

1. I have been able to laugh and see the funny side of things:

( )As much as I always could
( )Not quite as much now
( )Definitely not so much now
( )Not at all

2. I have looked forward with enjoyment to things:

( ) As much as I ever did
( ) Rather less than I used to
( ) Definitely less than I used to
( ) Hardly at all

3. I have blamed myself unnecessarily when things went wrong:

( ) Yes, most of the time
( ) Yes, some of the time
( ) Not very often
( ) No, never

4. I have been anxious or worried for no good reason:

( ) No, not at all
( ) Hardly ever
( ) Yes, sometimes
( ) Yes, very often

5. I have felt scared or panicky for no very good reason:

( ) Yes, quite a lot
( ) Yes, sometimes
( ) No, not much
( ) No, not at all

6. Things have been getting on top of me:

( ) Yes, most of the time I haven't been able to cope at all
( ) Yes, sometimes I haven't been coping as well as usual
( ) No, most of the time I have coped quite well
( ) No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping:

( ) Yes, most of the time
( ) Yes, sometimes
( ) Not very often
( ) No, not at all

8. I have felt sad or miserable:

( ) Yes, most of the time
( ) Yes, quite often
( ) Not very often
( ) No, not at all

9. I have been so unhappy that I have been crying:

( ) Yes, most of the time
( ) Yes, quite often
( ) Only occasionally
( ) No, never

10. The thought of harming myself has occurred to me:

( ) Yes, quite often
( ) Sometimes
( ) Hardly ever
( ) Never

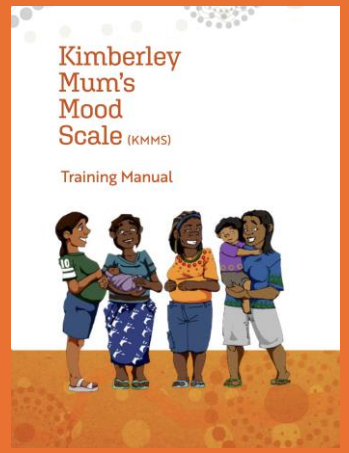
Kimberley Mum's Mood Scale (KMMS) Part 1

NAME:
DOB:
DATE:

Think about the past 7 days, not just how you feel today.

		Yes, always	Yes, sometimes	No, not much	No, never
1.	I can sit down and have a good laugh				
2.	I look forward for good things to happen				
3.	I blame myself when things go wrong				
4.	I worry too much and don't know why				
5.	I feel frightened and shaky a lot				
6.	I can't handle all the stress or I stress out				
7.	I feel really no good, like no-one loves me				
8.	I can't sleep because I am sad or think too much				
9.	I am so sad I have been crying				
10.	I think about doing something bad to myself or others				

Kimberley Mum's Mood Scale



Kimberley Mum's Mood Scale Part 2

PART 1 SCORE:

NAME:
DOB:
DATE:

Refer to the KMMS Manual for information on how to facilitate the yarn, guidelines for administration, examples of enquiring/exploring questions for each psychosocial domain, how to determine overall risk, and options for follow-up actions.

EXPLORE THE WOMAN'S STORY, NOTING THE SITUATION AND HER PROTECTIVE AND RISK FACTORS

SUPPORT:

MAJOR STRESSORS:

SELF-ESTEEM / ANXIETY:

RELATIONSHIPS:

CHILDHOOD EXPERIENCES:

SUBSTANCE MISUSE:

SOCIAL, EMOTIONAL AND CULTURAL WELLBEING:

OVERALL RISK OF DEPRESSION AND/OR ANXIETY (PLEASE TICK) Consider Part 1 score and the risk and protective factors identified during Part 2 in determining overall risk		
LOW	Self-care recommended	
MODERATE	Clinical assessment within 1 week	
HIGH	Clinical assessment required within 48–72 hours	
IMMEDIATE CONCERNS	Clinical handover required immediately	

FOLLOW-UP ACTIONS: Explore relevant referrals, or next steps with the woman.

Appendix C Questions for each psychosocial domain

Domain	*Psychosocial questions*	
Support	How are you feeling about becoming/being a parent? Do you feel like you have good support around you?	Who are your supports? How are they helping? Do you have someone to talk to about your feelings and your worries?
Major stressors	Are there any things happening in your life right now that are stressing you? Do you have any big worries or losses from the past year that are still worrying/affecting you?	How did/are you coping with these worries/stresses? How are you feeling about giving birth/history of birth experiences/pregnancy?
Self-esteem/anxiety	How are you feeling in yourself? Why do you think you are feeling like that? Do you feel like this just today, or much of the time? Are you worrying a lot or stressing out (feeling anxious)? Can you tell me what gives you those feelings?	How are you managing with everyday things like family, work, home life? Have you been previously diagnosed with depression or anxiety? Have you had medication before to help you manage your depression/anxiety?
Relationships	Having a baby can be a time of big change for everyone, especially the people that you are living with. Who is living in your house? How are they feeling about the pregnancy/baby? Do your family live nearby/with you? Are they supporting you? Has your relationship with the baby's father changed since pregnancy/having the baby?	Do you feel like you have a safe home for you and bub? Have you ever experienced any harmful behaviours from another person? Are these impacting you now? Are you experiencing any jealousy or violence in any of your relationships? Would you like to talk more about any of these things?
Childhood experiences	At this time (pregnancy/young baby) women often think back on their own childhood experiences. There might be good things or hard things that come up. Is there anything you are worrying about? If you would like to talk about anything I am here to listen.	What are some of your happy memories growing up? What were some worries or problems when you were younger? Tell me more about these memories/experiences. Would you like any support to talk about your childhood?
Substance use	Part of keeping you and baby strong is knowing if you are you currently using cigarettes, alcohol or other drugs. Are you currently using any of these?	How has your use changed since being pregnant/having baby? Does your use worry you? How/why? Would you like to get some support and help for these things?
Social and emotional wellbeing	How is your sleeping, eating and physical activity?	You have shared a lot today, thank you. Can you tell me some of the things that keep you strong?

Case 1 "Echoes in the Waiting Room"

What are your priorities for this consultation and follow-up?

- Gently validate her presence and effort in attending
- Provide **continuity of care** – same GP or clinician if possible
- Consider **antenatal mental health referral** or cultural liaison input
- Discuss options for **domestic violence screening** in a safe and private manner
- Consider engaging social worker or Aboriginal health liaison worker
- **Support her role as a mother**, even when her child is in care

2 Extent and nature of family, domestic and sexual violence

Key findings

Since the age of 15:

- 1 in 6 (17%, or 1.6 million) women and 1 in 16 (6.1%, or 548,000) men had experienced physical and/or sexual violence from a current or previous cohabiting partner.
- 1 in 20 (5.1%, or 935,000) people had experienced violence from a current or previous boyfriend, girlfriend or date—7.4% (694,000) women and 1.9% (174,000) men.
- 1 in 4 (23%, or 2.2 million) women and 1 in 6 (16%, or 1.4 million) men have experienced emotional abuse from a current or previous partner.
- More than 1 in 2 (57%, or 958,000) women and 1 in 4 (24%, or 247,000) men who have experienced emotional abuse from a previous partner have also been assaulted or threatened with assault.
- 1 in 5 (18%, or 1.7 million) women and 1 in 20 (4.7%, or 429,000) men have experienced sexual violence.

7 Family violence among Indigenous Australians

Key findings

- Family violence occurs at higher rates in Aboriginal and Torres Strait Islander communities than in the general population.
- In 2017, the majority of Indigenous assault victims recorded by police were victims of family violence, ranging from 64% (2,700) in New South Wales to 74% (3,900) in the Northern Territory.
- In 2016–17, Indigenous people were 32 times as likely to be hospitalised for family violence, compared with non-Indigenous people.
- In 2017–18, 16% (48,300) Indigenous children received child protection services.

'Family violence' is the preferred term for violence within Aboriginal and Torres Strait Islander communities, as it covers the extended family and kinship relationships in which violence can occur. It remains a critical social policy issue, placing a huge burden on communities, especially on women and children (Closing the Gap Clearinghouse 2016). The removal from land, and cultural dispossession over the past 200 years, have resulted in social, economic, physical, psychological and emotional problems for Indigenous Australians. Family violence against Indigenous Australians must be understood as both a cause and effect of social disadvantage and intergenerational trauma (Closing the Gap Clearinghouse 2016).

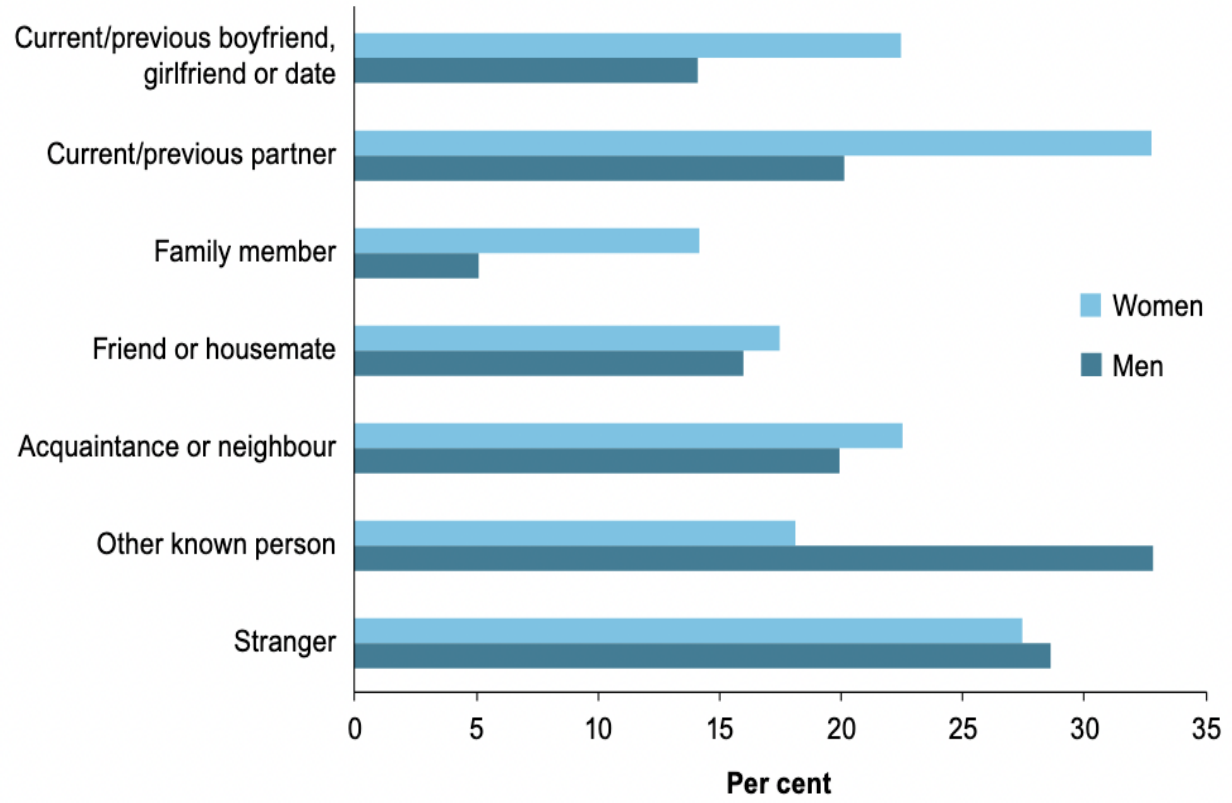
Australian Government
Australian Institute of Health and Welfare

AIHW

Family, domestic and sexual violence in Australia: continuing the national story

2019

Figure 6.18: Relationship to all perpetrators of sexual violence experienced since age 15, people with disability, by sex, 2016



Source: ABS 2018a.

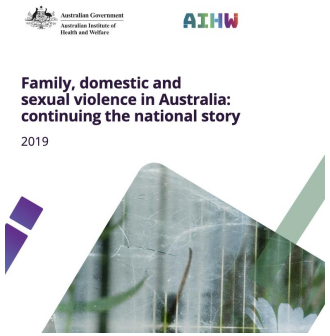


Figure 7.6: Indigenous domestic homicide victims, by type of homicide and sex of victim, 2014–15 to 2015–16

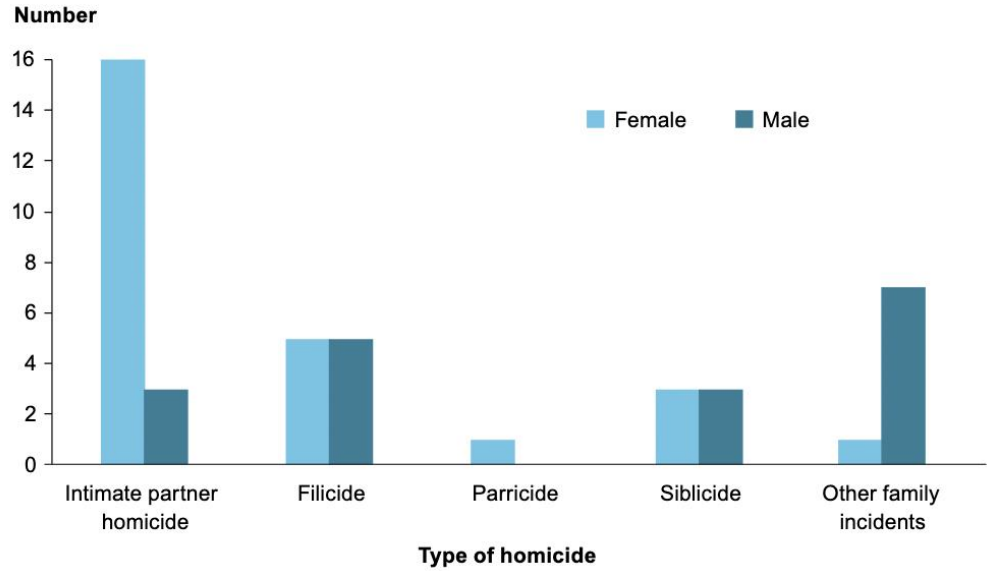
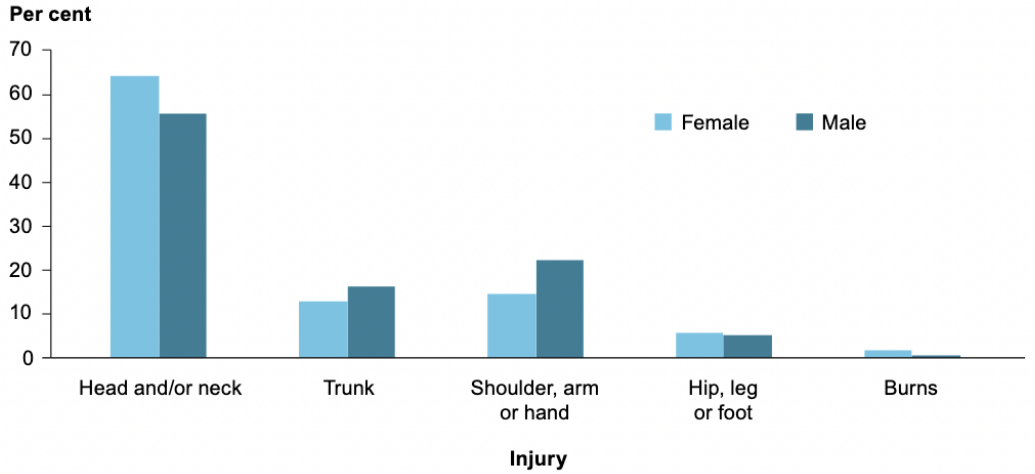


Figure 7.4: Physical assault hospitalisations among Indigenous Australians where the perpetrator was a spouse or partner, adults aged 15 and over, by type of injury, by sex, 2016–17



Source: AIHW National Hospital Morbidity Database.

Definition of controlling and coercive behaviour

The Government defines controlling and coercive behaviour as:

•Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

•Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

What is coercive control?

The cross-government definition of domestic violence and abuse is: any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members, regardless of gender or sexuality.

Recent research has shown that children and young people are not only impacted negatively by witnessing violence but are harmed by coercive and controlling behaviour even when physical violence is not present.

Coercive Control

From 26 May 2025, **coercive control** is a criminal offence in Queensland.

It is illegal for an adult to use abusive behaviours towards their current, or former, intimate partner, family member, or informal (unpaid) carer with the intention to control or coerce them.

The criminal offence captures patterns of physical and/or non-physical abuse used to hurt, humiliate, isolate, frighten, or threaten a victim-survivor.

The criminal offence carries a maximum penalty of 14 years imprisonment due to the serious nature of the offence and the harm coercive control can cause victim-survivors.

The criminal offence applies to abusive behaviours that occur from the day the law came into effect on 26 May 2025.

https://www.qld.gov.au/community/getting-support-health-social-issue/support-victims-abuse/need-to-know/coercive-control/coercive-control-laws

As the number of ACE increases, the risk for the following health problems increases in a strong and graded fashion:

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Foetal death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease (IHD)
- Liver disease

- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases (STDs)
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy

www.acestudy.org

RESEARCH Open Access

"Echoes of a dark past" is a history of maternal childhood maltreatment a perinatal risk factor for pregnancy and postpartum trauma experiences? A longitudinal study

Tracey Mackle[1*], Lucía Colodro-Conde[2], Therese de Dassel[1,3], Anastasia Braun[1,3], Adele Pope[1], Elizabeth Bennett[1], Alka Kothari[3,4], George Bruxner[4,5], Sarah E. Medland[2] and Sue Patterson[3,5]

Abstract

Background Although associations between maternal exposure to adverse childhood experiences (ACEs) and perinatal anxiety and depression are established, there is a paucity of information about the associations between ACEs and perinatal trauma and perinatal post-traumatic stress outcomes. For the purposes of this article, perinatal trauma is defined as a very frightening or distressing event that may result in psychological harm. The event must have been related to conception, pregnancy, birth, and up to 12 months postpartum.

Methods Women recruited at an antenatal appointment ($n = 262$) were invited to complete online surveys at two-time points; mid-pregnancy and eight weeks after the estimated date of delivery. The ACE Q 10-item self-reporting tool and a perinatal trauma screen related to the current and/or a previous perinatal period were completed. If the perinatal trauma screen was positive at either time point in the study, women were invited to complete a questionnaire examining symptoms of perinatal post-traumatic stress disorder and, if consenting, a clinical interview where the Post-traumatic Symptoms Scale was administered.

Results Sixty women (22.9%) reported four or more ACEs. These women were almost four times more likely to endorse perinatal trauma, when compared with those who either did not report ACEs (OR = 3.6, CI 95% 1.74 – 7.36, $p < 0.001$) or had less than four ACEs (OR = 3.9, CI 95% 2.037.55, $p < 0.001$). A 6–sevenfold increase in perinatal trauma was seen amongst women who reported having at least one ACE related to abuse (OR = 6.23, CI 95% 3.32–11.63, $p < 0.001$) or neglect (OR = 6.94, CI 95% 2.95–16.33, $p < 0.001$). The severity of perinatal-PTSD symptoms for those with perinatal trauma in pregnancy was significantly higher in those women exposed to at least one ACE related to abuse.

Conclusions Awareness of maternal exposure to childhood adversity/maltreatment is critical to providing trauma-informed approaches in the perinatal setting. Our study suggests that routine screening for ACEs in pregnancy adds clinical value. This adds to previous research confirming the relationship between ACEs and mental health complexities and suggests that ACEs influence perinatal mental health outcomes.

Keywords Adverse childhood experiences, Pregnancy, Postpartum, Perinatal outcomes, Post-traumatic stress disorder, Trauma

Illustrations by Storyset: https://storyset.com

Metro North Perinatal Trauma 2021 Maternity Birth Statistics

8557 births	Still births
	Neonatal deaths
	Babies born under <34 weeks
	Babies admitted to SCN
	Interventional Births (vacuum/forceps)
	Emergency C Sections
	Perineal Tears (3rd and 4th)
	Terminations of pregnancy (excl private) - 16-22 weeks > 22+1 Unborn Child High Risk notification

Metro North Perinatal Trauma 2021 Maternity Birth Statistics

8557 births

66 Still births

27 Neonatal deaths

415 Babies born under <34 weeks

1400 Babies admitted to SCN

795 Interventional Births (vacuum/forceps)

1588 Emergency C Sections

145 Perineal Tears (3rd and 4th)

199 Terminations of pregnancy (excl private)

25 - 16-22 weeks **20** > 22+1

671 Unborn Child High Risk notification

COPE Guidelines

2023

7.1 Mother-infant interaction[7]

The following table provides a list of prompts to assess difficulties in the mother-infant relationship. The list is not exhaustive and is not intended to be used as a checklist or formal assessment tool. Rather, it indicates areas of functioning that are important to the mother-infant relationship. If any concerns arise, consulting with and/or referring to the appropriate specialist service is a consideration.

Table 7.1: Indications of potential difficulties and protective factors in the mother-infant interaction

Psychosocial risk factors

- Unresolved family of origin issues
- History of physical/sexual abuse, family violence, childhood neglect
- Past pregnancy loss or excess pregnancy concern
- Unplanned or unwanted pregnancy
- Was the mother able to touch the baby on the day of birth?
- Did the mother have responsibility for infant care during the first week of life?
- Who is involved in the baby's care?
- Availability of emotional/social/practical support
- How much time does the mother spend away from the baby?
- Is the mother excessively worried about the baby?

Infant factors

- Is baby achieving normal developmental milestones?
- Is the baby growing adequately?
- Are there feeding difficulties, reflux, gastric distress, sleep difficulties?

Infant behaviour of concern (observed or reported)

- Gaze avoidance
- Flat affect
- Lack of crying
- Limited vocalising
- Emotionally under-responsive
- Interacts too easily with strangers (age-dependent)
- Unsettled sleep or feeding
- Difficult to console when distressed
- Irritable, constant crying
- Difficulty separating from parent (age-dependent)

Relationship factors (observed or reported)

- Is the mother thoughtful about her baby?
- Can the mother describe the baby's daily routine?
- Is the mother able to reflect on the baby's needs?
- Does the mother express empathy for the baby?
- Does the mother engage in enjoyable activities with the baby?
- Does the mother play/talk appropriately with the baby?
- Does she delight in her baby?
- Does the baby ever make her feel uncomfortable, unhappy or enraged?
- Is the mother excessively worried about the baby?
- Does the mother cope with the baby's distress?
- Does she respond and attend appropriately to the baby's cues?
- Are her responses consistent?
- Is she protective of the baby?

Maternal factors

- Current maternal psychopathy
- Antenatal or postnatal mood disorder
- Psychosis
- Diagnosed personality disorder
- Suicidal or homicidal ideation
- Negative symptoms (low motivation, anhedonia, blunted affect, poverty of thought/speech)
- Medication side-effects
- Substance abuse
- Engaging in dangerous or risk-taking behaviours (e.g. alcohol or drug misuse)

Protective factors

- Mother is sensitive to the baby
- Mother is able to monitor the baby's well-being adequately
- Mother is responsive to the baby
- Mother is able to cope with flexibility in her routine
- Mother has a close relationship with at least one other adult
- Mother is thoughtful about what might be going on in the baby's mind

THE PREGNANCY INTERVIEW-REVISED
November, 2007
Arietta Slade, Ph.D.

1. What changes have you made in how active you are…for example in what you eat, and how much you exercise?
   - Have there been any changes in how you are sleeping?
   - How do you feel about doing these things differently?

2. Can you remember the moment you found out that you were pregnant? (Pause to let her think.) Tell me about that moment… How did you feel? Why do you think you reacted that way?

3. Can you remember the FOB's reaction when he found out you were pregnant? (Pause) Describe that moment to me… How did you feel about his reaction? Why do you think he reacted that way?

4. Can you remember what your family's reaction was when you told them? (Pause) Describe that moment to me… How did you feel about their reaction? Why do you think they reacted that way?

5. Pregnancy is usually a pretty complicated time in terms of feelings, and ups and downs. Let's start with your good feelings…What are some of the good feelings you've had during your pregnancy? If they are able to name feelings, probe for two of them, one at a time. Think of a time when you felt ____... Can you tell me about that time? Why do you think you felt ____?

"A parental Bonding Instrument"

Perker, Tupling, Brown, 1979, British Journal of medical Psychology, 52, 1-10.

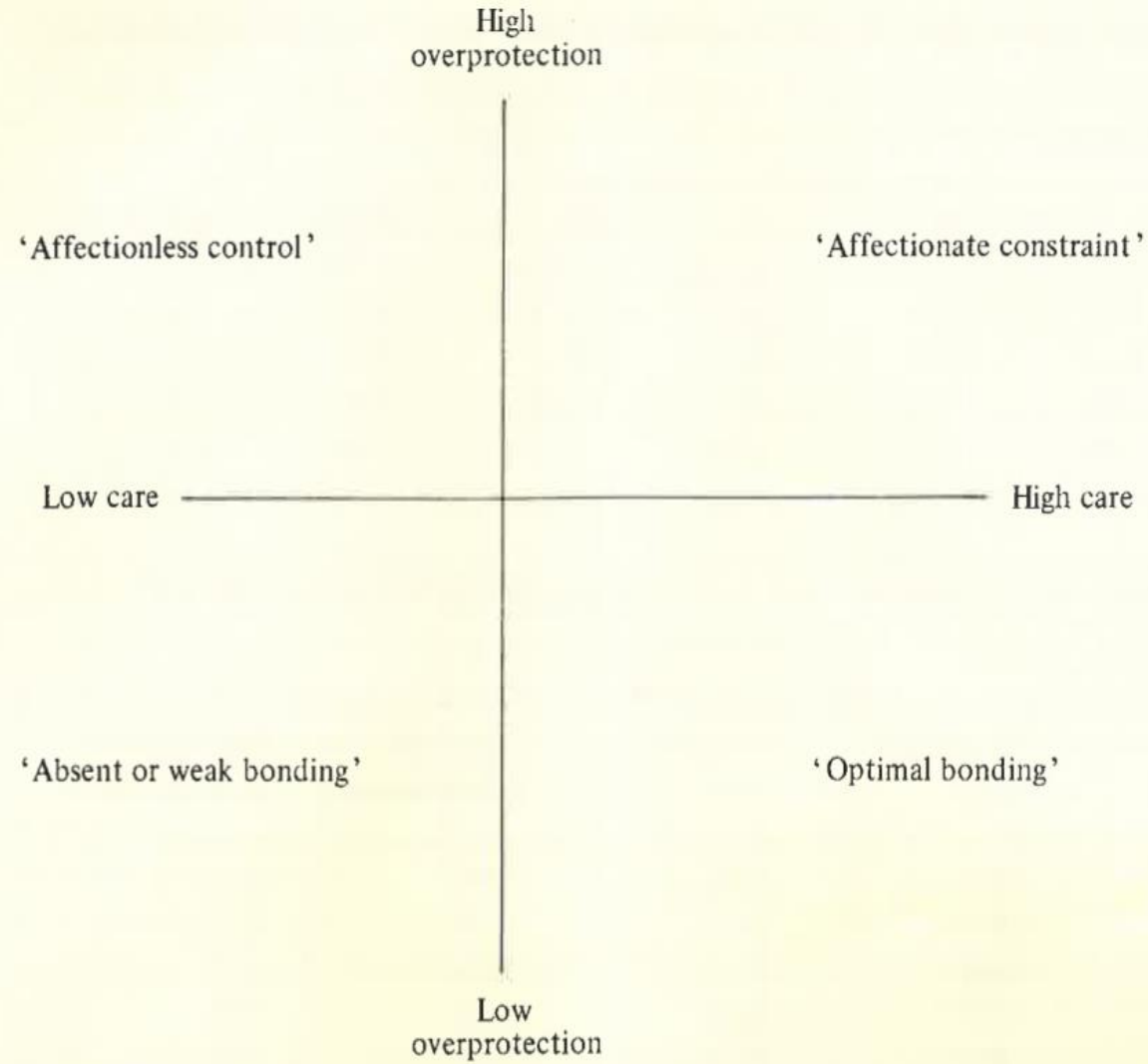


Figure 2. The two scales of the Parental Bonding Instrument showing the conceptualized parental bonding possibilities.

The Postpartum Bonding Questionnaire : a validation

Arch Womens Ment Health (2006) 9: 233–242
DOI 10.1007/s00737-006-0132-1

Archives of Women's Mental Health
Printed in Austria

Original contribution

The Postpartum Bonding Questionnaire: a validation

I. F. Brockington[1], **C. Fraser**[2], and **D. Wilson**[3]

Post Partum Bonding Questionnaire

Please indicate how often the following ae true for you.
There are no 'right' or 'wrong' answers. Choose the answer which seems right in your recent experience.

Factor	Scoring	Statement	Always	Very often	Quite often	Some-times	Rarely	Never
1	0 → 5	I feel close to my baby						
1	5 → 0	I wish the old days when I had no baby would come back						
2	5 → 0	I feel distant from my baby						
2	0 → 5	I love to cuddle my baby						
2	5 → 0	I regret having this baby						
1	5 → 0	The baby does not seem to be mine						
1	5 → 0	My baby winds me up						
1	0 → 5	I love my baby to bits						
1	0 → 5	I feel happy when my baby smiles or laughs						
1	5 → 0	My baby irritates me						
2	0 → 5	I enjoy playing with my baby						
1	5 → 0	My baby cries too much						
1	5 → 0	I feel trapped as a mother						
2	5 → 0	I feel angry with my baby						
1	5 → 0	I resent my baby						
1	0 → 5	My baby is the most beautiful baby in the world						
1	5 → 0	I wish my baby would somehow go away						
4	5 → 0	I have done harmful things to my baby						
3	5 → 0	My baby makes me feel anxious						
3	5 → 0	I am afraid of my baby						
2	5 → 0	My baby annoys me						
3	0 → 5	I feel confident when caring for my baby						
2	5 → 0	I feel the only solution is for someone else to look after my baby						
4	5 → 0	I feel like hurting my baby						
3	0 → 5	My baby is easily comforted						

The importance of an attuned relationship –

Still Face Experiment, Dr Edward Tronick

edward tronick still face experiment - Google Search

Case 2 "The Quiet Switch"

- Katherine is a 29-year-old woman who presents to her GP for a routine prescription review. She is quiet, speaks slowly, and avoids eye contact. She doesn't appear distressed but gives short responses, unless prompted.
- Katherine has a history of **schizoaffective disorder** and has previously been under a **Treatment Authority (TA)** for over a year, with case management through a community mental health team. She was discharged from that team about four months ago, and since then, her GP has taken over medication management. She has remained adherent and has not had recent hospital admissions.
- Her current medications include:
- **Lithium carbonate** IR oral 750mg (mood stabiliser)
- **Flupentixol decanoate** depot 200mg IMI 2 weekly(long-acting antipsychotic)
- **Aripiprazole** 15mg oral nocte (low dose augmentation)
- **Fluoxetine** 20mg oral nocte (SSRI for ongoing low mood)
- During today's consultation, Katherine shares—almost as an afterthought—that she thinks she may be pregnant. A urine bHCG test is positive. She could not recall the exact date of her last menstrual period but believes that she may have missed it for about 2 months.
- When asked how she feels about the pregnancy, she shrugs and says, "It's fine, I guess." She appears somewhat emotionally flat. She doesn't volunteer any information about her partner. When asked directly, she says she has been in a relationship "for a while," but avoids further discussion.
- Katherine lives alone in supported accommodation. She receives the DSP (Disability Support Pension), and her mother helps her with weekly groceries. She does not drive and does not have children. There is no prior involvement with child protection.
- She shares that she has been feeling "tired, but okay," and has been sleeping "more than usual." When asked about mood or thoughts of harm, she denies suicidal ideation but takes a long time to answer. She says, "I'm just not sure how I'm supposed to feel."
- There is no evidence of acute psychosis. However, her affect remains restricted, and her personal hygiene is mildly poor. When asked whether she's told anyone about the pregnancy, she says no. She appears to have no antenatal care arranged and doesn't express interest in next steps. The GP becomes concerned about her **capacity for pregnancy-related decision-making**, **medication safety**, and **emotional detachment**.

Case 2 "The Quiet Switch"

- *A 29-year-old woman with chronic mental illness presents to GP and is found to be about ?8 weeks pregnant.*
- History of **schizoaffective disorder**, previously under involuntary treatment (TA)
- Discharged from case management 4 months ago, now managed by GP
- Current medications: **lithium, flupentixol depot, aripiprazole, fluoxetine**
- Lives alone in **supported accommodation**, receives DSP
- Pregnancy news shared **incidentally** and with minimal affect
- **No current antenatal care** in place, vague about partner
- Displays **blunted affect, poor insight, reduced initiative**
- GP notes concern about her **capacity, risk, and engagement**

Case 2 "The Quiet Switch"

What mental health and perinatal risks are flagged in this case?

- Risk of **non-engagement** with antenatal care
- **Medication safety in pregnancy** (especially lithium and depot)
- Social isolation and lack of support
- **Poor insight**, possible impaired decision-making capacity
- Blunted affect and **emotional detachment**
- History of chronic mental illness → possible relapse risk
- Delay in disclosure of pregnancy, ambivalence regarding pregnancy and **no plan for support, poor bonding**

Case 2 “The Quiet Switch”

How would you approach conversations about pregnancy planning, treatment, and safety?

- Slow pacing, avoid overwhelming with medical terms
- Normalize emotional flatness while **gently probing decision-making**
- Introduce collaborative phrasing:
  “There are many ways we can support women through this time — we just need to find the one that fits you best.”
- Explore awareness of medication risks with soft entry:
  “Some medicines need review in pregnancy. We can look at that together, and I’ll guide you.”
- Offer to involve a **perinatal mental health team**, not just psychiatric referral
- Consider a **psychiatric review for capacity assessment**

Case 2 "The Quiet Switch"

What is your legal and clinical responsibility as the primary prescriber in this situation?

- Clarify **medication risks vs risk of abruptly ceasing the medications**
- Document **shared decision-making**, ensure capacity for consent
- Consider consultation with a **psychiatrist or obstetric physician**
- **Refer to maternity services early (MFM)**, ideally with mental health liaison
- Monitor for **deterioration**, as hormonal changes may destabilise symptoms
- May need to consider Mental Health Act provisions and Child Safety Notification if risks to self or baby arise

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"Common perinatal psychiatric complications"-
from “Infanticide and Filicide: Foundations in Maternal Mental Health Forensics, Wong & Parnham, 2021

Disorder	Prevalence	Symptoms	Onset	Duration	Usual treatment
“Baby blues”	30%–75%[a]	Sadness, emotional lability, irritability	Hours to days following delivery	2 weeks	Reassurance
Major depressive disorder (MDD)	10%–20%[b]	Insomnia, loss of energy, guilt, poor concentration, appetite changes, suicidal ideation	During pregnancy through up to 1 year postpartum	> 2 weeks	Psychotherapy and/or psychiatric medications, including antidepressants
Anxiety (including OCD)	15%–18%[c]	Anxiety, worry, intrusive thoughts, obsessions, compulsions	During pregnancy through up to 1 year postpartum	Typically weeks to months	Psychotherapy and/or psychiatric medications, including antidepressants
Bipolar disorder	2%–8%[d]	Features of MDD and mania or hypomania: grandiosity, decreased need for sleep, pressured speech, flight of ideas, distractibility, increase in activity, increased impulsivity	During pregnancy through up to 1 year postpartum	Several days or weeks up to months	Same as MDD; for severe illness (such as mania), hospitalization and/or psychiatric medications are required (e.g., lithium or other mood stabilizers, including antipsychotics)
Postpartum psychosis	0.1%–0.2%[a]	Hallucinations, delusions, disorganized thoughts or speech, fluctuating consciousness, cognitive impairment, severe insomnia, severe mood changes	Usually ≤ 2 weeks of delivery	Several days to weeks to months	Emergent psychiatric hospitalization; psychiatric medication typically required, such as lithium or other mood stabilizers including antipsychotics

Illustrations by Storyset: https://storyset.com

Effects of Untreated Antenatal Anxiety and Depression on Developing Foetus

Effects on fetus's developing HPA axis

(?transplacental passage of stress hormones)

- Decreased serotonin and dopamine
- Increased cortisol and noradrenaline
- Foetal neurological development (neural tube defects/ birth weight/head circumference)
- Newborns – decreased motor tone/increased irritability/decreased alertness
- Relationship between antenatal anxiety and “difficult” or “negative” infant behaviors in first few months of life controlling for postnatal mood, SES etc

**Changes in the Maternal Hypothalamic-Pituitary-Adrenal Axis in Pregnancy and Postpartum: Influences on Maternal and Fetal Outcomes, Duthie L, Reynolds R, Neuroendocrinology (2013) 98 (2): 106–115.*

Adverse Consequences for Mothers

- **Bonding with infant -**
- Risk factors for impaired maternal-infant bonding may include negative thoughts about the pregnancy during the antenatal period and primiparity
- **Marital discord**
- Suicidality ●**Suicidal ideation** – ●**Suicide attempts** - **Suicide deaths**
- Harming the baby — Postpartum depression may lead to thoughts of harming the baby, but is rarely associated with infanticide.
- **Thoughts of harming the baby** – Rumination about harming the baby can occur in postpartum depression
- Patients may describe these thoughts as “scary” or frightening, and typically express no intent of wanting to harm their infant
- Thoughts of harming the baby are generally experienced as unwanted, unacceptable (ego dystonic), and intrusive, and are usually not revealed unless patients are questioned directly
- Rumination about harming the baby may be due to postpartum psychosis and should prompt an evaluation for psychotic symptoms such as delusions or hallucinations. As part of the assessment, clinicians need to distinguish rumination about harming the baby without intent (an unwanted intrusive thought), from rumination with intent, which is often seen in postpartum psychosis.
- **Infanticide** – Infanticide is a rare event. 2 to 7 per 100,000 infants
- Neonaticide, infanticide, filicide
- **Recurrent depression**

Adverse Consequences for the Offspring

- Breastfeeding
- Abnormal development
- Physical health
- Growth
- Brain structure — Based upon magnetic resonance imaging, maternal postpartum depression is associated with smaller total gray matter volumes in infants, including thinner cortices in the frontal and temporal lobes
- Temperament —difficult infant and childhood temperament with inconsolability, irritability, fussiness, demanding behavior, problems regulating negative affect, and unusual sensory sensitivities
- Sleep — Mothers with postpartum depression may be less likely to properly position their infants for sleep (babies should be placed on their backs) ; problematic sleeping patterns in the infant, such as night-time awakenings and disorganized sleep
- Emotional and behavioural functioning — Postpartum maternal depression is associated with a small to moderately increased risk of problems with emotional regulation and social behavior/competence in the offspring ,Interpersonal and social skills that are delayed during the first two years of life in the children of mothers with postpartum depression include reacting to voices, smiling with eye contact, and pointing to selecting objects

Adverse Consequences for the Offspring

- Bonding with mother
- Motor functioning
- Vaccinations — It is not known whether children of depressed mothers are less likely to receive vaccinations, due to conflicting results across studies
- Maternal safety practices — Postpartum depression may be associated with decreased use of infant car seats and electrical outlet covers, and thus compromise infant safety
- Cognitive impairment — Postpartum maternal depression is associated with cognitive impairment in the offspring, including general cognitive performance, as well as executive functioning, intelligence, and language development
- General performance
- Executive functioning —Intelligence
- Language development
- Academic achievement - As an example, failing to achieve a passing grade in mathematics was 1.5 times more likely in the adolescent offspring of mothers with postpartum depression than the offspring of nondepressed mothers
- Psychopathology
- Externalizing problems – Symptoms of oppositional defiant disorder, conduct disorder, and/or attention deficit hyperactivity disorder
- Internalizing problems – Symptoms of anxiety disorders and depressive disorders

Can women take psychotropics in pregnancy and breastfeeding?

