PROJECT EVIDENCE

PROJECT EVIDENCE for Treatment of Mental Disorders. The project coordinator is Dr Allan Mawdsley. The version can be amended by consent. If you wish to contribute to the project, please email admin@mhyfvic.org

[6] Standard Treatment

a) Outpatient psychotherapies, medication and procedures

b) Inpatient psychotherapies, medication and procedures

c) Ancillary support services

[6 a] Outpatient psychotherapies, medication and procedures

Specialist mental health services should offer a range of therapeutic programs for disabling mental health problems in the community. Service provision, clinical research and training are closely linked in the Tier Three facilities but the practice guidelines published by those services should be implemented at all service delivery facilities.

These are grouped under six headings: (1) anxiety disorders, (2) mood disorders, (3) substance abuse disorders, (4) behavioural and relationship disorders, (5) eating disorders, (6) psychotic disorders. The Royal Australian and New Zealand College of Psychiatrists and the Australian Psychological Society provide information and clinical practice guidelines for the treatment of anxiety disorders in children. The guidelines set out below are an amalgam of information put out by these two groups.

Where children have mental health problems, parents are involved in the process of noting the symptoms, probably working with schools, identifying appropriate treatment options and monitoring and reviewing the treatment. Guidelines for selecting, monitoring and reviewing appropriate treatments are set out below. In a general sense treatment is successful when symptoms abate and/or the child or adolescent is able to continue or resume daily living activities. Clarifying what type of treatment is best and what to do when one treatment doesn't work can be challenging.

Parents can be engaged in a psychoeducation model, where the treating practitioner will meet with the parent/s occasionally to update and seek feedback but the work will be mainly done with the child. Such meetings will be with the child's knowledge and preferably consent. Parent/s can be important in learning strategies to manage their children's symptomatic behaviour, as well as developing a narrative in the family for the behaviour.

Another model which includes parents is family therapy, where the family is the client. Reviews of effective use of family therapy include Carr (2000), Evidence based practice in family therapy and systemic consultation 1> Child focused problems *Journal of Family Therapy* 22: 29-60; Cottrell and Boston (2002) Practitioner review: the effectiveness of child and family therapy for children and adolescents. *J Child psychology and psychiatry* 43(5), 573-586. Many papers document the effectiveness of family therapy models with eating disorders and school refusal in particular.

Context is important when identifying symptoms or changes in behaviour in children.

1. **Family stress** and/or illness is an example. When one or both parents are in a high stress situation, they are struggling to cope with the stress. Therefore, it is difficult to be aware of the child's stress and patterns of coping, thereby, usually unwittingly, creating emotional distance, being unable to identify the child's stress and to assist the child. Common examples of this type of family stress include parents fighting and separating, family violence, financial stress and/or unemployment, illness in any family member, stress associated with

caring responsibilities e.g. with aged parents or unwell person, migration, homelessness, post-natal depression.

2. **School / social issues** is another common example. These can be grouped in two broad categories
   a. Social / bullying concerns, where the child is uncomfortable in the social school community, feels alone and perhaps bullied, either by teachers or students.
   b. Academic performance issues, where the child feels or is made to feel s/he is underperforming at school. Often these issues require assessment to clarify whether there are learning patterns contributing to the performance issues and appropriate help to be given to the child and teachers. Learning difficulties often present as bad behaviour because the child does not understand why s/he is not like the others. ADHD and ASD are also in this category of context.

PE6a (i) Anxiety Disorders,

The Royal Australian and New Zealand College of Psychiatrists and the Australian Psychological Society provide information and clinical practice guidelines for the treatment of anxiety disorders in children. The guidelines set out below are an amalgam of information put out by these two groups.

