

# **Primary Care Mental Health Training**

**Workshop Outline  
& Resources  
2008**



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## Overview of the Workshops

- This 7 hour module, comprising 2x3.5hr workshops, has been developed for Basic Term GP Registrars in the Adelaide to Outback GP Training Program.
- It aims to provide an introduction to primary care mental health, and to provide a framework for practice.
- A range of consumers and carers have been consulted during the development of this workshop.
- Outlines of the 2x3.5 hr workshops and additional notes are provided below.

## Module Timetable

Workshop	Time	Breaks
1	3.5 hours	10 minutes
2	3.5 hours	10 minutes

## Module Outline

<p><b>Learning Objectives</b></p>	<p>At the end of this module, participants will:</p> <ol style="list-style-type: none"> <li>1 Have developed a greater understanding of mental health issues in the community (including aetiology and epidemiology).</li> <li>2 Appreciate the potential complexities of mental health presentations, including co-morbidities and chronicity.</li> <li>3 Appreciate the particular role of GPs in mental health care, and the roles of other health professionals.</li> <li>4 Have a greater understanding of the assessment and collaborative management planning and the monitoring and review process, including relapse prevention.</li> <li>5 Be able to undertake a systematic mental health assessment, including the use of assessment tools.</li> <li>6 Be able to implement 'watchful waiting'.</li> <li>7 Be confident with psycho-education using consumer friendly resources.</li> <li>8 Have a greater understanding of management strategies.</li> <li>9 Be confident with several brief evidence-based psychotherapeutic interventions.</li> <li>10 Have a greater appreciation of consumer and carer perspectives.</li> <li>11 Have greater knowledge of mental health services in the community and referral pathways.</li> <li>12 Be provided with a list of useful resources, including consumer self-help resources.</li> </ol>
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<p><b>Module Outline</b></p>	<p><b>Workshop 1 (3.5 hrs)</b></p> <ul style="list-style-type: none"> <li>• The context – mental health issues in the community, the role of GPs in primary care mental health.</li> <li>• The Interview and Assessment process.</li> <li>• Management Part 1.</li> <li>• Development of the Management plan.</li> <li>• Complex issues.</li> <li>• Attitudes to mental health care, consumer and carer views.</li> <li>• Resources.</li> </ul> <p><b>Workshop 2 (3.5 hrs)</b></p> <ul style="list-style-type: none"> <li>• Management Part 2.</li> <li>• Barriers to mental health care.</li> <li>• Case discussion.</li> <li>• Role of the psychologist, and other mental health professionals.</li> <li>• Relapse prevention.</li> <li>• Brief Interventions.</li> <li>• Resources.</li> </ul>
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## Workshop 1 Outline

<b>Icebreaker</b>  <b>Objectives</b>  <b>Guidelines</b>  <b>Expectations</b> 9.00-9.10am 10 mins	<ul style="list-style-type: none"> <li>Participants to say their name and where they are working.</li> <li>Learning objectives and program outline to be reviewed</li> <li>E.g. shared personal information / experiences are confidential.</li> <li>Registrars to be invited to share their expectations of the workshop.</li> </ul>
<b>Context</b> 9.10-9.40am  30 mins	<ul style="list-style-type: none"> <li>The context of mental health in the community (primary mental health care vs tertiary).</li> <li>Common issues and problems in the community, such as anxiety and depression (prevalence), to be outlined.</li> <li>Potential roles of the GP in primary care mental health (brainstorm and discussion).</li> </ul>
<b>The Interview and Assessment</b> 9.40am-10.15am  35 mins	<p>There will be discussion about interviewing and assessment process.</p> <p>A <i>clinical scenario</i> will be used.</p> <p>The Triage Assessment will be highlighted:</p> <ol style="list-style-type: none"> <li>Why now?</li> <li>Genogram</li> <li>Sequence</li> <li>Functioning</li> <li>System review.</li> </ol> <p>An <i>exercise</i> will be carried out using genograms.</p>
<b>Morning tea</b>	10 minute break
<b>Assessment cont.</b> 10.25-10.50 am 25 mins	<p>GP Assessment including physical assessment and use of Assessment Tools.</p> <p>DASS <i>exercise</i>.</p>
<b>Management</b> 10.50-12.05 pm  40 mins  35 mins	<p>Explanation of the concept of 'Watchful Waiting', and the 4 Step 'Back on track' approach -</p> <ol style="list-style-type: none"> <li>Exclude and explain</li> <li>Predicament</li> <li>Back to work</li> <li>Neuro-vegetative rehabilitation</li> <li>Feelings Good</li> </ol> <p>Risk assessment and management.</p> <p>Video re second part of Mary's story – managing social issues involved in the case. GP management planning including</p>

	<i>exercise</i> on completing the plan.
<b>Practical Issues</b> 12.05-12.15 pm 10 mins	The following issues will be outlined (proformas provided): <ul style="list-style-type: none"> <li>• Use of the mental health Medicare Items relating to assessment, management planning and review.</li> <li>• Level 1 and Level 2 Training.</li> <li>• Focussed Psychological Strategies.</li> <li>• The Better Access Program.</li> </ul>
<b>Attitudes to mental health</b> 12.15-12.40pm 25 mins	<ol style="list-style-type: none"> <li>1. <i>Discussion</i> about attitudes of GPs to mental health care, and how this might influence management.</li> <li>2. Views of consumer and carers highlighted, including <i>video</i> re adolescent consumers.</li> </ol>
<b>Resources</b> 12.40-12.50pm 10 mins	Sharing of resources, looking at websites, handouts and books. Comprehensive resource list to be provided.
<b>End Session</b> 12.50-100pm 10 mins	Summary, questions and evaluation

## The following articles will be provided to Registrars as pre-reading

Giron, M., Purificacion, M., Puerto Barber, J., et al. Clinical Interview Skills and Identification of Emotional Disorders in Primary Care. *Am J Psychiatry* 1998; 155: 530-535.

Hickie I, Andrews, G, Davenport, T. Measuring outcomes in patients with depression or anxiety: an essential part of clinical practice. *Med J Aust*, 2002; 177: 205-7

Howell, C. *Preventing depression relapse: a primary care approach*. Primary Care Mental Health. Primary Care Mental Health 2004: 2; 151-6.

Mynors-Wallis LM, Gath DH, Day A, Baker F. Randomised controlled trial of problem solving treatment, antidepressant medication, and combined treatment for major depression in primary care. *BMJ* 2000; 320: 26-30.