The simple answer is yes

- Category C medications
- We need to balance the risk to maternal mental health and the unborn baby

Australian Prescriber
VOLUME 48 : NUMBER 1 : FEBRUARY 2025

ARTICLE

Drug safety in pregnancy

SUMMARY

Drugs can affect the fetus in various ways, with the timing of exposure during pregnancy a key factor in determining both if and how a drug will impact a developing fetus.

The exclusion of women of childbearing age from clinical trials, and the challenges in conducting large epidemiological studies, have resulted in a paucity of data on the fetal and maternal safety of drugs in pregnancy.

In some patients, the benefits of drug treatment may outweigh the potential risks to the fetus. It is important for prescribers to assess and communicate the benefits and risks in the context of the individual patient.

The Australian categorisation system for prescribing drugs in pregnancy was implemented to guide prescribers; however, it has shortcomings and lessons can be learned from the systems of other countries.

Debra Kennedy
Senior Staff Specialist and Director of MotherSafe[1]
Conjoint Associate Professor[2]

Ronald Batagol
Independent Obstetric Medicine and Medication Safety Pharmacist[3]

[1] Royal Hospital for Women, Sydney
[2] School of Women's and Children's Health, University of New South Wales, Sydney
[3] Melbourne

- the thalidomide tragedy – in 1963 the Australian Drug Evaluation Committee (ADEC) was established to advise the Australian Government on the safety of new drugs and to monitor and evaluate potential adverse effects of already availablegs.

“The Australian categories for prescribing medicines in pregnancy (A, B1, B2, B3, C,D, X) were established by the ADEC and are still in use today, significantly influencing prescribing and how risks of drug exposures in pregnancy are perceived by healthcare professionals and consumers. While providing guidance for prescribers, the A to X categorisation is overly simplistic and may misleadingly imply there is a hierarchy of risk. For example, a drug labelled category B is not necessarily safer than a drug labelled category C, which can cause anxiety and confusion for prescribers and consumers. Where there are no or limited human data, the categories are assigned on the basis of data from animal studies and are not updated regularly, even when there are new (and potentially reassuring) human data available. Drugs within the same category do not always carry a similar level o frisk, and the categories do not consider the timing of pregnancy. Furthermore, they are not relevant for breastfeeding.

Because of these inherent problems, the FDA abandoned their A to X categorisation in 2015in favour of a descriptive labelling system. The Pregnancy and Lactation Labelling Rule provides a more consistent way of presenting relevant reproductive safety information about drugs, enabling prescribers to better understand and communicate the risks and benefits.”

Australian Prescriber , Vol 48, Number 1, Feb 2025.

Therapeutic Guidelines, Psychotropic, 2021

Table 8.26 Potential benefits and harms to the patient and fetus associated with psychotropic use during pregnancy

[NB1] [NB2]

	Fetus	Patient
Potential harms of psychotropic use	▪ miscarriage ▪ fetal death *in utero* ▪ stillbirth ▪ preterm birth ▪ congenital abnormality [NB3] ▪ growth restriction ▪ poor neonatal adaptation ▪ long-term neurodevelopmental effects [NB4]	▪ stress and worry about potential for harms from drug exposure
Potential benefits of psychotropic use	▪ reduced: • abuse and neglect • adverse outcomes from an active psychiatric disorder during pregnancy [NB5]	▪ reduced: • relapse of psychiatric disorder • suicide • self-harm • relationship deterioration • use of harmful substitutes (eg alcohol)

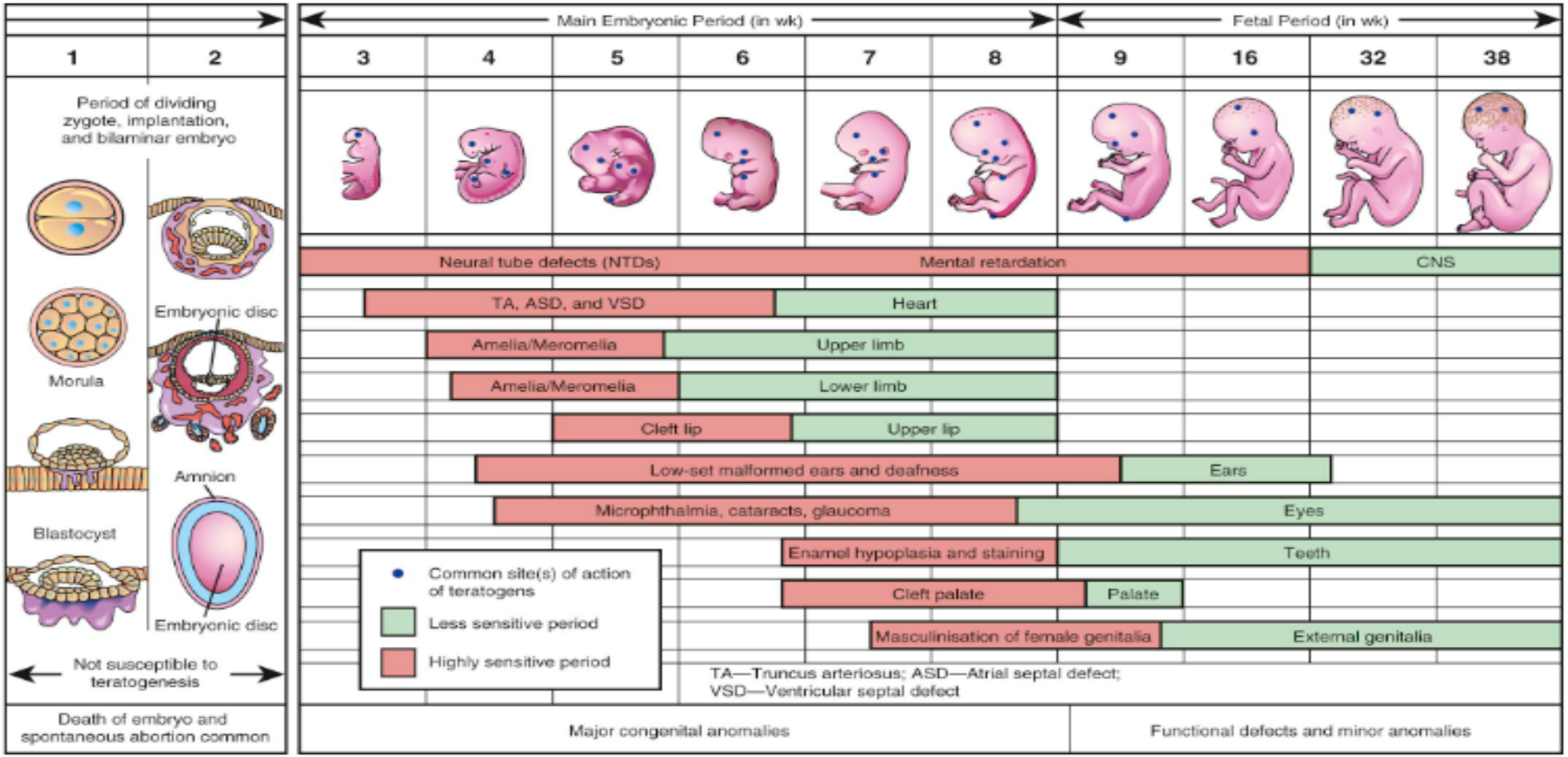


Figure 11.2

Critical periods in human prenatal development.

(Kliegman: Nelson Textbook of Pediatrics, 19th ed. 2011 Saunders; 9781437707557; Figure 6.7. From Moore KL, Persaud TVN: Before we are born: essentials of embryology and birth defects, ed 7, Philadelphia, 2008, Saunders/Elsevier. 9781437720013)

Figure 8.54 Approach to perinatal lithium use

[NB1] [NB2]

Remind the patient of signs of lithium toxicity and the importance of maintaining adequate hydration.

Check kidney function and blood lithium concentration every 4 weeks during pregnancy until 34 weeks gestation, and weekly thereafter. Consider more frequent monitoring if hyperemesis gravidarum or nausea and vomiting are problematic.

Check thyroid function at 12, 24, 36 and 40 weeks gestation.

Encourage the patient to have a high-resolution ultrasound and fetal echocardiography at 18 to 20 weeks to detect cardiac malformation.

At admission to hospital for delivery:

- check kidney function and blood lithium concentration
- withhold lithium until delivery [NB3]
- consider administering intravenous hydration.

If intrapartum complications (eg haemodynamic instability) occur, check intrapartum blood lithium concentration.

Immediately after delivery:

- check the patient's kidney function and blood lithium concentration
- check cord blood lithium concentration and thyroid stimulating hormone (TSH) and T_4 concentrations
- seek paediatric assessment of the neonate for lithium-associated complications and toxicity
- restart lithium under expert advice; because of the high risk of relapse, aim for a blood lithium concentration of 0.8 to 1.0 mmol/L for the first 4 weeks postpartum; check the concentration twice a week for the first 2 weeks. At 4 weeks postpartum, return to the prepregnancy dosage and target lithium concentration.

NB1: Ideally, the management of a patient taking lithium during the perinatal period should be multidisciplinary, with liaison between the general practitioner, psychiatrist, obstetric team and paediatrician. The patient should have a clear childbirth plan that is shared with the multidisciplinary team. If possible, delivery should take place in a tertiary hospital with a specialist neonatal care unit and psychiatric team; alternatively, seek advice from the patient's psychiatrist and a paediatrician.

NB2: Kidney clearance increases during pregnancy and decreases over a period of 2 weeks following delivery, with parallel changes in lithium concentration and, potentially, effectiveness.

NB3: Vascular volume rapidly reduces immediately after birth—to reduce the risk of toxicity, withhold lithium at the onset of labour, or for 24 hours before a planned caesarean section. Do not routinely reduce the dosage of lithium before delivery because this increases the risk of relapse.

Table 11.22 Toxic effects associated with serum lithium concentration

Serum lithium concentration	Toxic effects
0.5 to 1.0 mmol/L (therapeutic)	no toxicity or minimal toxicity: tremor
1.0 to 2.5 mmol/L	mild toxicity: tremor, hyperreflexia, nausea, vomiting, diarrhoea
2.5 to 3.5 mmol/L	moderate toxicity: rigidity, ataxia, drowsiness, confusion
more than 3.5 mmol/L	severe toxicity: coma, seizures, myoclonus, hypotension, bradycardia, QT-interval prolongation

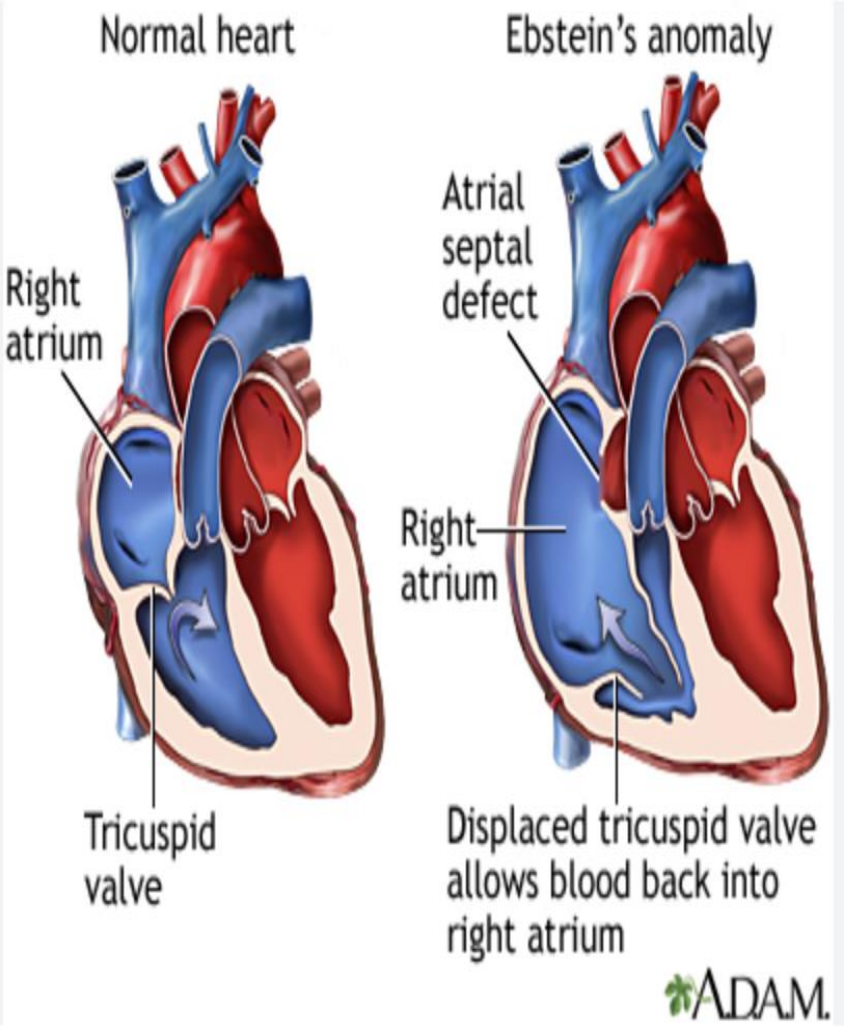
Fornaro, M., E. Maritan, et al. (2020). **"Lithium exposure during pregnancy and the postpartum period: A systematic review and meta-analysis of safety and efficacy outcomes."** The American Journal of Psychiatry **177**(1): 76-92.

- Lithium prescribed during pregnancy was associated with higher odds of any congenital anomaly (N = 23,300, k = 11; prevalence = 4.1%, k = 11; odds ratio = 1.81, 95% CI = 1.35–2.41; number needed to harm (NNH) = 33, 95% CI = 22–77) and of cardiac anomalies (N = 1,348,475, k = 12; prevalence = 1.2%, k = 9; odds ratio = 1.86, 95% CI = 1.16–2.96; NNH = 71, 95% CI=48–167).
- Lithium exposure during the first trimester was associated with higher odds of spontaneous abortion (N = 1,289, k = 3, prevalence = 8.1%; odds ratio = 3.77, 95% CI = 1.15–12.39; NNH = 15, 95% CI = 8–111).
- Comparing lithium-exposed with unexposed pregnancies, significance remained for any malformation (exposure during any pregnancy period or the first trimester) and cardiac malformations (exposure during the first trimester), but not for spontaneous abortion (exposure during the first trimester) and cardiac malformations (exposure during any pregnancy period).
- Lithium was more effective than no lithium in preventing postpartum relapse (N = 48, k = 2; odds ratio = 0.16, 95% CI = 0.03–0.89; number needed to treat = 3, 95% CI = 1–12).
- The qualitative synthesis showed that mothers with serum lithium levels < 0.64 mEq/L and dosages < 600 mg/day had more reactive newborns without an increased risk of cardiac malformations.
- Conclusions: The risk associated with lithium exposure at any time during pregnancy is low, and the risk is higher for first-trimester or higher-dosage exposure.
- Ideally, pregnancy should be planned during remission from bipolar disorder and lithium prescribed within the lowest therapeutic range throughout pregnancy, particularly during

Lithium

- Teratogenesis
  - Ebstein's anomaly 1-2:1,000 c/w general population 1:20,000 i.e. 20-40 times higher risk
- Intrauterine growth effects
  - ?increase birth weight
  - polyhydramnios
- Neuro-behavioural toxicity
  - No differences compared with non exposed children.
- Neonatal toxicity
  - "floppy baby" syndrome
  - Neonatal hypothyroidism and nephrogenic diabetes insipidus have been described
- **Use during pregnancy**
  - High resolution ultrasound and fetal echocardiography at 16-18 weeks MFM
  - Early Counselling + TOP discussion
  - Close monitoring of levels (vomiting, sodium intake) + cord blood Li levels
  - Renal excretion and haemo-dilution occurs towards term necessitating an increase in dose;
  - cease Li 24-48 h prior delivery and reinstate post delivery.
  - Vigilant monitoring during delivery and immediate postpartum to avoid toxicity due to reduction in vascular volume

- Immediate recommencement post partum if ceased in pregnancy at pre pregnancy dose
- Adequate hydration in labour
- Breastfeeding traditionally discouraged*



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ACTA PÆDIATRICA NURTURING THE CHILD | WILEY

ORIGINAL ARTICLE

Lithium use during breastfeeding was safe in healthy full-term infants under strict monitoring

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Abstract

Aim: Previous studies on breastfeeding during lithium therapy have shown conflicting results. The aim of this study was to evaluate the safety when practising thorough follow-up of the infants.

Method: This retrospective study focused on women with lithium medication, and their breastfed infants born between 2006 and 2021 in Stockholm, Sweden. Information about infant serum lithium concentrations and clinical status was collected from medical records.

Results: In total, 30 infants exposed to lithium through breastmilk, 21 girls and 9 boys, were included. The median age at follow-up was 40 days (range 8–364 days). The median lithium serum concentration was 0.10 mmol/L in the second week of life (range <0.05–0.7 mmol/L), 0.08 in week 2–4 (range <0.05–1.2), 0.06 in the second month of life (range <0.05–0.2) and 0.07 after 2 months of age (range <0.05–0.2). Unexpectedly high lithium concentrations were found in two infants in the first month of life. Apart from poor weight gain, no adverse effects were found.

Conclusion: Serum lithium concentrations in breastfed infants were stabilised at barely measurable levels after the first weeks of life. Before that, concentrations higher than the mothers were found. Lithium treatment during breastfeeding can be considered safe under strict follow-up.

Review

Postpartum psychosis: A proposed treatment algorithm

Psychopharm

Journal of Psychopharmacology
1–11

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Chaitra Jairaj[1,2,3], Gertrude Seneviratne[1,4], Veerle Bergink[5,6,7], Iris E Sommer[8] and Paola Dazzan[9,10]

Abstract

Background: Postpartum psychosis (PPP) is a psychiatric emergency that generally warrants acute inpatient care. PPP is marked by the sudden onset of affective and psychotic symptoms with a rapid deterioration in mental state. Evidence suggests that PPP is a discrete disorder on the bipolar disorder spectrum with a distinct treatment profile and prognosis.

Methods: We conducted a PubMed database search for various terms involving PPP and its treatment and included peer-reviewed articles published in English.

Objective: To provide a treatment algorithm for the management of PPP based on available evidence.

Results: Pharmacological therapy is the mainstay of PPP management in the acute phase. Evidence points to a combination of antipsychotics and lithium in the acute treatment of PPP. Electroconvulsive therapy can offer a rapid treatment response where required. Lithium appears to have the best evidence for relapse prevention and prophylaxis in PPP. Psychoeducation is essential and psychosocial interventions used in bipolar disorder may be effective in PPP.

Conclusion: Early detection and prompt treatment with antipsychotics and lithium, followed by maintenance treatment with lithium, is associated with a favourable prognosis in PPP.

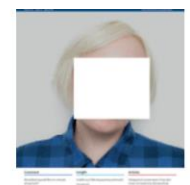
Breastfeeding and lithium: is breast always best?

Megan Galbally, Veerle Bergink, Simone N Vigod, Anne Buist, Philip Boyce, Prabha Chandra, Rolland Kohan and Louise M Howard

Lancet Psychiatry, The, 2018-07-01, Volume 5, Issue 7, Pages 534-536, Copyright © 2018 Elsevier Ltd

Breastfeeding confers clear public health benefits on mother and infant. [1] Over the past 20 years, the fertility of women with severe mental disorders, including bipolar disorder and schizophrenia, has increased. [2] [3] This situation raises the clinical question of how to weigh the benefits versus the risks of breastfeeding in this population.

During the early postpartum period, there is substantial risk of relapse for women with severe mental disorders. [2] Such relapse is associated with considerable distress for women, and can result in separation from their infant for hospital admission, and the potential removal of the infant from maternal care. To reduce the risk of relapse, a comprehensive relapse prevention plan that includes prophylactic medication, minimisation of sleep deprivation, reduction of stimulation, and provision of psychosocial support is encouraged; however, such a plan might be incompatible with breastfeeding. [4] [5]



Lancet Psychiatry, The

Volume 5, Issue 7

Lithium

Psychotropics

1st trimester	Monitoring required
2nd trimester	Monitoring required
3rd trimester	Monitoring required
Category	D
Human placental transfer	Yes

Pregnancy Summary

Lithium use during the first trimester may be associated with an increased risk of congenital heart defects and other adverse effects (1-4). A rare cardiovascular defect, Ebstein's anomaly in the newborn has been noted in lithium-exposed infants. The relative risk for Ebstein's anomaly with first trimester exposure to lithium is 1 in 2000 births, which is 10 times that of the rate for the general population (1 in 20,000). Hence, the relative risk for Ebstein's anomaly may be increased, but the absolute risk is still relatively small (1, 3, 5).

Lithium exposure was not associated with any pregnancy complications (such as preeclampsia, gestational diabetes or postpartum haemorrhage) or adverse delivery outcomes (6).

Lithium

Psychotropics

Excreted into milk	Yes
Milk to plasma ratio	0.5 (16)
Relative infant dose	0.87 to 30.1% (17)
Recommendation	Monitoring required

Breastfeeding Summary

Lithium is excreted into breast milk. No adverse effects have been observed or reported in breastfed infants (16-18). However, due to highly variable lithium milk levels, cessation of breastfeeding is often the preferred choice. Recommendations on whether to continue lithium while breastfeeding must be tailored to individuals (19). Consultation with a perinatal psychiatrist is recommended if the initiation, continuation or discontinuation of lithium therapy is required during breastfeeding.

Women who choose to breastfeed their healthy full-term infant while taking lithium should closely observe the breastfed infant for signs and symptoms of lithium toxicity. These symptoms include lethargy, poor feeding and hypotonia. Regular laboratory monitoring of the infant's serum lithium levels, renal functions and thyroid functions are

Section 4.4

Special warnings and precautions for use

Section 4.6

Fertility, pregnancy and lactation

Use in males of reproductive potential

A retrospective observational study indicates an increased risk of neurodevelopmental disorders (NDDs) in children born to men treated with valproate in the 3 months prior to conception, compared to those treated with lamotrigine or levetiracetam (see Section 4.6 Fertility, Pregnancy and Lactation).

Despite study limitations, by way of precaution, the prescriber should inform the male patients of this potential risk. The prescriber should discuss with the patient the need for effective contraception, including for the female partner, while using valproate and for 3 months after stopping the treatment. The risk to children born to men stopping valproate at least 3 months prior to conception (i.e., allowing a new spermatogenesis without valproate exposure) is not known.

The male patient should be advised:

not to donate sperm during treatment and for 3 months after stopping the treatment

of the need to consult his doctor to discuss alternative treatment options, as soon as he is planning to father a child, and before discontinuing contraception

that he and his female partner should contact their doctor for counselling in case of pregnancy if he used valproate within 3 months prior to conception.

The male patient should also be informed about the need for regular (at least annual) review of treatment by a specialist experienced in the management of epilepsy or bipolar disorder.

The specialist should at least annually review whether valproate is the most suitable treatment for the patient. During this review, the specialist should ensure the male patient has acknowledged the risk and understood the precautions needed with valproate use.

Risk to children of fathers treated with valproate

- A retrospective observational study on electronic medical records in 3 European Nordic countries indicates an increased risk of neurodevelopmental disorders (NDDs) in children (from 0 to 11 years old) born to men treated with valproate in the 3 months prior to conception compared to those treated with lamotrigine or levetiracetam.
- The adjusted cumulative risk of NDDs ranged between 4.0% to 5.6% in the valproate group versus between 2.3% to 3.2% in the composite lamotrigine/levetiracetam monotherapy group exposure. The pooled adjusted hazard ratio (HR) for NDDs overall obtained from the meta-analysis of the datasets was 1.50 (95% CI: 1.09-2.07).
- Due to study limitations, it is not possible to determine which of the studied NDD subtypes (autism spectrum disorder, intellectual disability, communication disorder, attention deficit/hyperactivity disorder, movement disorders) contributes to the overall increased risk of NDDs. Alternative therapeutic options and the need for effective contraception while using valproate and for 3 months after stopping the treatment should be discussed with male patients of reproductive potential, at least annually (see section 4.4 Special Warnings and Precautions for Use).

https://www.tga.gov.au/news/safety-updates/potential-risk-neurodevelopmental-disorders-children-born-men-taking-sodium-valproate

Betcher, H. K. and K. L. Wisner (2020). **"Psychotropic treatment during pregnancy: Research synthesis and clinical care principles."** Journal of Women's Health **29**(3): 310-318.

- Selective serotonin reuptake inhibitors or serotonin–norepinephrine reuptake inhibitor medications are not associated with higher rates of birth defects or long-term changes in mental development after adjustment for confounding factors associated with underlying psychiatric illness.

- Lithium exposure is associated with an increased risk for fetal cardiac malformations, but this risk is lower than previously thought (absolute risk of Ebstein's anomaly 6/1,000).

- Antipsychotics, other than risperidone and potentially paliperidone, have not been associated with an increase in birth defects; olanzapine and quetiapine have been linked with an elevated risk of gestational diabetes.

Due to the dramatic physiological changes of pregnancy and enhanced hepatic metabolism, drug doses may need to be adjusted during pregnancy to sustain efficacy.

Untreated maternal psychiatric illness also carries substantial risks for the mother, fetus, infant, and family.

The goal of perinatal mental health treatment is to optimally provide pharmacotherapy to mitigate the somatic and psychosocial burdens of maternal psychiatric disorders.

Regular symptom monitoring during pregnancy and postpartum and medication dose adjustments to sustain efficacy constitutes good practice.

Massachusetts General Hospital Centre for Women's Mental Health

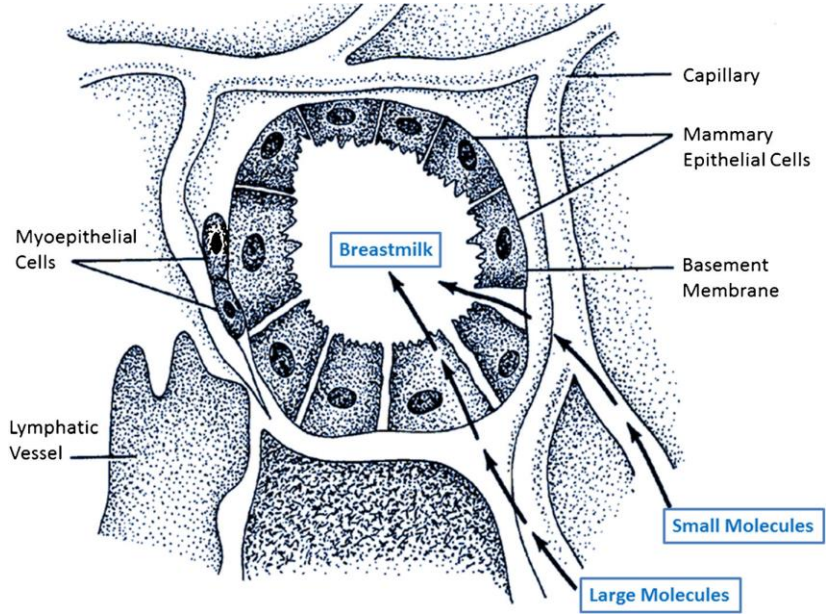
https://thewomenspbmg.org.au/medicines/

https://www.choiceandmedication.org/queenslandhealth/printable-leaflets/

Drug transfer into breastmilk

- Many medications are safe in breastfeeding
- Medication properties influence passive and active secretion into breastmilk
- Agent must be orally active to have an effect
- Many medications previously contraindicated are actually safe
- Not infrequently, breastfeeding ceased due to medication concerns when safety data does exist
- Many medications have little or no data; but the theoretical risk of transfer may be very low – a mother may choose to breastfeed after a discussion about risk versus benefit
- Can observe infant and do drug levels and biochemistry if necessary

Factors affecting drug transfer



- **<u>Drug</u>**
- Size – only small molecules pass freely
- pH
- Protein binding – more protein bound – less into breastmilk
- Fat content – lipid soluble drugs concentrate in milk fat
- Half life
- Active transported into breastmilk and active metabolites

Anderson (2018) Pharm Res 35:45

Maternal and Infant Factors

Maternal

- Milk volume: Little exposure in colostrum, reduced mixed feeding
- Milk composition: Milk with higher fat will increase the total amount of drug in breast milk
- Mastitis – paracellular pathway re-opens – increased drug in milk

Infant

- Prematurity
- Age of infant
- Milk intake

Drugs and Lactation Database (LactMed)

< Prev Next >

Bethesda (MD): National Library of Medicine (US); 2006-.

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The LactMed® database contains information on drugs and other chemicals to which breastfeeding mothers may be exposed. It includes information on the levels of such substances in breast milk and infant blood, and the possible adverse effects in the nursing infant. Suggested therapeutic alternatives to those drugs are provided, where appropriate. All data are derived from the scientific literature and fully referenced. A peer review panel reviews the data to assure scientific validity and currency.

- LactMed https://www.ncbi.nlm.nih.gov/books/NBK501922/
- Hale's Medications In Mother's Milk
- https://thewomenspbmg.org.au/medicines (via CKN)
- RBWH hospital pharmacists
- ***NOT MIMS or drug insert***

SSRI Neonatal "withdrawal" symptoms = serotonin discontinuation syndrome

Central nervous system (motor restlessness, jittery baby, yawning, tremors,poor sleep, crying, convulsions)

Respiratory (respiratory distress)

Gastrointestinal (diarrhoea, feeding problems, reflux and sneezing, vomiting, jaundice)

Onset within 3-4 days post-partum

Use last 2-3 days

BUT...

10% control babies have similar sx

Babies of depressed women exhibit greater neonatal irritability and poorer neonatal adaptation

3 Assessment

Suspect NAS and investigate to determine diagnosis in any baby who displays signs of NAS.

3.1 Signs NAS

Clinical presentation can be non-specific and variable in intensity and duration. Additionally, similar signs can occur across all substance classes and this is compounded when there is maternal polysubstance use. There may also be no signs of withdrawal.

Table 5. Signs of NAS

Signs[7,34-36]	Substances implicated	Neurotransmitter[7,34,35]
• Sleeping problems	• Opioids • TCA • SSRI • SNRI • Methamphetamines • Alcohol*	• Decreased serotonin
• Poor feeding • Hypertonia • Jitteriness	• SSRI • SNRI	• Increased serotonin
• Hyperirritability	• Opioids • Methamphetamines • Inhalants • Nicotine* • Alcohol*	• Decreased dopamine
• Hyperphagia • Increased stress	• Opioids	• Increased corticotrophin
• Hyperthermia • Hypertension • Tachycardia • Tremors	• Opioids • SSRI • SNRI • Alcohol*	• Increased noradrenaline
• Sweating • Vomiting • Diarrhea • Yawning • Sneezing • Sleeping problems	• Opioids • TCA • SSRI • SNRI • Alcohol*	• Increased acetylcholine
• Jittery • Irritability	• Benzodiazepines • Barbiturate • Solvents • Caffeine	• Increased GABA (gamma aminobutyric acid)

*Multiple or unknown/uncertain neurotransmitter involvement[37]

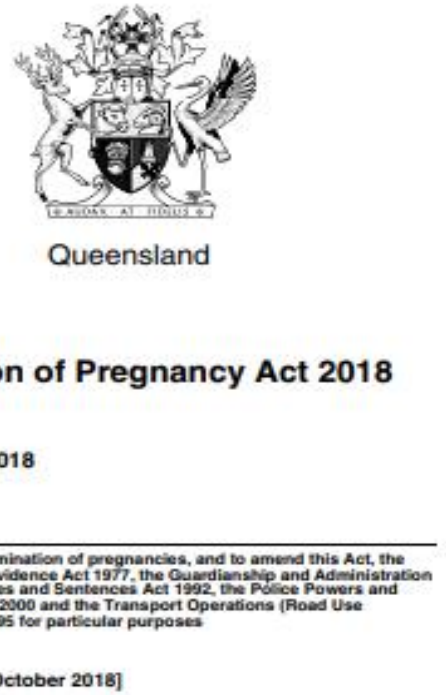
Appendix B: Finnegan Neonatal Abstinence Severity Score Description

	Sign	Description
Central nervous system	Excessive high pitched cry	• Baby cries intermittently or continuously for **up to 5 minutes** despite caregiver intervention • Baby is unable to decrease crying within a 15 second period using self-consoling measures
	Continuous high pitched cry	• Baby cries intermittently or continuously for greater than 5 minutes despite caregiver intervention • NB: Since a baby's cry may vary in pitch, this should not be scored if high pitched crying is not accompanied by other signs described above
	Sleep	• Longest period baby sleeps within the entire scoring interval including light and deep sleep • Light—irregular breathing, brief opening of eyes at intervals, some sucking movements • Deep—regular breathing, eyes closed, no spontaneous activity
	Hyperactive Moro reflex*	• Baby exhibits pronounced jitteriness of the hands during or at the end of the test for Moro reflex
	Markedly hyperactive Moro reflex*	• Baby exhibits jitteriness and repetitive jerks of the hands and arms during or at the end of the test for the Moro reflex
	Mild tremors when disturbed**	• Baby exhibits observable tremors of the hands or feet when being handled
	Moderate to severe tremors when disturbed**	• Baby exhibits observable tremors of the arm(s) or leg(s) with or without tremors of the hands or feet when being handled
	Mild tremors when undisturbed**	• Baby exhibits observable tremors of the hands or feet whilst undisturbed
	Moderate to severe tremors when undisturbed**	• Baby exhibits observable tremors of the arm/s or leg/s with or without tremors of the hands or feet whilst undisturbed
	Increased muscle tone when the baby is awake and not crying	• Baby has tight flexion of the arms and legs that is unable to slightly extend the arms or legs
	Excoriation	• First appearance or increase on baby's chin, knees, cheeks, elbow, toes or nose due to friction burn not nappy area excoriation from loose stools
	Myoclonic jerks	• Baby exhibits twitching movements of the muscles of the face or extremities or jerking movements of the arms or legs
	Generalised convulsions	• Baby has generalised activity involving tonic (rigid) extensions of all limbs (or may be limited to one limb only), or manifested by tonic flexion of all limbs; or generalised jitteriness of extremities that do not stop when the limbs are flexed or held • Features of subtle seizures may be present including eye staring, rapid eye movements, chewing, fist clenching, back arching and cycling motion of limbs with or without autonomic changes
Gastrointestinal	Excessive sucking	• Baby shows increased >3 times rooting while displaying rapid swiping movements of hand across mouth prior to or after a feed
	Poor feeding	• Baby either demonstrates excessive sucking prior to a feed, yet sucks infrequently during feeding, taking small amounts and/or demonstrates an uncoordinated sucking reflex or continuously gulps the milk and stops frequently to breathe
	Regurgitation	• Baby regurgitates not associated with burping 2 or more times during a feed
	Projectile vomiting	• Baby has ≥1 projectile vomiting episode occurring during or immediately after a feed
	Loose stools	• Scored if stool which may or may not be explosive is curdy or seedy in appearance • A liquid stool, without a water ring on the nappy should also be scored as loose
	Watery stools	• Baby has soft, mushy or hard stools that are accompanied by a water ring on the nappy
Respiratory/vasomotor	Sweating	• Baby has perspiration on forehead, upper lip or back of neck • Do not score if sweating is due to overheating for example from cuddling or swaddling
	Fever	• Baby has a temperature as per score sheet
	Frequent yawning	• Baby yawns > 3 times within scoring interval
	Mottling	• Baby has mottling on chest, trunk, arms or legs
	Nasal stuffiness	• Baby has noisy respirations due to the presence of exudate, with or without a runny nose
	Sneezing	• Baby sneezes >3 times in the scoring interval occurring as individual episodes or may occur serially
	Nasal flaring	• Baby has this at any time during the scoring interval • Score only if present without other evidence of lung or airway disease
	Respiratory rate	• Baby must not be crying when this is assessed

*Moro reflex: Do not perform when the baby is crying or irritable
**Mild tremors when undisturbed observe for at least 2 undisturbed periods of 60 seconds
Adapted from: D'Apolito K. A scoring system for assessing neonatal abstinence syndrome. Instruction Manual. 1994.