Childhood anxiety disorders involve excessive fear or anxiety that differs from normal developmental fears through its intensity or persistence beyond the appropriate developmental period. The fears or anxiety can manifest in physical symptoms of distress (headaches, stomach aches, skin disorders), perfectionism, excessive reassurance seeking, great difficulty dealing with change, nightmares and difficulty going to sleep at the beginning of the night. Anxiety disorders in children can include separation anxiety disorder, specific phobias, social anxiety disorder and generalised anxiety disorder, and can also lead to school refusal.

Anxiety disorders in children have an ongoing, pervasive and negative impact on relationships, family life and school adjustment. Anxious children develop a pattern of avoidance of many family and school activities, which prevents them from enjoying developmentally appropriate activities. Many of the anxiety disorders that develop in childhood will persist into adulthood if not treated.

Various published studies have reported that one in five children and adolescents are identified with a range of elevated symptoms of anxiety throughout development.

Cognitive behavioural therapy (CBT) aimed at teaching children to identify and regulate their emotions is the gold standard for treating anxiety. However, when working with children it is essential that these skills are delivered in a developmentally appropriate way. Play therapy techniques and parenting skills training are highly valuable in ensuring children are engaged and understanding skills, and it is important that parents have the knowledge to reinforce coping at home. There are specific treatment components to give skills to families and teachers in order to maximise positive treatment gains. Both individual and group formats have proven to be effective, with the key target of normalisation, rather than stigmatisation, being emphasised in both formats.

Key targets for CBT treatments should include: increasing self-awareness; promoting empathy skills; relaxation skills and self-management training; mindfulness and attention training; challenging and replacing unhelpful thinking; increasing positive coping role models and support networks; building step plans and exposure exercises; problem-solving skills training; friendship skills; and maintenance and generalisation of skills. (Barrett 2014).

Where children are exhibiting anxiety symptoms it is important for parents to be involved in the process. It is increasingly documented that anxiety patterns run in families and where there is an anxious child it is likely that others in the family also have had to manage anxiety. Involving parents in the process of helping their children can be very reassuring for everyone in the family if it is done compassionately and cooperatively. The accepted wisdom is that

anxiety is an instinct which is adaptive and that when it becomes clinically intrusive, needs to be managed rather than taken away. Management strategies for anxiety are a lifelong process and teaching them to children is important

Whilst initial treatment options for anxiety disorders are cognitive-behavioural therapy (face-to-face or delivered by computer, tablet or smart-phone application), cost and accessibility can be factors which hinder treatment.

Where access to these treatments is not possible and/or where the symptoms are severe and not responding to psychological treatments, pharmacotherapy (a selective serotonin reuptake inhibitor or serotonin and noradrenaline reuptake inhibitor together with advice about graded exposure to anxiety triggers), or the combination of cognitive-behavioural therapy and pharmacotherapy can be offered. Whilst results of medication can be effective in terms of reduction of symptoms and enhanced capacity for daily living activities, review of side effects and plans to reduce of cease medication over a period of time are important.

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Andrews, Gavin et al., *Australian & New Zealand Journal of Psychiatry* 2018, Vol. 52(12) 1109-1172 DOI: 10. 1177/0004867418799453

Barrett, P. (2014) Treatment guidance for common mental health disorders: Childhood anxiety disorders *InPsych* 2014 Vol 36. October | Issue 5

PE6a (ii) Mood Disorders,

The Royal Australian and New Zealand College of Psychiatrists and the Australian Psychological Society provide clinical practice guidelines for mood disorders with up-to-date guidance and advice regarding the management of mood disorders. Depressive and bipolar disorders are addressed.

Depressive disorders are characterised by persistently low mood and loss of interest and pleasure in previously enjoyed activities, as well as a range of other emotional, cognitive, physical and behavioural symptoms, including fatigue, sleep and appetite disturbance, reduced energy, concentration difficulties, feelings of low self esteem, excessive guilt or feelings of worthlessness and/or hopelessness and helplessness and suicidal ideation or ambivalence about living.