Whiteford, H. Depression in primary care: expanding the evidence base for diagnosis and treatment. *Medical Journal of Australia*, 2008; 188, S1021-102

## Context

This section will help Registrars to;

- develop a greater understanding of mental health issues in the community (including aetiology and epidemiology),
- appreciate the potential complexities of mental health presentations, including co-morbidities and chronicity, and
- appreciate the particular role of GPs in primary mental health care.

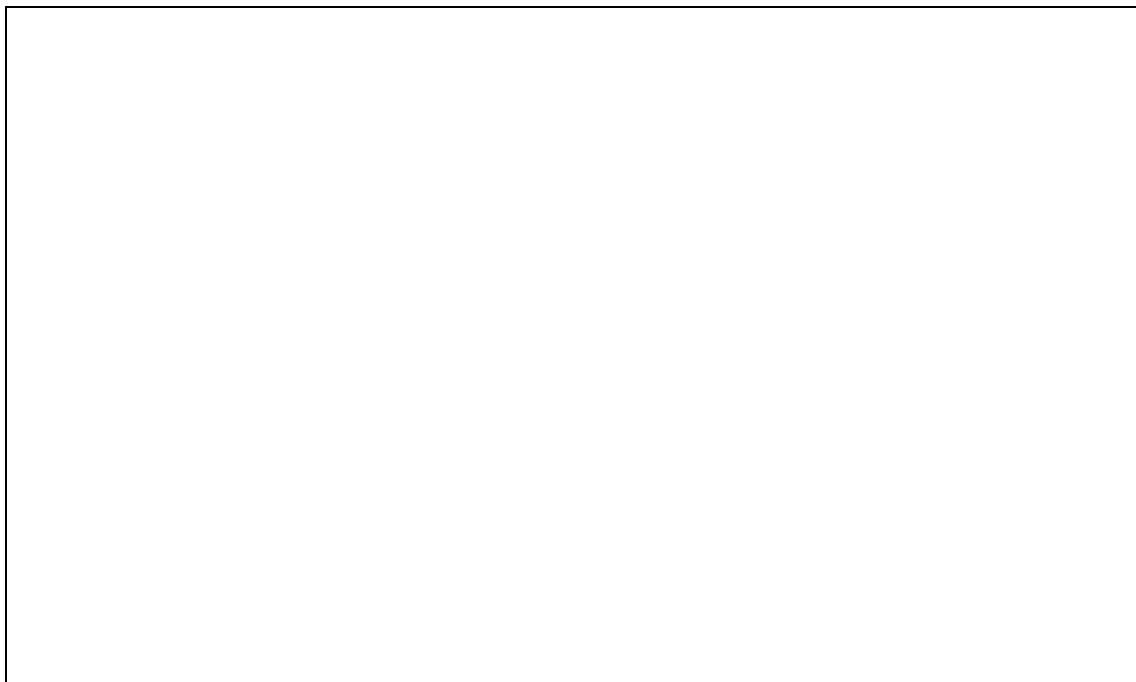
Primary care mental health provides optimal care for many patients and should not be seen as a second rate form of psychiatric intervention. GPs have extensive knowledge of a patient's community and often prior knowledge of the patient and their family. This information and their capacity to build on a relationship over time mean that GPs are well placed to provide optimal assessment and management of many primary care mental health presentations.

The context of primary care mental health will be provided;

- mental health issues in the community (range being seen by GPs, contrast with tertiary care),
- epidemiology including prevalence of mental health problems, such as anxiety and depression, eating disorders, post-natal depression and bipolar disorder.

The important role of GPs will be highlighted via;

- a *brainstorm* of potential GP roles,
- reflection on the various ways GPs get involved in mental health, and
- an outline of available training and support for GPs.



## Interview and Assessment

This section aims to provide Registrars with;

- a greater understanding of the interview and assessment process, and
- a framework for undertaking a systematic mental health assessment.

Issues related to the interview process will be outlined, including;

- communication skills such as listening and asking questions with psychological content;
- the importance of rapport, reassurance and repetition;
- the need for an interview framework, and
- providing information to the patient and family/carers.

The following *clinical scenario* will be used to illustrate the interview / assessment process.

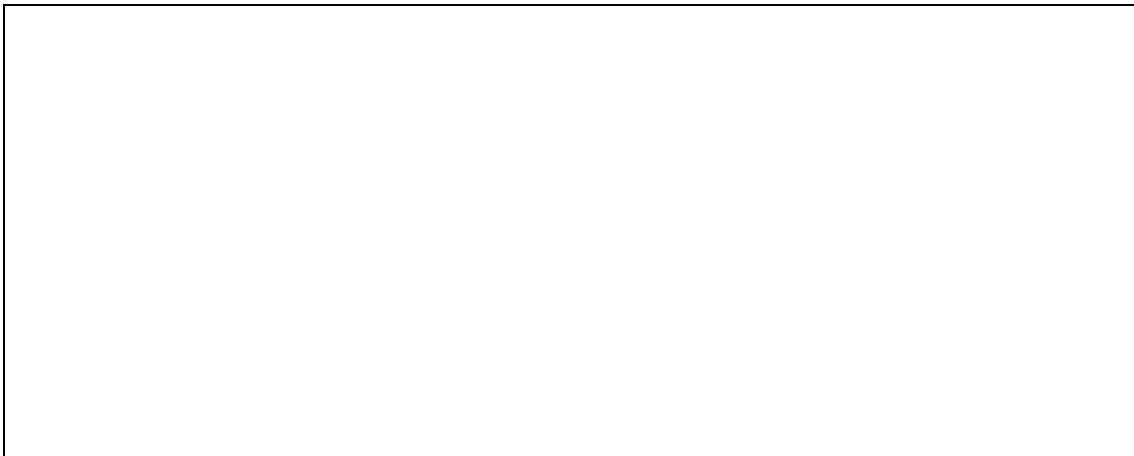
*Mary, a 28 year old woman is referred by a community health worker with possible post-natal depression. Mary trained as a teacher and met Tim whilst working in a rural town. Tim grew up on the family farm and only ever wanted to be a farmer. The drought has forced Tim and Mary to leave the farm to seek work in the city for the time-being.*

*Mary and Tim are under a lot of stress, moving off the farm, having young children and trying to manage financially. Mary stopped work several years ago as she has 2 young children. The children have been unwell with reflux and asthma. Mary is struggling to get enough sleep and finds herself feeling irritable. Tim works at a brewery and is drinking a lot at night. Mary and Tim are arguing a lot about money and the future.*

The Triage Assessment will be highlighted (see power-point):

1. Why now?
2. Genogram
3. Sequence
4. Functioning
5. System review

A *genogram exercise* for Mary will be undertaken.