Termination of Pregnancy Act 2018

- As of 3rd December 2018 the ToP Act applies to termination of pregnancy in Queensland.
- Termination performed by a registered medical practitioner, is no longer a criminal offence under the Criminal Code;
- nor is it a criminal offence for a woman to consent to, assist in or perform a termination on herself.
- The purposes of the ToP Act are to:
  - Enable reasonable and safe access by women to termination
  - Regulate the conduct of registered and student health practitioners in relation to



Queensland

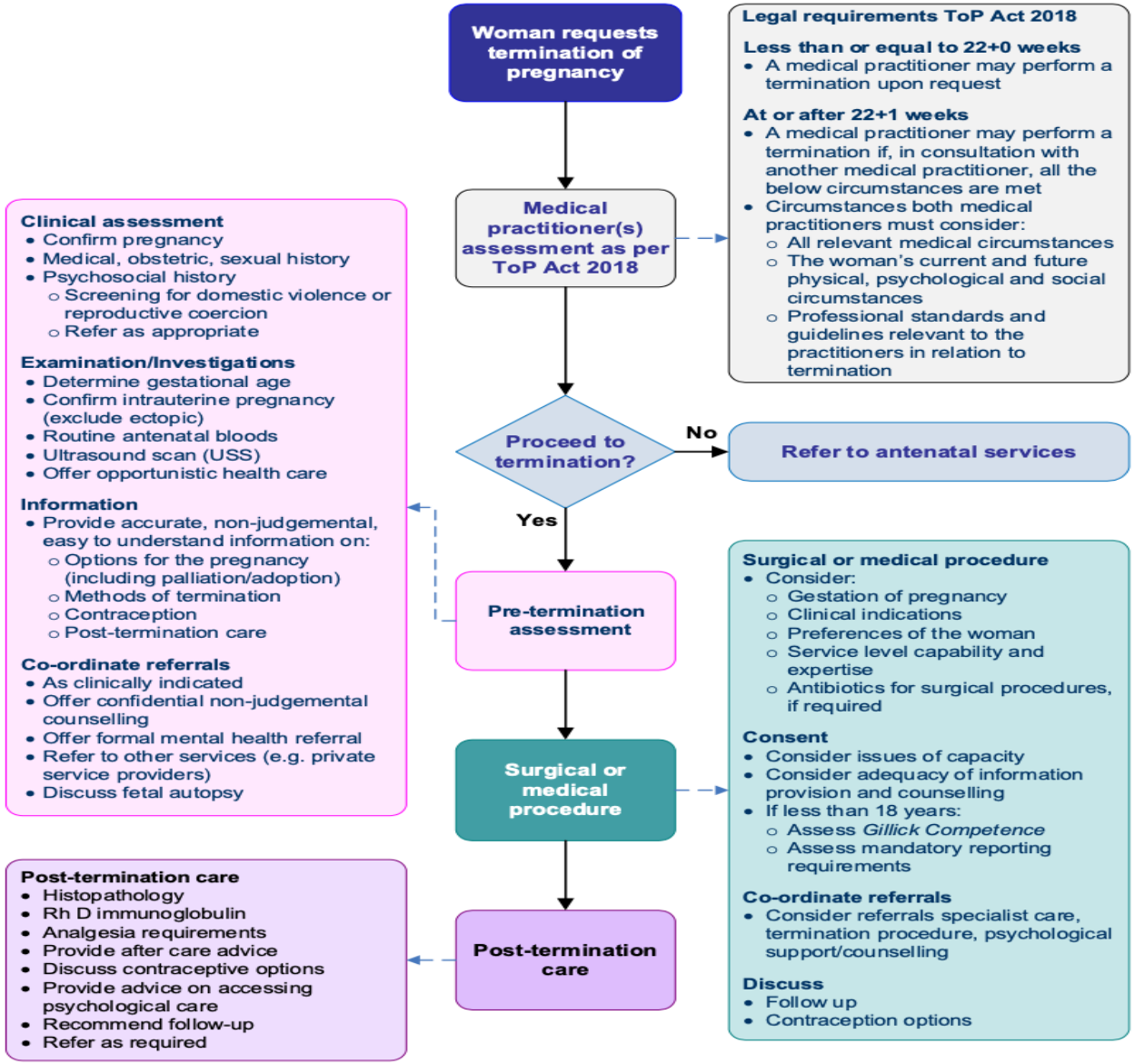
Termination of Pregnancy Act 2018

Act No. 23 of 2018

An Act about the termination of pregnancies, and to amend this Act, the Criminal Code, the Evidence Act 1977, the Guardianship and Administration Act 2000, the Penalties and Sentences Act 1992, the Police Powers and Responsibilities Act 2000 and the Transport Operations (Road Use Management) Act 1995 for particular purposes

[Assented to 25 October 2018]

Flow Chart: Summary of termination of pregnancy



Conscientious objection
- Disclose objection if termination is requested
- Without delay, transfer care to other service or to provider who does not have conscientious objection

ToP: termination of pregnancy, Rh D: rhesus D

Queensland Clinical Guidelines: Summary of termination of pregnancy Flowchart: F19.21-1-V4-R24

www.health.qld.gov.au/__data/assets/pdf_file/0029/735293/g-top.pdf

4.1 Consent

Table 10. Consent

Aspect	Consideration

Consent	• Follow usual consent processes and standards including:
	  ○ Assessment of capacity
	  ○ Discussion of available methods of termination
	  ○ Risks and complications of each method of termination

Capacity to consent	• An adult can give consent (has capacity) if they[14]:
	  ○ Understand the nature and effect of decisions about the matter
	  ○ Freely and voluntarily makes decisions about the matter and
	  ○ Can communicate the decisions in some way

Adults with impaired capacity	• Termination of a pregnancy of an adult who lacks capacity is considered to be "special healthcare"[14,15] • An attorney, legal guardian or substitute decisionmaker cannot give consent for another person to undergo a termination • The Queensland Civil and Administrative Tribunal may consent for an adult with impaired capacity to undergo a termination "only if the Tribunal is satisfied that it may be performed by a medical practitioner under the ToP Act"[15]
Young person Gillick competent[16]	• A young person is considered *Gillick* competent when they achieve sufficient maturity and intelligence to enable them to understand fully what medical treatment is proposed[16] • A *Gillick* competent young person can consent to medical procedures, in the same way as an autonomous adult with capacity • The decision about whether a young person is *Gillick* competent is a matter for the treating practitioner • Consider additional elements of informed consent when obtaining consent from a *Gillick* competent young person (e.g. the ability to freely and voluntarily make decisions without coercion) • The law requires that when a competent young person chooses not to include their parents/guardians in consultation, this must be respected, and confidentiality not breached • Involve appropriately skilled healthcare professionals for assessment of *Gillick* competency, psychosocial assessment and family court matters *where clinically indicated* • Refer to Queensland Health: *Guide to informed decision making in healthcare*[11]

Young person <u>not</u> Gillick competent	• For a young person deemed not to have capacity (*Gillick* competent), the Supreme Court in its *parens patriae* jurisdiction[15] may authorise the termination
	  ○ The Supreme Court must act in the best interests of the young person
	  ○ A young person's parents/guardian cannot provide consent to a termination
	• Involve appropriately skilled healthcare professionals for assessment of *Gillick* competency, psychosocial assessment and family court matters *where clinically indicated*
	• Escalate these cases to the Executive Director of Medical Services or equivalent (e.g. Medical Superintendent) for urgent attention

4.2 Young person less than 14 years

A young person less than 14 years may be considered *Gillick competent*. Assess individual circumstances. Refer to Table 10. Consent.

Table 11. Young person less than 14 years

Aspect	Consideration

Young person less than 14 years	• Each HHS determines its capability to provide termination healthcare for young people less than 14 years
	• Involve social worker support
	• If not considered *Gillick* competent:
	  ○ Involve appropriately skilled healthcare professionals for assessment of *Gillick* competency, psychosocial assessment and family court matters
	  ○ Refer to Table 10. Consent
	• Provide non-judgemental pre-termination psychological counselling by an appropriately qualified healthcare professional
	  ○ Refer to Section 5.1 Psychological support
	  ○ Include documented evidence of the pre-termination counselling in the medical record
	• Refer to the Queensland Health: *Guide to informed decision making in healthcare*[11]

Definition of Capacity: Guardianship and Administration Act

The definition of 'capacity' in the **Guardianship and Administration Act (Queensland)** is as follows:

(a) capacity, for a person for a matter, means the person is capable of—

(i) **understanding** the nature and effect of decisions about the matter; and

(ii) freely and **voluntarily making decisions** about the matter; and

(iii) **communicating** the decisions in some way.

Note: This Act does not apply to minors in Queensland, though helpful to reflect on the principles

QCAT

Queensland Civil and Administrative Tribunal

QCAT

Queensland Civil and Administrative Tribunal

For office use only	
Case number:	
Date:	
Registry:	
Sent to:	

Form Number 57 (version 2)
Queensland Civil and Administrative Tribunal Act 2009
Guardianship and Administration Act 2000

Application for consent to special health care for an Adult

Refer to the attached instructions prior to filling out this form

Part A APPLICATION DETAILS

What order are you applying for?

- ☐ Sterilisation procedure
- ☐ Termination of pregnancy
- ☐ Donation of tissue
- ☐ Prescribed special health care

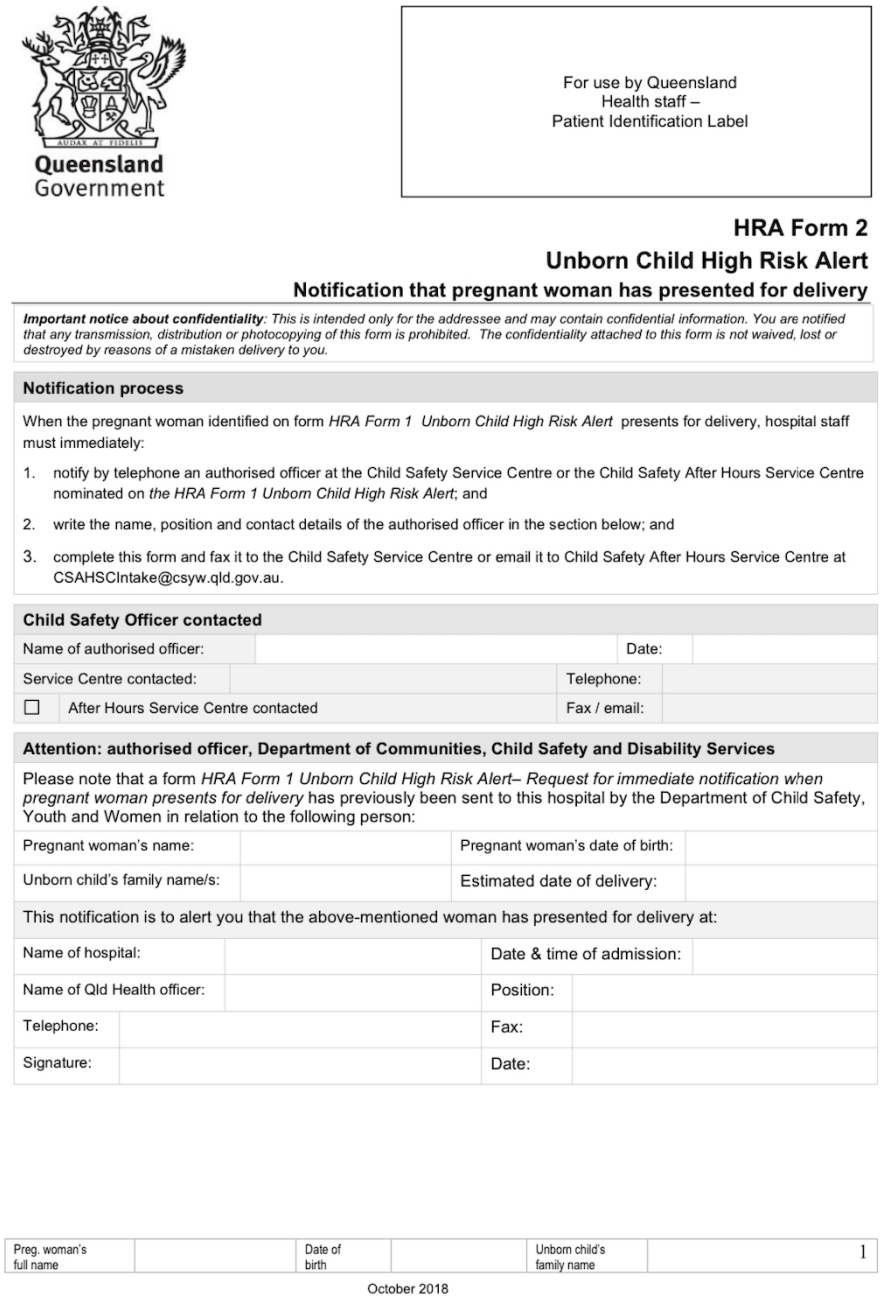
UCHRA

Unborn Child High Risk Alerts

An Unborn Child High Risk Alert (UCHRA) is generated by the Department of Child Safety, Youth and Women in response to child protection concerns raised prior to the birth of a child.

In the instance that an UCHRA has been activated by Child Safety Services, staff should:

- Not disclose to the pregnant woman that an UCHRA has been received from Child Safety Services.
- Undertake a search of HBCIS, ieMR and the UCHRA toolkit every time a pregnant woman is admitted for delivery (the search should include the pregnant woman's name, plus any known aliases).
- Not separate a mother and baby unless a copy of the relevant order has been received by the HHS.
- Notify Child Safety that the pregnant woman has presented for delivery by immediately calling Child Safety Services and completing a HRA FORM 2 (DOC, 863KB).



Queensland Government

For use by Queensland Health staff – Patient Identification Label

HRA Form 2

Unborn Child High Risk Alert

Notification that pregnant woman has presented for delivery

Important notice about confidentiality: *This is intended only for the addressee and may contain confidential information. You are notified that any transmission, distribution or photocopying of this form is prohibited. The confidentiality attached to this form is not waived, lost or destroyed by reasons of a mistaken delivery to you.*

Notification process

When the pregnant woman identified on form *HRA Form 1 Unborn Child High Risk Alert* presents for delivery, hospital staff must immediately:

1. notify by telephone an authorised officer at the Child Safety Service Centre or the Child Safety After Hours Service Centre nominated on *the HRA Form 1 Unborn Child High Risk Alert*; and
2. write the name, position and contact details of the authorised officer in the section below; and
3. complete this form and fax it to the Child Safety Service Centre or email it to Child Safety After Hours Service Centre at CSAHSCIntake@csyw.qld.gov.au.

Child Safety Officer contacted

Name of authorised officer:		Date:	
Service Centre contacted:		Telephone:	
☐ After Hours Service Centre contacted		Fax / email:	

Attention: authorised officer, Department of Communities, Child Safety and Disability Services

Please note that a form *HRA Form 1 Unborn Child High Risk Alert– Request for immediate notification when pregnant woman presents for delivery* has previously been sent to this hospital by the Department of Child Safety, Youth and Women in relation to the following person:

Pregnant woman's name:		Pregnant woman's date of birth:	
Unborn child's family name/s:		Estimated date of delivery:	

This notification is to alert you that the above-mentioned woman has presented for delivery at:

Name of hospital:		Date & time of admission:	
Name of Qld Health officer:		Position:	
Telephone:		Fax:	
Signature:		Date:	

Preg. woman's full name		Date of birth		Unborn child's family name	

October 2018

TO

Temporary assessment order

CAO

Court assessment order

Temporary assessment order

A temporary assessment order (TAO) is a three day order made by a magistrate under the *Child Protection Act 1999*.

An officer from the Department of Children, Youth Justice and Multicultural Affairs or the Queensland Police Service can apply to the magistrate for the order.

The purpose of a temporary assessment order is to:

- allow child safety officers or police officers to assess whether the child or young person has been harmed or is at risk of harm
- make sure the child or young person is safe while an investigation and assessment occurs.

A temporary assessment order can allow any of the following actions (despite a parent's objection):

- contact with a child or young person by child safety officers or police officers
- medical examination or treatment of the child or young person
- temporary custody of the child or young person during the investigation and assessment period. This generally means that the child or young person will not stay in their home
- child safety officers or police officers to enter and search a place to find a child or young person.

A temporary assessment order can also direct a parent not to have contact with their child or young person, or to only have supervised contact.

Court assessment order

A court assessment order (CAO) is an order made by the Childrens Court under the Child Protection Act 1999.

The purpose of a court assessment order is to:

- allow child safety officers or police officers to assess whether a child or young person has been harmed or is at risk of harm
- make sure the child or young person is safe while the investigation and assessment occurs.

A court assessment order can last for up to four weeks from the day the application is first brought before the court, even if the matter has been adjourned.

- The order will state the date when it ends.
- The Childrens Court can extend the order once for a further period of up to four weeks, if it is in the child or young person's best interests.

If a court assessment order application is made to the Childrens Court, both parents will be served with the application and will have an opportunity to attend court and be heard by the magistrate.

Table 24.1. *A framework for assessing parenting*

Focus on parenting:
Capacity to attend to child's physical, intellectual, social and emotional needs
Capacity to provide a stable and nurturing environment (secure base)
Age-appropriate understanding and expectations of child
Capacity to initiate or follow, and enjoy child centred activity (play)
Evidence for physical or sexual abuse

Focus on mentally ill parent:
Level of disturbance, instability and violent tendencies (impulse control)
Behaviour and psychiatric symptoms directly affecting parenting capacity and ability, including alcohol/drug addiction and level of commitment to child
Attitude to social norms/relationship to society
Sense of responsibility for self, child and family/capacity to acknowledge any risk to child
Level of paranoia/capacity to form trusting relationships
Use of help/clinical interventions/potential ± motivation for change including relevant past history

Focus on 'well'/other parent (if relevant):
Attitude to illness of partner
Relationship to child
Commitment to maintaining the family
Capacity to be available/intervene on child's behalf if and when necessary
Health/emotional resources

Focus on the marriage/partnership (if relevant):
Style and intensity of marital conflict
Ability to communicate
History of violence/spouse abuse
Capacity to work together as parents

Focus on the child:
Developmental progress
Child's attachment status (including fear of parent)
Capacity for self-protection
Unusual behaviours and characteristics
Relationships outside the nuclear family, including extended family, peers and school

Focus on context and extended family:
Degree and patterns of support from extended family, including parents' relationship to own parents
Quality of non-family network
Financial/housing status

Case 3 “Too Much, Too Loud, Too Soon”

- Aisha is a 33-year-old woman, married, with two children. She recently gave birth to her second child, now 10 weeks old. She presents to her GP during a routine postnatal check-up, accompanied by her husband and baby.
- She appears tired and irritable. She apologises for being “a bit sharp” and describes herself as “not coping” in a house that “feels too loud, too messy, and way too much.” When prompted, she says she “just can’t get on top of things,” and feels like “everyone else seems to manage better.” She frequently compares herself to other mothers and describes her frustration with “never-ending routines.”
- Her first child is 4 years old and attends kindy. Her husband works full-time. There is no formal history of psychiatric illness. However, she has always been described as “very sensitive,” and struggled socially in high school. She had a history of being labelled “fussy” or “picky” with foods and textures since childhood.
- Aisha admits that she’s always felt different but never sought help. During the pregnancy, she experienced significant insomnia, anxiety about labour, and discomfort with frequent medical appointments. Since the birth, her mood has become increasingly unstable. She bursts into tears “for no reason,” avoids seeing visitors, and feels “disconnected” from the baby.
- She finds breastfeeding difficult—not due to latch or supply, but due to intense discomfort when the baby brushes against her skin, especially on her upper arms. She says, “It’s like something crawling over me. It makes my skin want to crawl off.” She also says she can’t tolerate feeding her baby yogurt, though she tries—feeding as quickly as possible while turning her face away.
- When her GP asks more detailed questions, Aisha reveals longstanding difficulties with focus, time management, emotional outbursts, and sensitivity to lights, sounds, and smells. She has never tolerated yogurt, cannot eat certain textures, and can’t **conc**entrate unless everything is in the “right” order. Her eating patterns have been irregular for years—she skips meals or binge eats “to shut off the noise.”
- There are no overt psychotic symptoms or suicidal thoughts. However, she frequently feels ashamed, overwhelmed, and frustrated. Her husband is supportive but also confused—he believes this might just be postnatal hormones. Aisha agrees to consider a mental health plan, though she appears sceptical that talking therapy will help. “I just don’t want to be a problem,” she says. “Maybe I just wasn’t meant to be a mum of two.”

Case 3 "Too Much, Too Loud, Too Soon"

- *A 33-year-old mother of two, struggling postnatally with emotional dysregulation and sensory overwhelm*
- Recently gave birth to second child (now 10 weeks old)
- No formal psychiatric history, but longstanding **sensitivity to sound, touch, and food**
- Distress linked to **routine disruptions, sensory overstimulation, emotional burnout**
- Describes **difficulty breastfeeding** due to discomfort with baby's touch
- Reveals history of **focus issues, emotional outbursts, disordered eating behaviours**
- Self-critical, ashamed, and disconnected from baby
- Subtle signs of **undiagnosed neurodivergence (ASD/ADHD traits)** emerging
- No psychosis or suicidality, but **risk of under-recognition and missed support**

Case 3 “Too Much, Too Loud, Too Soon”

What symptoms or traits here might suggest neurodivergence?

- Longstanding **sensitivity to touch, sound, and smell**
- Discomfort with feeding textures (yogurt), tactile defensiveness during breastfeeding
- **Rigid routines**, need for things to be “just right”
- Emotional reactivity, shame, and **meltdowns under stress**
- History of **disordered eating**, often sensory-driven
- High-functioning appearance → risk of **underdiagnosis**

Case 3 "Too Much, Too Loud, Too Soon"

Why might perinatal transitions exacerbate these symptoms?

- Loss of structure → increases executive dysfunction
- Sleep disruption → worsens **emotional regulation**
- Sensory demands (crying, breastfeeding, mess, clutter) overload nervous system
- Increased social contact (health visits, family) may **intensify masking stress**
- Hormonal shifts worsen baseline vulnerabilities
- Role identity change (from 1 to 2 children) → challenges in cognitive flexibility

Case 3 "Too Much, Too Loud, Too Soon"

How could you explore these issues in a sensitive, non-pathologising way?

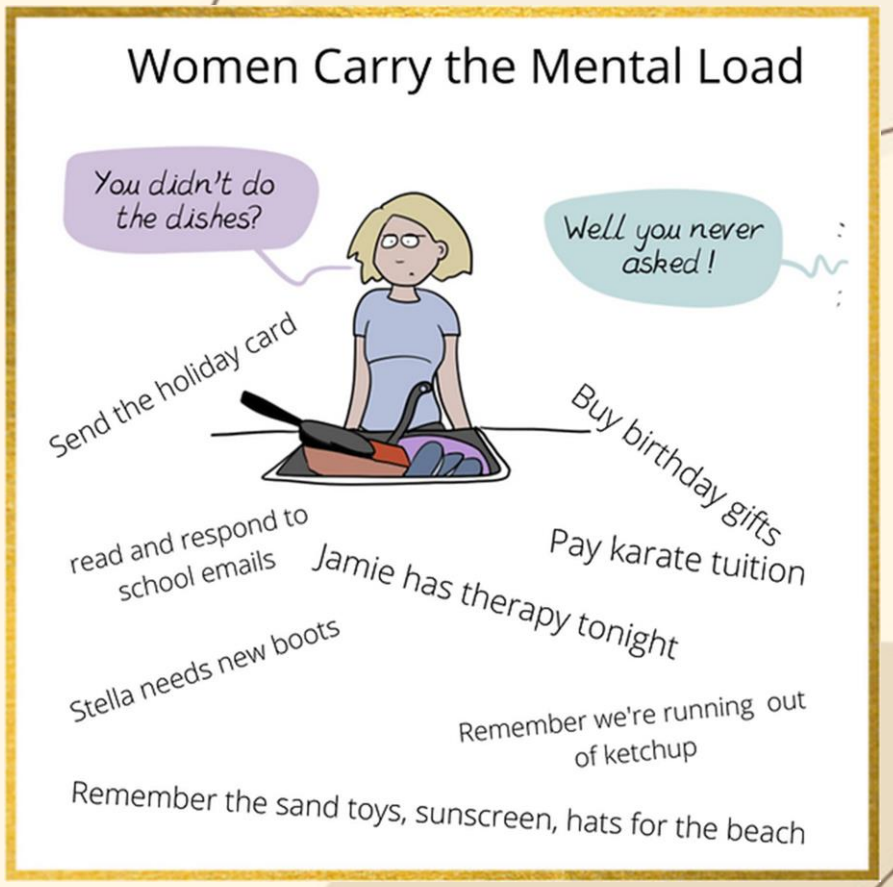
- Use **curiosity over correction**
- Normalize difference: "Some women find that second time around, things feel different—and sometimes it brings up old patterns that haven't been noticed before."
- **Avoid** labelling **too early!!!**. Focus on **function, regulation, coping**
- Use questions like:
  "Have you always noticed certain things that make you more reactive or drained?"
  "Are there times of the day that feel harder, noisier, more frustrating?"
- Acknowledge strengths: "You've managed a lot. Sometimes those strengths also hide the strain."

Case 3 "Too Much, Too Loud, Too Soon"

What supports might be beneficial, and how could you frame them?

- **Perinatal psychologist** skilled in ASD/ADHD
- GP Mental Health Plan → focus on **sensory regulation, cognitive overload, identity**
- Normalize sensory overwhelm postpartum as a sign to **pause, not push**
- Consider **assessment** only if Aisha expresses interest—not mandatory
- Encourage psychoeducation: "Understanding your wiring might help you take pressure off."
- Frame support as **self-understanding**, not fixing: "You're not broken. But things might make more sense with the right lens."

Social and lifespan transitions and ADHD



Transitions away from external structure

- Highschool to university
- Living at home or with others to living alone
- Maternity leave
- Retirement
- Losing the routine of school aged children.

Transitions towards greater 'executive functioning' load

- Carrying the 'mental load' of running a family (often with children with ADHD/ASD)
- Moving into managerial positions at work

Risk of premature death

- Danish study found an increased mortality rate among individuals with ADHD. *(Dalsgaard et al)*
- Females with ADHD had a higher risk of premature death, with relative risk being almost three times that of women without ADHD.
- Females with ADHD were more likely to die prematurely compared with unaffected females, than males with ADHD were compared with unaffected males (although absolute risk still greater for males)
- Risk of premature death was greatest in those diagnosed in adulthood, largely due to accidents

Attention-deficit/hyperactivity disorder in pregnancy and the postpartum period

Olivia Scoten, BHSc; Katarina Tabi, PhD; Vanessa Paquette, PharmD; Prescilla Carrion, MSc; Deirdre Ryan, MB; Nevena V. Radonjic, MD, PhD; Elizabeth A. Whitham, MD; Catriona Hippman, PhD

TABLE 2
Treatments commonly used to treat ADHD in the perinatal period

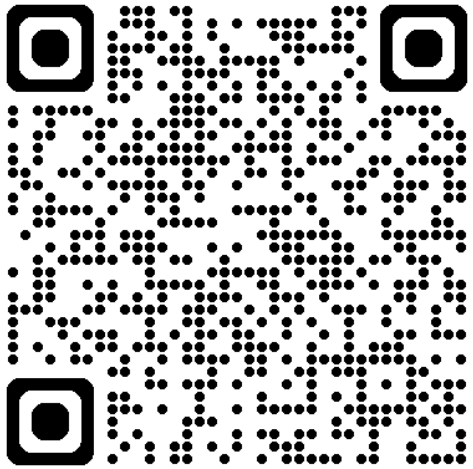
Severity of Symptoms	Treatment and Self-Management
Mild to moderate	A. Psychoeducation B. Self-management or coaching C. Psychotherapies i. Cognitive behavioral therapy (CBT) ii. Mindfulness-based interventions iii. Dialectical behavior therapy
Moderate to severe	Treatment for mild to moderate symptoms plus: D. Pharmacotherapy (medications) i. Stimulants a. Amphetamine-based stimulants b. Methylphenidate-based stimulants ii. Nonstimulants

ADHD, attention-deficit/hyperactivity disorder.

Scoten. Attention-deficit/hyperactivity disorder in the perinatal period. Am J Obstet Gynecol 2024.

SUMMARY

- Assessment (maternal-infant relationship, Obs Hx, Family support)
- Diagnostic criteria
- Red flags, Risk assessment - broad
- Treatment
- Referrals, Liaison
- Resources



Brisbane North

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- Medical
- Mental Health
  - Addictions
  - ADHD in Adults
  - Anxiety in Adults
  - Bipolar Affective Disorder
  - Child and Youth Mental Health
  - Deliberate Self-harm
  - Depression in Adults
  - Eating Disorders in Adults
  - GP Mental Health Treatment Plan
  - Mental Health Stepped Care
  - Pandemic Mental Health
  - Physical Health and Mental Illness
  - Perinatal Mental Health
    - Infant Mental Health
    - Psychotropic Medications in the Perinatal Period
    - Pre-pregnancy Emotional Health and Well-being
    - Emotional Health and Well-being in Pregnancy
    - Postpartum Emotional Health and Well-being
  - Post-traumatic Stress Disorder (PTSD)
  - Problem Gambling
  - Psychosis
  - Suicide Prevention in Adults

Mental Health / Perinatal Mental Health / Emotional Health and Well-being in Pregnancy

Emotional Health and Well-being in Pregnancy

Red flags

- Risk of self-harm or suicide
- Decompensated or deteriorating mental health condition
- Substance abuse
- Eating disorder
- Very young or advanced maternal age

Background

About emotional health and well-being in pregnancy

Assessment

1. Screen patients as early as possible in the pregnancy for depression, other mental health disorders, and substance use disorders.
2. If the patient is an Aboriginal and Torres Strait Islander or culturally and linguistically diverse (CALD), consider language and cultural appropriateness. See Department of Health Pregnancy Care Guidelines – Pregnancy Care for Aboriginal and Torres Strait Islander Women and Pregnancy Care for Migrant and Refugee Women.
3. Take a history and check:
   - for symptoms of anxiety and depression.
   - suicide risk.
   - personal and family history of mental disorders.
   - for demographical and psychosocial risk factors.
4. Consider screening tools.
5. If the patient has a pre-existing mental health condition (e.g., bipolar disorder, schizoaffective disorder, eating disorder, schizophrenia, severe depression), consider additional factors which may require intervention.
6. Assess if the patient is starting to feel bonded with her unborn baby:
   - Check the patient's attributions and ideas about the unborn baby's behaviour
   - Some mothers may feel that their baby is angry with them or doesn't like them and this is why they are kicking, or that the baby is coming into the world to punish them. This should prompt further assessment for a serious mental health problem.
7. Ask about smoking and alcohol and other drug use, and discuss associated risks. See The Royal Women's Hospital – Pregnancy, Drugs & Alcohol.
8. Consider other conditions that may cause symptoms of or aggravate depression or anxiety (if relevant).
9. Examine the patient:
   - Check blood pressure.
   - Record height and weight.
   - Calculate BMI.
10. Arrange investigations:
    - Antenatal bloods – see also Routine Antenatal Care pathway.
    - Consider general biochemistry (i.e., E/LFTs) and other investigations for co-morbidities e.g., TSH, HbA1c, vitamin D, vitamin B_{12}/folate, iron studies.
11. Consider using the Initial Assessment and Referral Decision Support Tool (IAR-DST) to assess functioning and severity, and to assist decisions about the intensity and type of care the patient requires.

General Practice Liaison Officer Program presents

Connecting The Dots

Navigating Mental Health in Primary Care

Child & adolescent psychiatry

Dr Gaynor Andresen

Child & Adolescent Psychiatrist | Caboolture Hospital

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Child and Adolescent Mental Health
School Refusal
SSRIs

Dr Gaynor Andresen

MBBS, FRANZCP, adv cert C&A psych

Acknowledgement limitations

- 10-15 min consult
- May not have background information
- May only be cross sectional

Learning objectives

- School refusal
  - Definition
  - Causes
  - Consequences
  - Basic management
- Antidepressants in children and adolescents
  - When, why and what
  - Suicide risks
  - Treatment emergent activation syndrome
  - Other risks

Case scenario

- Aylin is a 13 year old female brought in by her mother Sally for concerns around her behaviour and school attendance.
- Sally is known to you, in general good health, with a history of post partum depression and recent difficulties with anxiety in the context of recent separation from Aylin’s father.
- Aylin has only previously attended for childhood vaccinations and minor illnesses.
- Aylin is in grade 8 at the local public high school.
- Sally is concerned that Aylin is starting to miss a lot of school and is acting out at home

- Aylin is fairly monosyllabic with Sally talking for her. Her gaze is downcast, and she is fidgeting with her hands throughout.
- Sally reports in retrospect Aylins attendance began to decrease last year initially with getting to school late and with more minor physical illnesses. This year it's become increasingly difficult to get Aylin to school and when Sally tries Aylin is shouting and crying. Aylin seems to be spending more time in her room and appears more irritable.
- The school have reported that Aylin has been missing some classes, and they have found her in the toilets during class time. The school have raised concerns earlier in the year as Aylin's attendance rate has decreased to 70% and appears to be getting worse rapidly.

What questions would you ask?

- Dad continues to live in the area and he and Sally are doing 50:50 care. Dad also struggles to get Aylin to school but works from home so is able to get her there more often but late. Sally has started a new job in the past couple of months and cannot afford to be late to work.
- Aylin reports she is friendly with a couple of people at school and denies any bullying.
- Her grades have dropped since primary school but she has been able to get C's so far.
- She has not had any suspensions or expulsions.
- She shrugs in response to your questions about mood, she has spent a weekend recently with primary school friends and enjoyed that, she is still making art and attending dance lessons. Though mum reports she has missed a couple of dance lessons recently due to feel nauseated.

- Aylin’s sleep is poor on school nights with delayed initiation which she reports is associated with ruminating on attending school tomorrow.
- She reports that’s she’s having episodes at school where she feels she is going to vomit, her heart is racing and it feels hard to breath. These are the times she is hiding in the school bathrooms which brings some relief. This is also happening in the mornings before school with increasing frequency.
- She did try some self harm by cutting but didn’t find it effective so hasn’t done it again. She denies any suicidal ideation.
- She doesn’t drink coffee or energy drinks. She denies any vaping, smoking or substances.
- Mum and Dad both have a history of panic attacks.
- Aylin has a history of some separation anxiety in early primary school.

Now what are your thoughts?

What’s different about diagnosis in children and adolescents.

- Young people can appear significantly different from one review to the next.
- Accurate one-off cross-sectional assessment in a 15-minute review is near impossible.
- Symptoms can be attributed to normal adolescent development and vice versa. Knowledge normal adolescence and variations needed.
- Irritability, tantrums more common in child and adolescent depression and may be more obvious than low mood.

What’s different about diagnosis in children and adolescents.

- Many mental health disorders are just starting to appear and will take time to evolve.
- Symptoms more influenced by family dynamics, and school and social environment than with adults
- Knowledge of the family context is key. Up to 57% in under 13 depression associated with adverse childhood experience such as child maltreatment, parental maladjustment, interpersonal loss, economic hardships. Compared to 20-30% past 13 years old.

Definition school refusal

- Aka school can’t, school avoidance.
- Significant emotional distress in relation to attending school causing a pattern of difficulties with and decline in school attendance despite reasonable parental attempts to have the child attend school.
- Impacts both genders equally and across all social classes.
- Differs from truancy which is usually is done with friend, without parental knowledge and outside of the home

Causes school refusal

- Generally multifactorial.
- Likely bi-directional relationship with mental health disorders.
- Child factors
  - Psychological: anxiety, depression, trauma
  - Developmental disorders and learning disabilities: ADHD, ASD, speech and language, intellectual impairment, dyslexia.
  - Poor physical health

Causes school refusal

- Family factors
  - Stressful life events
  - Poor parental mental or physical health
  - Diminished parental resources
  - Parenting style

Causes school refusal

- School factors
  - Poor fit for child – eg excessively large school, overemphasis on academics.
  - Transitions – starting primary school or high school. Change in school.
  - Bullying and friendship difficulties
  - Classroom environment
  - Transport

Consequences school refusal

- Short term consequences
  - Worsening mental health
  - Falling behind academically
  - Social isolation
  - Family conflict
  - Disruption normal developmental tasks

Consequences school refusal

- Long term consequences
  - Reduced employment and educational opportunities
  - Poorer interpersonal relationships
  - Long term mental health difficulties
  - Substance use
  - Economic disadvantage

Management school refusal

- Early intervention is essential, harder to treat the longer it continues.
- Tiered approach depending on severity and timeframe
- Idea of main contributing factors allow targeting of issues.

Management School Refusal

- School Supports
  - Guidance counsellors
  - Time out cards and safe spaces
  - Modified attendance expectations and graduated returns
  - Link in with interests
  - May be able to support with assessments re WISC, speech and language assessments.

Management School Refusal

- Child Supports
  - Treat child anxiety or depression.
  - Consider previously missed learning or developmental disorders.
  - Psychology for relaxation training, social skills training, problem solving.
  - Retain everything you can. Do not take away current enjoyed meaningful activity that is getting the child out of the house and with peers. Nurture connections with friends.

Management school refusal

- Family Supports
  - Referral triple p
  - Online resources
  - Treat parental mental health and substance problems
  - Community resources
  - Flexible work places, time off work.
  - Carer burnout
  - Family therapy or relationship counselling

Management school refusal

- Schooling alternatives
  - Changing school may help.
  - Sometimes the school will just be the wrong fit though location and economic privilege will determine options.
  - flexi schools, distance ed, home school, TAFE and work.

Antidepressants in children and adolescents

- Psychotherapy and supportive care is first line for anxiety, OCD and mild depression.
- Risks with untreated/undertreated depression and anxiety which in a young person includes missing key developmental tasks, long term poor outcomes of school refusal, deteriorating mental health, suicide.
- What is the GPs role given the access issues with psychiatrists and paediatricians?

Antidepressants in children and adolescents

- Lean more towards trialling an antidepressant in those:
  - older age. rare for anyone to prescribe in pre-primary school age kids, more common in early adolescents.
  - Those with stronger biological loading
  - Those with more severe illness
  - Psychological care not available
- Think twice with
  - Unclear diagnosis
  - Younger age
  - Mild illness
  - Children in care
  - Children with co-morbid intellectual or developmental disability or brain injury.

Antidepressants in children and adolescents

- Think of as opening a window of opportunity and don't miss it.
- Have clear expectations with the young person and family around time to effect and what symptoms we expect it to help with.
- Start at lower than usual doses, kids more sensitive to adverse effects.
- Consider an even lower starting dose in anxiety.
- Fluoxetine at 10mg for depression, but if agitation or for anxiety start at 5mg. For pre-adolescents can even start with second daily dosing.
- There's more evidence available for the safety and efficacy of fluoxetine in this age group.
- Given approval in OCD fluvoxamine and sertraline also reasonable.
- Half lives can be shorter in kids so twice daily dosing may be needed other than fluoxetine which has long half life. Especially at low doses of sertraline and at any dose of fluvoxamine.

What about the suicide risk?