Clinically significant depression differs from regular mood fluctuation in its severity and persistence. When symptoms appear resistant to change in circumstance, and when they interfere with ability to perform normal day-to-day activities or general psychosocial functioning, assistance should be sought.

Depression is likely to be caused by a complex interplay of biological and environmental risk factors. The main factors include genetic (between 30 and 40%), traumatic experiences such as neglect and physical or sexual abuse and stressful life events such as loss of close relationships and major health problems for the child or family member, other familial stress factors such as poverty, bullying, trauma associated with refugee experiences.

Many children who have depression also have anxiety symptoms, most commonly generalized anxiety disorder (estimated at 67% of cases). Other comorbid conditions are social phobia, panic disorder, substance related disorder, obsessive compulsive disorder and eating disorders.

The way symptoms are likely to present for children will vary with age and cultural factors. For example, children under 12 years of age are more likely to present with somatic symptoms, anxiety, poor sleep, eating disturbance, social withdrawal. Many children in this age group can continue their daily activities whilst reporting and displaying depressive thoughts and feelings. Conversely, children aged 12 years and older are less likely to be able to continue their daily activities whilst they are depressed, more likely to express feelings of low worth, guilt, blame of self or others, failure, suicidal ideation and withdraw from regular activities such as sport and friendship circles. Academic performance is more likely to fall away and rebellious behaviour may be present.

Depressive disorders comprise several diagnoses distinguished by the precipitants and/or the frequency, intensity and duration of episodes. The following classification is widely accepted.

Primary:

- Bipolar Disorders
- Depressive Disorders

Secondary:

- Premenstrual Dysphoric Disorder
- Substance-induced mood disorder
- Mood disorder due to a medical condition such as endocrine disorders.

Bipolar Disorders.

The presence or history of mania/hypomania is the defining element of bipolar disorders and distinguishes them from depressive disorders. Mania or hypomania are rarely encountered in childhood but may emerge in adolescence or young adulthood. The excitable behaviour of children with Attention Deficit Disorders, Conduct Disorders and substance abuse problems should not be misinterpreted as manic symptoms. Most individuals will also have experienced one or more major depressive episodes, which often precede the onset of mania. Because of this, it may take five or more years before the definitive diagnosis is established.

As the onset of depressive disorders in children occurs most commonly in the context of stressful relationship and situational events, that require appropriate psychosocial intervention, an underlying biological predisposition may not be evident in early stages. Successful response to psychosocial interventions does not rule out the possibility of predisposition. Any episode of depression should be assessed and managed as necessary. If there are recurring episodes that have stronger physiological symptoms, the possibility of emerging bipolar disorder should be kept in mind. This is important in adolescence when the propensity for suicidal ideation heightens.

Most adult patients with bipolar disorder will suffer from multiple episodes of depression and mania during their lifetime and, therefore, in almost all cases long-term treatment is necessary. The course of illness and trajectory are difficult to predict and even with adequate treatment, almost half of all bipolar patients will have another episode within two years, and the majority will experience further illness within five years.

Depressive Disorders

Major Depressive Disorder (MDD) shows the features described above, without a history of manic features. It may vary in intensity from mild to severe. Two related disorders share some of the features; Adjustment disorder with depressed mood results from identifiable life stressors; Dysthymic disorder is a fluctuating mood state in which a person experiences depressed mood for more days than not over a period of two years (or one year in children and adolescents) and is closely linked to personality style.

Assessment of Depressive Disorders

Assessment carried out by the clinician usually includes a clinical interview with parents and child – with younger children play tools are often used as appropriate for their age. Self-report scales are also often used to assist – their effectiveness depends on the child's preparedness to share his/her inner experiences. Scales usually have a form for parents and possibly teachers to report their perception of the child's feelings. It is common for parents to differ between themselves in respect to their perception and report of their child's experience and for one or both parents to report different perceptions about the child's feelings than the child does. There is value in these differences and the clinical can work with these differences to assist families to move forward to hear each other so that the depression can be heard.