The GP assessment involves history taking, examination and appropriate investigations. It is often done over several appointments and includes;

- taking a holistic approach,
- excluding underlying medical problems (examination and investigations),
- identifying co-existing issues e.g. substance use issues, physical health concerns (e.g. post myocardial infarct – as many as 60% of individuals become depressed – Schrader, 2006),
- a mental state examination (Appearance, Behaviour, Conversation, Affect, Perception, Cognition – memory, orientation, attention, thinking, Insight, Judgement, Intelligence & Rapport),
- the use of assessment tools.

The use of various *assessment* tools will be discussed, including:

- a. screening tools - to see if the condition is likely, such as the FEAR questionnaire,
- b. diagnostic tools – such as the DASS,
- c. severity rating scales - such as 0-10 scales and the DASS.

Examples of assessment tools will be provided, and Registrars will be able to practice using them. The following examples will be outlined:

a) FEAR questions are a useful *screening* tool for anxiety

#### FEAR

- (1) How often, if at all, have you been worried in the past month? (**F**earful)
- (2) Do you think you have always been a worrier? (**E**ver)
- (3) Do you find that you are using alcohol or other substances to help you cope with your worry? (**A**lcohol)
- (4) In the past month, have you felt so fidgety or restless that you could not sit still? (**R**estless)

A positive response to one or more of the four questions indicates a 74% chance of having an anxiety disorder (Krasucki, C., Ryan, P., Ertan T, *et al.* *The FEAR: a rapid screening instrument for generalized anxiety in elderly primary care attenders.* *Int J Geriatr Psychiatry* 1999; 14: 60-8.)

b) 0-10 scale

Draw a 10 cm line, with 0 at one end and 10 at the other. 0 represents absence of the problem and 10 the most severe that the problem could be. Ask the patient to indicate the severity of the problem on the line.

For example, in the past week how much have you suffered from .....

0 \_\_\_\_\_ 10  
(not at all) (extremely severe)

Adapted from the MINI International Neuropsychiatric Interview, by Sheehan, D., Janavs J., Baker, R, *et al.* University of South Florida, Tampa, Jan 2000)

c) K10 and DASS (see Appendices) An exercise will be carried out to provide Registrars with experience in talking about assessment tools with their patients, and in particular in administering the DASS.

## Management Part 1

This section aims to help the Registrar develop greater understanding and skills in the management process, including;

- collaborative management planning and the monitoring and review process,
- implementing 'watchful waiting',
- undertaking effective psycho-education using consumer friendly resources.

### Watchful waiting

The concept of 'Watchful Waiting' will be outlined and discussed

- in relation to children and adolescents, and
- in relation to the scenario involving Mary.

### 4 Step 'Back on track' approach

Note - this section will address risk assessment and management. Refer to the power-point for further information.

1. *Exclude, explore and explain* – exclude acute danger or trauma
  - a. suicidal
  - b. abuse

If present, these will need specific intervention (e.g. notification) or referral. Explore what might be bugging this patient e.g. grief, peer or family issues. Explain e.g. “we don’t know what is causing the pain, but we do know there is nothing dangerous going on. It may get better on its own, but it will be quicker if you work hard at it”.

2. *Back to work*

3. *Neuro-vegetative rehabilitation* eg sleep, eating, drugs, exercise

4. *Feeling Good* i.e. being good at feelings rather than expecting to always feel good.

A video providing further information about Mary’s story will be shown. It will lead into discussion about managing complex social issues, and several *communication exercises*..

This scenario will also be used to lead into discussion about management planning, including,

- developing collaborative treatment goals and implementing a plan that focuses on identification of problems and strategies to address these problems,
- monitoring progress and relapse prevention.

An *exercise* will be carried out based on communicating with Mary about the complex social issues.

It is vital to offer to involve family and carers in management, and to be guided by the consumer in regard to this, eg active involvement in management planning, psycho-education may be very beneficial (see resource section).

Monitoring the progress of consumers will be emphasised as an important part of management as well as relapse prevention. The use of assessment tools which monitor severity, such as the DASS, will be discussed in Workshop 1. Relapse prevention planning will be addressed in Workshop2.

The following practical issues will be addressed through explanation and handouts;

- use of the relevant mental health Medicare Items relating to assessment, management planning and review,
- use of reminder and recall system,
- Level 1 and Level 2 Training,
- Focussed Psychological Strategies, and

- the Better Access Program.

Information on medication will be provided (including referral to resources such as the DATIS reviews and clinical management guidelines). Registrars will also be directed to their Supervisors for further information.

### Attitudes to mental health

This section aims to assist Registrars in;

- having a greater appreciation of consumer and carer perspectives, and
- having a greater knowledge of mental health services in the community and referral pathways.

A consumer and carer will be invited to participate in this section. GP attitudes to mental health care, and consumer and carer views will be explored through *discussion* with GPs, a psychiatrist, a consumer and carer. A video relating the views of adolescents about seeing GPs will also be utilized.

Registrars will be provided with a list of useful resources, including consumer self-help resources.

### Resources

Exercise: sharing of resource ideas, including books and websites – a number of websites will be shown e.g. Beyondblue, Keeping the blues away, Headspace and Moodgym.

A comprehensive resource list is provided in the appendices.

## Outline of Workshop 2

<b>Icebreaker Learning Objectives Guidelines Expectations</b> 9.00-9.10am 10 minutes	Participants to share where they are now working and how they are finding mental health in practice.  Brief review of learning objectives, course outline and workshop guidelines / expectations (Refer to Module Outline).
<b>Management Part 2: Barriers to care</b> 9.10-9.20am 10 mins	<i>Brainstorm:</i> From experience in GP setting, what helps and hinders mental health care in the community? A consumer/carer will participate in this discussion.
<b>Discussion of adolescent case</b> 9.20-10.20am 60 mins	Small group case <i>discussion</i> re adolescent case (using 4 step 'Back on track' approach).
<b>Morning tea</b>	10mins
<b>Discussion of adult case. Brief interventions in practice.</b> 10.30-11.15am  45 mins	Small group case <i>discussion</i> of adult cases brought by Registrars. Information from a psychologist about training, roles, referral to be highlighted. Roles of other health professionals to be discussed.  Interventions to be covered: <ol style="list-style-type: none"> <li>1. Use of relapse prevention plans.</li> <li>2. Problem-solving i.e. defining the problem, exploring potential solutions, weighing up the advantages and disadvantages of each solution, choosing the best possible solution, steps to carry out, review.</li> </ol> <i>Exercise</i> - modelling of problem-solving and fish-bowl exercise.
Brief interventions for anxiety 11.15-12.30 am  75mins	<ol style="list-style-type: none"> <li>3. Relaxation strategies -               <ol style="list-style-type: none"> <li>a. use in practice</li> <li>b. choosing a relaxation technique</li> <li>c. physical relaxation, breathing techniques, visualization, mindfulness</li> </ol> </li> </ol> <i>Exercise</i> - modelling and practise of relaxation strategies in pairs.
<b>Resources</b> 12.30-12.45 15 mins	Sharing of further resources, including internet based programs – <i>demonstration</i> .