- Complex area to study.
  - See TGA review April 2021 “antidepressant utilisation and risk of suicide in young people”
- Increased risk of suicidal ideation, suicide attempts and dsh. No proven link between anti-depressants and completed suicide.
- In Australia all antidepressant use for mental illness is off label in children and adolescents other than sertraline and fluvoxamine in OCD.
- In other countries
  - In the UK fluoxetine approved for over 8 years old for MDD
  - In the USA fluoxetine is approved for mdd 8 years old and over.
    - Fluoxetine, fluvoxamine, sertraline for OCD
- Paroxetine and venlafaxine (an snri) may be worse for suicidal ideation

Safety precautions

- Anyone under the age of 25 should be warned regarding risk emergent/exacerbation suicidal ideation and behaviour
- Basic safety planning
  - Carers should be in charge of medications.
  - Consider locking up medications, sharps, ligatures. Consider access to guns.
  - Educate re red flag symptoms
  - How will it be monitored/communicated within the home
  - Contact numbers for emergencies.
- Monitor for emergence or worsening of SI and behaviours in first 2-4 weeks of treatment. Plan follow up visits.

Treatment emergent activation syndrome

- Motor or mental restlessness, insomnia, impulsiveness, talkativeness, disinhibition, aggression.
- Potential inc risk of suicide
- More common in younger children than in adolescents.
- Occurs early on or with dose increases.
- Again low start dose with slow up titration and close monitoring especially in younger children.
- Distinguishing from treatment induced mania challenging and based on timing of onset and of resolution when dose decreased or ceased.
- Warn parents, encourage to cease and seek advice

Other risks

- Risk of manic switch. Bipolar often not declared itself in adolescence. Increased suspicion with family hx of bpad or scz, personal hx early onset significant depression, worsening sx with anti-d, hypersomnia,
- Risk of serotonin syndrome. Consider drug use re mdma/ecstasy, other prescribed medications.
- Overdoses – relatively safe in overdose.
- GI side effects and headaches
- Sexual adverse effects

Why isn’t it working, what if it doesn’t work?

- Adherence problems
- Wrong dose
- Wrong diagnosis, missed co-morbidity.
- Unrealistic expectations – eg emotional dysregulation in emerging BPD.
- Increased complexity in children in care and with developmental disabilities.
- Is not going to be effective if real issue is trauma, significant family dysfunction, etc
- Review adherence, review the diagnosis, consider missed co-morbidities, consider psychosocial stressors, consider change to alternative SSRI, refer to specialist.

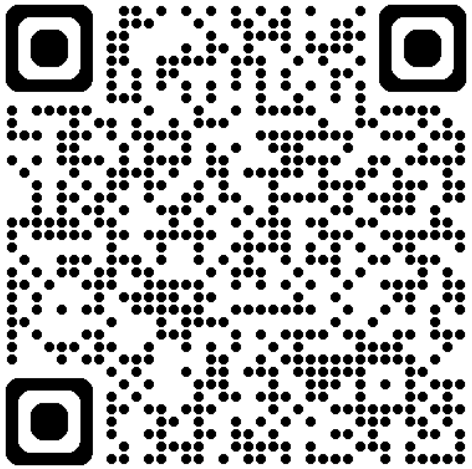
Mental Health Supports under 18

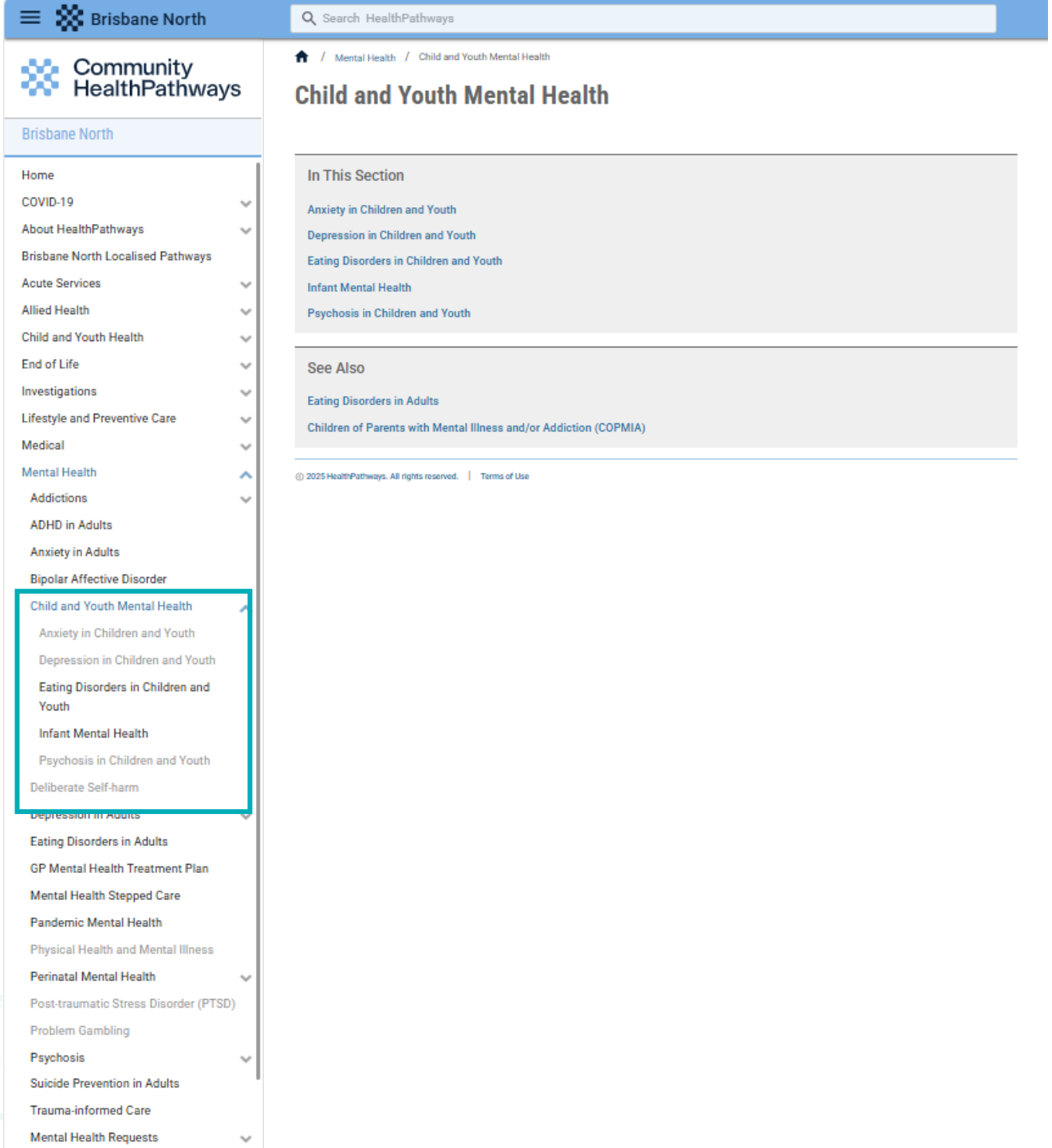
- GP psychiatry support line
  - To speak to child psychiatrist book by phone on 1800 16 17 18
- Crisis numbers
  - 1300 MHCALL – 1300 642 255
  - QCH ART line – 07 3068 2555 (Greater Brisbane Catchment Area)
- QLD health
  - CYMHS
  - Paediatrician

Mental Health Supports under 18

- Headspace
  - Caboolture, Redcliffe, Nundah. Many more.
  - 12-25 years old
- Intercept
  - Caboolture.
  - 10-25 year olds
  - School based youth support program
- YAMBI (Youth Action Moreton Bay Initiative)
  - 12-21 years old
  - Individual and family support. Mentoring and case management.
- Online resources
  - Triple P
  - Reachout Australia
  - School Can’t Australia


GP PSYCHIATRY SUPPORT LINE
ABOUT
BOOKING
WEBINARS
REGISTER
GP PSYCHIATRY SUPPORT LINE
HELPING AUSTRALIA'S GPs
MANAGE THE MENTAL HEALTH
OF THEIR PATIENTS
1800 16 17 18
FREE CALL: 7AM TO 7PM (AEST) MONDAY – FRIDAY
NOT A REFERRAL, TRIAGE OR EMERGENCY SERVICE - EXCLUSIVE TO GPs

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Post-traumatic Stress Disorder (PTSD)
Problem Gambling
Psychosis
Suicide Prevention in Adults
Trauma-informed Care
Mental Health Requests
Mental Health / Child and Youth Mental Health
Child and Youth Mental Health
In This Section
Anxiety in Children and Youth
Depression in Children and Youth
Eating Disorders in Children and Youth
Infant Mental Health
Psychosis in Children and Youth
See Also
Eating Disorders in Adults
Children of Parents with Mental Illness and/or Addiction (COPMIA)
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General Practice Liaison Officer Program presents

Connecting The Dots

Navigating Mental Health in Primary Care

Finding the right care

Stephen Giles

Initial Assessment & Referral Coordinator | Brisbane North PHN

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Case study one – *Alice*

Alice, 61F with a history of moderate-severe anxiety and depression, exacerbated by chronic back pain. She has a professional background as a palliative care nurse. Her personal history includes experiences of domestic and family violence (DFV). Lives alone.

Protective factors - a strong bond with her daughter and grandson, as well as the companionship of her two dogs. These provide her with emotional support and a sense of purpose.

Sees her GP on a regular basis, good relationship. Complex physical health issues are managed well by GP and local public hospital.

No alcohol or other drugs. No suicidal ideation. Some thoughts in the past stating, “Sometimes I go into a black hole” but never an identified plan or intent - no recent imminent thoughts, plan or intent.

Alice has been assessed by her GP at an IAR Level 3 for her anxiety and depression. Her GP has also completed a Mental Health Treatment plan.

Case study one – *Alice's goals*

- "Improve my overall well-being by fostering a positive outlook on life.
- Increase independence despite the limitations imposed by chronic pain
- Engage more with the community to reduce social isolation and build supportive relationships
- Find meaningful work where I can help others and experience the joy of making a difference in people's lives
- I want to learn skills through DBT or other psychological therapy to help deal with my feeling of depression and anxiety"

Case study one – *Alice's care options*

- Wellbeing coach- SANE
- Peer worker- GROW
- Community Art Group each Friday
- Dialectical Behaviour Therapy (DBT) skills group every second Wednesday with the Medicare Mental Health Centre-Stride Caboolture

Case study two – *Lisa*

Mother, with partner, two children
Female, Aboriginal, 30
Presented to GP to gain support for an alcohol addiction which was affecting her mental health (anxiety/suicidal thoughts)
Lives with partner and children, has no pets
Unemployed (recently lost warehouse job)
Limited family supports. Limited community supports
Strong in her Aboriginal identity
Stable Centrelink income
Stable housing with Department of Housing

An IAR assessment was completed. Level 3. Based on moderate anxiety symptoms and some concerns about her persistent suicidal ideation.

Case study two – *Lisa goals*

- “Reduce my alcohol intake so I can feel better.
- Do something about my anxiety and stop feeling so negative about myself
- Connect with likeminded people my age and meet new people
- See someone about training courses and job opportunities”

Case study two – *Lisa's care options*

- Alcohol and other drug services- Institute for Urban Indigenous Health (IUIH) or Lives Lived Well.
- Short term therapy- IUIH or Brisbane MIND Suicide Prevention.
- Additional support- 13YARN
- Social connections- Footprints- Chill, Chat and Create

medicare Mental Health | 1800 595 212

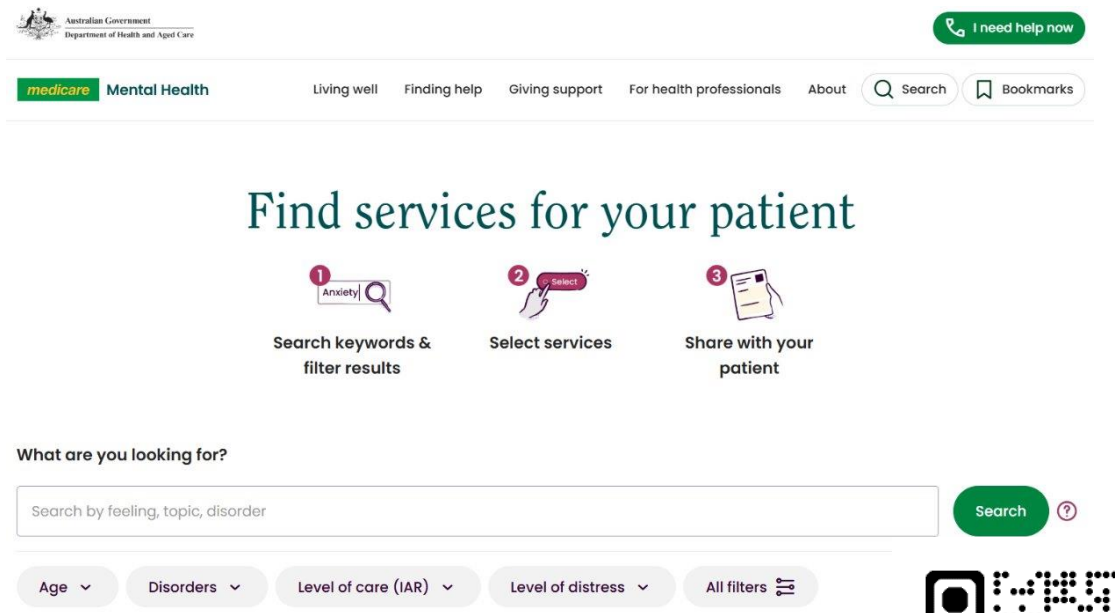
- The national **Medicare Mental Health** phone service provides assessment and navigation to connect people to the right mental health services for them.

- Medicare Mental Health is a free service, available for anyone who needs mental health and wellbeing support. Medicare Mental Health is also available to friends, carers, families, **GPs and other health professionals to help find a suitable service for the people their supporting**.

- When you call, you will be asked to enter your post code and then the call is routed through to the local Medicare Mental Health team. **You can call Medicare Mental Health on 1800 595 212 (Monday to Friday 8.30 am – 5.00 pm)**

medicare Mental Health

- The **Medicare Mental Health** website (previously Head to Health) (https://www.medicarementalhealth.gov.au/) includes a **service finder** for health professionals at that enables searching for services using a number of different filters, including by IAR level of care.



Initial Assessment and Referral (IAR) Levels of Care

- 8 Domains
  - Symptom severity and distress
  - Harm
  - Functioning
  - Impact of co-existing conditions
  - Service use and response history
  - Social and environmental stressors
  - Family and other supports
  - Engagement and motivation

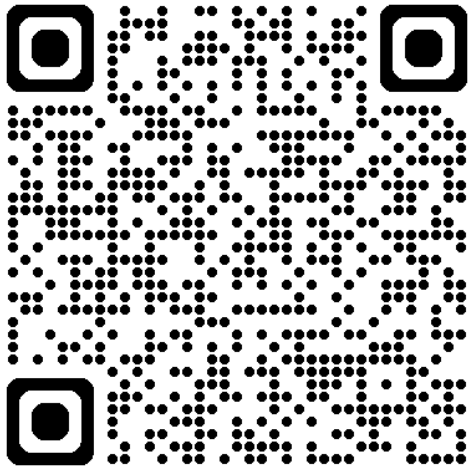
- 5 Levels of Care
  - 1- Self Management
  - 2- Low intensity
  - 3- Moderate intensity
  - 4- High intensity
  - 5- Acute and specialist care

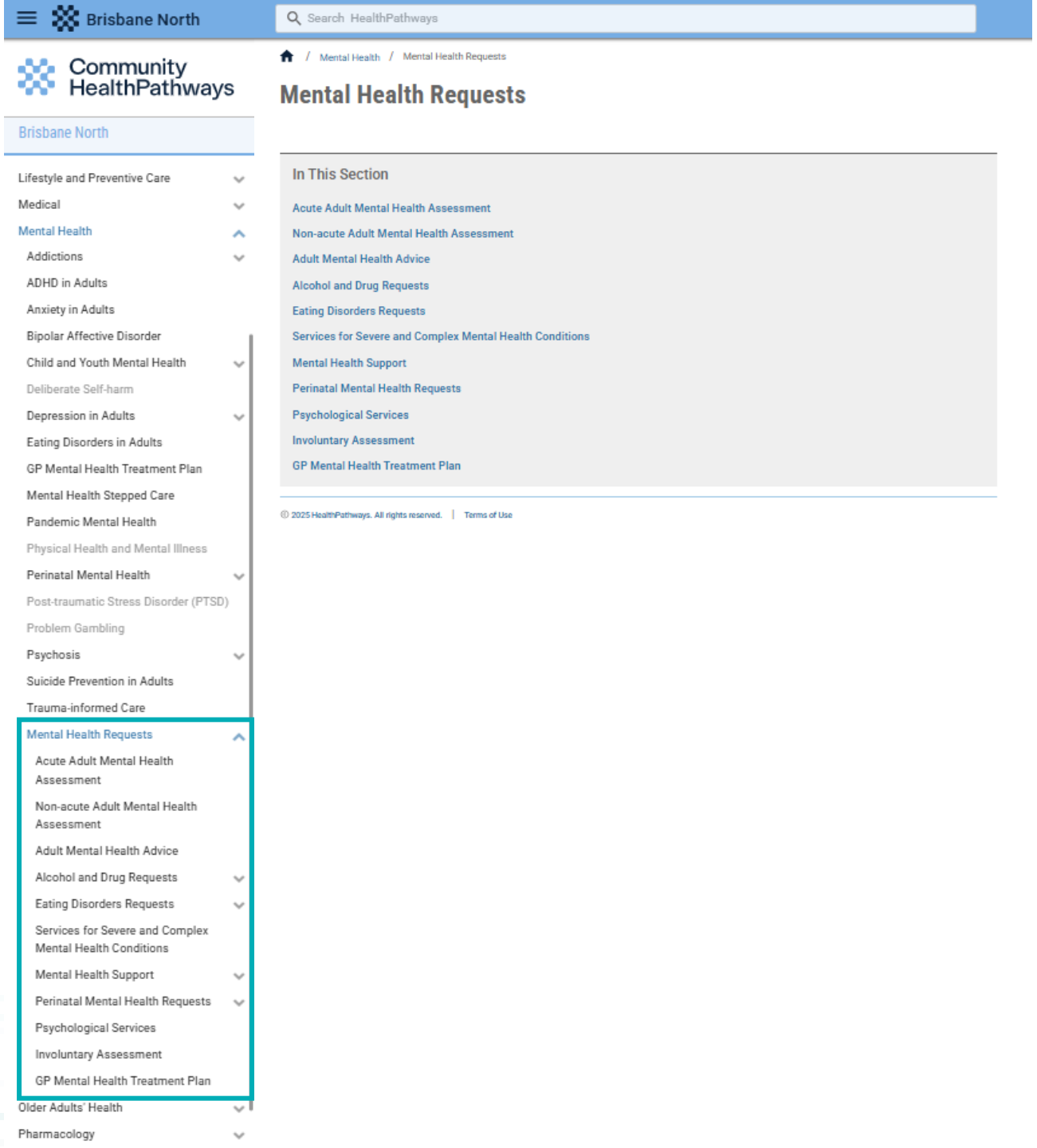
Referring options

Brisbane North PHN Commissioned Services and Medicare Mental Health eReferral
https://phnbnws.redicase.com.au/#!/referral/create

Metro North Prospectus-See individual groups and organisations
https://brisbanenorthphn.org.au/web/uploads/downloads/Mental-health-services/Recovery-Support-Prospectus-2025.pdf

Brisbane North PHN Mental Health and Alcohol and Other Drugs webpage
https://brisbanenorthphn.org.au/our-programs/mental-health-services

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Psychological Services
Involuntary Assessment
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Pharmacology
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Non-acute Adult Mental Health Assessment
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Eating Disorders Requests
Services for Severe and Complex Mental Health Conditions
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Perinatal Mental Health Requests
Psychological Services
Involuntary Assessment
GP Mental Health Treatment Plan
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General Practice Liaison Officer Program presents

Connecting The Dots

Navigating Mental Health in Primary Care

Medicinal cannabis

A/Prof Stephen Parker

Director of Research | Metro North Mental Health

Clinical Lead, Early Psychosis | Metro North Mental Health

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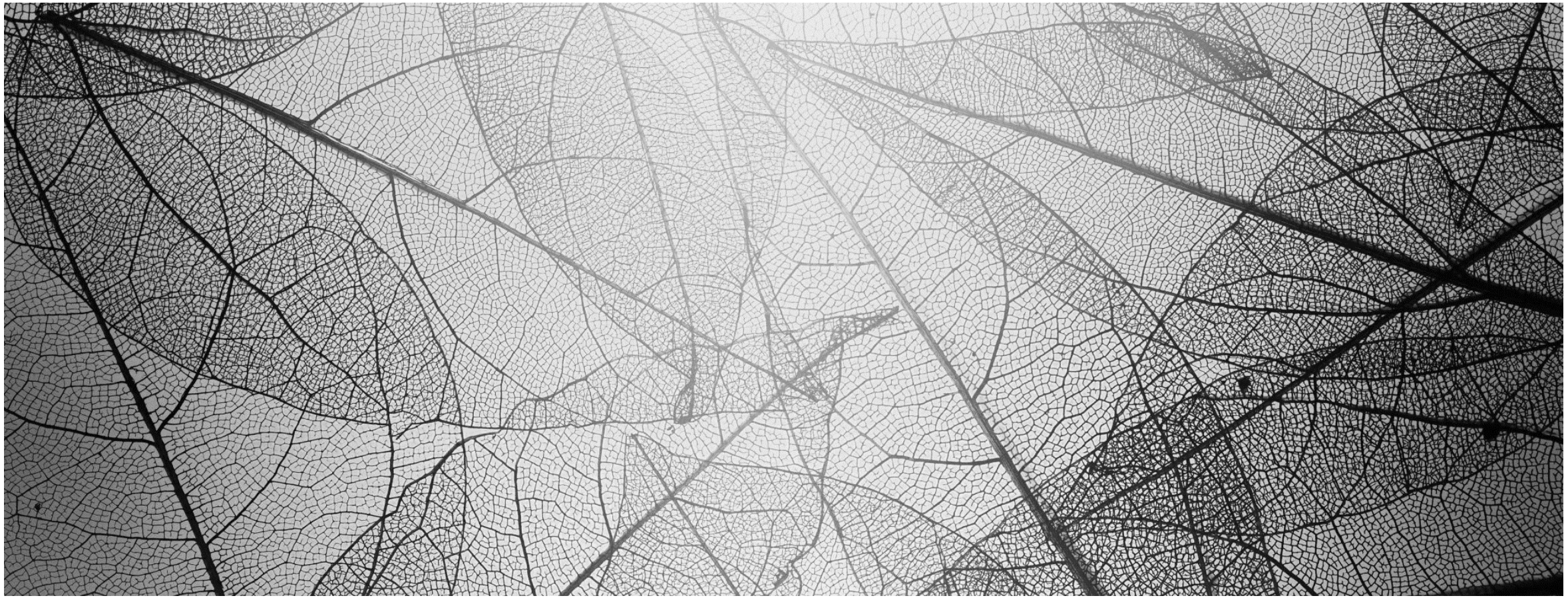
An Australian Government Initiative

Queensland Government
Metro North Health

New horizons
or snake oil and wishful thinking

The promise of medicinal cannabis and psychedelics in treating mental disorders



For a [hu]man always believes more readily that which [t]he[y] prefer… (Francis Bacon, 1620)

Acknowledgements

I acknowledge Country; this land traditionally known as Meanjin, belonging to and cared for by the Turrbal Jaggara peoples.

Declarations

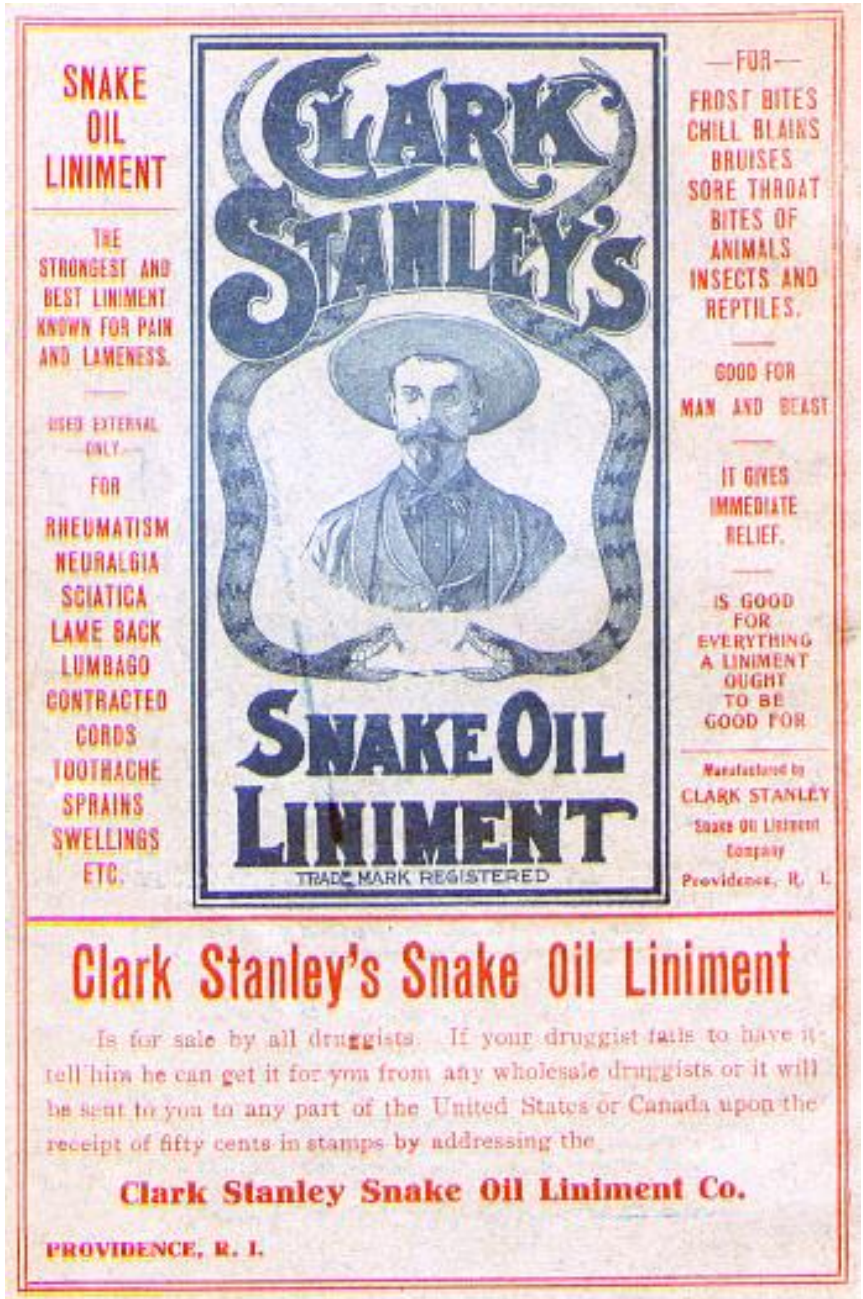
Employment:
Metro North Mental Health
Metro North Clinician Research Fellowship (2024-2027)

Related work:
QIMR-B's Parting Trial (Psilocybin for prolonged grief disorder)
Australian CPG on MDMA-assisted Psychotherapy for PTSD [Evidence review team]
P-CANS (prescribed cannabis and stimulant trends at RBWH admissions)
QCMHR's CANCloz Trial (CBD for treatment resistant schizophrenia)

Research funding: *
The Common Good Foundation, Metro North Foundation
Johnson & Johnson
PA Foundation
RANZCP Foundation
Suicide Prevention Australia.

Honoraria: *
Johnson & Johnson
RANZCP
Queensland Psychotherapy Training
CSL Seqirus
Tasmania Health
Lundbeck/Otsuka

* Last 5- years



Definitions

Snake oil

'a substance that is sold as a medicine but that is not at all effective and may be harmful...'

(Cambridge dictionary)

Wishful thinking

'the tendency to overestimate the likelihood of desirable events and underestimate the likelihood of undesirable events… In contrast to heuristics… [it] originates in the application of individual preferences that are linked to affective experiences.'

(Aue, Nusbaum, & Cacioppo, 2011; p.911) [1]

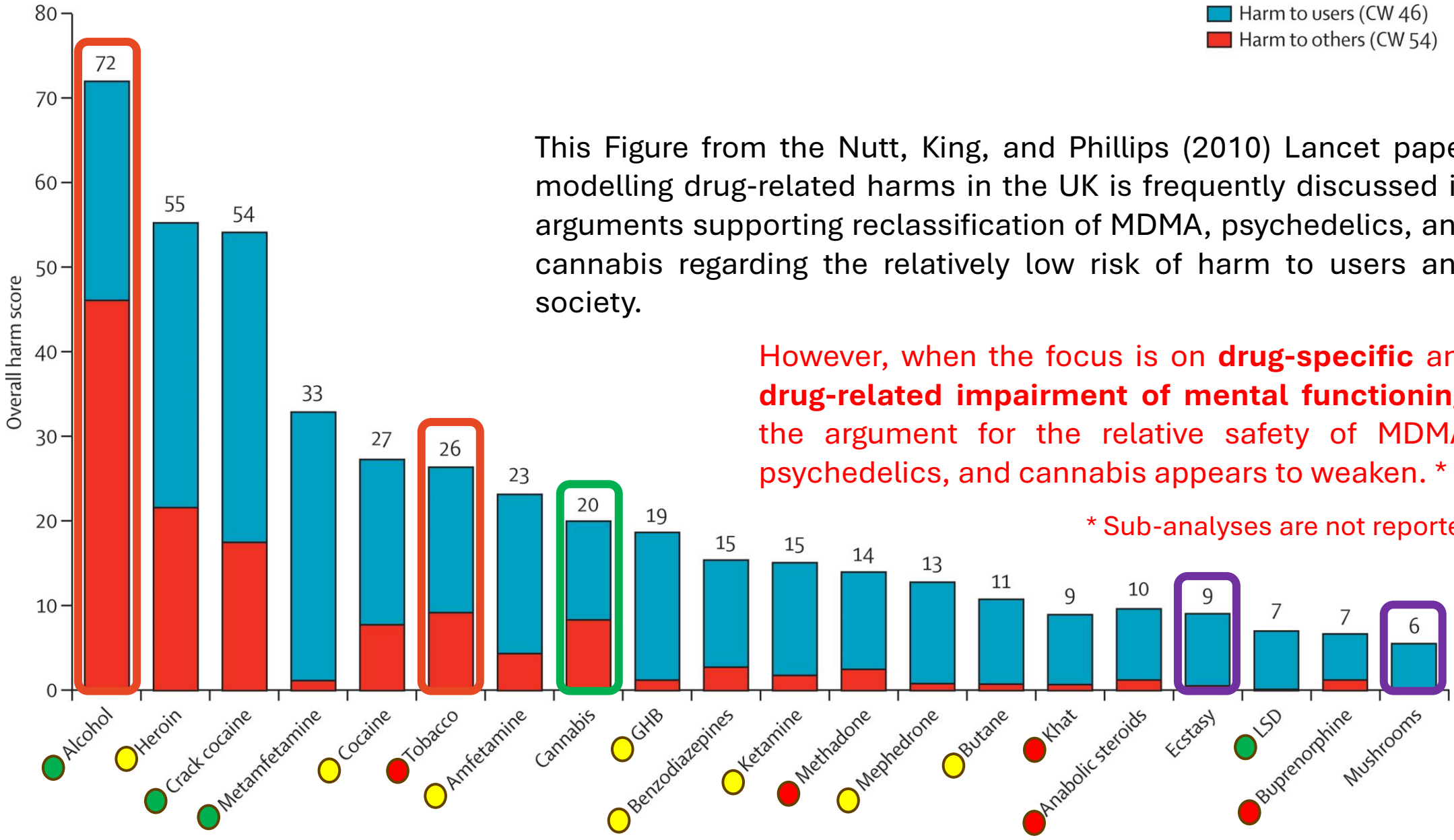
Changes in the regulatory environment have opened access to previously proscribed drugs to treat mental disorders in Australia

Cannabis

- In 2016, the Federal Government passed legislation enabling the prescription of cannabis products by registered healthcare professionals.
- **Public demand**, rather than advances in the evidence base, was instrumental in informing this change.
- The TGA regulates the supply of medicinal cannabis products, **and most of these are unregistered drugs**.
- The TGA guidance emphasises 'medicinal cannabis products containing THC are generally **not appropriate** for patients who have a previous psychotic or concurrent active mood or anxiety disorder'.
- Access to medicinal cannabis products is via the Special Access Scheme (SAS) or the Authorised Prescribed Scheme (AP).
- In Queensland, medicinal cannabis can be prescribed for **any patient** with **any condition** if the prescriber believes it is clinically appropriate (and with relevant TGA approval if indicated (S4 & S8)).

Psilocybin and MDMA

- The TGA changed the classification of Psilocybin and MDMA (effective 01/07/2023) from S9 (prohibited substances) to S8 (controlled substances), permitting authorised psychiatrists to prescribe these drugs under specific circumstances.
- These changes followed an application by Mind Medicine Australia (MMA, a registered charity) and **concerted, coordinated advocacy**.
- **MDMA** is approved for the treatment of **PTSD,** and **Psilocybin** is approved for **treatment-resistant depression**.
- Prescribers must obtain approval under the Authorised Prescribed Scheme and from an NMHRC-registered HREC.
- There are currently no TGA-approved MDA or psilocybin products.
- Australia is an outlier. For example, the **US FDA rejected** an application for **MDMA-assisted psychotherapy in 08/2024**, citing the need for more research.

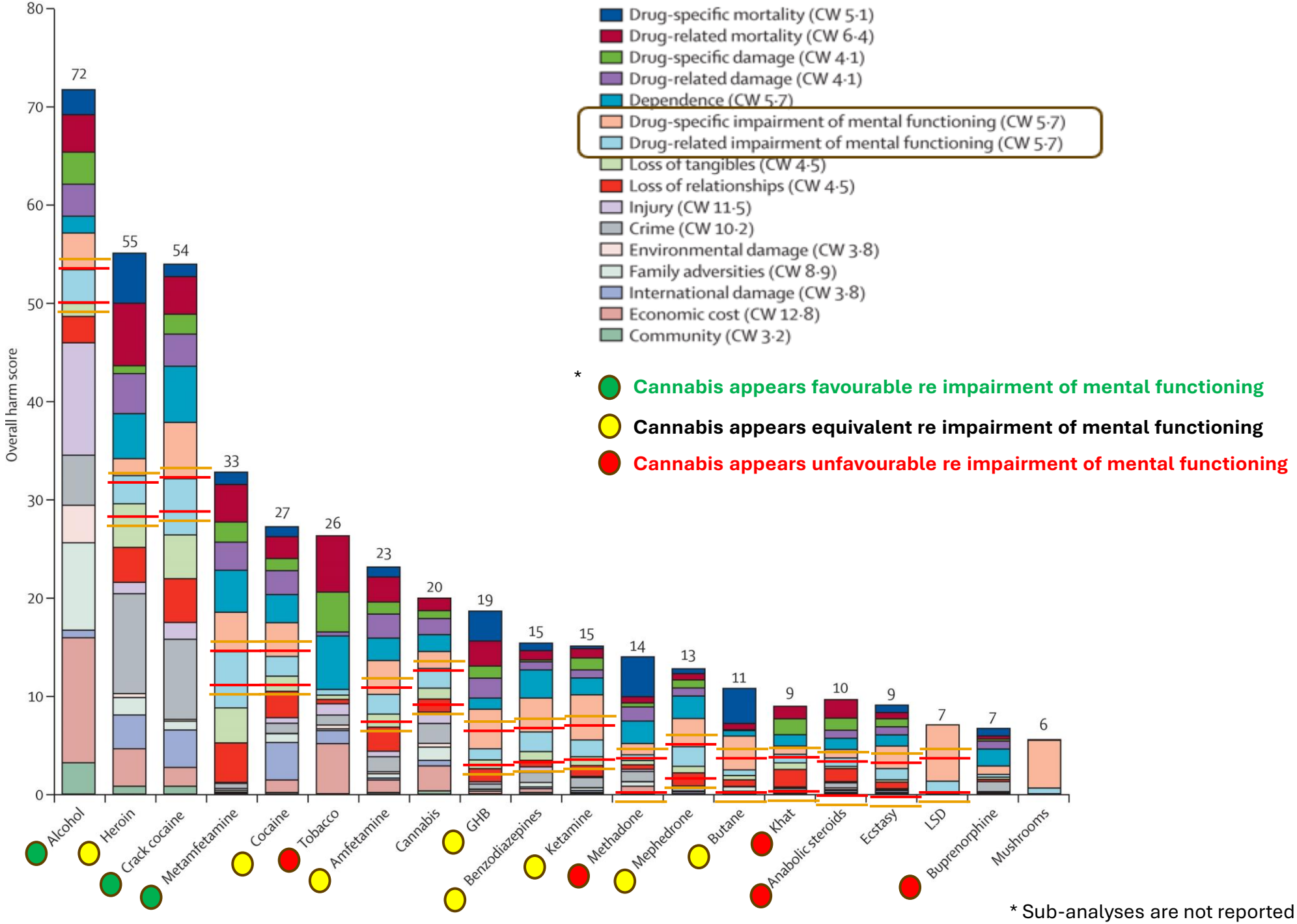


This Figure from the Nutt, King, and Phillips (2010) Lancet paper modelling drug-related harms in the UK is frequently discussed in arguments supporting reclassification of MDMA, psychedelics, and cannabis regarding the relatively low risk of harm to users and society.