This process can be facilitated using the Australian Children's Depression Scale (Lang and Tisher 2004), a set of boxes and cards which the child posts into one of five boxes. This scale offers a form for children, parents, teachers and health professionals and invites and encourages conversation between family members about the child's feelings. It also offers norms against which the child's depression can be evaluated.

Assessment using the biopsychosocial and lifestyle model (BPSL Model) considers predisposing, precipitating and perpetuating factors. These are obtained through detailed information gathering, a comprehensive clinical assessment, including a detailed mental state examination and the careful piecing together of corroborative information. The appraisal of context is pivotal because this provides the understanding as to ***why*** a person has a mood disorder at this particular point in their life and is best constructed via thorough clinical assessment. Children who express their distress or adjustment to stressors by sharing depressive feelings or by behaving differently are often trying to communicate their distress as best they can – most young children in particular do not have the language to communicate depression. Accordingly, appraisal of context is important in assisting families to hear their children's response to stressors. Facilitating hearing a child's depression can be a significant treatment.

The components of the model represent seemingly distinct domains, however recent research has shown that there are important iterative links between various components, and these cumulatively contribute to the onset and maintenance of mood disorders. The model provides the necessary framework for the development of a mood disorder formulation in an individual.

Aims of treatment.

The general aims of treatment of any mood disorder are to relieve symptoms, reduce the morbidity associated with the mood disorder and limit the disability and self-harm risk or potential risk of fatality. The end goal is achieving recovery to premorbid level of functioning with improved health awareness and quality of life.

More specifically, treatment objectives include sharing of the clinician's biopsychological understanding of the child's/ family's presenting concerns. Psychoeducation concerning factors relevant in the maintaining of the depression and recommended evidence-based treatments and interventions. Establishing goals for treatment and methods or indicators for success or lack of success of treatment options is important, preferably using concrete measures such as "returning to school once a week", changing eating habits in a specific way, connecting with peer group on a basis that can be reported. Indicators such as these are preferable to "feeling better" which is harder to measure for all family members. Explaining the treatment process and indicators for closure, clarifying who will attend for treatment sessions, monitoring and managing risk and planning for closure including work around relapse prevention are all part of this process.

Main treatment modalities reported in the literature are Cognitive behaviour therapy, brief psychodynamic therapy, interpersonal therapy (including family therapy) and CBT self-help programs. A common underlying theme/narrative for depressed people is a belief that they are a failure in life. This repetitive narrative is sometimes expressed, but in children often not. Nonetheless, it drives children's thoughts, feelings and behaviours and often drives them to behave

in a way consistent with that belief. For example, expressing suicidal ideation ("everyone would be better off if I was not here") or behaving badly to invite punishment confirming they are bad. All treatment modalities need to create a safe space where such underlying and repetitive narratives can be heard without judgment as a first step before offering cognitive restructuring options and an opportunity to try a more positive view of himself/herself. Ideally, the parents would be engaged in this process.

Where treatment fails to assist the child / family, a review is important and other referral options should be considered, including a second opinion from another clinician. Medication options should also be considered and discussed, including benefits and reported side effects.

Types of Treatment

Biological Treatments

The biological treatments commonly used in adult psychiatry have very little place in child and adolescent services. There is no indication for ECT (with a possible exception for catatonic psychotic states), no evidence for the use of Transcranial Magnetic Stimulation, and minimal usefulness of medication. Mood stabilizer medication is only relevant after a diagnosis of bipolar disorder has been established, which is generally not until adulthood.

A trial of anti-depressant medication is reasonable for cases that have strong physiological symptoms (sleep disturbance, appetite disturbance, weight loss, anergia, anhedonia) poorly responsive to psychosocial interventions. If used, it is a component in a case management plan, avoiding any message that "problems are solved by pills". *A*n adequate trial of an antidepressant should be a minimum of three weeks at the recommended therapeutic dose. If no improvement is apparent, the use of medication should be re-considered (rather than increasing dosage or switching to alternative anti-depressants, as is usually done with adult patients).