<b>End Session</b> 12.45-1.00pm 15 mins	Summary, questions and evaluation.
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## Management Part 2

Registrars will be asked to reflect on their recent experience in the GP setting, and on barriers to care i.e. what helps and hinders mental health care in the community. A consumer / carer will participate in this discussion.

*Small group discussion* will follow about;

- use of information, skills, resources following Workshop1,
- an adolescent scenario (using 4 step 'Back on track' approach).

Registrars will also bring an adult case to discuss.

Information from a psychologist about training, roles and referral process will be provided, and linked to the case discussions.

A series of brief interventions will also be covered, and Registrars will be given the opportunity to see the skills modelled and to practice them.

### 1. A relapse prevention plan

There are three steps in developing a plan for managing relapse adapted from 'Keeping the Blues Away A Guide to Managing Depression (Howell, 2007).

1. Identify the early warning symptoms, such as difficulty sleeping, tiredness, tearfulness, loss of interest in usual activities, or increased irritability (WHO, 1997; Hickie, 2000).

Early warning symptoms of depression
1. 2. 3.

2. Identify possible high-risk situations for relapse, such as stress or being overtired.

List of possible high-risk situations
1.

<p>2.</p> <p>3.</p>
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Consider strategies to protect one's self, for example, problem-solving or relaxation techniques.

How to cope with high-risk situations

3. Prepare an emergency plan to put into action when the depression is relapsing, such as

- Monitoring and challenging thinking.
- Focusing on the here and now.
- Taking some time out.
- Getting support from friends or family.
- Making an earlier, or urgent, appointment with the GP.
- Using medication (restarting or increasing the dose under the guidance of the GP).
- Talking with your GP or mental health professional.
- Expressing how you feel.
- Using problem-solving (Murtagh, 2001).

Emergency plan for relapse (including contact numbers)

## 2. Problem-Solving

This technique will be outlined and modelled by the presenters, and then the GP Registrars will be able to practice the technique in a *fish-bowl exercise*. The following notes are taken from 'Keeping the Blues Away A Guide to Managing Depression' (Howell, 2007).

When feeling stressed or depressed, negative thoughts can seem overwhelming, and it can be harder to think through a problem clearly. Structured problem solving involves sorting out what the problems are and looking at logical, practical ways of dealing with each of them (WHO, 1997; Andrews, 1998). The aim is to decide on the best possible solution for the problem, which may not be a perfect solution, but it will usually be helpful.

General rules for problem solving:

1. When learning the technique, start with more straightforward problems rather than complex ones.
2. Set aside time without distraction to facilitate clear thinking.
3. Consider one problem at a time.
4. Go through all the steps.
5. When making a list of possible solutions, write down all ideas even if some seem wild – in the end an achievable solution will need to be chosen, but the process of writing down all the possibilities often generates good ideas.
6. When planning how to carry out the solution, be realistic – are the resources (e.g. time, money ) available.
7. Include plans on how to deal with difficulties or negative responses that might arise (such as looking at what went right and what went wrong, and what alternative strategies could be used).
8. Think about how positive outcomes will be managed, as these might involve adjusting to change.
9. As with goal-setting it is useful to set a time by which to carry out the solution.
10. Remember that even partial success is a win, and the process of problem solving is a learning process (WHO, 1997).

The steps involved in problem solving are:

1. define the problem in everyday terms
2. make a list of all possible solutions
3. evaluate the solutions; that is, think about the advantages and disadvantages of each solution
4. choose the best possible solution
5. plan how to carry it out – this involves breaking the solution down into steps
6. review how you progress.

Registrars will see this technique modelled by the presenters, and then have the chance to use the technique in a *fish-bowl exercise*. A sheet to photocopy and use for problem solving is provided in the appendices.

### 3. Relaxation Strategies

A range of relaxation techniques will be outlined, *modelled and practiced* by the GP Registrars in pairs.

The following notes are taken from 'Keeping the Blues Away A Guide to Managing Depression' (Howell, 2007).

There are physical and mental benefits from relaxing, including positive effects on blood pressure and the immune system, improved sleep and reduced anxiety (Magarey, 1989; Ward, 1996). Relaxation is also a positive experience and gives a sense of control. Relaxation techniques are part of a holistic approach to health and especially important to learn in depression and anxiety. A range of basic techniques will be covered, and one may suit an individual better than another.

One of the first forms of relaxation to learn is physical relaxation. When muscles are tense they tighten and become shorter in length, and the body can get used to holding that area in a tense state. When muscles relax they lengthen and become looser and more comfortable. Progressive muscle relaxation is one way to relax physically (Davies, 2000; Hickie, 2000).

### Progressive Muscle Relaxation

Advise the person to go to the toilet beforehand, sit or lie in a comfortable position, make sure they are warm enough and that they loosen any tight clothing, uncross the legs and arms and remove glasses. Allow 15 to 20 minutes initially for this form of relaxation.

Begin with letting the eyes close.  
Relax each of these areas by being aware of any tension and letting it go. Feel the muscles loosen and lengthen

- the muscles of the face (forehead, around the eyes, in the cheeks, around the mouth, in the jaw area)
- the scalp and the neck, especially the muscles at the back of the neck
- across the shoulders and down into the shoulder blades
- the muscles of the upper arms, the forearms, into the hands and fingers
- let the chest muscles relax
- and the muscles of the back, all the way up and down the spine
- relax the tummy muscles and the buttock muscles
- let relaxation flow down into the legs, through the thigh muscles, calf muscles and into the feet.

Enjoy the feelings of physical relaxation for as long as you want to, open your eyes when you are ready and return to your day.

### Breathing techniques

Another key in learning to relax is to breathe effectively (Singh, 1996). When stressed the breathing rate can increase and breathing can become shallow, for example. The usual resting breathing rate in an adult is about 12 breaths per minute, and when anxious it may go up to 25 breaths per minute.