However, when the focus is on **drug-specific** and **drug-related impairment of mental functioning**, the argument for the relative safety of MDMA, psychedelics, and cannabis appears to weaken. *

* Sub-analyses are not reported

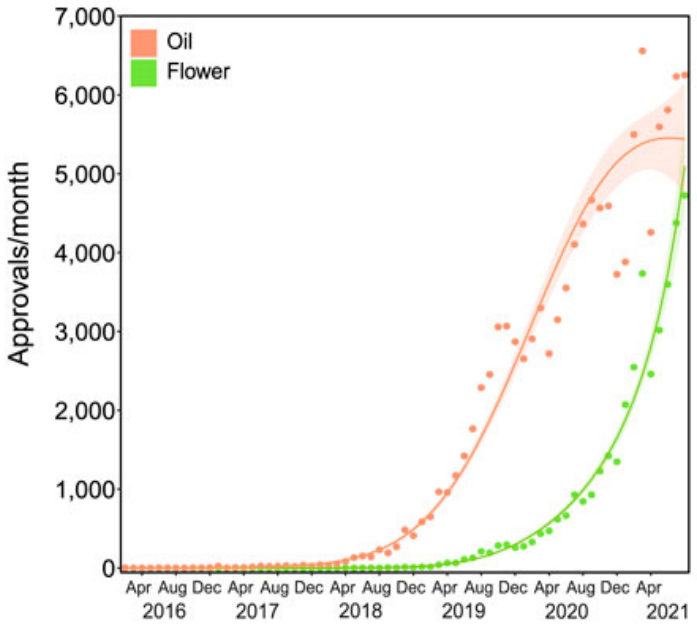
The Lancet 2010 3761558-1565 DOI: (10.1016/S0140-6736(10)61462-6)



* Sub-analyses are not reported

The Lancet 2010 3761558-1565 DOI: (10.1016/S0140-6736(10)61462-6)

There has been an exponential uptake of medicinal cannabis in Australia (SAS-B)

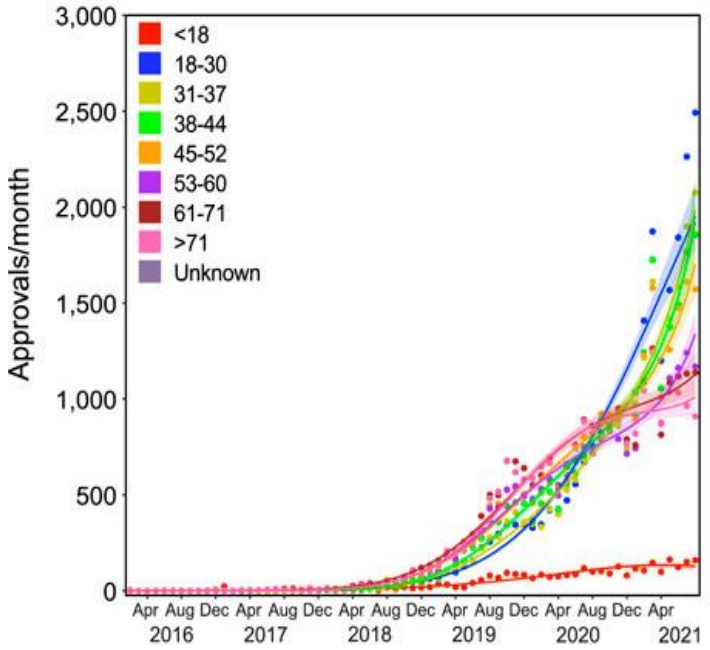


Products intended for inhalation (i.e., smoking) are being increasingly prescribed.

There are no current vaporising devices with TGA approval.

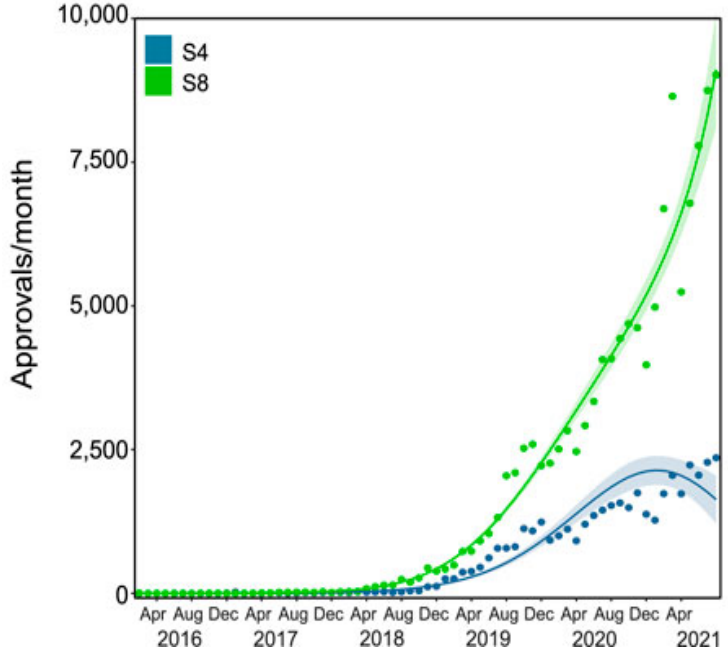
Most smoked cannabis in Australia is concurrently taken with tobacco.

Harms associated with smoking are well established.



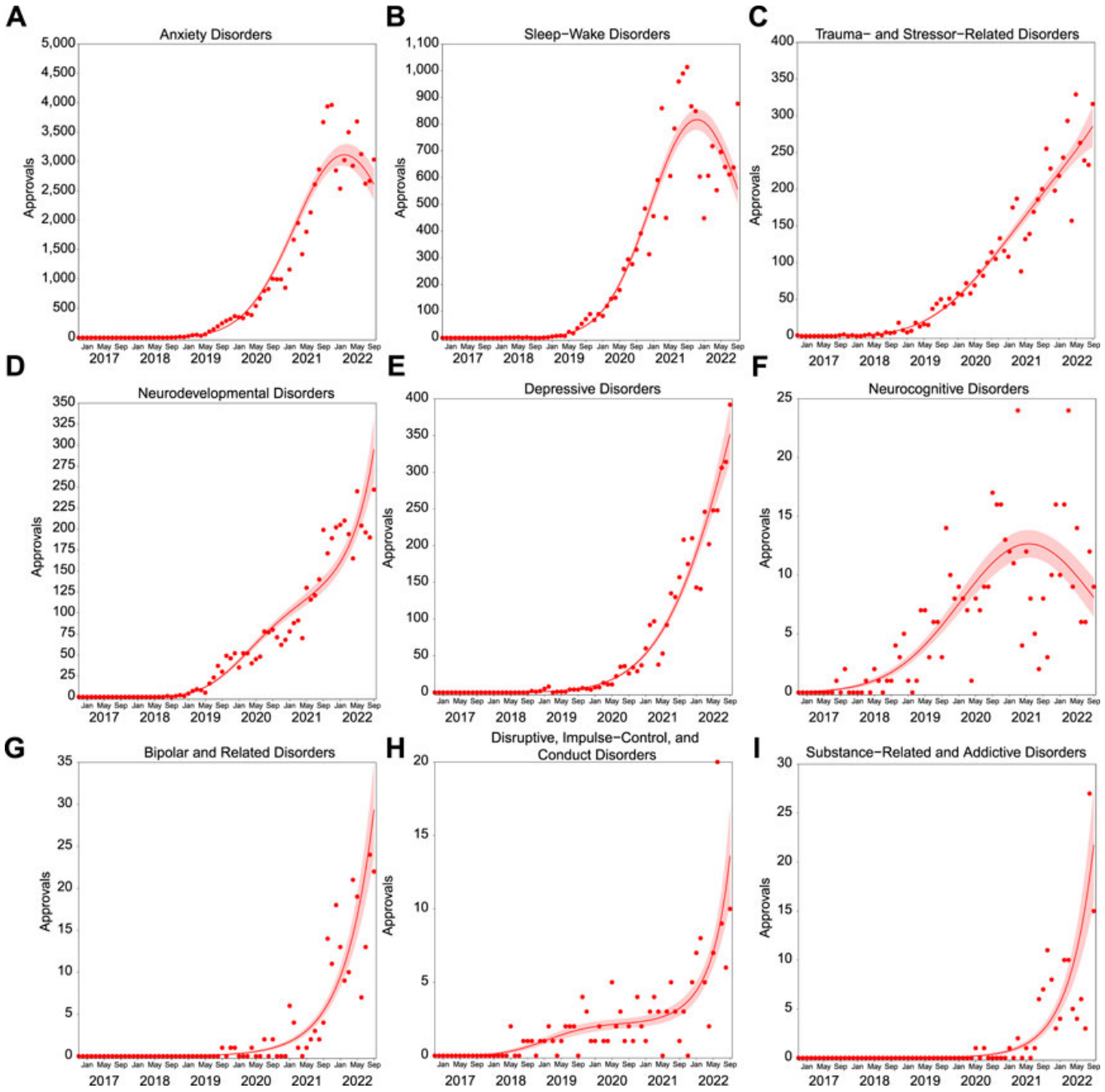
Young Australians (18-30 years) are the highest recipients of medicinal cannabis prescriptions.

There are known specific mental health risks associated with cannabis use in youth.



THC-dominant products account for most prescriptions (CBD-dominant in only ~20%).

MacPhail SL, Bedoya-Pérez MA, Cohen R, Kotsirilos V, McGregor IS, Cairns EA. Medicinal cannabis prescribing in Australia: an analysis of trends over the first five years. Frontiers in Pharmacology. 2022 May 10;13:885655.



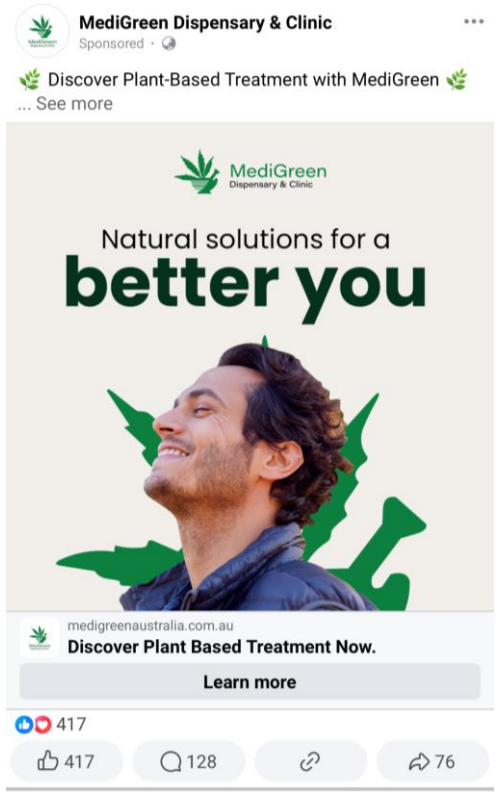
Mental health conditions account for more than a third of listed indications for medicinal cannabis prescribing under SAS-B (2017-2022).

Most mental health-related approvals are for **anxiety disorders** (66.7%), then **sleep-wake disorders** (18.2%), then **trauma and stressor-related disorders** (5.8%).

Trends suggest declining prescriptions for anxiety and sleep-wake disorders but **increasing prescribing** for **trauma- and stressor-related**, **neurodevelopmental**, and **depressive disorders**.

Cairns EA, Benson MJ, Bedoya-Pérez MA, Macphail SL, Mohan A, Cohen R, Sachdev PS, McGregor IS. Medicinal cannabis for psychiatry-related conditions: an overview of current Australian prescribing. Frontiers in Pharmacology. 2023 Jun 6;14:1142680.

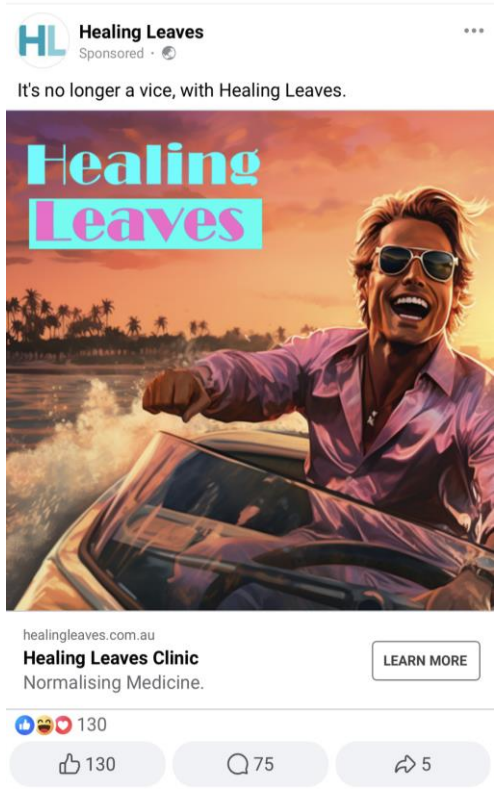
Does evidence support medicinal cannabis in the management of mental disorders?

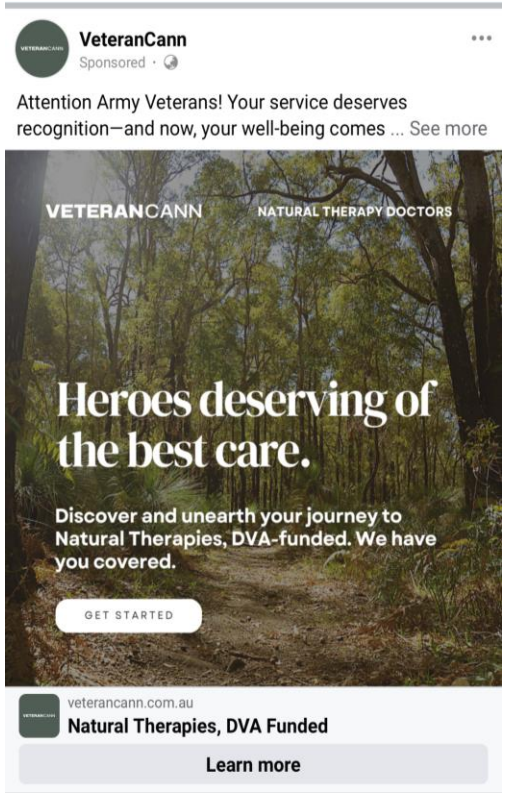


"There is **scarce evidence** to suggest that **cannabinoids improve depressive** disorders and symptoms, **anxiety** disorders, **attention-deficit hyperactivity disorder**, **Tourette syndrome**, **post-traumatic stress disorder**, or **psychosis**. There is very **low quality evidence** that pharmaceutical THC (with or without CBD) leads to a **small improvement** in symptoms of **anxiety among individuals with other medical conditions**…."

Black N, Stockings E, Campbell G, Tran LT, Zagic D, Hall WD, Farrell M, Degenhardt L. Cannabinoids for the treatment of mental disorders and symptoms of mental disorders: a systematic review and meta-analysis. The Lancet Psychiatry. 2019 Dec 1;6(12):995-1010.

Does evidence support medicinal cannabis in the management of mental disorders?

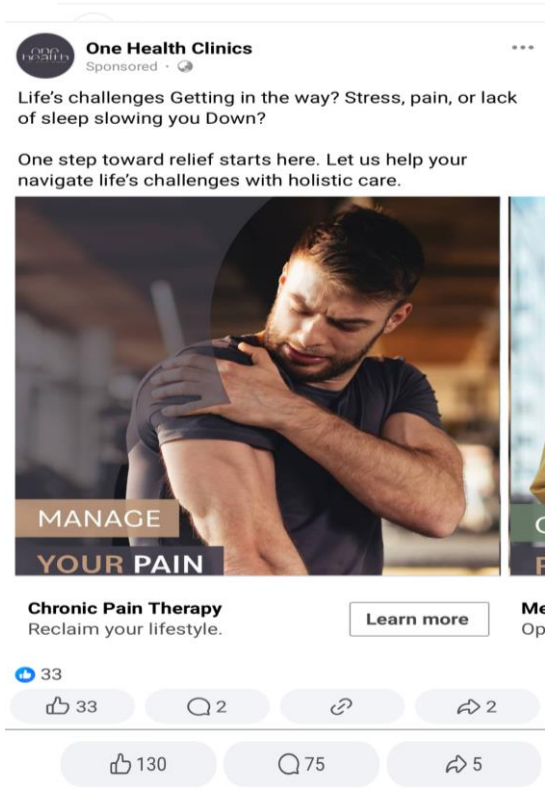


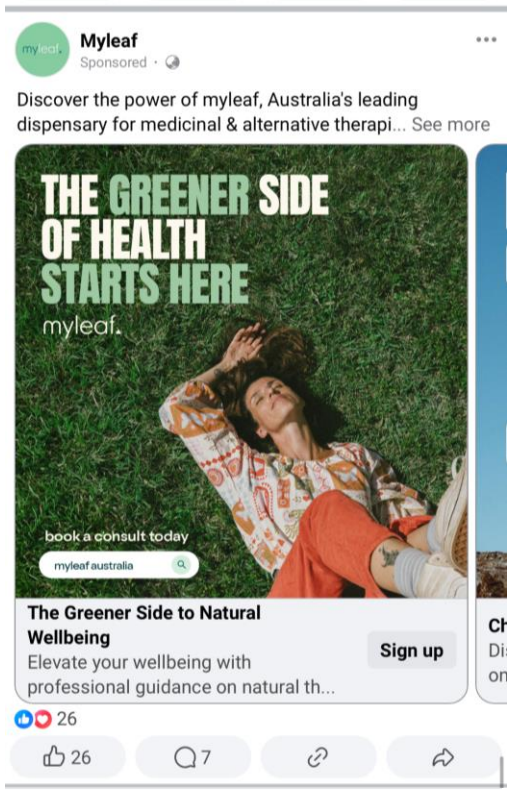


"…**[I]nsufficient evidence** was found for efficacy of CBD and THC to **manage affective disorders**, **anxiety disorders**, or **PTSD**. Therefore, medical cannabis **should not be recommended** for treating patients with these disorders. Further research should investigate the safety and efficacy of managing psychiatric disorders with cannabinoids…"

Stanciu CN, Brunette MF, Teja N, Budney AJ. Evidence for use of cannabinoids in mood disorders, anxiety disorders, and PTSD: a systematic review. Psychiatric Services. 2021 Apr 1;72(4):429-36.

What do we know about cannabis and mental health?





- While cannabis is known for its immediate relaxing effects, there is evidence that it **may worsen** the anxiety of people with **pre-existing anxiety disorders** [6].
- Cannabis use is associated with **increased risk of depression** (OR 1.29), and with heavy use conferring higher risk [21].
- Cannabis use can **precipitate psychosis in vulnerable individuals**, and for around **50%** of people affected, this **will become an enduring psychotic disorder** (i.e., schizophrenia) [7].
- There is evidence suggesting cannabis use is associated with a **3-fold risk** of developing a **new onset manic episode** (the hallmark of bipolar disorder) [8].
- Δ9-Tetrahydrocannabinol (THC) is known to be associated with an **increased risk of psychosis** and **poorer prognoses** for people with an **established psychotic disorder** [9-11].
- Established evidence also links cannabis use with adverse **neurocognitive impacts** [12-14] and **mental health issues** in **youth** [15-17].

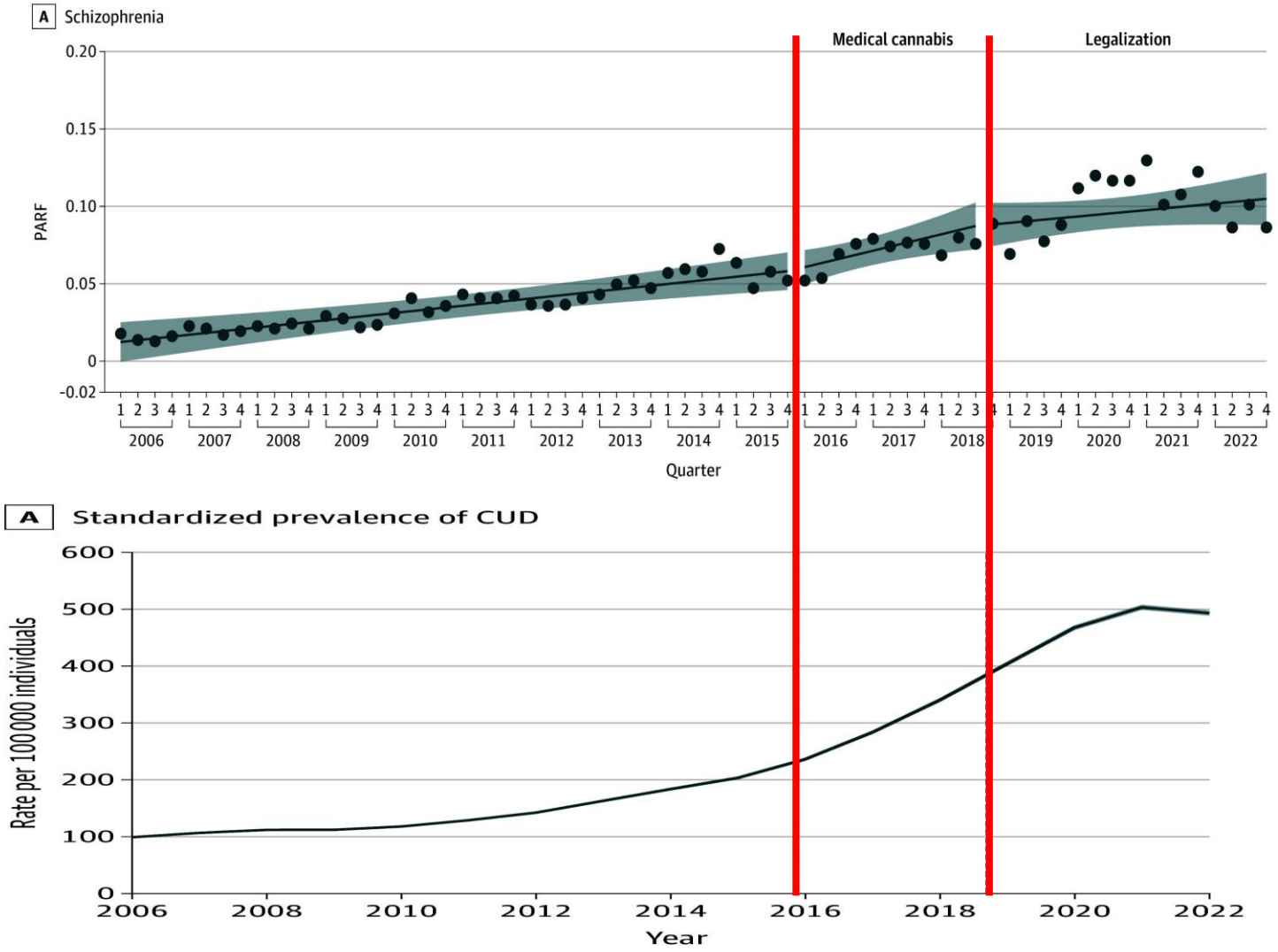
Are there real-world risks associated with increasing the acceptability and access to cannabis through legislative change?

Population cohort study in Ontario, Canada, including >13 million individuals aged 14-65 without a history of schizophrenia (2006-2022 period).

0.6% of people **without Cannabis Use Disorder (CUD)** developed **schizophrenia** versus **8.9% of those with CUD**.

The **population-attributable fraction** * **of cannabis use associated with schizophrenia increased** from **3.7 to 10.3%** in the **post-legalisation** period.

* The proportion of incident cases attributable to this risk factor



Myran, D. T., Pugliese, M., Harrison, L. D., Solmi, M., Anderson, K. K., Fiedorowicz, J. G., Finkelstein, Y., Manuel, D., Taljaard, M., Webber, C., & Tanuseputro, P. (2025). Changes in Incident Schizophrenia Diagnoses Associated With Cannabis Use Disorder After Cannabis Legalization. *JAMA network open*, *8*(2), e2457868. https://doi.org/10.1001/jamanetworkopen.2024.57868

It is too early in Australia's PAT journey to know how things will pan out...

TRIAL ID	STUDY TITLE
347906	The CAP Study: Evaluating a comprehensive universal and targeted intervention designed to prev
362111	Drug assisted psychotherapy to treat posttraumatic stress disorder in war veterans, using 3,4-m
364375	MDMA (3,4-methylenedioxy-N-methylamphetamine) and tinnitus
378101	Psilocybin-assisted psychotherapy for the treatment of depression and anxiety associated with
379084	A Phase 1 study to evaluate Safety, Tolerability and Pharmacokinetics of Ultramicronized-Palmit
381476	A randomised, double-blind, placebo-controlled trial of repeated microdoses of lysergic acid die
381526	Safety and tolerability of psilocybin-assisted physiotherapy in healthy volunteers
382650	PsiConnect: Brain Connectivity and Context under Psilocybin
383711	Psilocybin-facilitated treatment for methamphetamine Use Disorder: A pilot study (Psi-MA)
384219	Brain Activity Effects of Psychedelic Medicines
384394	Study to Evaluate the Safety, Tolerability, Pharmacokinetics, and Pharmacodynamics of Single-As
385758	Assessing the effects of Lysergic acid diethylamide (LSD) microdosing in people experiencing dep
385868	Exploratory trial to assess the efficacy and safety of Psilocybin-Assisted Psychotherapy (PAP) in
385929	Swinburne Three-dose Psilocybin Assisted Psychotherapy (3PAP): a clinical trial of 2 vs 3 doses

ANZCTR

A 'raft of unanswered questions' remain as Australia's first psychedelic therapy clinic opens

Costing $24,000 for nine months, some experts say more evidence is needed on effectiveness of MDMA and psilocybin treatments

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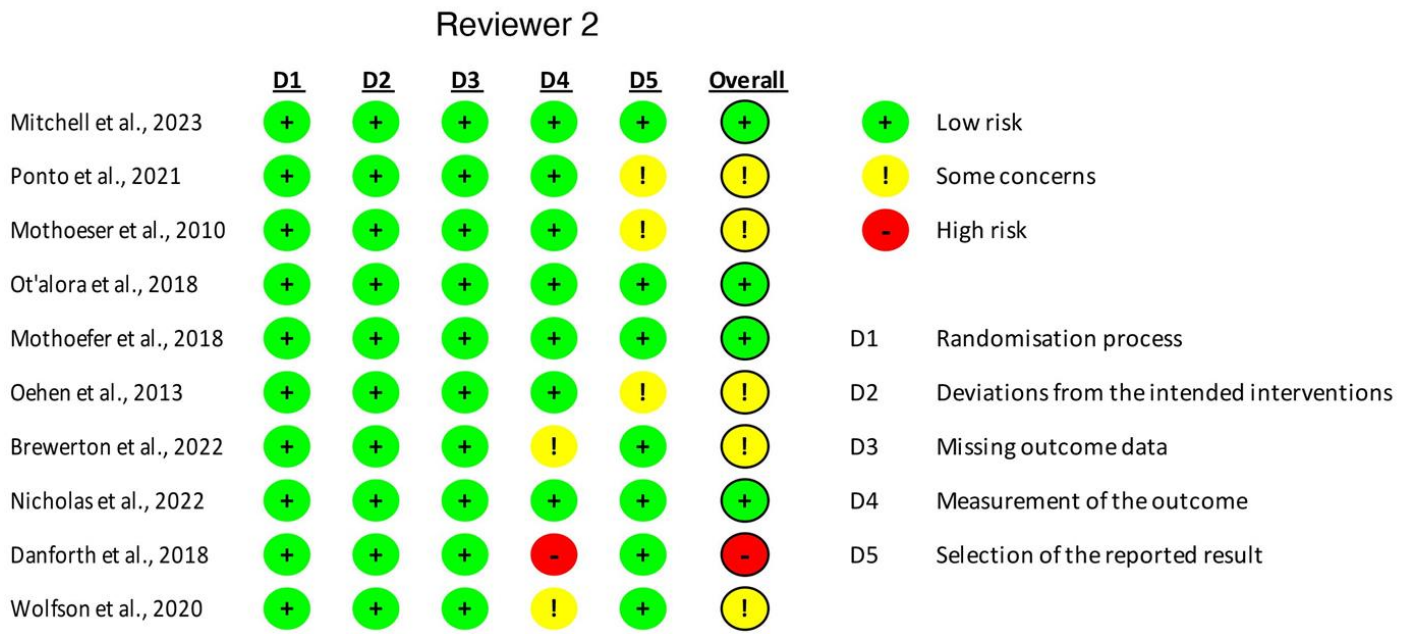
Clarion Clinics is the first psychedelic-assisted therapy clinic to open in Australia after the TGA approved the use of MDMA and psilocybin treatments. Photograph: Filip Konikowski/Clarion Clinics



There is promising early evidence from RCTs considering MDMA assisted therapy for PTSD…

However, at least some level of concern is present about the risk of bias for most of the available studies…

Oestreich, Lena K. L. and McGovern, Hugh and Nadeem, Zohaib and Coundouris, Sarah and Parker, Stephen, A Systematic and Meta-Analytic Review on Psilocybin and 3,4-Methylenedioxymethamphetamine in the Treatment of Mental Illnesses: Effects of Dosage, Psychotherapeutic Support, and Antidepressant Use on Treatment Efficacy. Available at SSRN: https://ssrn.com/abstract=4913736

Journal of Affective Disorders
Available online 17 July 2025, 119866
In Press, Journal Pre-proof What's this?

Research paper

Development of an Australian Clinical Practice Guideline on methylenedioxymethamphetamine (MDMA)-assisted Psychotherapy for Post-traumatic Stress Disorder

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Public consultation for the draft of the Australian Clinical Practice Guideline for the Appropriate Use of Methylenedioxymethamphetamine (MDMA)-assisted Psychotherapy (MDMA-AP) for Post-traumatic stress disorder (PTSD)

This form invites responses to specific questions on the draft Guideline for the use of MDMA-AP for PTSD.

You can access the draft Guideline here.

Please note:

- Where possible, please **refer to the relevant section, recommendation, or statement** of the guideline when providing your comments.
- You do not need to provide comments on every question. We encourage you to focus on those areas most relevant to you and/or your organisation.

If you experience any technical difficulties submitting your feedback, please contact alene.yong1@monash.edu. *(Please note that this email is for technical support only; we will not be responding to feedback on the draft guideline through this address.)*
The closing date for submissions is 31 August 2025.

Consultation link

Conditional recommendation against

Recommendation 1

For people living with PTSD, the Guideline Development Group conditionally recommends against the routine use of MDMA-AP. If MDMA-AP is used, it should be limited to adults (≥18 years old) with PTSD symptoms for at least 6 months duration post-diagnosis, with moderate or severe PTSD symptoms in the past month (CAPS-5 total severity score ≥28), who have received an adequate trial of first-line evidence-based treatments, and who are not likely to be re-exposed to the index or other significant trauma during treatment.

Only in research settings

Recommendation 2

Do not use MDMA-AP for the treatment of PTSD outside of clinical trials with appropriate ethical approval in people less than 18 years old.

Only in research settings

Recommendation 3

Do not use MDMA-AP for the treatment of PTSD outside of clinical trials with appropriate ethical approval in people who 1) have not had PTSD symptoms for at least 6 months duration post-diagnosis; 2) did not have at least moderate PTSD symptoms in the past month (CAPS-5 total severity score ≥28); 3) have not received an adequate trial of first-line evidence-based treatments; or 4) are likely to be re-exposed to the index or other significant trauma during treatment.

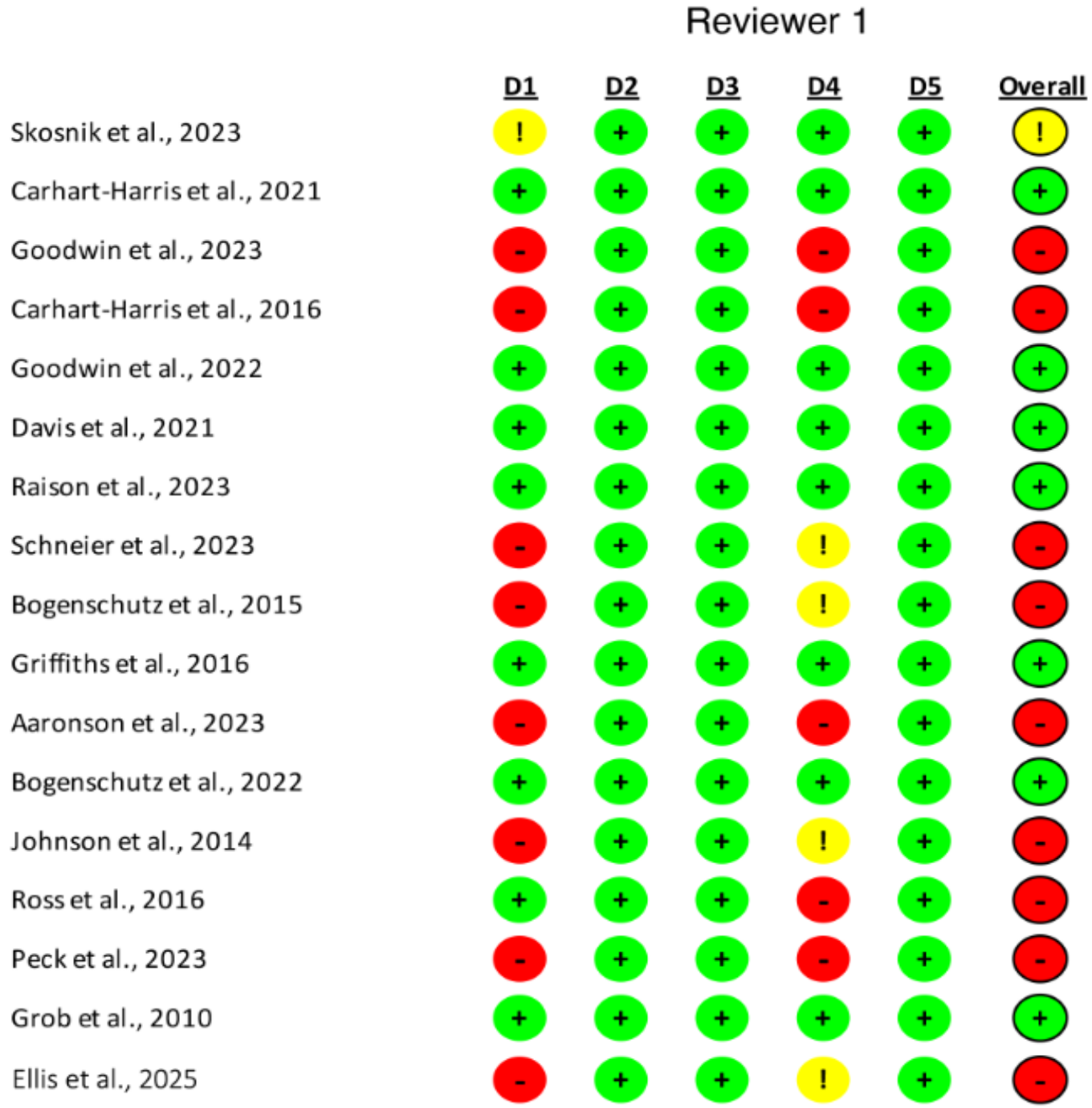
Strong recommendation against

Recommendation 4

For people living with PTSD, the Guideline Development Group strongly recommends against the use of MDMA-AP in patient groups who have been excluded from existing clinical trials for safety reasons. These patient groups include but are not limited to those who are pregnant or breastfeeding, with cardiovascular disease (e.g., uncontrolled hypertension, cardiac arrhythmia), psychotic disorder, suicide-related distress (i.e., currently experiencing suicidal thoughts and/or behaviour), and people with current use of medications that may interact with MDMA.

There is also promising early evidence from RCTs considering psilocybin assisted therapy for treatment-resistant depression…

But also, methodological limitations are present across studies (randomization, blinding, outcome assessment)…



Oestreich, Lena K. L. and McGovern, Hugh and Nadeem, Zohaib and Coundouris, Sarah and Parker, Stephen, A Systematic and Meta-Analytic Review on Psilocybin and 3,4-Methylenedioxymethamphetamine in the Treatment of Mental Illnesses: Effects of Dosage, Psychotherapeutic Support, and Antidepressant Use on Treatment Efficacy. Available at SSRN: https://ssrn.com/abstract=4913736

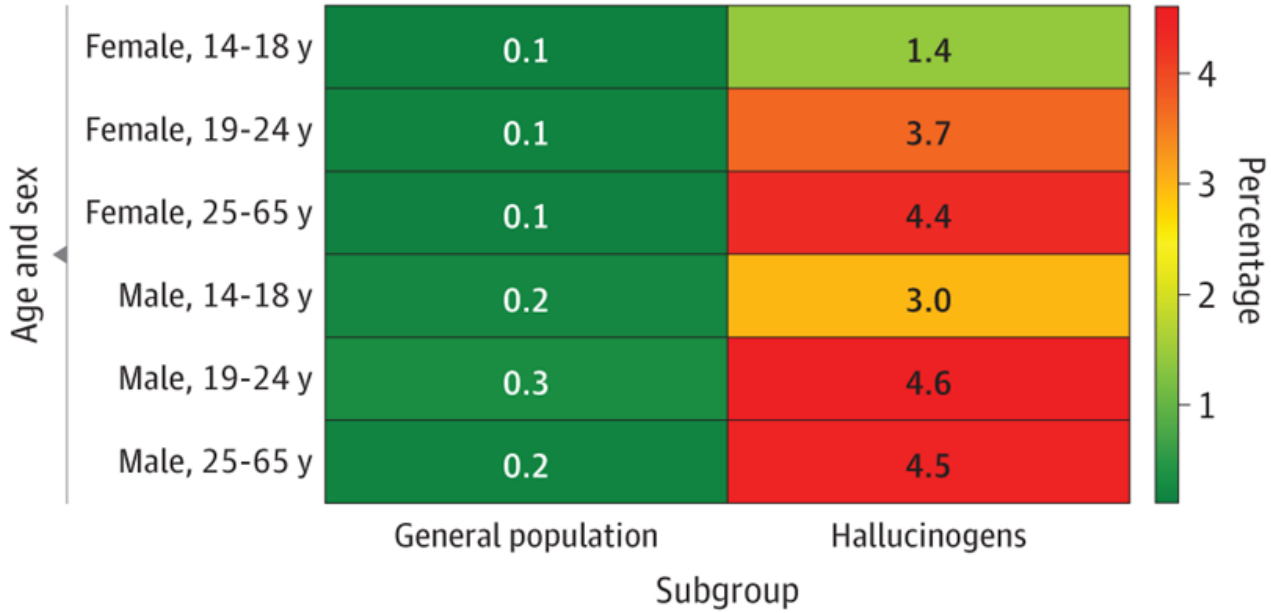
Are there real-world risks associated with increasing the acceptability and access to hallucinogens?