Psychological Treatments

Cognitive Behavioural Therapy
Interpersonal therapy
Family therapy

Though there is little evidence for differential effectiveness across the various psychotherapies, this does not imply that unstructured or eclectic approaches are supported in the psychological treatment of depression. There is strong clinical consensus that treatment is best guided by well-trained therapists using an evidence-based treatment manual, tailored to the individual patient, and with proper attention to the therapeutic relationship.

Social Treatments

Family psychoeducation
Family/friends
Formal support groups
Community groups
Caregivers
Schooling/ employment/ housing

Lifestyle Treatments

There is evidence that lifestyle issues can adversely affect the onset, severity and duration of depression and, conversely, can play a role in ameliorating depression. A discussion with patients about lifestyle issues can assist overall engagement with care and help build rapport. This is not telling them what to do, but exploring with them the meaning of the issue and what would empower them to get the best outcome for themselves. Personal cleanliness, grooming, diet and exercise are closely related to their mastery of their circumstances as well as being central to self-image.

The discussion issues could include Diet, Exercise, Smoking cessation, Alcohol cessation, Ceasing drugs, Sleep.

If done within a family context such discussions have a high risk of derailment from personal development into authority and control battles. However, with care, such discussions could assist both personal development and family functioning.

Clinical Management of Bipolar Disorder

Compared with major depressive disorder, bipolar disorder is more complex and difficult to treat. Although rarely seen before adulthood, manic symptoms can occur within depression as mixed features, and with increasing severity from hypomania and mania through to mania with psychosis. The pharmacotherapy of mania involves treatment with anti-manic agents. The fundamental goals of such medications are to reduce arousal, agitation and aggression, and begin the process of treating core manic symptoms including behavioural disturbances and psychosis, if it is present.

In long-term treatment, it is important to maintain euthymia and only if this can be ensured should a gradual reduction of medication dosage be considered along with withdrawing medication to achieve monotherapy. Maintaining compliance and ensuring adequate adherence to treatment instructions is extremely important. The main goal of maintenance treatment is to prevent future episodes of illness (recurrence) and enhance resilience. In practice, even with optimal treatment, complete prophylaxis is seldom achieved; therefore, subsidiary goals warrant consideration. These include reducing the number, intensity and length of episodes and achieving functional mood stability with fewer inter-episode subsyndromal symptoms.

Clinical Management of Major Depressive Disorder

In mild to moderate episodes of MDD, psychological management alone may be adequate, especially early in the course of illness. However, episodes of greater severity, and those that run a chronic course, are likely to require the addition of antidepressant medication, or some other combination of psychological and pharmacological treatment. In severe episodes of MDD pharmacotherapy is typically needed and, where there is a high risk of suicide or when the patient's welfare is threatened hospitalization is sometimes necessary.

Where children do not respond well or sufficiently to psychological treatments, and medication is needed, it is important to review the language for the need for medication. Many young people resist medication, seeing this as evidence they are "not normal" and "can't cope" without pills. Also, after taking medication for a while and feeling better they often decide "they don't need it any more" and stop or vary the dosage. This can be difficult for parents and for clinicians. Often parents don't know their children have not been complying with medication until there is a change of behavior or reversion to old behaviours. This can lead to request for increased dosage etc.

When medication is prescribed, the conversation with the child and the family is important, in terms of psychoeducation for child and parents. Best outcome will be where the child has ongoing therapeutic relationship where s/he can feel free to discuss changes s/he might want to make, perhaps including monitoring or rating his/her symptoms. A therapeutic relationship with parents is also helpful, assisting them to monitor their child's symptoms and to discuss any concerns. Battles between parents and children around taking medication should be avoided. Children and families also need psychoeducation about interactions between psychotropic medications and substance usage.