Try this range of breathing techniques and find out what suits you:

- Breathe in and out through your nose if comfortable with this, or in through the nose and out through the mouth. Simply be aware of the breath in and then the breath out. Breathe at a gentle slow pace, and feel the cooler air moving in. Breathe out and feel the warmer air. Say “relax” as you breathe out and let go of tension and stress as you do so.
- Abdominal breathing or diaphragmatic type breathing. Effective breathing means expanding your chest by lowering the diaphragm – in doing so the abdomen moves outwards. Try abdominal breathing in sitting or standing or lying. Place your hands over your abdomen – let them relax. Breathe in and feel the hands rise, breathe out and feel them fall. Repeat. Make an effort to pause and breathe in this way several times during the day.

### Visualisation

If the individual is able to visualise, then following on from physical relaxation, they may want to try a visualisation technique. Choose a special and safe place that is peaceful and relaxing to imagine. It may be curled up in a chair with a book, or it might be walking along a beach. Then the person imagines being in that special place and doing what they enjoy. Get in touch with the different sensations such as the feel of the breeze, the smells, or the colour of the sky. Don't worry about thoughts that may come into the mind - let go of concern about them and let them drift past. Whenever the person is ready to finish the relaxation, they gradually head back to the present moment and reorientate themselves to where they are and the day. Counting one up to five can allow the person a few moments to reorientate themselves.

### Mindfulness

Mindfulness is about being aware and paying attention in the present moment. The following is an example of a mindfulness meditation:

“Make yourself comfortable in a warm and quiet place, and allow your eyes to close. Take a little while to become aware of the sensations in the body, and let yourself be still. Become aware of the parts of the body touching the chair or bed, allow yourself to relax into the chair or bed. Be aware of each part of the body and let go of any muscle tension, from the muscles in the face down through the shoulders and arms, the chest and tummy, down through the legs to the feet and toes. Allow relaxation to flow through the body, letting go of any tension, let it

ease away. Be aware if your mind wanders away from your focus on muscle relaxation. That is okay and happens from time to time. Be patient with yourself and gently refocus your attention on letting go.

For a while be aware of the breath - as you gently breathe in and out. Feel the air warm as you breathe in through your nose, feel the air pass down through the lungs, using your tummy breathing, and then breathe out and let go, relax.

Now practice mindfulness of sounds. Bring your attention to your ears and your hearing. Listen to the sounds around you. Simply be open to sounds as they arise. Let the sounds come into your awareness. Equally you can let go of the awareness of sounds.

Be aware of any thoughts that come into the mind, observe them and sit with them for a while. Be curious about your thoughts and where your mind leads. You can be aware of thoughts and you can let go of them - just as you would observe clouds floating across the sky and then disappearing into the distance. There are some helpful thoughts and some that are not helpful. You have choice with thoughts, to take them on board or to watch them pass. Spend as long as you want relaxing, and when you are ready to realert simply be aware of the body again and slowly open the eyes as you are ready, comfortable and in the here and now”.

## Appendices

1. K10 test
2. DASS
3. Power-point presentations
4. GP Mental Health Plan
5. Problem-solving
6. Resources

**K10 TEST**

Name: ..... Date: .....

**Please indicate how you have felt by placing a number between 1 and 5 in the space provided to the right of each statement**

1 ----- 2 ----- 3 ----- 4 ----- 5  
*none of the time      a little of the time      some of the time      most of the time      all of the time*

1. In the past 4 weeks, about how often did you feel tired out for no good reason?	_____
2. In the past 4 weeks, about how often did you feel nervous?	_____
3. In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?	_____
4. In the past 4 weeks, about how often did you feel hopeless?	_____
5. In the past 4 weeks, about how often did you feel restless or fidgety?	_____
6. In the past 4 weeks, about how often did you feel so restless you could not sit still?	_____
7. In the past 4 weeks, about how often did you feel depressed?	_____
8. In the past 4 weeks, about how often did you feel that everything was an effort?	_____
9. In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up?	_____
10. In the past 4 weeks, about how often did you feel worthless?	_____
<b>K10 =</b>	<input type="checkbox"/>

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**DEPRESSION, ANXIETY, STRESS****Depression Anxiety Stress Scale (DASS)**

	<b>DASS</b>			
<b>Indications</b>	Assess quantitative scores for depression, anxiety and stress in out-patient population.			
<b>Limitations</b>	Not to replace diagnostic judgement.			
<b>Scoring Tips</b>	Use transparency sheet. Add 7 'A', 'D' & 'S' items separately, then double the score obtained. Refer to z scores if you wish, pg 24.			
<b>Cut-off Scores</b>		<u>Depression</u>	<u>Anxiety</u>	<u>Stress</u>
	Mild	10-12	7-9	15-17
	Moderate	13-19	10-14	18-25
	Severe	20-26	15-19	26-33
	Extreme	27+	20+	34+
<b>Comments</b>	Scores depression, anxiety and stress in one test. See pg 25 for <i>anxiety only</i> or pg 35 for <i>depression only</i> . Reliably correlated with Beck scale. Australian norms used, good scale. 3 scores in one test. Based on the last 7 days. <i>Patient to fill out.</i>			
<b>Reference</b>	Lovibond, S. & Lovibond, P. (1995). <i>Manual for the Depression Anxiety Stress Scales</i> . Psychology Foundation of Australia Inc. Sydney, NSW.			

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## DASS

Name: ..... Date: .....

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you **over the past week**.

*The rating scale is as follows:*

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of time
- 3 Applied to me very much, or most of the time

1. I found it hard to wind down	0	1	2	3
2. I was aware of dryness of my mouth	0	1	2	3
3. I couldn't seem to experience any positive feeling at all	0	1	2	3
4. I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5. I found it difficult to work up the initiative to do things	0	1	2	3
6. I tended to over-react to situations	0	1	2	3
7. I experienced trembling (eg, in the hands)	0	1	2	3
8. I felt that I was using a lot of nervous energy	0	1	2	3
9. I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10. I felt that I had nothing to look forward to	0	1	2	3
11. I found myself getting agitated	0	1	2	3
12. I found it difficult to relax	0	1	2	3
13. I felt down-hearted and blue	0	1	2	3
14. I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15. I felt I was close to panic	0	1	2	3
16. I was unable to become enthusiastic about anything	0	1	2	3
17. I felt I wasn't worth much as a person	0	1	2	3
18. I felt that I was rather touchy	0	1	2	3
19. I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20. I felt scared without any good reason	0	1	2	3
21. I felt that life was meaningless	0	1	2	3