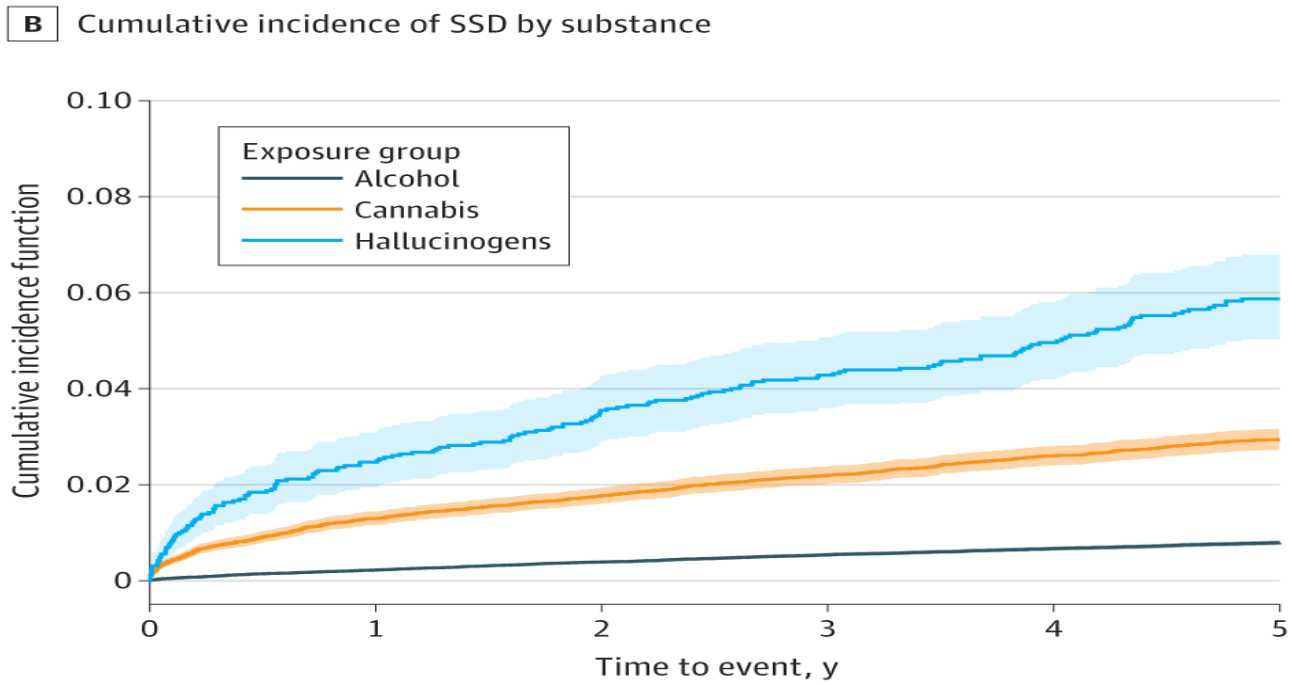
Population cohort study in Ontario, Canada, including >9 million individuals aged 14-65 without a history of psychosis (2008-2021).

Rates of ED visits relating to hallucinogen use increased by 86.4% between 2008-2012 and the 2013-2021 periods (3.4 to 6.4 / 100,000).

Hallucinogen-related ED visits had a significantly **higher risk of developing a schizophrenia spectrum disorder** in the subsequent three years **than the general population** (HR 3.53, CI 3.05-4.09), and those with **ED visits relating to alcohol** (HR 4.66, CI 3.82-5.68) **and cannabis** (HR 1.47, CI 1.21-1.80).

* After adjusting for mental illness and substance use





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New horizons, snake oil, or wishful thinking?

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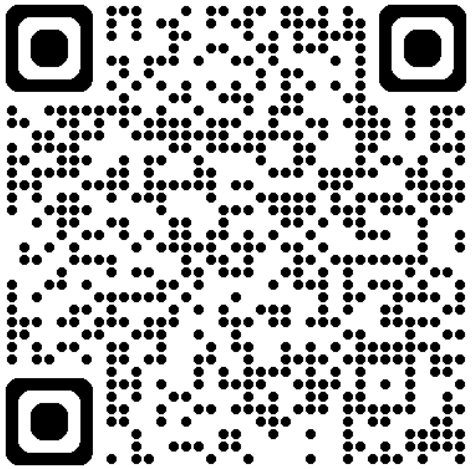

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Pharmacology / Medicinal Cannabis

Medicinal Cannabis

See also Cannabis Use and Dependence.

Background

About medicinal cannabis

Assessment

1. Only consider cannabis when evidence-based treatments (e.g., medication and therapies) have been tried and found ineffective or are contraindicated.
   - Cannabis is not currently considered first-line management.
   - Clinicians are not compelled (either medically or legally) to provide a prescription for cannabis products.
2. Assign one prescriber to manage the patient's Schedule 8 medications.
3. Complete a comprehensive clinical assessment.
4. Assess for contraindications and cautions:
   - Contraindications for cannabis products containing tetrahydrocannabinol (THC)
   - Relative contraindications where caution is recommended
5. Consider research and evidence for using medicinal cannabis in specific symptoms and conditions.
6. Consider adverse events and drug interactions.

Management

1. If you do not consider medical cannabis to be appropriate, decline treatment, and explain your reasons to the patient. Offer an alternative if one is available.
2. If you are uncertain about prescribing medical cannabis but believe there may be medical benefit of trialling it, consider seeking advice or requesting assessment from a specialist in the management of the disease/disorder for which medicinal cannabis is being considered.
3. Discourage self-sourced products due to:
   - increased risks of adverse effects and side-effects
   - variable quality, constituents, and concentration of active ingredients
   - potential contaminants.
4. Consider the need for shared care management and specialist input.
5. Provide patient education about cannabis medicines and advice about accessing further information.
6. Decide on a medicinal cannabis product to prescribe.
7. If necessary, obtain permission to prescribe medicinal cannabis:
   - Commonwealth regulations
   - Queensland regulations
   - Regulations for drug-dependent patients
   - Further questions about regulations
8. Consider dosing and route of administration.
9. Develop a treatment plan.
10. Obtain informed consent in writing.
11. Write a prescription for the medication and/or device for the pharmacist to order stock:
    - Check QScript before issuing a prescription for S8 medications.
    - Monitor and review every 4 to 12 weeks.

General Practice Liaison Officer Program presents

Connecting The Dots

Navigating Mental Health in Primary Care

The Art of Psychopharmacology

Dr Conor O'Luanaigh

Consultant Older Adult Psychiatrist & Deputy Clinical Director, Community Mental Health Services

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
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The Art of Psychopharmacology

Dr. Conor O'Luanaigh MB MRCPsych FRANZCP FPOA

Consultant Older Adult Psychiatrist

Deputy Clinical Director Community Mental Health Services

What you will not learn from this

- Pharmacodynamics
- Pharmacokinetics
- Receptor profiles
- Side effects
- Etc etc etc….

What I hope you will take away from this

- It’s not always what you prescribe it’s **how** you prescribe

Why is this important

Compliance /adherence is a big issue

Systematic review by Semahegn et al 2020 – close to 50% of patients with major psychiatric disorders are non-adherent

Focus was on the patient factors that influence adherence e.g. patient's attitude to medications, patient's substance abuse, patients perceived stigma

But no mention of the doctor factors that might be an influence…

So called treatment resistance , and treatment nihilism…

What is our goal?

- To convince our patients that our proposed treatment is the correct treatment that will work for them and help them.
- If it’s just about the treatment itself why is there so much variability in response?

We are of value…

Brief report

Psychiatrist effects in the psychopharmacological treatment of depression

Kevin M. McKay, Zac E. Imel, Bruce E. Wampold

University of Wisconsin, Madison, United States

- Researchers historically ignored the potential effect that psychiatrists have on patient outcomes, thereby assuming that psychiatrists are equally effective.
- The variance in BDI scores due to psychiatrists was 3 times greater than the variance due to medication!
- The top 1/3 of psychiatrists got better outcomes with placebo than bottom 1/3 got with active drug!
- Given this, it can be concluded that effective treatment psychiatrists augment the effects of the active ingredients of anti-depressant medication as well as placebo.

The Doctor as the drug...

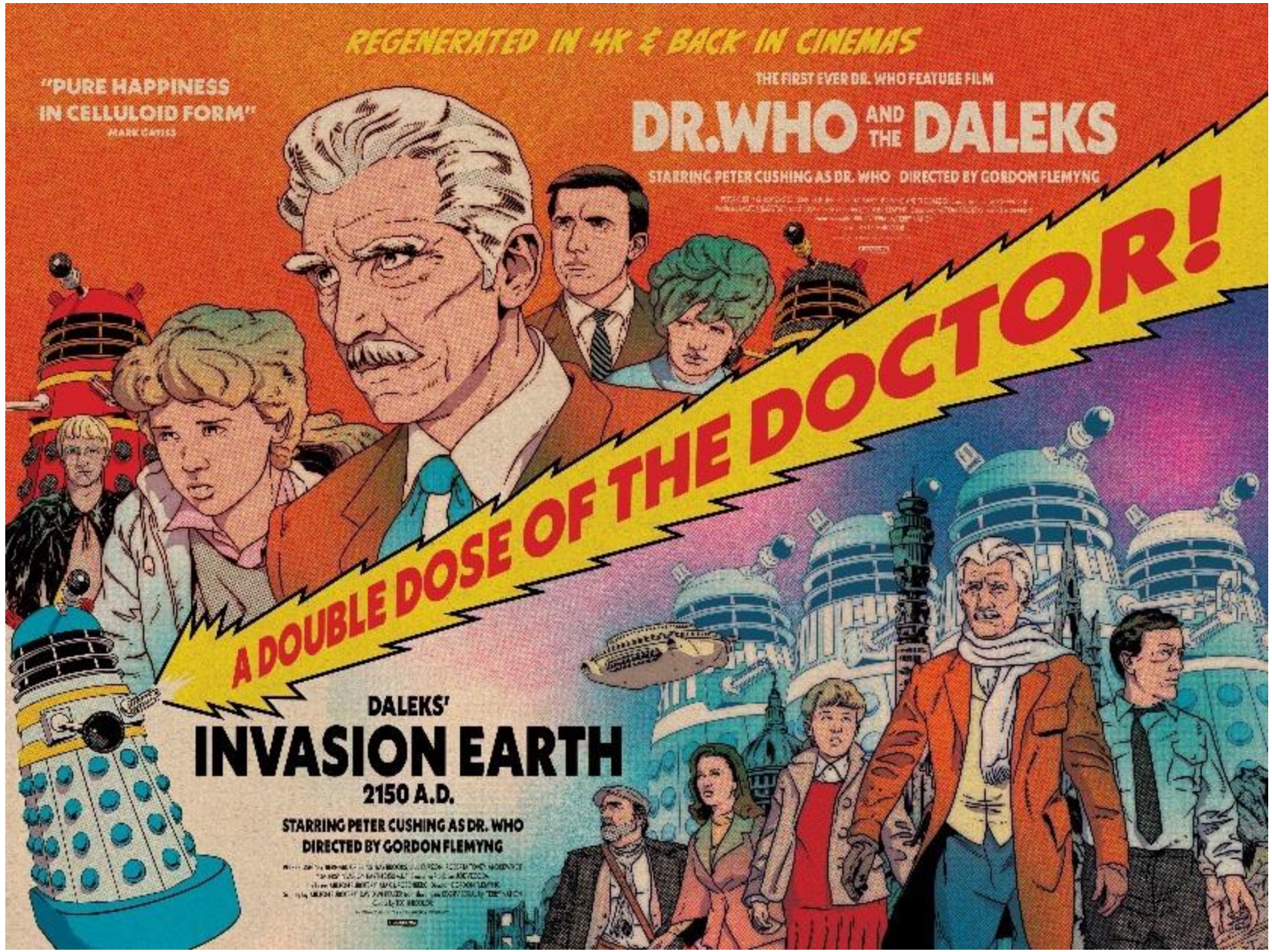
- Michael Balint's seminal work 'the doctor his patient and the illness'
  - Personal qualities , attitudes and behaviours of the doctor
  - Importance of self-awareness and reflective practive.
  - The doctor as a drug
  - The doctor patient relationship central to healing
  - The collusion of anonymity

It’s not what you say it’s how you say it…

Appointment Length, Psychiatrists’ Communication Behaviors, and Medication Management Appointment Adherence

Mario Cruz, M.D.
Debra L. Roter, Dr.P.H.
Robyn F. Cruz, Ph.D., B.C.-D.M.T.
Melissa Wieland, Ph.D., M.P.H.
Susan Larson, M.S.
Lisa A. Cooper, M.D., M.P.H.
Harold Alan Pincus, M.D.

- Significant relationship between positive voice tone ratings and appointment adherence
- This was actually more important than length of appointment and patient-centred communication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‘Is that the yellow one……’

Effect of colour of drugs: systematic review of perceived effect of drugs and of their effectiveness

Anton J M de Craen, Pieter J Roos, A Leonard de Vries, Jos Kleijnen

Abstract

***Objectives*—To assess the impact of the colour of a drug's formulation on its perceived effect and its effectiveness and to examine whether antidepressant drugs available in the Netherlands are different in colour from hypnotic, sedative, and anxiolytic drugs.**

***Design*—Systematic review of 12 published studies. Six studies examined the perceived action of different coloured drugs and six the influence of the colour of a drug on its effectiveness. The colours of samples of 49 drugs affecting the central nervous system were assessed using a colour atlas.**

***Main outcome measures*—Perceived stimulant action versus perceived depressant action of colour of drugs; the trials that assessed the effect of drugs in different colours were done in patients with different diseases and had different outcome measures.**

***Results*—The studies on perceived action of coloured drugs showed that red, yellow, and orange are associated with a stimulant effect, while blue and green are related to a tranquillising effect. The trials that assessed the impact of the colour of drugs on their effectiveness showed inconsistent differences between colours. The quality of the**

BMJ VOLUME 313 21-28 DECEMBER 1996

- Red/yellow/orange = activating/potent
- Blue/green = calm
- White= analgesia
- Capsules > tablets

Psychodynamic Psychopharmacology

Impact of the physical characteristics of the medication + the symbolic aspect of taking or refusing a medicine and the interpersonal relationship tied to a medication = meaning effects.

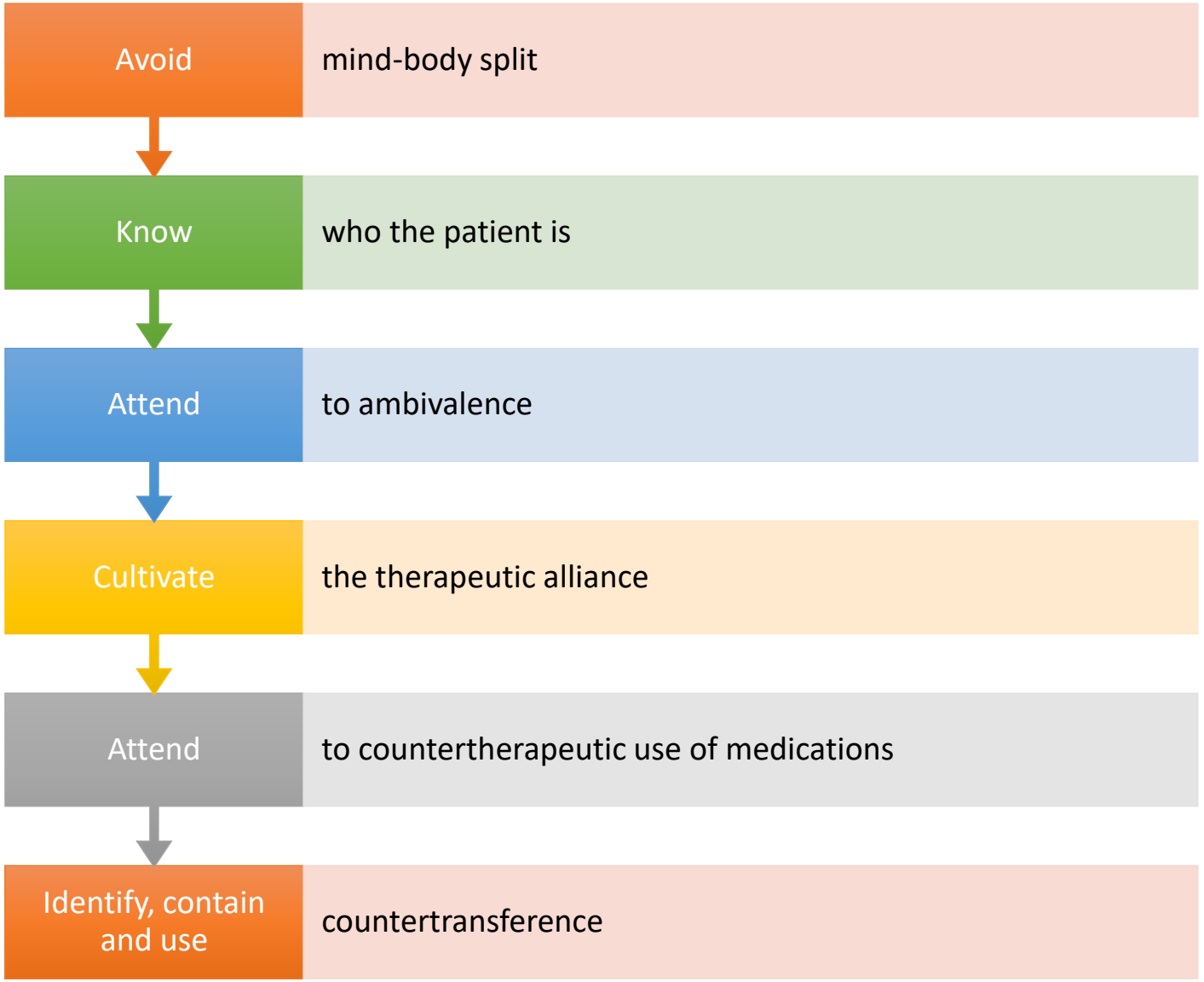
integrates meaning effects to help anticipate roadblocks/pitfalls

Emphasis on how rather than what to prescribe.

Considers how patients are similar (diagnostic criteria) – ***but***

Acknowledges and incorporates the central role of meaning and interpersonal factors

Psychodynamic psychopharmacology



Avoid a Mind-Body Split

Think integratively not reductionistically.

Recovery from mental illness represents interplays of biological and psychosocial factors.

Pressure to adjust medication rather than address a psychological stressor.

Patients who are defensively invested in experience of not being responsible for illness behaviours – present their symptoms in form of argument for a biological explanation.

Avoid Mind Body Split

- Recognise patient as both subject and object
- Biological model – patient seen as ‘victim’ of a disease
- No internal resources to enhance recovery.
- All ‘healing’ power lies with the doctor/prescriber
- Need to see patient as potential agent and ally in recovery process.
- Treatment contract should emphasise the central role of patient in managing the illness and thus recovery.
- Patient may also be adversary (sick role behaviour , secondary gains)

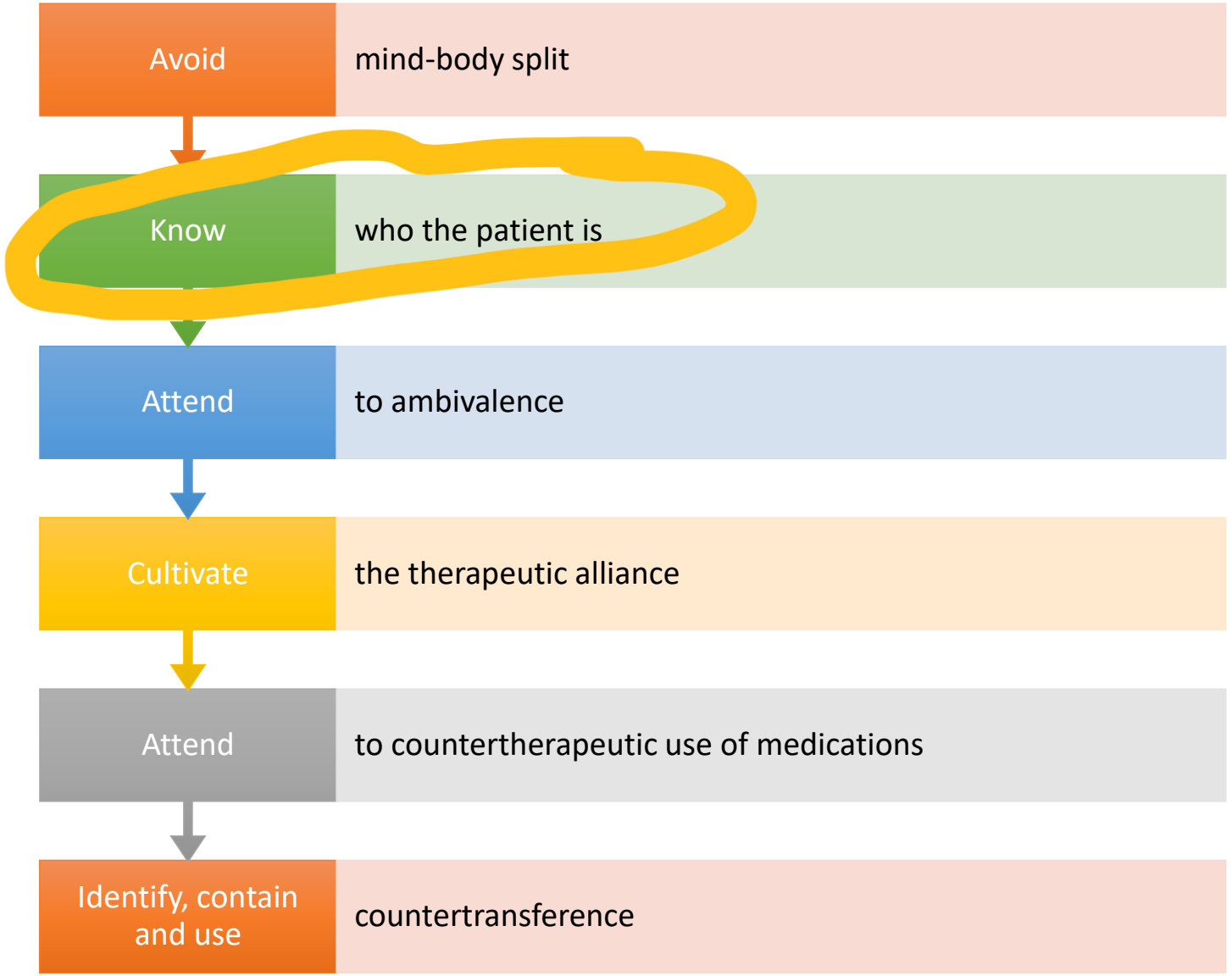
Avoid Mind Body Split

Non-pharmacological factors in treatment response

- Reasons can be obsure
- ? Direct effect to side effects
- ? Nocebo
- ? Treatment alliance lacking

Educate about potency of psychosocial factors.

- Power of placebo effect
- Treatment alliance
- Patient’s expectancies
- Desire for change


Avoid
mind-body split
Know
who the patient is
Attend
to ambivalence
Cultivate
the therapeutic alliance
Attend
to countertherapeutic use of medications
Identify, contain and use
countertransference

Know who the patient is…

- More than just a diagnosis.
- Non-clinical patient characteristics that affect treatment outcome

Table 2
Patient characteristics affecting treatment outcome

Patient Characteristics	Evidence
Neuroticism	Joyce & Paykel,[31] 1989
	Scott et al,[32] 1995
	Bagby et al,[26] 2002
	Steunenberg et al,[33] 2010
Defensive Style	Kronström et al,[34] 2009
Locus of Control	Reynaert et al,[35] 1995
Autonomy	Peselow et al,[36] 1992
Sociotropy	Peselow et al,[36] 1992
Social Disadvantage	Hahn,[37] 1997
Acquiescence	McNair et al,[38] 1968
	McNair et al,[39] 1970
	Fast & Fisher,[40] 1971
Attachment Style	Ciechanowski et al,[41] 2001
	Ciechanowski et al,[42] 2006
	Comninos & Grenyer,[43] 2007
Expectations of Treatment	Meyer et al,[44] 2002
	Krell et al,[45] 2004
	Aikens et al,[46] 2005
	Gaudiano & Miller,[47] 2006
	Sneed et al,[48] 2008
Treatment Preferences	Lin et al,[49] 2005
	Iacoviello et al,[50] 2007
	Kocsis et al,[51] 2009
	Raue et al,[52] 2009
	Kwan et al,[53] 2010
Ambivalence About Medications	Sirey et al,[54] 2001
	Aikens et al,[55] 2008
	Warden et al,[56] 2009
Secondary Gains Associated With Illness	van Egmond & Kummeling,[57] 2002
Autonomous Motivation for Treatment	Zuroff et al,[58] 2007
Readiness to Change	Beitman et al,[59] 1994
	Lewis et al,[60] 2009

Know who the patient is

Neuroticism – negative correlations in both short term and long term response to medication as well as risk of recurrence.

Autonomy – positive correlation

Sociotropy (focus on pleasing others) – negative correlation.

High autonomy +low sociotropy (74%response rate) vs
low autonomy +high sociotropy (38.5% response rate)

Know who the patient is

- Anxious –fearful attachment – similar to sociotropy
- Dismissive or avoidant attachment – ‘one strike you’re out’
- Secure attachment show an earlier response to antidepressants compared to fearful attachments
- Understanding of attachment can guide decisions
- Difficulties of adherence associated with dismissive attachments can be reversed by good communication / building of alliance.

Know who the patient is….

Patient expectations of treatment – Placebo

Krell et al – patients with high expectations of drug treatment showed 90% antidepressant response rate vs patients with moderate expectations of treatment who only had 33% response rate.

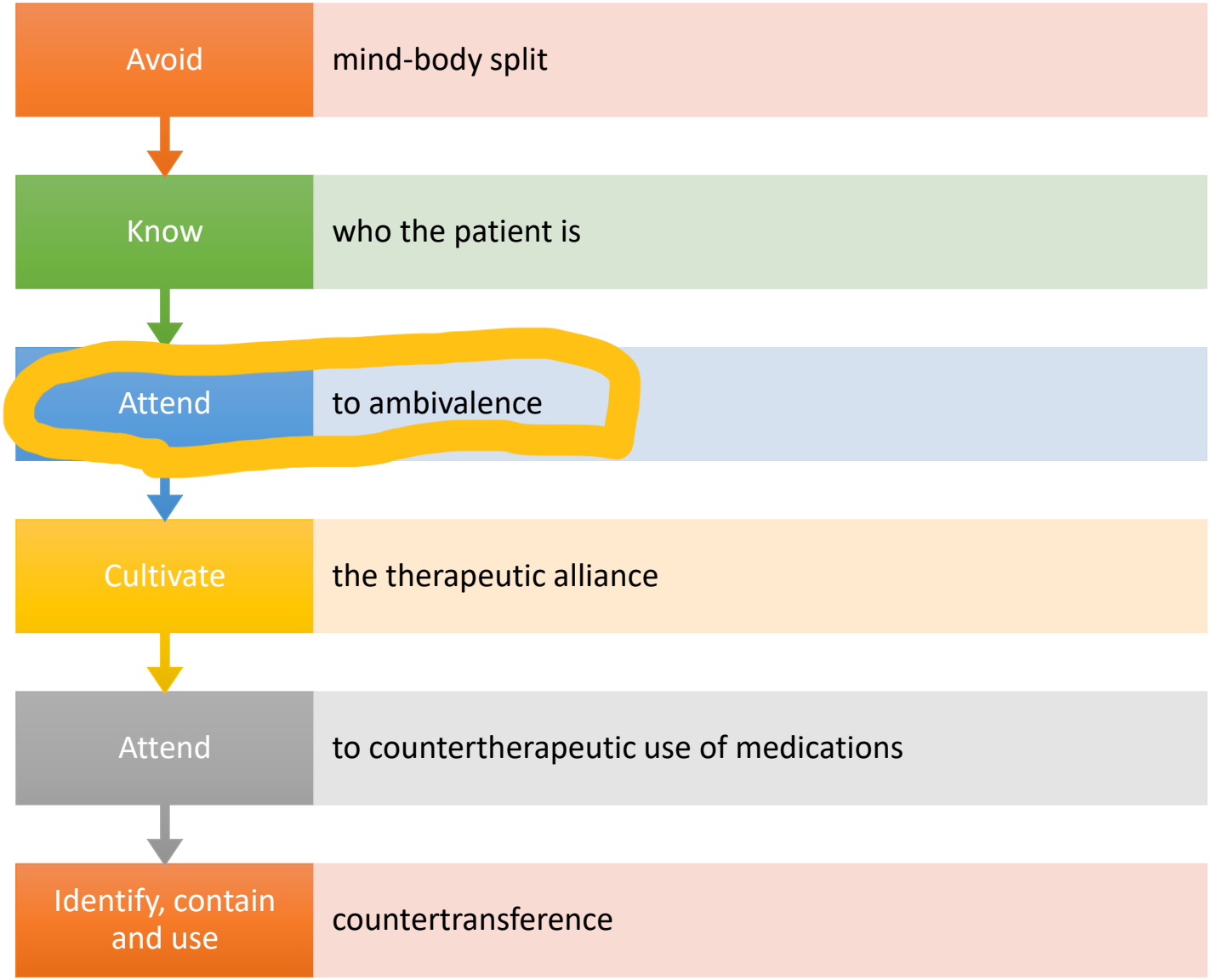
Helpful to discuss expectations.

Psychoeducational and supportive strategies may increase expectations.

Know who the patient is..

- Nocebo responders….
- Conscious expectations of harm.
- Link to neuroticism
- Socially disadvantaged groups – more nocebo prone.
- Acquiescence – ‘easily surrendering to the will of others’ - unable to say no with their voices do so with their bodies.
- Discussing potential nobebo factors before side effects emerge may help with options as opposed to discontinuing.

Psychodynamic psychopharmacology



Attend to the patient's ambivalence about loss of symptoms…

Transference based expectations of caregivers.

Problems in real relationship between doctor and patient.

Psychiatric meds – infused with threats to identity and stigma.

Study looking at patient's representations of psychiatric medication

- 44% soothing
- 39% improving mood
- 47% dependence
- 56% adverse effects
- Perception of dangerousness easily balanced therapeutic effects

Attend to the patient's ambivalence..

Early ambivalence -2x more likely to discontinue, 3x more likely to stop meds prematurely in context of side effects

Inquire specifically about ambivalence

How you ask is important – if asked in broad/general way – 2-4% identify ambivalence.

When asked in more specific way – e.g. if you develop side effects how likely are you to stop meds – 23-36% will signal their ambivalence.

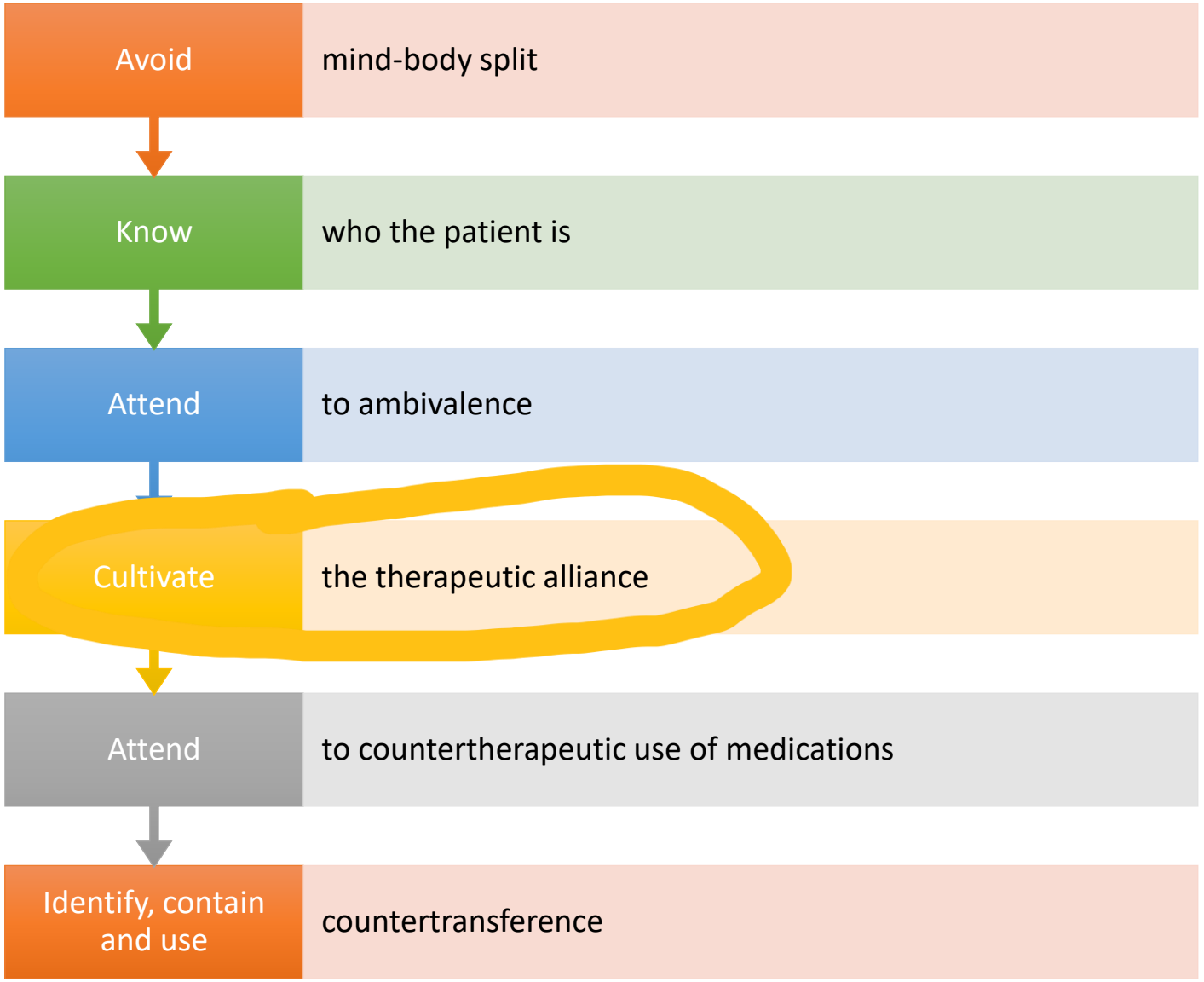
Attend to patient's ambivalence..

- Ambivalence about illness.
- Studies of illness benefits(secondary gain) – approx. half patients can identify secondary benefits that derive from sick role.
- Implications – patients who expect some gain from their illness are less likely to experience remission of their symptoms.
- Treatment refractory → ambivalence about illness as possible source of resistance.
- At early stage of treatment – explore what patient stands to lose if treatment works…

Attend to the patient's ambivalence..

- Inoculate the ambivalent patient.
- Demonstrate sensitivity and concern about side effects
- Psychoeducation about time course of side effects.
- Psychoeducation about lack of immediate effect.
- Shape prescribing strategies to patient's ambivalence
  - Adherence affected by concern for side effects – start low go slow.

Psychodynamic psychopharmacology



Cultivate the therapeutic alliance

Table 3
Characteristic of the doctor-patient relationship promoting improved outcomes

Outcome-Enhancing Characteristics of the Doctor-Patient Relationship in Pharmacotherapy	Evidence
Overall Effectiveness of the Doctor	McKay et al,[7] 2006
The Doctor's Positive Attitude About the Medication	Downing et al,[20] 1973
Therapeutic Alliance	Krupnick et al,[6] 1996 Weiss et al,[27] 1997 Klein et al,[28] 2003 Blatt & Zuroff,[29] 2005
Good Communication	Lin et al,[66] 1995 Bultman & Svarstad,[24] 2000 Bull et al,[67] 2002
Involvement of the Patient in Decision-Making	Clever et al,[68] 2006 Loh et al,[69] 2007 Woolley et al,[70] 2010
Agreement About Diagnosis	Woolley et al,[70] 2010
Autonomy-Promoting	Zuroff et al,[58] 2007

Cultivate the therapeutic alliance

- Support the patient's agency
- Patients with external locus of control less likely to benefit
- Patients who view their depression as non-biological seem to benefit more from antidepressant treatment .
- Biological reductionist explanations of illness while may relieve self-blame, may in long run promote treatment resistance
- Patients who perceive doctors as supporting their autonomy feel more inwardly motivated for treatment – strong predictor of treatment outcome

Cultivate the therapeutic alliance

- Alliance is not the same as compliance
- Alliance is a two way street
- Both doctor and patient enter a negotiation in which neither submits to the will of the other.
- Both find a way to feel invested in treatment.
- Doctor is not the ultimate authority
- The ‘customer’ (patient) is not always right

Cultivate the therapeutic alliance

- Focus on communication
- Needs to be clear and collaborative
- Involves active listening
- Non-authoritarian orientation to problem solving
- Especially important with people with who have a dismissive attachment style.
- Increased adherence when communication with depressed patient involves encouragement to engage in pleasurable activities.

Cultivate the therapeutic alliance

Elicit patient preference for type of treatment.

Kocsis et al – patients receiving preferred treatments remitted 45-50% of the time.

Patients receiving non-preferred treatments only showed 22% remission rate for psychotherapy and only 7.7% for medications.

Patients assigned to non-preferred treatments are more likely to not even start treatment and drop out after starting.

Cultivate the therapeutic alliance

- Involve the patient in decision making.
- Selection of treatment goals, medication, and dosing schedule.
- Depressed patients involved in treatment decisions – 2.3x more likely to stay on medications.
- Patients who disagreed with diagnosis and felt uninvolved in decision making – 7.3x more likely to stop treatment.
- Shown to have better 18-month treatment outcomes
- Art of forging an alliance often involves thoughtfully choosing one’s battles

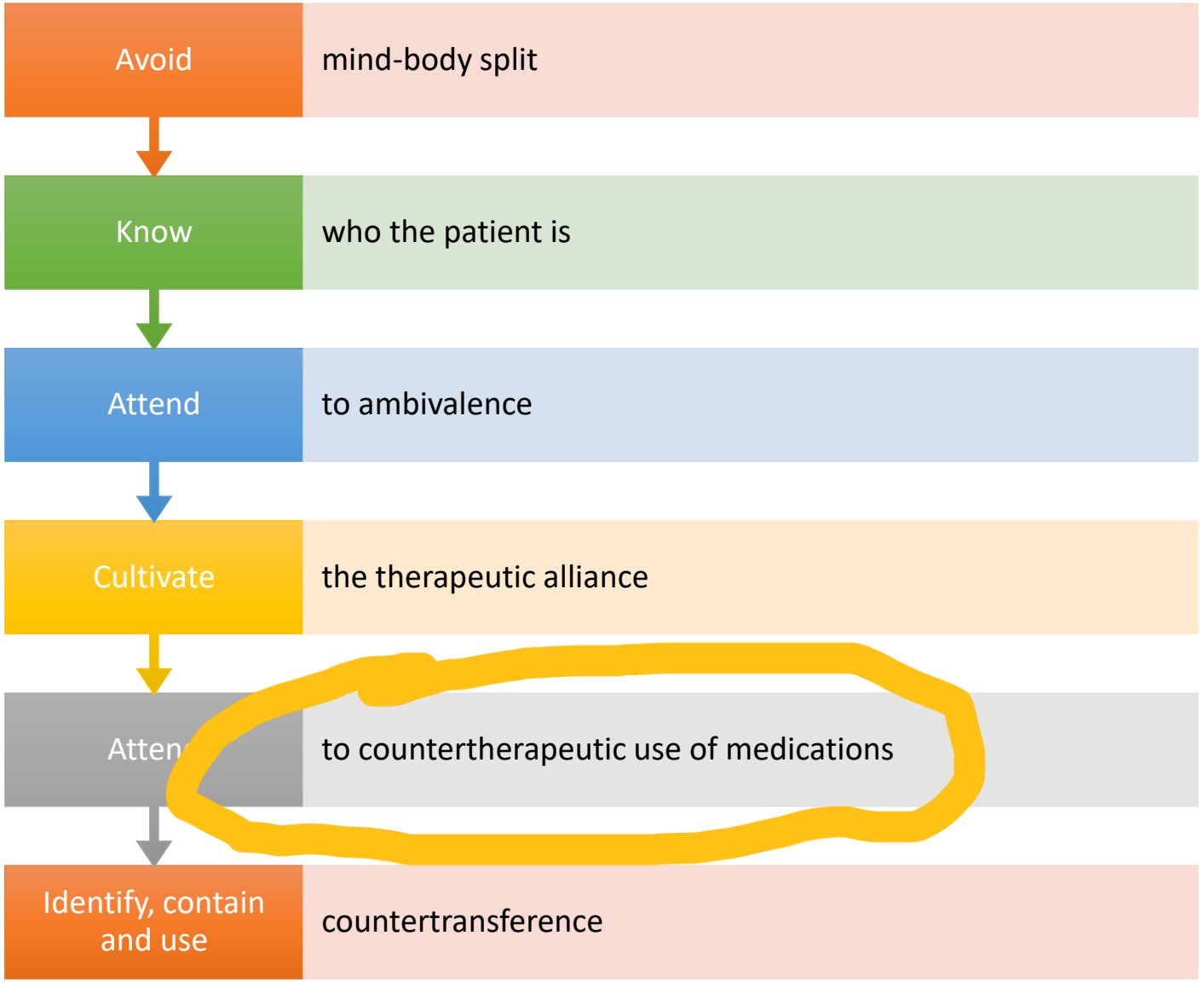
Cultivate the therapeutic alliance

Increase the dose … of the doctor

More frequent contact shown in improved treatment adherence.

Remember most treatment studies involved weekly or biweekly meetings with doctor or doctor representative – so could argue that in order for ‘treatment’ to be evidence based, it needs to follow similar schedule

Psychodynamic psychopharmacology



Address countertherapeutic use of medications

We are often attentive to misuse of opiates and bzds.

Less likely to consider antipsychotic recreational use.

Even less likely to consider treatment has been turned to countertherapeutic ends particularly when patient experiences the treatment as ‘helpful’

Treatment resistance ***from*** medications

Lets take an example

- Sally sees her GP complaining of being stressed and overworked at home.
- She feels 'depressed' and is tearful.
- GP starts her on escitalopram 10mg
- She comes back a few weeks later and feels much better.
- Several months later dose is increased as she 'relapses'
- She responds again.
- She and GP believe she has responded well to escitalopram
- It has treated 'her depression'

Or has it.....

Now Sally believes that she 'needs' antidepressants to stay well.

Few years later – Sally represents with similar symptoms as before

'antidepressant not working anymore'

What next? Increase the dose ...add in another drug....refer to psychiatrist

'treatment resistance' vs …..'sick role behaviour'

The 'BPD' with 'BPAD'……

Patient reports feeling better with certain medications but overall is not better /improving.

Patients who have tendencies to rely on more primitive defense mechanisms such as splitting or projective dynamics.

E.G. patient with BPD who also gets diagnosed with BPAD and commenced on mood stabiliser. Patient may report immediate reduction in dysphoria at receiving the BPAD diagnosis with risk that this is attributed to the medication.

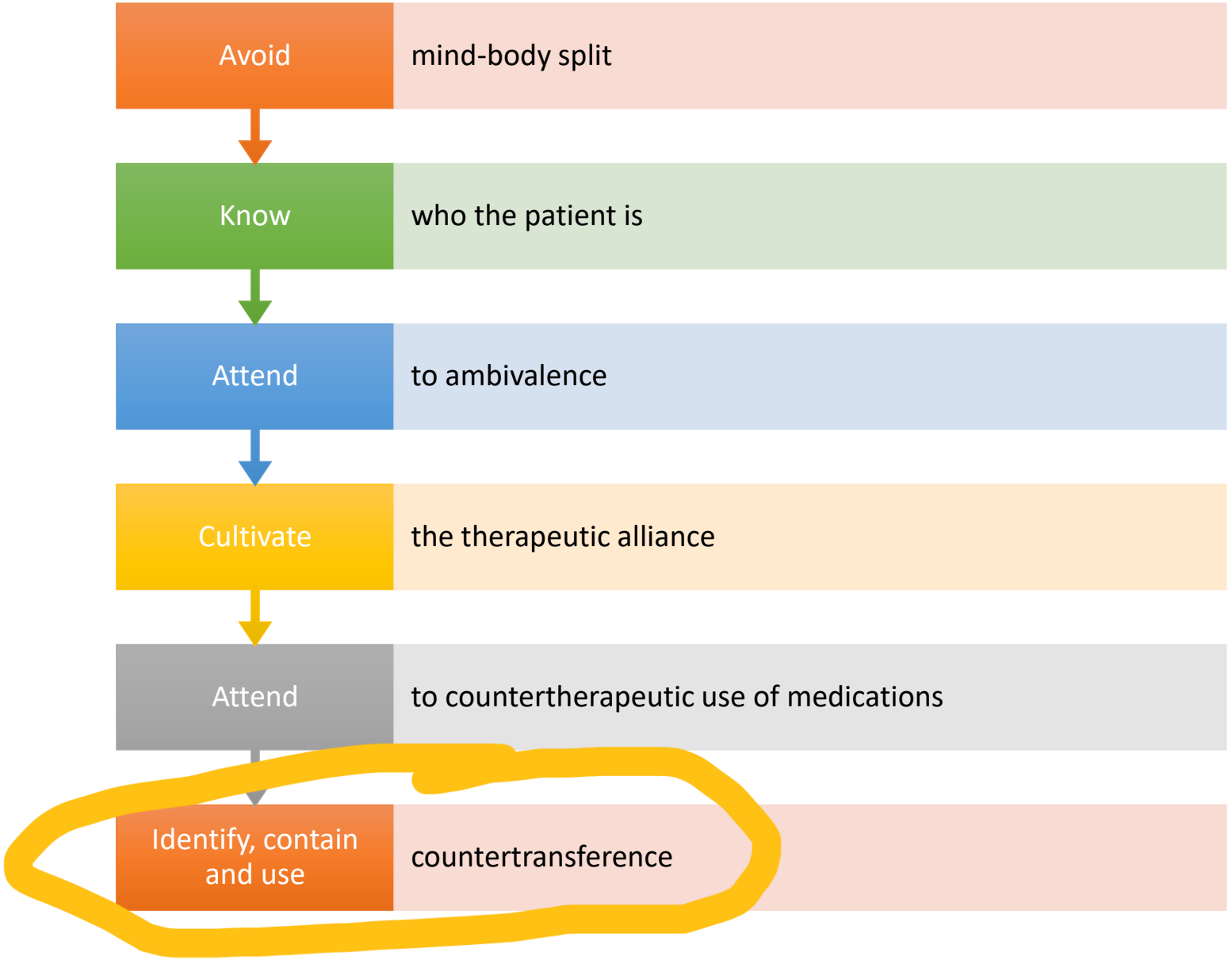
The patient can create stable split where he/she can remain 'good' while all badness is located in 'my bipolar'.

Patient can report feeling 'better' but do actually worse as they no longer feel personally responsible for symptomatic/maladaptive behaviours

Patients who experience people as 'dangerous'/unreliable may attempt to replace people with pills. Medicalized universe becomes increasingly depopulated.

If pills are used to manage normal negative feelings there is a lost opportunity in interpersonal competence and resilience. Patients who turn too much to doctors to solve their problems of living become treatment resistant from their treatment.

Psychodynamic psychopharmacology



Identify and contain counter transference

- Countertransference prescribing – focus on managing the experience of the prescriber rather than the patient.
- Emotional response of the prescriber becomes the primary impetus for the prescription.
- Countertransference feelings of anger, hopelessness, helplessness or even despair – with prescriptions being unconsciously aimed at reducing these feelings.
- Colleagues are crucial
- Develop a dynamic formulation for reference.

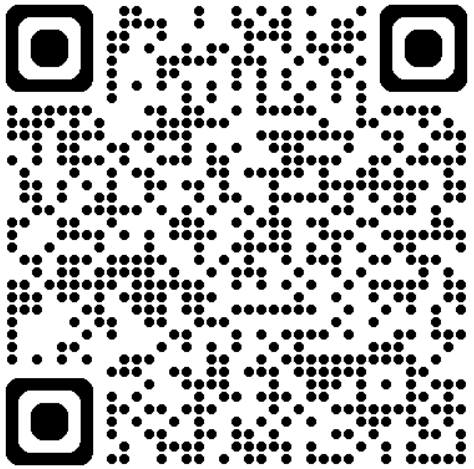
Summary

- Risk of Biological reductionistic approaches dominating practice
- Patient care is steered away from meaning and relationship effects.
- Patients become passive recipients of medical interventions.
- The field has succumbed to a ‘delusion of precision’.
- Settled for treating a disorder rather than a whole person
- Instead avoid the mind body split
- Consider psychodynamic approach to prescribing as outlined

Put simply….

Balance instillation of hope with honest humility regarding limitations of medications.

Encourage patients to mobilize their own agency – partners.



Brisbane North

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  - Older Adults' Weight and Nutrition
  - Unexpected Deterioration in an Older Person
- Older Adults' Health Requests

Older Adults' Health / Depression in Older Adults

Depression in Older Adults

See also Antidepressants for Older Adults.

Red flags

- Suicidal thoughts
- Psychotic features

Background

About depression in older adults

Assessment

1. Take a history from the patient and carer if available:
   - Assess symptoms.
   - Consider using a validated screening tool to assist in screening, diagnosis, and monitoring.
   - Check medications that may cause or worsen depression.
   - Ask about alcohol intake or any recreational drug use.
   - Ask about the presence of a family history of mental health conditions.
   - Assess for co-morbidities – consider performing an older persons' health assessment.
2. Perform and document a mental state examination.
3. Assess for suicide risk. Evaluate for previous suicide attempts, intent, plan, and means according to the Suicide Prevention in Adults pathway.
4. Consider differential diagnosis:
   - Delirium, dementia, and depression – see the Cognitive Impairment and Dementia pathway
   - Bereavement
   - Anxiety
5. Consider arranging investigations:
   - Blood tests
   - CT/MRI head if indicated
   - ECG (useful if considering medication).

Management

Practice point

Combine medication with non-drug interventions

Always combine antidepressant treatment with non-medication treatment e.g., active support, exercise, and psychological therapy.

1. If immediate risk of harm to the patient or others, request acute adult mental health assessment.
2. Minimise use of any drugs, alcohol, and medications that may exacerbate depression. Arrange a Medication Management Review if required.
3. Manage any common co-morbidities – Consider preparing a General Practice Chronic Condition Management Plan (GPCCMP)

General Practice Liaison Officer Program presents

Connecting The Dots

Navigating Mental Health in Primary Care

Eating disorders

Dr Kate Murphy | *Director, Queensland Eating Disorder Service*

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Queensland Eating Disorder Service (QuEDS)

A Brief Overview of Eating Disorders 2025

Dr Kate Murphy,

Consultant Psychiatrist and Director of QuEDS

Metro North Health | Queensland Government

Metro North Health acknowledges the Traditional Custodians of the land upon which we live, work and walk, and pay our respects to Elders past, present and emerging.

Metro North Health | Queensland Government

agenda

An overview of accessing care for eating disorders in QLD

Brief overview of diagnosis in eating disorders

Physical assessment in eating disorders

Consideration of guidelines for admission

Overview of treatment and prognosis

Call to action for all health practitioners

Supported by government

Lays out a framework for health care providers to follow in order to have systems in place to identify individuals who have eating disorders or who are at risk of developing and ED to provide the best stepped care approach

Early identification and prevention are key to support change

Lived experience as experts

QuEDS

Queensland Eating Disorder service – operationally under Metro North – based at Windsor (service development, education and intake) and Indooroopilly (Treatment), clinics at Spring Hill Community Mental Health clinic

Statewide service and support to the Eating Disorder Specialist Services (EDSS) - Gold Coast, Metro South, West Moreton, Darling Downs, Sunshine Coast, Townsville, North Queensland

We offer:

- Specialist assessment clinic (MDT – medical/ dietitian/ nursing) – diagnostic clarification, treatment recommendations – generally a 1-off assessment 90minutes minimum and support to GP

- Treatment – evidence based individual intervention (CBTe, SSCM, MANTRA, CBT-t) and group options (Day program (SMT + therapy) and Schema therapy)

- Consultation services – Individual peer support/ MDT support to any professional teams who are providing clinical services to patients with eating disorders/ malnutrition online

- Education – inpatient training, community training, CBTe and SSCM, medical education, dietitian masterclasses, annual forum, SMT etc

- Supervision – individual and group supervision within discipline and across the MDT – to both public and private providers of care

- Research – full time research officer with multiple projects and including wider stakeholders

Identification and initial assessment by GP/ clinic nurse

Diagnostic clarification and treatment recommendation

- Private psychiatrist and/or programs
- Queensland Eating Disorder Service (QuEDS)
- Eating Disorder Specialist Services (EDSS) *Gold Coast, Sunshine Coast, Cairns, Metro South, Townsville, West Moreton, Darling Downs*
- Child and Youth Mental Health Eating Disorder program (EDP)

Consultation/ peer support/ formal education and supervision

- QuEDS
- EDSS
- Australia and New Zealand Academy of Eating Disorders - ANZAED

General information for individuals/ families and key supports

- Eating Disorders Queensland (EDQ)
- Butterfly Foundation
- Inside Out
- National Eating Disorder Collaboration (NEDC)
- Eating Disorder Families Australia (EDFA)

Treatment services
QuEDS, EDSS, CYMHS EDP
Private providers – Eating Disorder Management Plan (EDMP)
EDQ/ Inside out e-therapies

<u>Inpatient/ residential:</u>
New Farm clinic
Robina Hospital Program
Cooinda Hospital/ Buderim Private
Wandi Nerida
H-floor RBWH

How to refer to QuEDS

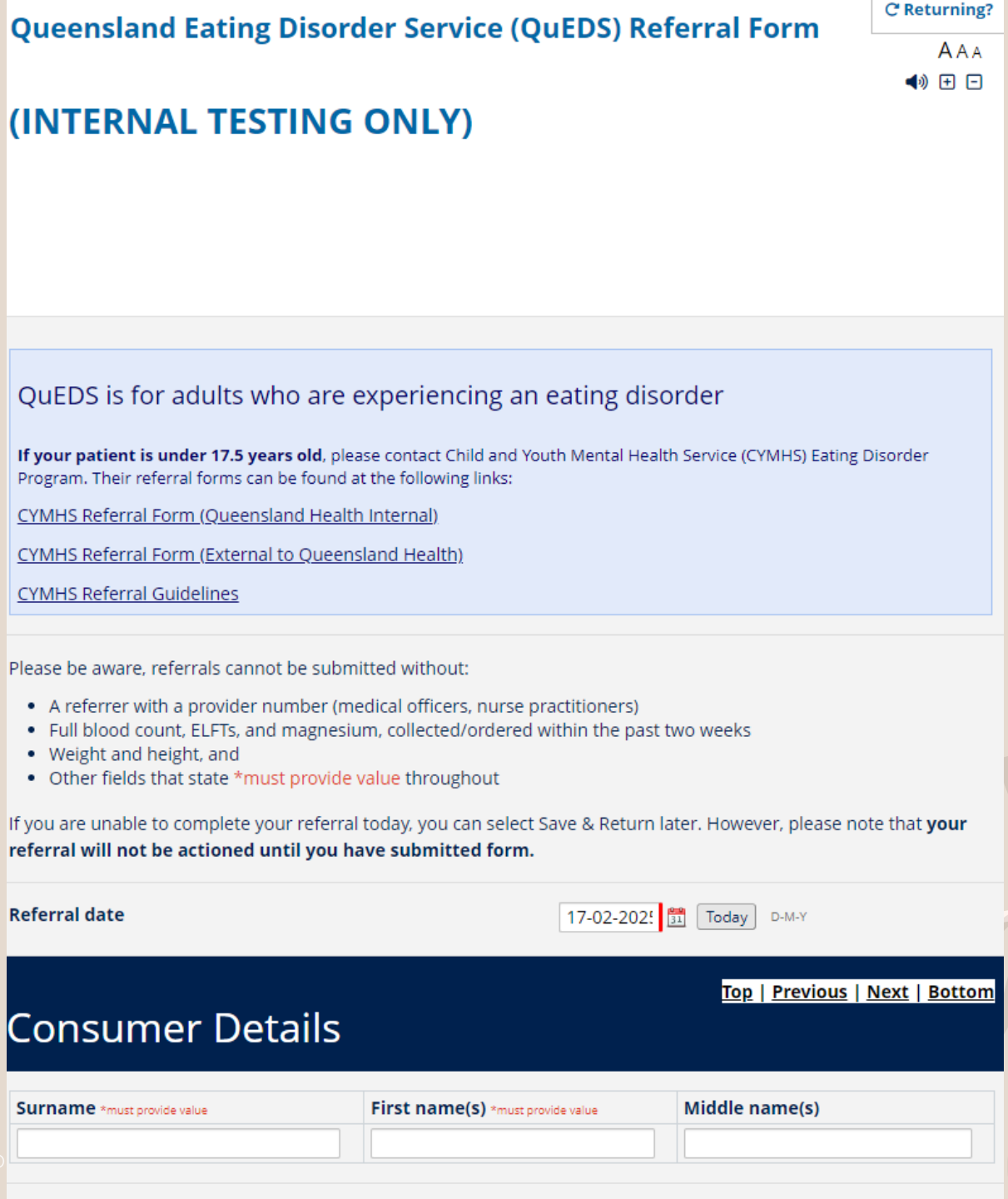
Old referral form will stop being accepted from March 1 2025

New referral form – REDCap electronic form

Will require the form to be completed in full prior to sending through so would suggest having a longer appointment with the patients to support this information

Too often our referrals are not complete and unable to be processed and therefore this will cut down on that happening

It is ultimately the decision of the GP (with support if needed) if the patient is medically unstable, as per the guidelines, to need a hospital admission and should discuss this with the patient and organise



Queensland Eating Disorder Service (QuEDS) Referral Form

Returning?

AAA

(INTERNAL TESTING ONLY)

QuEDS is for adults who are experiencing an eating disorder

If your patient is under 17.5 years old, please contact Child and Youth Mental Health Service (CYMHS) Eating Disorder Program. Their referral forms can be found at the following links:

CYMHS Referral Form (Queensland Health Internal)

CYMHS Referral Form (External to Queensland Health)

CYMHS Referral Guidelines

Please be aware, referrals cannot be submitted without:

- A referrer with a provider number (medical officers, nurse practitioners)
- Full blood count, ELFTs, and magnesium, collected/ordered within the past two weeks
- Weight and height, and
- Other fields that state *must provide value throughout

If you are unable to complete your referral today, you can select Save & Return later. However, please note that **your referral will not be actioned until you have submitted form.**

Referral date 17-02-202 Today D-M-Y

Top | Previous | Next | Bottom

Consumer Details

Surname *must provide value	First name(s) *must provide value	Middle name(s)

Shared care

QuEDS are not a case management service

If you consider case management appropriate – either directly related to the eating disorder or a co-occurring mental health condition, please contact local MH-Call

All QuEDS input is voluntary and requires consent – patients can be on a Treatment Authority but their attendance at QuEDS is voluntary

All patients sign up to the non-negotiables of care

This includes regular medical monitoring by their own GP – depending on weight, nutritional intake and medical stability – weekly, fortnightly or monthly – we will make recommendations based on our assessment

We cannot safely engage in therapy if medical risk is not safety-netted and therefore it is a requirement of care

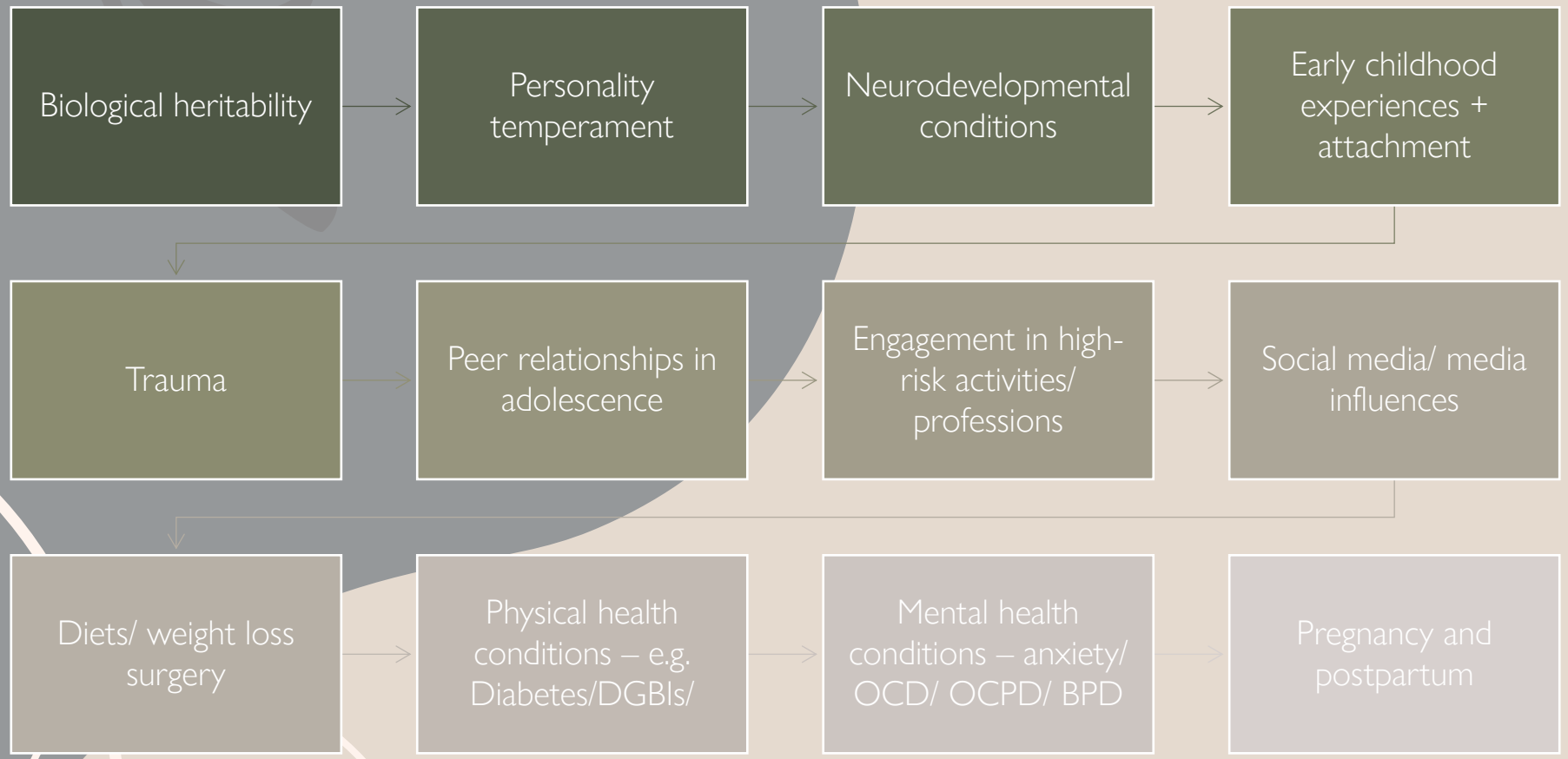
What is an eating disorder??

It is a **serious mental disorder that contributes to significant morbidity and mortality**

Combination of distorted thinking alongside distressing behaviours

High levels of distress and very poor social and occupational functioning

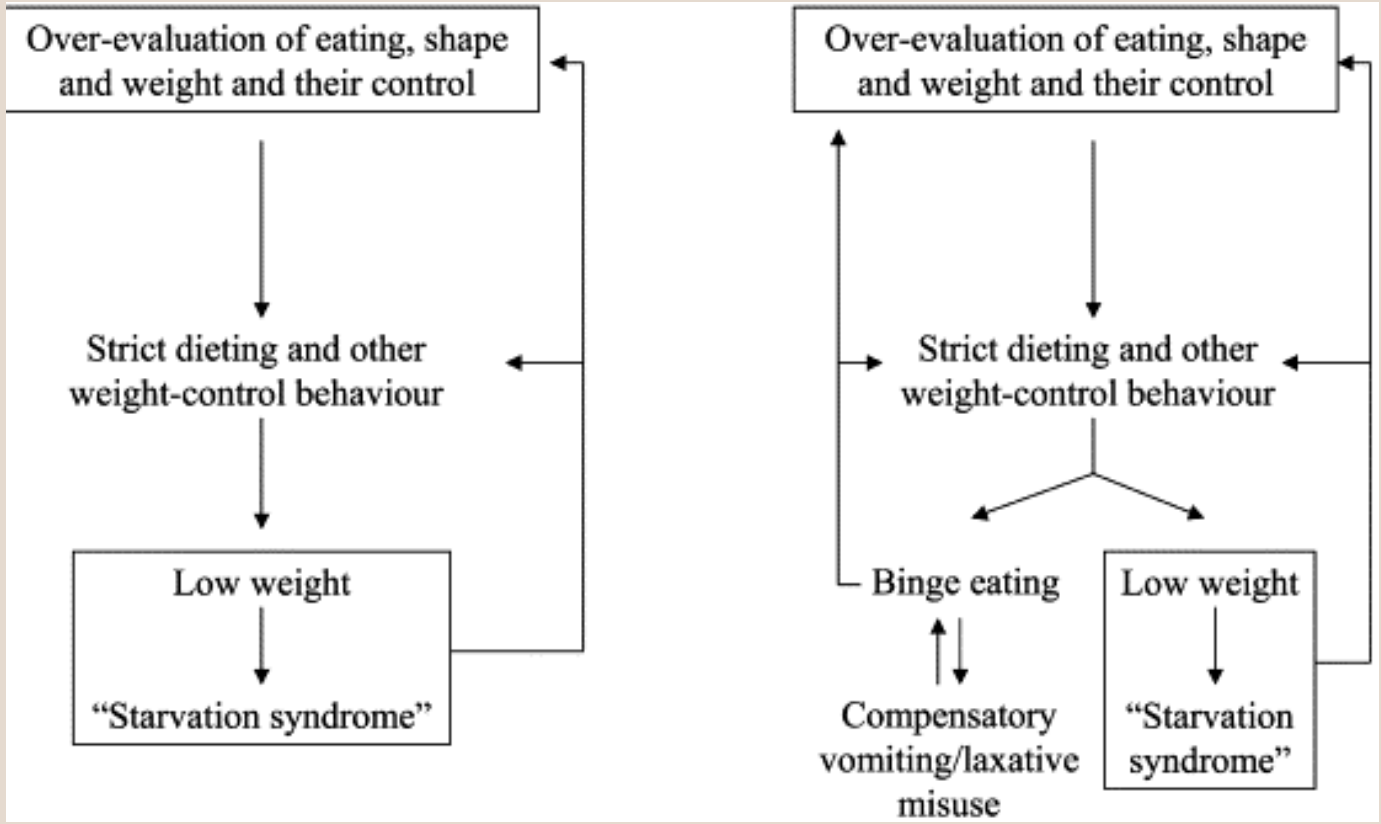
Risk factors in Eating Disorders



Continuum of relationship with food and weight/ shape

Cognitive transdiagnostic model of Eating Disorders

FAIRBURN ET AL



Making a diagnosis

- You cannot determine by looking at someone if they have an eating disorder or not
- Similarly, you can't exclude an eating disorder by only looking at them
- Diagnosis requires clinical assessment and examination to identify the cognitive disturbance and the relevant physical health parameters
- The identification of risk is particularly important to guide clinical decision making

Anorexia Nervosa

Anorexia nervosa is a psychological illness that has serious physical, emotional and social consequences.

It is characterised by body image distortion with an obsessive fear of gaining weight, which manifests itself through depriving the body of food. It often coincides with increased levels of exercise

Restricting type — this is the most known type of anorexia nervosa, whereby a person severely restricts their food intake. Restriction may take many forms (e.g. maintaining very low calorie count, restricting types of food eaten, eating only one meal a day) and may follow obsessive and rigid rules (e.g. only eating food of one colour)

Binge-eating or purging type — this type of anorexia nervosa forms when a person restricts their intake as above, but also has regularly engaged in binge-eating or purging behaviour (e.g. self-induced vomiting, over-exercise, misuse of laxatives, diuretics or enemas).

'Atypical' anorexia nervosa refers to people who meet the standard diagnostic criteria for anorexia nervosa, except for the weight component (OSFED diagnosis can be used) (BMI >18.5)

Bulimia Nervosa (BN) and Binge Eating Disorder (BED)

Bulimia nervosa is a serious psychiatric illness characterised by recurrent binge-eating episodes (the consumption of abnormally large amounts of food in a short period of time), followed by self-induced vomiting, fasting, over-exercising and/or the misuse of laxatives, enemas or diuretics. There is a psychological preoccupation with weight and shape concerns.

Bulimia nervosa differs from binge eating disorder (BED). While binge episodes in both illnesses are associated with a sense of loss of control and are followed by feelings of guilt and shame, a person experiencing bulimia nervosa will immediately engage in compensatory behaviours such a vomiting or exercise. There does not have to be a preoccupation with weight and shape concerns – the impairment usually stems from the distress associated with binge episodes.

ARFID

AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER (ARFID) IS DEFINED BY THE DSM-5 AS AN EATING OR FEEDING DISORDER CHARACTERISED BY A PERSISTENT AND DISTURBED PATTERN OF FEEDING OR EATING THAT LEADS TO A FAILURE TO MEET NUTRITIONAL/ENERGY NEEDS.

- FEAR OF CONSEQUENCES ASSOCIATED WITH EATING/FEEDING (EG CHOKING OR TO AVOID DISTRESSING GI SYMPTOMS IN DGBI)
- SENSORY SENSITIVITY, SUCH AS AVOIDING FRUIT AND VEGETABLES, CRUNCHY FOODS OR INCONSISTENT TEXTURES OR TASTES
- LACK OF INTEREST IN EATING OR FOOD, FOR EXAMPLE FORGETTING TO EAT, NOT FEELING HUNGRY, LACK OF PLEASURE IN EATING

DIAGNOSIS IS ASSOCIATED WITH AT LEAST ONE OF THE FOLLOWING:

(1) SIGNIFICANT WEIGHT LOSS (OR FAILURE TO ACHIEVE WEIGHT GAIN/PHYSICAL GROWTH IN CHILDREN);

(2) SIGNIFICANT NUTRITIONAL DEFICIENCY;

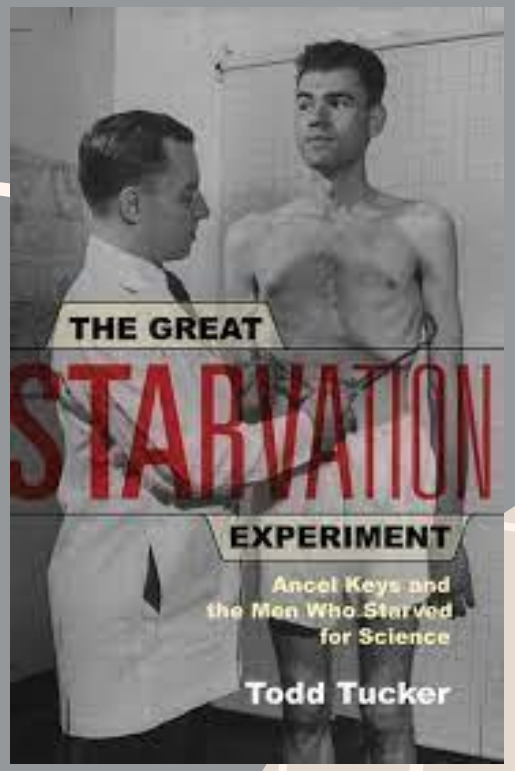
(3) DEPENDENCE ON TUBE FEEDING (SUPPLYING NUTRIENTS DIRECTLY TO THE GASTROINTESTINAL TRACT) OR ORAL NUTRITIONAL SUPPLEMENTS;

(4) MARKED INTERFERENCE ON AN INDIVIDUAL'S PSYCHOSOCIAL FUNCTIONING (E.G., IMPACTS ON DAILY ACTIVITIES)

OSFED Other Specified Feeding and Eating Disorders

- According to the DSM-5 criteria, to be diagnosed as having OSFED, a person must present with symptoms similar to other eating disorders but not meet the full criteria of, for example, anorexia or bulimia. This does not mean that their illness should be taken any less seriously.
- A diagnosis might then be allocated that specifies a specific reason why the presentation does not meet the specifics of another disorder. These could be any of the following:
- Atypical anorexia nervosa — This is where all criteria is met for anorexia, except significant weight loss. The individual's weight might be within or above the normal range.
- Binge eating disorder (of low frequency and/or limited duration) — When all of the criteria for BED are met, but binges happen less frequently than expected or have been occurring for less than three months.
- Bulimia nervosa (of low frequency and/or limited duration) — When a person has all the symptoms of bulimia but the binge eating and subsequent purging occurs at a lower frequency and/or for less than three months.
- Purging disorder — This is when a person eats what is considered a 'normal' amount of food (i.e. does not engage in binges or food restrictions) but still uses laxatives or self-induced vomiting to influence their weight or shape.
- Night eating syndrome — When someone either wakes up during the night to eat or consumes a lot of food just before going to bed, after their evening meal. Night eating syndrome is diagnosed when the behaviour cannot be better explained by environmental influences or social norms or by another mental health disorder (such as BED)
- Unspecified Feeding and Eating Disorder

medical considerations



"SICK ENOUGH" A GUIDE TO THE MEDICAL COMPLICATIONS OF EATING DISORDERS BY JENNIFER GAUDIANI - AMERICAN PHYSICIAN WHO NOW CLINICALLY OVERSEAS AN EATING DISORDER INPATIENT FACILITY – MDT (THEREFORE A SERVICE SIMILAR TO THIS DOESN'T EXIST HERE IN QLD).