**S** =     **A** =     **D** =

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**DASS SCORING TEMPLATE**

S  
A  
D  
  
A  
D  
S  
A  
S  
  
A  
D  
S  
S  
D  
  
S  
A  
D  
D  
S  
  
A  
A  
D

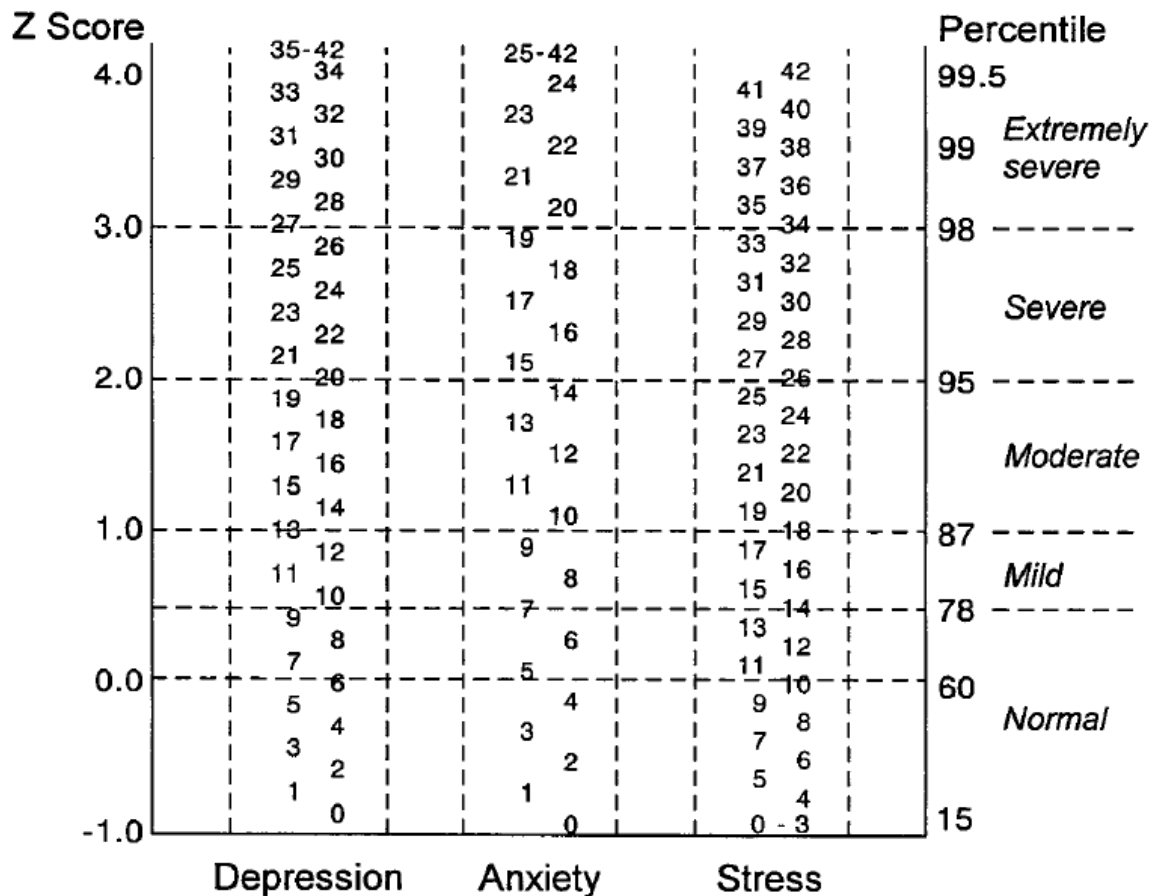
Multiply each sum by 2  
D =  
A =  
S =

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## DASS Profile Sheet

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_



For each scale, draw a horizontal line through the score obtained for that scale, and fill in the dotted lines below to form a bar graph. The heights of the bars are in Z score units and may be compared with each other and with the severity labels. Note that conversion to percentiles on the right hand axis is approximate only.

## Appendix 3 – Powerpoint Presentations

## **Appendix 4 - GP Mental Health Plan**

**GP MENTAL HEALTH CARE PLAN (MBS ITEM NUMBER 2710)  
PATIENT ASSESSMENT**

<b>Patient's Name</b>		<b>Date of Birth</b>	
<b>Address</b>		<b>Phone</b>	
<b>Carer details and/or emergency contact(s)</b>		<b>Other care plan</b> Eg GPMP / TCA	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>GP Name / Practice</b>			
<b>AHP or nurse currently involved in patient care</b>		<b>Medical Records No.</b>	

<b>PRESENTING ISSUE(S)</b> What are the patient's current mental health issues	
---	--

<b>PATIENT HISTORY</b> Record relevant biological psychological and social history including any family history of mental disorders and any relevant substance abuse or physical health problems	
---	--

<b>MEDICATIONS</b> (attach information if required)	
--	--

<b>ALLERGIES</b>	
------------------	--

<b>ANY OTHER RELEVANT INFORMATION</b>	
---------------------------------------	--

<b>RESULTS OF MENTAL STATE EXAMINATION</b> Record after patient has been examined	
--	--

<b>RISKS AND CO-MORBIDITIES</b> Note any associated risks and co-morbidities including risks of self harm &/or harm to others	
--	--

<b>OUTCOME TOOL USED</b>	<b>RESULTS</b>
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<b>DIAGNOSIS</b>	
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GP MENTAL HEALTH CARE PLAN (MBS ITEM NUMBER 2710)

**PATIENT PLAN**

<p><b>PATIENT NEEDS / MAIN ISSUES</b></p>	<p><b>GOALS</b> Record the mental health goals agreed to by the patient and GP and any actions the patient will need to take</p>	<p><b>TREATMENTS</b> Treatments, actions and support services to achieve patient goals</p>	<p><b>REFERRALS</b> Note: Referrals to be provided by GP, as required, in up to two groups of six sessions. The need for the second group of sessions to be reviewed after the initial six sessions.</p>

<p><b>CRISIS / RELAPSE</b> If required, note the arrangements for crisis intervention and/or relapse prevention</p>	
---	--

<p><b>APPROPRIATE PSYCHO-EDUCATION PROVIDED</b> YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p>	<p><b>PLAN ADDED TO THE PATIENT'S RECORDS</b></p>	<p>YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p>	<p><b>COPY (OR PARTS) OF THE PLAN OFFERED TO OTHER PROVIDERS</b></p>	<p>YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p> <p>NOT REQ'D <input type="checkbox"/></p>
---	---	--	--	--