RESPONSES ARE VERY VARIABLE AND CAN BE DIFFICULT TO PREDICT

CAVE PERSON BRAIN – "I MUST BE IN FAMINE, AND WE HAVE TO PROTECT" – EFFECTS INCLUDE SLOWED METABOLISM, HYPOTHALAMIC HYPOGONADISM, HYPERVIGILANT BRAIN

BONE MARROW SUPPRESSION(NEUTROPENIA, ANAEMIA AND THROMBOCYTOPENIA), LIVER MALFUNCTION (AUTOPHAGY), SKIN AND HAIR DYSFUNCTION

GASTROPARESIS AND REDUCED COLONIC MOTILITY (CONSTIPATION) AND DGBI (OVERLAP)

BONE DENSITY LOSS (Z SCORES LESS THAN -2.0 OR FRACTURES FROM FALLING FROM STANDING HEIGHT OR LESS WITHOUT TRAUMA = OSTEOPOROSIS IN 20–50-YEAR-OLDS AND Z SCORES UNDER -1.0 IN OVER 50-YEAR-OLDS

CONSERVING HEAT - LANUGO HAIR AND ACROCYANOSIS

STARVING HEART CHANGES +/- ORTHOSTATIC VITAL CHANGES – PULSE RATE IS SLOW AT REST DUE TO INCREASED VAGAL TONE AND THEIR HEARTS/MUSCLES HAVE LOST MUSCLE MASS FROM RESTRICTION – SO WHEN THEY STAND UP THEIR HEART RATE RISES (SOMETIMES DRAMATICALLY) WITH LITTLE EXERTION

IN AN ATHLETE'S HEART CARDIAC AND SKELETAL MUSCLES ARE STRONG AND CONDITIONED – AS A RESULT THEY NEED LESS OXYGEN TO DO ANY GIVEN TASK – THEREFORE WHEN THEY STAND UP AND WALK AROUND – THEIR HR/BP USUALLY DO NOT CHANGE MUCH

EXTREME PRESENTATIONS – DYSPHAGIA, AUTOPHONIA, LAGOPHTHALMOS, SUPERIOR MESENTERIC ARTERY SYNDROME/NUTCRACKER SYNDROME AND PANCREATITS

SUDDEN DEATH ?CARDIAC ARREST DUE TO ARRYTHMIAS FROM ELECTROLYTE DISTURBANCE/ STRUCTURAL CHANGES OR RELATED TO HYPOGLYCAEMIA AND THEREFORE LACK OF GLUCOSE TO CARDIAC MUSCLE

Purging and its effects

DENTAL DAMAGE

OESOPHAGEAL DISEASE, BARRETT'S OESOPHAGUS

RINSING -> HYPOTHERMIA

RUMINATION

PAROTID GLAND ENLARGEMENT AND FACE SWELLING

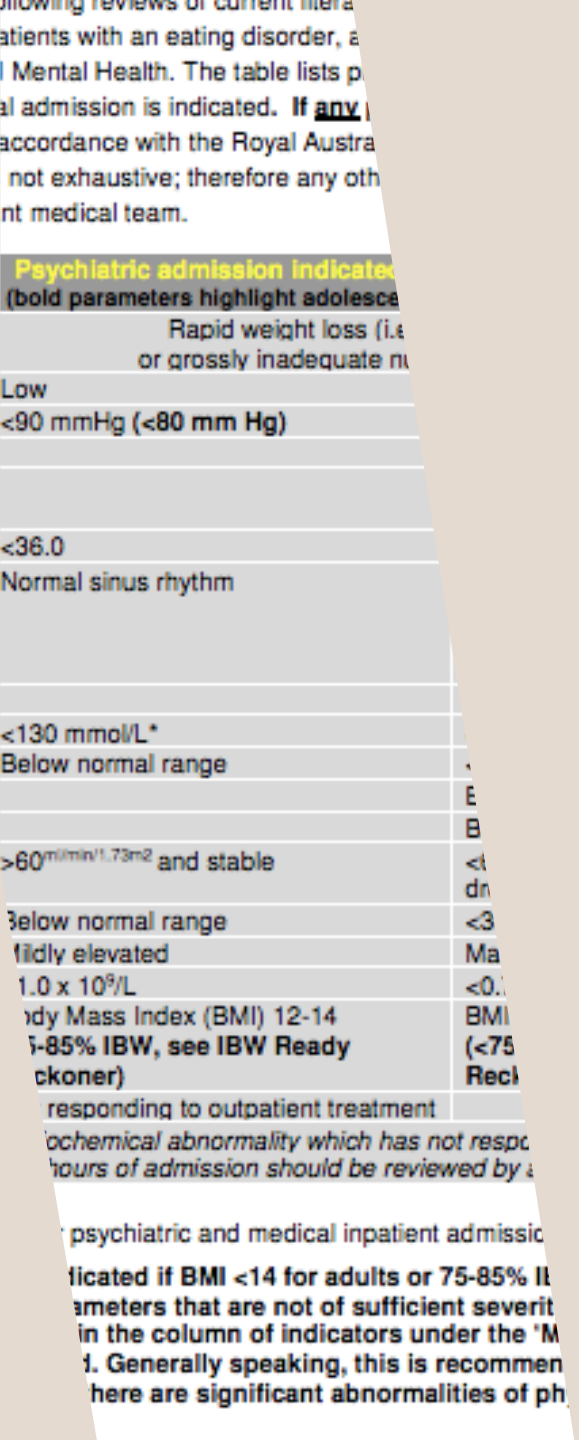
GI TRACT BLEEDING

MELANCOLIS COLI AND CHRONIC NAUSEA/ CRAMPS WITH LAXATIVE MISUSE

THYROID DISORDER

HYPOKALAEMIA, LOW BICARBONATE AND DEHYDRATION WITH RENAL IMPAIRMENT

PSEUDO-BARTTER SYNDROME – INCREASED ALDOSTERONE LEVELS WHICH THEN HOLDS ONTO FLUID AND DUMPS POTASSIUM



QuEDS guidelines for admission to hospital

They are a guideline to support decision making

Do not replace clinical examination and judgement

Please try to avoid use of language that suggests people "aren't unwell enough"

QuEDS and stakeholders have completed the first draft of admission criteria review

12 months of work so far

- Steering group – monthly meetings with updates from all subgroups
- Director of QuEDS
- Team Leaders
- Senior QuEDS dietitian
- Senior QuEDS social work
- Senior QuEDS Psychologist
- Senior QuEDS OT
- QuEDS CNC Service development
- Eating Disorder Lived experience worker EDQ
- Carer/key supports lived experience worker EDQ
- Research Officer, QuEDS

- Subgroups
- Medical
- Nursing
- Allied Health
- Nutrition
- Research

- Additional considerations contributors
- Perinatal
- Diabetes
- Neurodivergence
- Co-occurring personality vulnerabilities/disorders
- Bariatric surgery
- ARFID
- DGBI

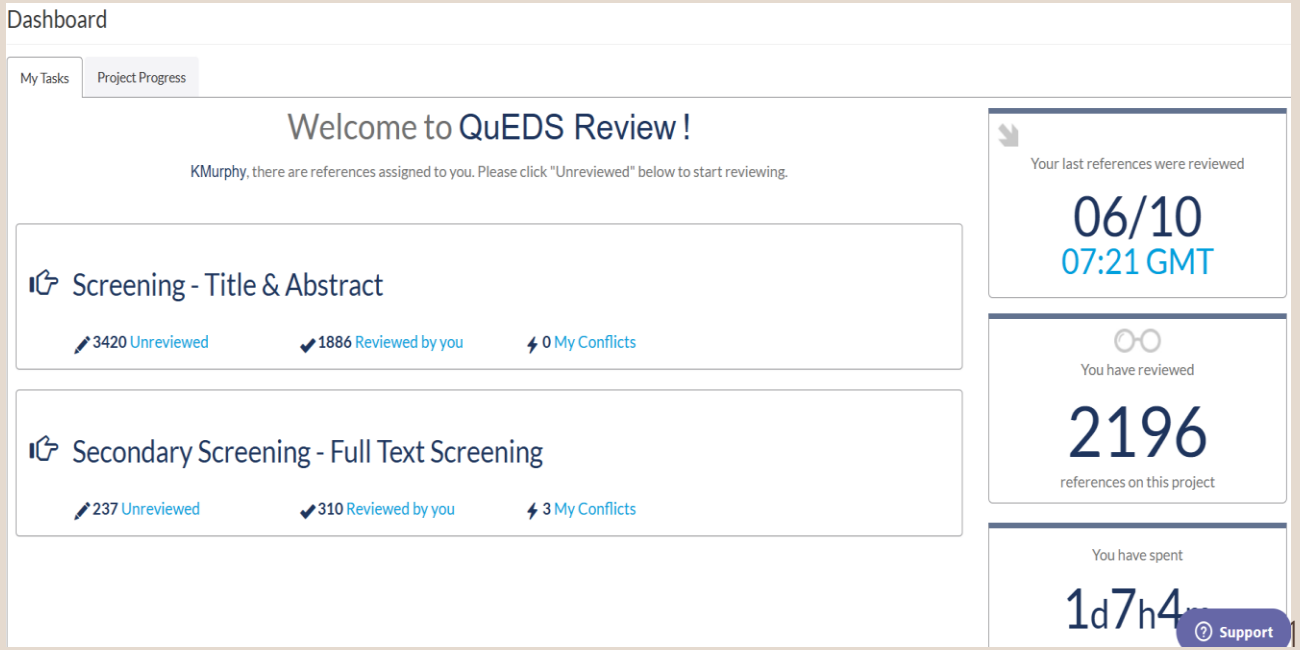
- *Legal services*

Redesign of the guideline document

- *Wanted the guideline to be up to date, evidence informed, easily accessed, relevant for all parts of the state, easy to read and to implement without needing specific eating disorder specialist teams involved, use of appropriate recovery orientated language*
- The guideline is divided into 3 main sections:
- Section 1. Background and context – this section is intended to support an overall understanding of eating disorders and the current health care system approaches to supporting individuals with eating disorders.
- Section 2. Multi-disciplinary (MDT) clinician guidance – this section is intended for clinicians to pull out as separate documents so that they have information to support their work in the assessment, treatment and support of individuals whilst they are in hospital settings. (Medical, Nutritional/dietetics, Nursing and Allied Health)
- Section 3. Special consideration groups – this section is intended to support the usual guidelines for individuals who have other co-occurring medical/physical or mental health conditions.
- Eg. If you are a nurse in an inpatient setting providing care for an individual who has an eating disorder and has diabetes – you can go straight to sections 2 B and 3 C for that particular individuals care plan.
- Can then use the remainder of the document to support own learning or to help with conversations with the individual and their family/ key supports

Research and Medical subgroup

- **Cardiovascular risk factors for serious adverse health events in individuals with eating disorders: A systematic review**
- **Dr Kate Murphy, Dr Morgan Sidari, Dr Elizabeth Eggins, Dr Thomas Skerlj, Dr Kirsten McMahon, Dr Stephen Parker, Jana Waldmann**
- *The systematic search identified 19,458 records. The de-duplicated results (n = 12,487) were imported into AI-enhanced review software – DistillerSR – for screening. At title and abstract screening stage, 5,813 citation records were excluded because they did not relate to cardiac issues in the context of eating disordered consumers (broadly defined). A total of 1,125 citation records were considered potentially eligible and progressed to full-text screening*



- Director of QuEDS
- Director of internal medicine RBWH
- Senior staff Specialist in medicine at Logan, Sunshine Coast University Hospital and Cairns
- Director of Consultation Liaison at RBWH
- Consultant Liaison psychiatrist Metro South
- Senior Dietitian Metro South
- Research Officer QuEDS

- Not published yet so not current guidelines/ hasn't been accepted by OCP

- *Lay out has changed – to really consider the assessment that is required for everyone irrespective of their weight/ size*
- *Made some changes according to the management of electrolytes policy that is accepted statewide*
- *Clarity on weight loss criteria and stand-alone BMI*
- *Removed PT from the table – this is not due to finding that it is NOT a clinical indicator of risk but there is a lack of evidence*
- *Removed the oral intake criteria because the reliability is poor*

PLEASE NOTE THIS IS IN DRAFT AND IS NOT YET PUBLISHED – THEREFORE PLEASE REFER TO CURRENT GUIDELINE

ASSESSMENT OF EATING DISORDERS IN ADULT EMERGENCY DEPARTMENTS and INDICATORS FOR ADMISSION
Complete usual triage Emergency Department assessment
Minimum assessment to be completed for all individuals with a diagnosed OR suspected eating disorder
• Measure blood pressure and heart rate at rest plus postural changes (sitting and standing with 2 minutes in between)
• Collect blood tests including full blood count, electrolytes, liver function tests, glucose, phosphate, magnesium
• Calculate current BMI
• Obtain an objective measure of any weight changes within the past 4 weeks
• Calculate oral intake over the past 4 weeks and in particular the past 5 days
• Complete mental health screening assessment by psychiatric emergency team including a risk assessment of suicide.
• *Consider further assessment for sepsis (increased risk in this population) particularly when tachycardia or other signs of infection are present.

INDICATOR OF ADMISSION TO ADULT MEDICAL WARD (if any one of these factors is present)	INDICATOR OF ADMISSION TO AN ADULT MENTAL HEALTH WARD (if any of these factors is present)
• Systolic BP <80mmHg	• Systolic BP <90mmHg
• Systolic Postural BP drop of >20mmHg (2 minutes apart)	
• Resting Heart rate <40bpm or >120bpm*	• Resting Heart rate <50bpm
• New ECG changes including QTc >460ms or ST/T wave abnormalities.	
• Temperature <35.5C	• Temperature <36.0C
• Glucose (venous) <3.0mmol/L	
• Potassium <3.0mmol/L	• Potassium <3.5mmol/L
• Sodium <125mmol/L	• Sodium < 130mmol/L
• Magnesium < 0.7mmol/L	
• Phosphate <0.7mmol/L	
• eGFR <60ml/min or 25% drop within 1 week	
• Albumin <30g/L	
• LFTs (AST or ALT) > 2x upper limit of normal	
• Neutrophils <1.0 10/L	
• BMI <13.0 kg/m2	• BMI < 15.0 kg/m2
• >10% total body weight loss over 4 weeks** or, more than 1kg/ week for over 4 weeks**	• ≥25% total body weight loss in 6 months or less**
	• Oral intake of less than 1000kcal/day for ≥ 4 weeks or more**
**Measured, objective or verifiable loss	**Measured, objective or verifiable loss
• If none of the above parameters are identified during assessment in the emergency department then please refer all individuals to psychiatric emergency for a mental health assessment prior to discharge.	• Significant deterioration or lack of progress in community despite access to eating disorder treatment. • Suicide risk that is considered to be acutely higher as compared with individual baseline or as compared with community population.

Individuals who have blood glucose of 3.0-4.0mmol/L or postural tachycardia are exhibiting features of clinical deterioration and require increased monitoring in the community with nutritional support.

Individuals in larger bodies/ higher weight individuals

- Weight stigma, shame, diet culture and social justice
- There are still fundamental assumptions made (often by medical staff) about these individuals
- Higher weights are often viewed by society and by much of medicine as not only dangerous but morally lax
- BMI charts are on the walls of health care facilities and all too often people go to the doctors for a sore throat and end up with recommendations regarding dieting or exercising
- Can you imagine what that does to an individual who is presenting with concerns about an eating disorder?
- BMI is not an indicator of longevity, and it is not correct to say that being thin means being healthy
- Bias treatment recommendations – knee pain is treated with "diet recommendations" vs PT, yoga, massage or physio
- Medical and surgical care outcomes – weight loss prior to knee surgery is not evidence based to improve outcomes
- If the person has "achieved" weight loss prior to surgery, then the nutritional deficiency effects on wound healing etc are reduced
- Health at Every Size (HAES) – does NOT mean "everyone at every body size is healthy" – it's a subtler message that "working in an attuned way with one's body and eating and moving in a flexible way to the extent one chooses can improve health independent of any weight change"
- We do recognise the health implications of increased adiposity/ type 2 diabetes
- Please consider the risk of eating disorders in those individuals who you are considering use of GLP-1 treatments or who you are considering referring to bariatric surgery – these individuals will inevitably develop more serious eating disorder pathology if this is not considered in the first instance

Treatments for Eating Disorders

1. Medical stability
2. Nutrition and meal planning
3. Reversal of starvation effects
4. Supportive psychotherapy
5. Family and carers support
6. SMT
7. Compassion therapy and distress tolerance

thank you

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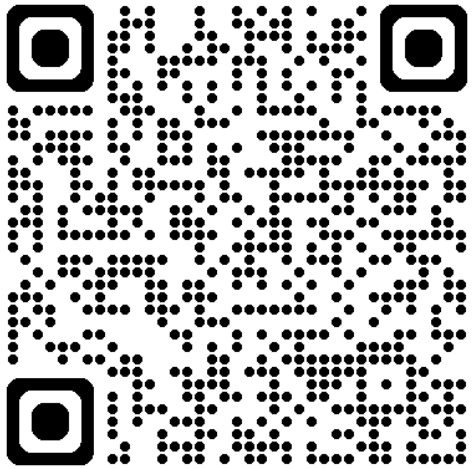

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Mental Health / Eating Disorders in Adults

Eating Disorders in Adults

Red flags

- Pregnant with low BMI and failure to gain adequate weight
- Suicide risk

Background

About eating disorders in adults

Assessment

Practice point

Seek collateral information

Patients with eating disorders may be difficult to engage, as they often don't realise the need for treatment or deny the reality of the problem. When possible, seek the patient's consent and obtain collateral information from family or carers.

1. Consider an eating disorder in people who present with any suggestive features.
2. Seek the patient's consent to obtain collateral information from:
   - family, carers, or significant others.
   - other health providers. If relevant, seek patient's permission to access their Queensland Health mental health record via the Health Provider Portal (i.e., The Viewer).

   Patients with eating disorders may be difficult to engage as they often don't realise the need for treatment, or deny the reality of the problem.
3. Explain limits of confidentiality to the patient.
4. Consider using one of the available screening tools to determine the likelihood of an eating disorder – note that routine screening of adults is not recommended:
   - SCOFF questionnaire
   - Eating disorder screen for primary care (ESP)
   - Binge-eating disorder screener – 7 (BEDS-7)
5. Take a history. This may be done over several appointments to build a rapport and avoid overwhelming the patient. An EDE-Q questionnaire may facilitate the process. Ask about:
   - weight – note that this is not the most reliable measure of severity.
   - physical activity and food-related behaviours.
   - signs or symptoms of severity and physiological changes.
   - psychosocial factors.
   - co-morbidities and medications.
6. Examine the patient for changes at every visit:
   - Check general appearance, alertness, and hydration status, and record baseline parameters.
   - Consider physical findings indicating other complications of disordered eating.
   - Consider on-the-spot BGL (glucometer) test.
   - Perform a 12-lead ECG, (particularly if BMI ≤ 16 or hypokalaemia) – look for concerning ECG changes.
   - Consider completing a mental state examination.
7. Arrange baseline investigations:
   - Arrange baseline FBC, E/LFTs (including calcium, magnesium, and phosphate), TSH, iron studies, Vitamin B_{12} and folate, BGL

General Practice Liaison Officer Program presents

Connecting The Dots

Navigating Mental Health in Primary Care

GP self care & wellness

Dr Rachel Hannam – *Guest speaker*

Clinical Psychologist

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Welcome lovely GPs ☺

Connecting the Dots: Navigating Mental Health in Primary Care

GP Stress and Burnout:
A biopsychosocial perspective

Dr Rachel Hannam, PhD
Owner / Clinical Director

north brisbane psychologists

Lutwyche & Aspley

Since 2012

(07) 3726 5595 | rachel@northbrisbanepsychologists.com.au

Ten Tips for Burning Out In Style!

1. **Say 'Yes' to everything**: If boundaries were important, why was there no course at Uni? Who needs boundaries when you have dedication?
2. **Sleep four hours max:** Sleep is overrated. Sleep upright in your scrubs. Melatonin is for poets & baristas.
3. **Skips meals, hydration, humour and joy**: Fuel your body with intravenous coffee and regret. Mental health is a myth. Laughter is suspicious. Joy is for nurses on annual leave.
4. **Ditch your hobbies**: Once into art, netball, jazz? Nup! Instead, doom scroll PubMed at 3am, argue on Twitter about the latest guidelines, get into Facebook wars. Balance is for the weak.
5. **Emotionally attach to every patient:** Take every death and AHPRA complaint deeply personally. Channel that pain into your core identity until you become a human version of a grief burrito.

Ten Tips for Burning Out (cont)

6. **Overload on documentation:** Avoid templates. Do notes like a novel. Bonus points: You finish yesterday's notes during your own colonoscopy.
7. **Don't seek help:** Vulnerability, like therapy, is for people with feelings and spare time.
8. **Believe your negative self-talk:** Your inner critic is a highly qualified medical consultant. Let shame and Imposter Syndrome direct your career choices like a drunk, depressed Uber driver.
9. **Focus on things outside your control:** If you can't fix it, fret. Every day. You'll never run out of things to worry about.
10. **Isolate yourself:** If you're not turning down invitations with: "*Sorry, I'm on call…* " are you even committed to your own collapse?

Your Thoughts?

1. Signs of burnout? Have you ever *burnt-out* - even a little bit?

2. How would you rate it?

3. Can it ever be a ‘gift’?

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Burnout - Chronic Stress Poorly Managed?

Situation specific - May only feel this way at work, less pervasive than Dep / Anx

1. **Emotional exhaustion** - Overextended, drained, 'running on empty'
2. **Diminished accomplishment** - Self-doubt, diminished sense of purpose
3. **Depersonalization -** Cynicism, numbing, irritability, sarcasm, callousness

Loneliness / lack of connection is a core dimension and bi-directional

Susceptible to:

- Mental health impacts - Depression or anxiety
- Physical health impacts - Lowered resistance to illness
- Behavioural impacts - Absenteeism, reduced efficiency & job performance

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Stress is not one thing!

- **Stress** versus **Stressor**
- Stress is a reaction in body and mind to deal with perceived threats or demands
- **Secondary emotions** include *anxiety*, *worry*, *overwhelm*, *anger*, *frustration*, *upset, resentment*
- What are the **primary emotions**?
  - Scared, fearful
  - Hurt, grief
  - Confused, unclear
  - Lonely, isolated
  - Self-consciousness, humiliation, shame
  - Powerlessness

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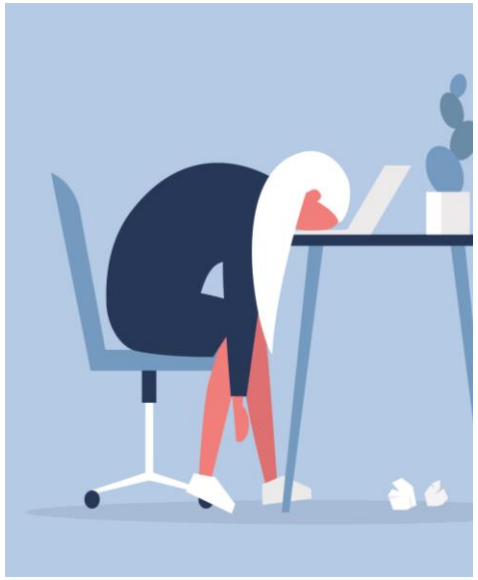
Triggers for stress - Fix the workplace or fix the worker?

Research on Common Stressors



- **External (Workplace)**
  - Role + cognitive overload - long hours, decision fatigue
  - Lack of rewards, recognition, feedback
  - Lack of resources
  - Interpersonal conflicts, values conflicts
  - Social-emotional isolation

- **Internal (Worker)**
  - Cognitive Distortions - Catastrophise, Personalize, “Shoulds”, B&W Thinking
  - Schemas - Unrelenting standards, Self-sacrificing, Shame, Punitiveness
  - Maladaptive coping - Avoidance, fixation, overeating, substance misuse
  - Complaining / victim mindset
  - Personal life ‘spillover’

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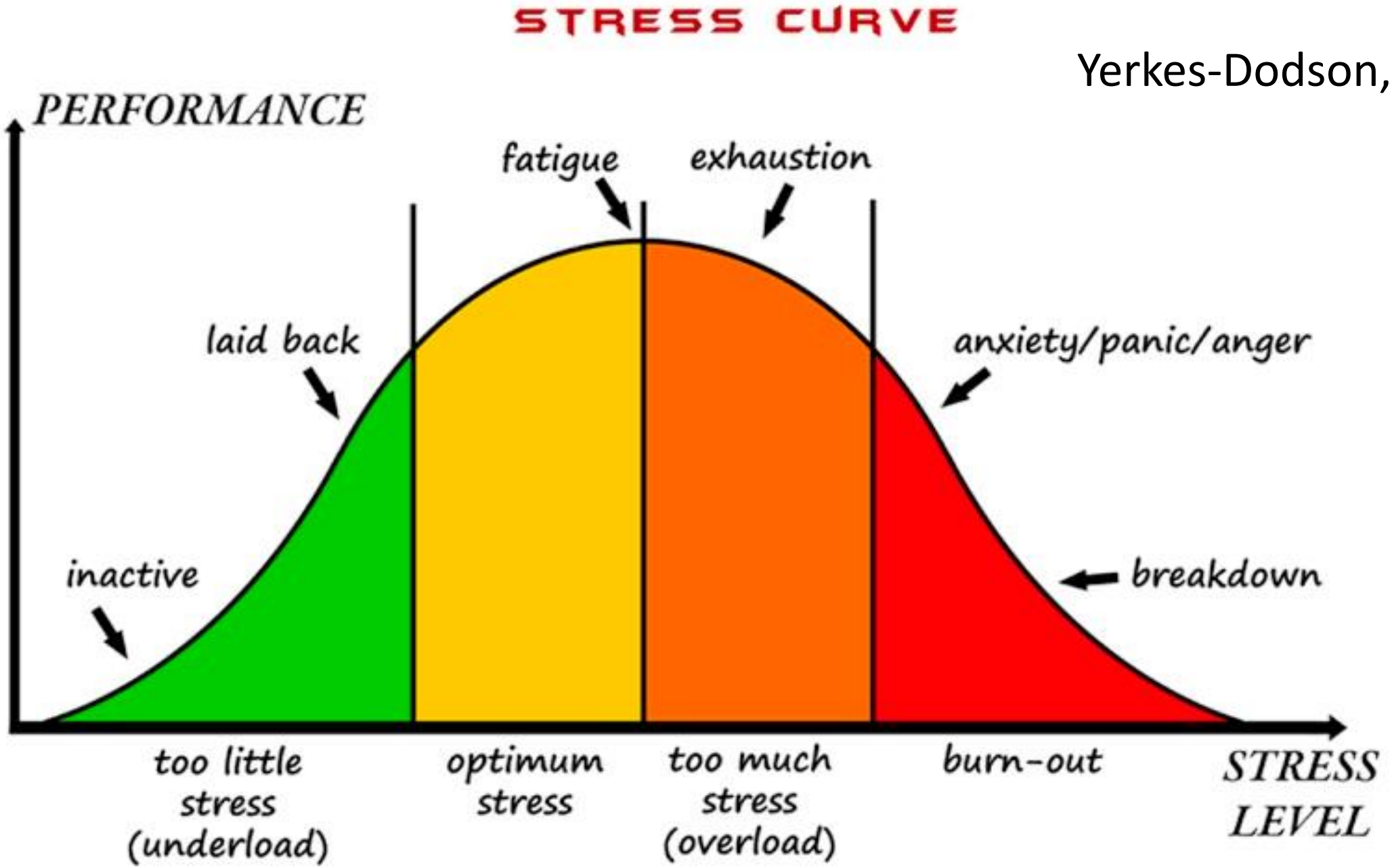
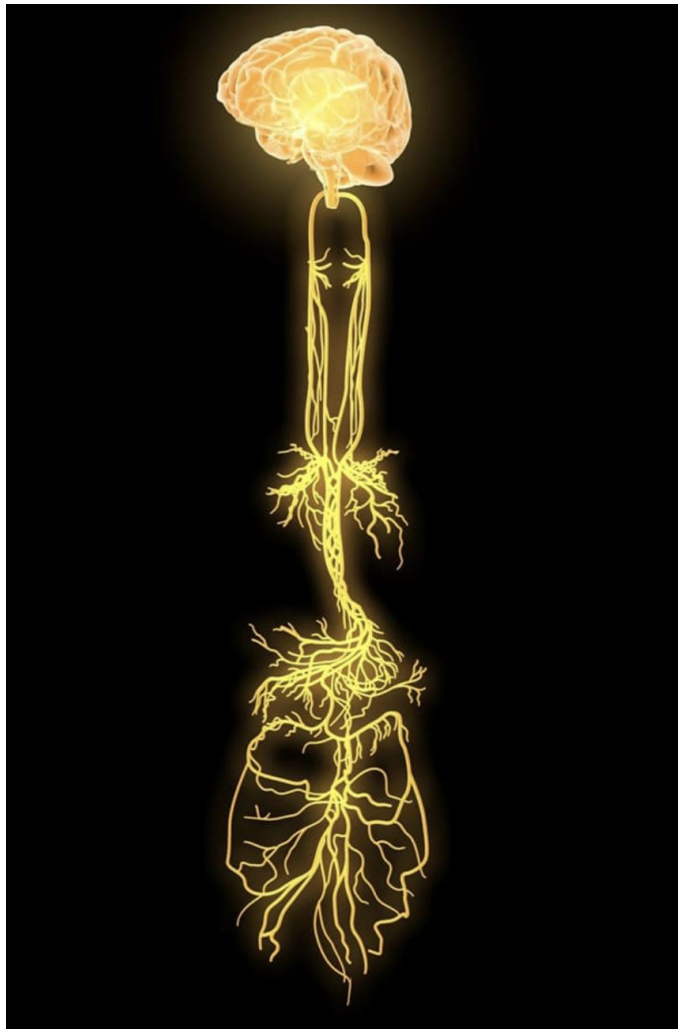
Yerkes-Dodson, 1908



Neurobiology of Grace Under Pressure

- Create poise and calm
- Return to ‘flow’
- Deliberateness / mindfulness / awareness

- **Vagus nerve** regulates our inner See-Saw:
  - Sympathetic Nervous System (SNS)
    (Fight-Flight-Freeze-Fawn)
  - Parasympathetic Nervous System (PNS)
    (Rest-&-Digest, Safe-&-Social)



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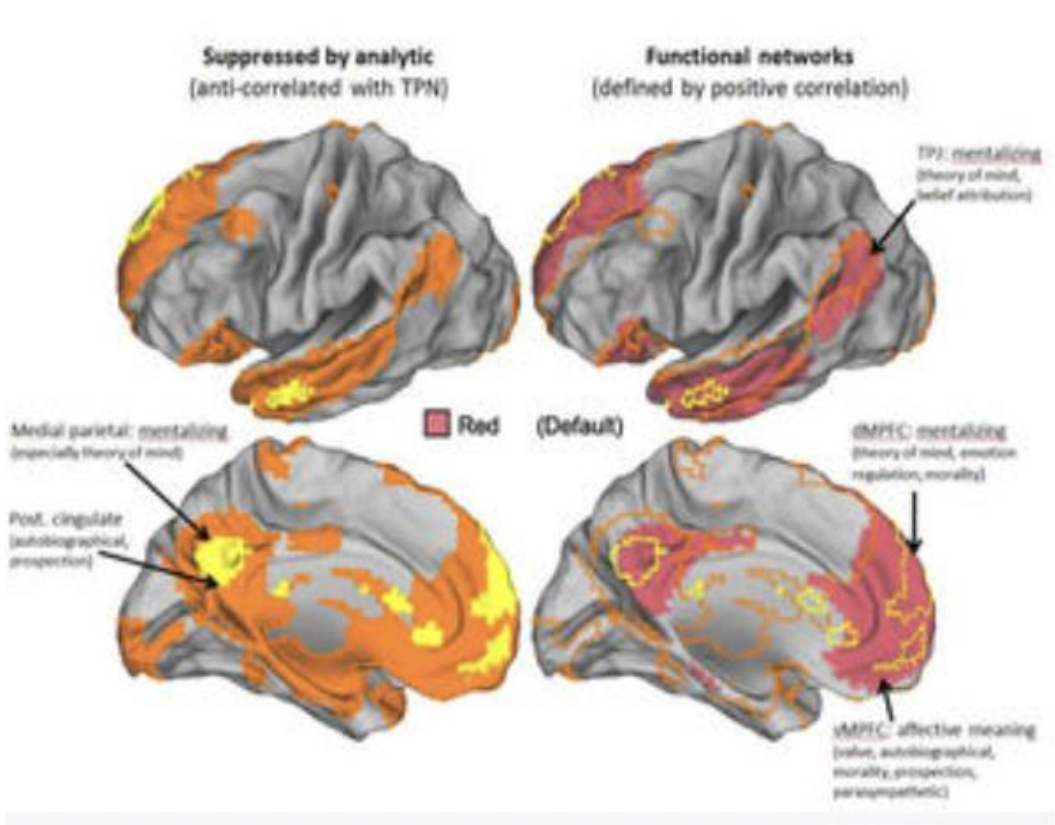
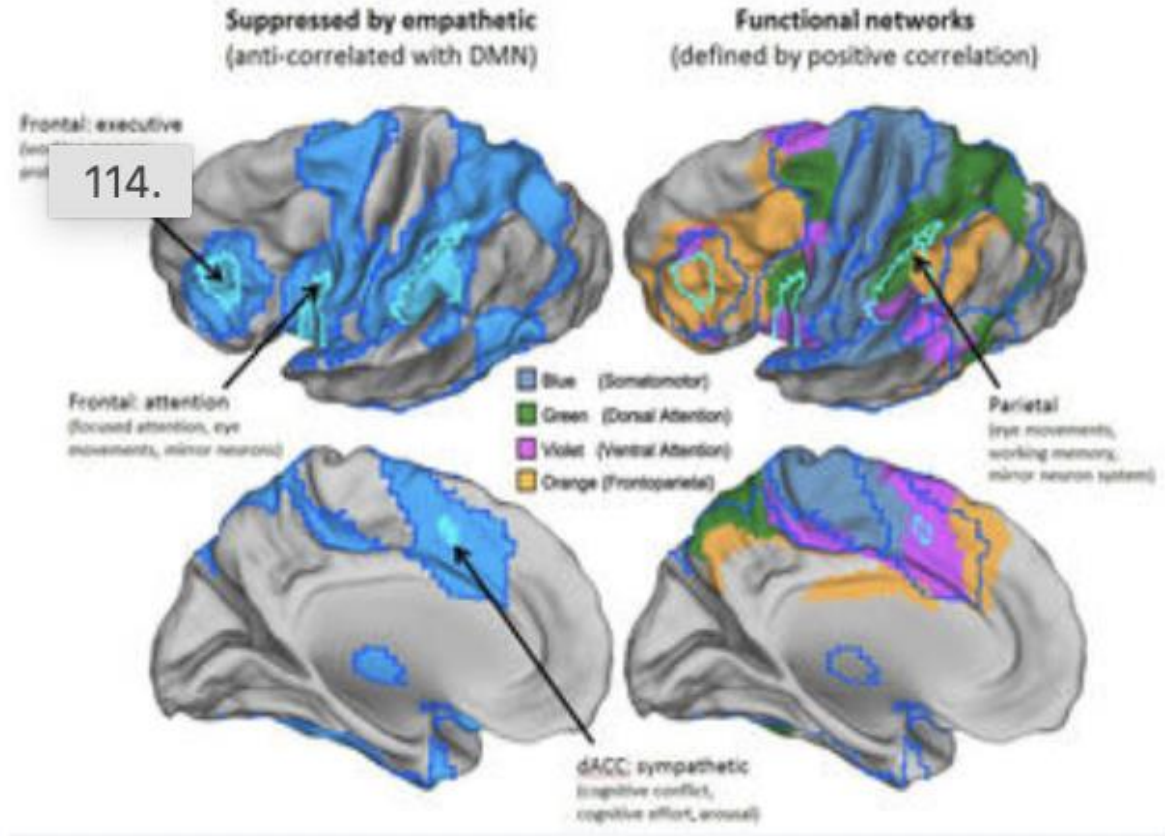
The Default Mode Network (**DMN**) and the Task Positive Network (**TPN**) = Flow



DMN: *Mentalistic*



TPN : *Mechanistic*

Regulate the Vagus Nerve and the DMN

Brains Respond Well to Tasks 

We are 3 x more effective when in a flow state. Here are some tasks:

- **Pay attention to your attention**
- **Deploy respiration control -** Slow deep breaths, double/triple inhale
- **Stop and see – Notice / name things**
- **Gratitude – Savour things** 
- **Learn to name and use feelings** – IPT and EFT *
- **Reframe** – Manage worry & shame, dig into beliefs*
- **Self-compassion** – see Professor Kristin Neff *

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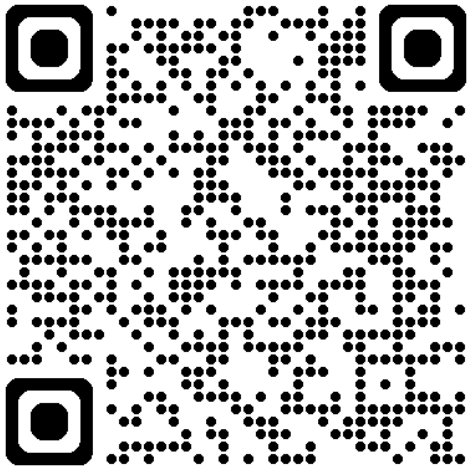
"If you were your own patient, would you be satisfied with the care you're giving yourself?"

- MHTPs/EDMP Tips & Requirements: **QR Code** on back of flyers
- CONTACT ME rachel@northbrisbanepsychologists.com.au
- CONTACT ME for recommendations about which Psychologist may be best suited for your patient (0478 789 321)
- CONTACT ME for a consult if your answer to the above is NO!

north brisbane psychologists



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Specific Populations / Clinician Health / Clinician Health - Self-care

Clinician Health - Self-care

This pathway is about caring for your own physical and mental health as a medical practitioner. While some elements of the pathway may be useful to other health professionals, it has been written specifically for doctors.

See also Clinician Health – Caring for Colleagues.

Background

About clinician health – self-care

Management

1. Plan self-care in advance:
   - Have your own general practitioner. Do not be your own general practitioner.
   - Plan a yearly preventive health visit.
   - Analyse and respond to potential barriers to accessing formal health care.
2. Be aware that doctors as patients can have unsatisfactory interactions and consultations due to:
   - patient factors.
   - treating doctor factors.
   - the unique nature of the consultation.
3. Use strategies for getting the maximum benefit from the consultation.
4. Respect your doctor's choice to charge a fee for their services.
5. Care for your own well-being by prioritising good lifestyle habits:
   - Meet your basic needs of existence every day.
   - Ensure adequate sleep and nutrition.
   - Avoid excess alcohol.
   - Be physically active.
   - Cultivate outside interests.
   - Maintain connections with family and friends.
   - Spend time outside and in nature.
   - Consider mindfulness or meditation.
   - Plan adequate leave and time off for holidays.
6. Monitor yourself for warning signs:
   - Symptoms of burnout
   - Changes in weight, sleep, or energy levels
   - Maladaptive coping mechanisms
   - Decreased enjoyment in usual activities, social withdrawal
   - Other potential indications – may be easier to identify in others than yourself
7. Take sick leave where appropriate. Do not work when unwell.
8. Consider the risks associated with your workplace and job and develop strategies to mitigate:
   - Workplace safety is the responsibility of both the employer and the individual.
   - Modify what you can and discuss risks with your employer where appropriate.
   - Consider contacting the Australian Medical Association (AMA) for advice and support regarding safe work conditions.
9. Ensure you are immunised against relevant communicable diseases and seek independent medical advice and management of any specific health risks or vulnerabilities.

Optional activity

Quality improvement activity

1.0 MO | Self log

Use the online form to capture quality improvements you have implemented or plan to implement as an outcome of this educational activity.

1. Use the QR to open the online form
2. Complete the online form
3. Once completed, you will receive an email with your answers
4. Self log the activity with your answers as supporting evidence.

Optional activity
Multi-choice quiz

2.0 RP | Points allocated for you

20 questions to reflect upon knowledge and learnings from today's event.

Link will be provided via email early next week.

You will have until midnight Sunday 10 August 2025 to complete the quiz.

Any questions?
Please contact:
MetroNorthGPLO@health.qld.gov.au

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GP and primary care education

Presentations and further resources from past education events

- Caboolture Hospital education
- Cardiology
- Championing Generalism Workshop (updated 2025)
- Diabetes
- Gastroenterology and Hepatology
- Gender Services
- Genetics
- Gynaecology (updated 2024)
- Haematology and Oncology
- Heart Failure
- Immunology & ENT (updated 2024)
- Kidney Health
- Maternity (updated 2025)
- Men's Health (updated 2024)
- Mental Health (updated 2024)
- Neurology
- Orthopaedics (updated 2024)
- Paediatric
- Persistent Pain Management
- Respiratory
- Rheumatology
- Sexual Health
- Skin Cancer (updated 2024)
- Spinal health
- Surgery
- Urology

Contact

Email: MNGPLO@health.qld.gov.au

Refer a patient

Access the referral guidelines to refer a patient.

Call the GP hotline for enquiries about referring on **1300 364 938**

General Practice Liaison Officer Program

0499 112 282

MetroNorthGPLO@health.qld.gov.au

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Thank you!