<p><b>COMPLETING THE PLAN</b> On completion of the plan, the GP is to record that s/he has discussed with the patient:</p> <ul style="list-style-type: none"> <li>- the assessment;</li> <li>- all aspects of the plan and the agreed date for review; and</li> <li>- offered a copy of the plan to the patient and/or their carer (if agreed by patient)</li> </ul>	
--	--

<p><b>DATE PLAN COMPLETED</b></p>	<p><b>REVIEW DATE</b> (initial review 4 weeks to 6 months after completion of plan)</p>
-----------------------------------	---

<p><b>REVIEW COMMENTS</b> (Progress on actions and tasks) Note: If required, a separate form may be used for the Review.</p>	<p><b>OUTCOME TOOL RESULTS ON REVIEW</b></p>
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## Appendix 5 – Problem-solving

### **PROBLEM SOLVING**

#### **STEP 1.**

Define the problem – that is, write down in your own words what you think the problem is.

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#### **STEP 2.**

Make a list of all the possible solutions to the problem.

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#### **STEP 3.**

What are the advantages and disadvantages for each solution?

Solution (1)

*Advantages*

*Disadvantages*

Solution (2)

*Advantages*

*Disadvantages*

Solution (3)

*Advantages*

*Disadvantages*

#### **STEP 4.**

Based on the solution that seems to have the most advantages rather than disadvantages, choose the best possible solution for now.

**STEP 5.**

Do some planning – what steps will you need to do to carry out this solution?

Step (1) \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

(4) \_\_\_\_\_

(5) \_\_\_\_\_

(Plan as many steps as you need)

**STEP 6.**

Review how the problem solving is going. What has worked and been achieved?

What still needs to be worked on?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

[Repeat the steps for other problems]

(Adapted from the GlaxoSmithKline Signals II program; Andrews G. & Hunt C. Treatments that work in anxiety disorders. *MJA Essentials*.)

## Appendix 6 - Resources

### Books

#### Books on Depression

Kidman, A. (1999). *Feeling Better. A Guide to Mood Management*. Biochemical and General Services.

*This wise book has many useful charts and tips.*

Tanner, S., Ball, J. (1991). *Beating the Blues. A Self-Help Approach to Overcoming Depression*. Doubleday.

*An excellent book explaining the cognitive approach to treating depression. There is a chapter about depression written for family.*

Howell, C. (2007). *Keeping the blues away A guide to managing depression*. University of Adelaide.

*An evidence-based program aiming to reduce the severity and relapse of depression, incorporating a range of evidence-based strategies and manualised. Computer-assisted version also available See [www.keepingthebluesaway.com](http://www.keepingthebluesaway.com)*

Preston, J. (2000). *You can beat depression. A Guide to Prevention & Recovery*. (2<sup>nd</sup> Ed.) Impact Publishers.

*A very readable book, with good sections on the causes of depression and relapse prevention.*

Aisbett, B. (2000). *Taming the Black Dog. A guide to overcoming depression*. Harper Collins.

*A helpful and very readable book, incorporating a cognitive approach. It has amusing cartoons and is particularly liked by young people.*

Golant, M., Golant, S. (1996). *What to Do When Someone You Love Is Depressed. A Practical, Compassionate, and Helpful Guide*. Henry Holt and Co.

*A useful book for friends and relatives to read. It explains depression, its impact on relationships, and how to support the person with depression as well as look after oneself.*

#### Books on Anxiety

Aisbett, B. (1993). *Living with it. A survivor's guide to Panic Attacks*. Angus & Robertson.

*Another good little book by this author. A seemingly light-hearted approach to panic attacks, but full of gems of wisdom and based on a cognitive therapy. Most people find this a really useful book.*

Fox, B. (1996). *Power Over Panic. Freedom from Panic / Anxiety Related Disorders*. Longman.

*A very readable book on anxiety and panic, using case histories to illustrate important points.*

Marks, I. (1978). *Living with Fear Understanding and Coping with Anxiety*. McGraw Hill.

*A gold standard book on anxiety. More lengthy, but a good read if you want more detailed information.*

#### Books on Cognitive Therapy

Tanner, S., Ball, J. (1991). *Beating the Blues. A Self-Help Approach To Overcoming Depression*. Doubleday.

Burns, D. (1980). *Feeling Good. The New Mood Therapy*. Signet.

*Explains cognitive therapy for depression. Is quite detailed, but has sections that apply to the individual can be focussed on.*

Burns, D. (1989). *The Feeling Good Handbook*. Plume.

*The self-help guide that accompanies "Feeling Good. The New Mood Therapy". Lengthy.*

Greenberger, D., Padesky, C. (1995) *Mind Over Mood. Change How You Feel by Changing the Way You Think*. The Guilford Press.

*A clearly set out, practical book with exercises to be completed.*

Padesky, C., Greenberger, D. (1995). *Clinician's Guide to Mind Over Mood*. The Guilford Press.

#### Books on relaxation / lifestyle

Wilson, P. (1995). *Instant Calm*. Penguin.

Hopkins, C. (1997). *101 Shortcuts to relaxation*. Bloomsbury.

Carlson, R. (1977) *Don't Sweat The Small Stuff ... and it's all small stuff*. Hyperion.

Gawler, I. (1987). *Peace of Mind*. Hill of Content.

## Websites

### Australian

Beyondblue:

[www.beyondblue.org.au](http://www.beyondblue.org.au)

MoodGym

<http://moodgym.anu.edu.au>

Blue pages

[www.bluepages.anu.edu.au](http://www.bluepages.anu.edu.au)

Keeping the blues away A guide to managing depression

[www.keepingthebluesaway.com](http://www.keepingthebluesaway.com)

Mental health and well being (Department of Health and Ageing):

[www.health.gov.au/hsdd/mentalhe](http://www.health.gov.au/hsdd/mentalhe)

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

CRUFAD (Clinical Research Unit for Anxiety Disorders University of NSW) -

Information on diagnosis and treatments, for those with anxiety and for professionals working in the area:

[www.unsw.edu.au](http://www.unsw.edu.au)

Mood Disorders Unit, University of New South Wales – general information about depression:

[www.mdu.unsw.edu.au](http://www.mdu.unsw.edu.au)

The Panic and Anxiety Hub - aiming to help people learn about anxiety disorders:

[www.paems.com.au](http://www.paems.com.au)

Site established by SANE

[www.sane.org/](http://www.sane.org/)

Professor John Murtagh patient information sheets on depression and anxiety (Go to John Murtagh GP series):

[www.nevdgp.org.au](http://www.nevdgp.org.au)

National Prescribing Service – Therapeutics information

[www.nps.org.au](http://www.nps.org.au)

Healthy Skepticism

[www.healthyskepticism.org/](http://www.healthyskepticism.org/)

*For young people*

Headroom  
[www.headroom.net.com](http://www.headroom.net.com)

Headstart  
[www.headstart-gp.com.au/](http://www.headstart-gp.com.au/)

Beyondblue website for young people  
[www.ybblue.com.au](http://www.ybblue.com.au)

SANE website for young people  
[www.itsallright.org](http://www.itsallright.org)

Centre for Adolescent Health  
[www.rch.org.au/cah](http://www.rch.org.au/cah)

Reachout website  
[www.reachout.com.au](http://www.reachout.com.au)

*About grief*

Grieflink  
[www.grieflink.asn.au](http://www.grieflink.asn.au)

Centre for Grief Education  
[www.grief.org.au](http://www.grief.org.au)

*About lifestyle issues*

'Sleep Better Without Drugs' program information  
[www.sleepbetter.com.au](http://www.sleepbetter.com.au)

British

Site of the Royal College of Psychiatrists in the United Kingdom - has sections on depression and anxiety:  
[www.rcpsych.ac.uk/public/help/welcome.htm](http://www.rcpsych.ac.uk/public/help/welcome.htm)

World Health Organisation site - useful information sheets on depression and anxiety:  
[www.whoguidemhpcuk.org/](http://www.whoguidemhpcuk.org/)

The Happiness Project  
[www.happiness.co.uk](http://www.happiness.co.uk)



## Community Resources

Mental Health Resource Centre – (08) 8221 5166  
Provides information on community resources.

Mood Disorders Association – (08) 8221 5170

SANE Helpline (Information and referral re mental health problems) – 1800 688 382

SA Panic and Anxiety Disorders Association – (08) 8373 2161

Obsessive-Compulsive Disorders Support Service – (08) 8231 1588

Connect – Social anxiety support Network of Australia –  
(08) 8221 5166

Association for Friends and Relatives of the Mentally Ill –  
(08) 8221 5166

GROW Community Centre – (08) 8231 6566

Community Health Centres (listed in phonebook)

Relationships Australia bookshop, library and courses – (08) 8245 8100

Local libraries (listed in phonebook)

## Treatment Services

Centre for Anxiety and Related Disorders (Flinders Medical Centre) – (08) 8204 4779.

The Centre for the Treatment of Anxiety and Depression (Thebarton) – (08) 82228100

Local community health centres.

Community mental health teams of the State Mental Health Services.

To find out more about private psychologists, psychiatrists, or qualified hypnotherapists the following organisations can be contacted:

- Royal Australian and New Zealand College of Psychiatrists – (08) 8239 2911
- The Australian Psychological Society – 1800 333 497
- The Australian Society of Hypnosis (SA Branch) – (08) 8233 6422

GP Access to Psychiatry Services (GP PASA)  
One-off assessments (Item 291) by psychiatrist  
81722050

VVCS (Veterans and Veterans Families Counselling Service) 1800011046

Kids Help Line 1800551800

Parent Helpline 1300789978

### **Emergency Numbers**

Lifeline – 131 114

Crisis Care Unit 131611

Mental Health 24 hour Statewide Emergency – 131 465

Alcohol and Drug Information Service – 1300 131 340

Domestic Violence Crisis Service 1300782200

Domestic Violence Helpline 1800800098

## REFERENCES

Andrews G, Hunt C, (1998). Treatments that work in anxiety disorders. *MJA Practice Essentials, Mental Health*, 26-32.

Davies J. (2000). *A Manual of Mental Health Care in General Practice*. Commonwealth Department of Health and Aged Care.

Giron, M., Purificacion, M., Puerto Barber, J., et al. Clinical Interview Skills and Identification of Emotional Disorders in Primary Care. *Am J Psychiatry* 1998; 155: 530-535.

GlaxoSmith Kline Signals Program.

Hickie, I. (2000); An approach to managing depression in general practice. *Med J Aust*, 2000; 173: 106-110.

Hickie I, Andrews, G, Davenport, T. Measuring outcomes in patients with depression or anxiety: an essential part of clinical practice. *Med J Aust*, 2002; 177: 205-7

Howell, C. Preventing depression relapse: a primary care approach. *Primary Care Mental Health*. 2004; 2; 151-6.

Howell, C. (2007). *Keeping the blues away. A guide to reducing the relapse of depression*. ISBN 0-9750422-1-1

Krasucki C, and Ryan P. *Int J Geriatr Psychiatry*; 1999;14: 60-68. As reported in GlaxoSmithKline Signals Program.

Lovibond SH, & Lovibond PF. (1995). *Manual for the Depression Anxiety Stress Scales*. (2nd. Ed.) Sydney: Psychology Foundation.

Magarey, C. (1989). Meditation and Health. *Patient Management*, 1989; May: 89-102

Mynors-Wallis LM, Gath DH, Day A, Baker F. Randomised controlled trial of problem solving treatment, antidepressant medication, and combined treatment for major depression in primary care. *BMJ* 2000; 320: 26-30.

Schrader, G.D., Cheek, F., Hordacre, A., & Marker, J. (2006). Predictors of depression 12 months after cardiac hospitalisation: the Identifying Depression as a Comorbid Condition (IDACC) study. *Australian and New Zealand Journal of Psychiatry* 40, 1025-1030. [IF=1.9]

Sheehan D, Janavs J, Baker R, *et al.* (2000). The MINI International Neuropsychiatric Interview, University of South Florida, Tampa

Singh, H. Introducing stress management into general practice. *Aust Fam Phys*, 1996; 25: 1261-64

Ward E, King M, Lloyd M, Bower P, Sibbald B. Randomised controlled trial of non-directive counselling, cognitive-behaviour therapy, and usual general practitioner care for patients with depression. I: Clinical effectiveness. *BMJ*, 2000; 321:1383-88.

Whiteford, H. Depression in primary care: expanding the evidence base for diagnosis and treatment. *Medical Journal of Australia*, 2008; 188, S1021-102.

World Health Organisation (WHO) Collaborating Centre for Mental Health and Substance Abuse. (1997). *Management of Mental Disorders Treatment Protocol Project*. Vol. 1. (2<sup>nd</sup> ed.)