Notes from:
Gin S Malhi et al. "**R**oyal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders" *Aust.NZ J Psychiat.* 2015:49 (12) 1-185.

PE6a (iii) Substance Abuse Disorders

Substance misuse is the harmful use of drugs or alcohol for non-medical purposes. Often associated with the use of illicit drugs, legal substances can also be misused, such as alcohol, prescription or over-the-counter medication, caffeine, nicotine and volatile substances (e.g. petrol, glue, paint). Most people with a substance use disorder are using alcohol.

Misuse is characterized by a preoccupation with or craving for the substance, a greater priority to substance use than other goals and/or a difficulty controlling consumption. Use of the substance may continue despite negative impacts on other activities, roles, relationships and physical and mental health. Increased tolerance to the substance and withdrawal symptoms may also occur. Broad impacts on social and cognitive functioning and on physical and mental health emerge. Diffuse cognitive impairment may persist for up to 12 months post-detoxification in alcohol dependence. Psychological comorbidity is common, particularly mood and anxiety disorders. (Kavanagh and Connor, 2014 InPsych).

Addiction is a physical and/or psychological need to use a substance, often caused by regular continued use. Some substances are more highly addictive than others. Some people are more likely to become addicted to a substance depending on mental, physical and lifestyle factors.

People use drugs and alcohol for many reasons – to relax, have fun, socialise, cope with problems, escape life or dull emotional/physical pain. Using substances to cope doesn't make problems go away and can make them worse or add new problems to the mix. Becoming dependent on drugs in order to cope, rather than getting help or finding positive solutions, can create longer term problems.

Substance abuse and addiction can have short-term and long-term impacts on physical, mental, social and financial health. Referral is indicated for:

- **Physical health** - nausea, aches and pains, sleep problems, weight gain/loss, infections, accidents, illness or chronic disease.
- **Mental health** - depression, anxiety, paranoia, psychosis
- **Personal relationships** - family problems, arguments, relationship breakdowns, loss of friends
- **Work or financial** - job loss, trouble at work or study, debt, unemployment
- **Social impacts** - loss of interest or time to do things you like, reduced participation in social activities, criminal problems, anti-social behaviours, isolation

Signs and Symptoms of Substance Abuse

- Regular or continued substance use to cope emotionally, socially or physically
- Neglecting responsibilities and activities that are important or enjoy (e.g. work, study, family, hobbies, sports, social commitments)
- Participating in dangerous or risky behaviours as a result of substance use (e.g. drink driving, unprotected sex, using dirty needles)
- Relationship problems (e.g. arguments with partner, family, friends, or losing friends)
- Physical tolerance – needing more of the substance to experience the same effects
- Withdrawal – physical and mental withdrawal symptoms when not using the substance, or needing the substance to feel "normal"
- Losing control of substance use – being dependent or unable to stop even if wanted

- Substance use takes over life (e.g. spending a lot of time using, finding or getting the substance and recovering from the effects, waking up planning how to access the substance or how to pay for it or hide from others and constantly thinking about this).
- General change in the child's behaviour, academic, sporting and social, such as withdrawal from previous activities
- Sleeping and eating changes

It is difficult for substance abusers to accept that there is a problem and to ask for help. When concerned that a child is using substances it may be helpful to consult a clinician such as a psychologist to discuss how to broach the subject with the child. Whilst external limits have some role, the main solution to substance misuse depends on strengthening the internal locus of control through the person "owning" the need for change. For success it is necessary for the affected person to:

1. **Recognise that substance use has become a problem** - realizing and accepting that one is abusing or addicted to substances is the first step to finding help.
2. **Seek support** - getting through this solo can be difficult. Talk to friends, family, your doctor, other health professionals or a telephone helpline about the substance use.
3. **Investigate options for help** - manage and treat substance misuse and addiction through counselling, medication, rehabilitation centres, self-help programs or support networks. A number of options might need to be tried before finding what works – it's important to keep trying.
4. **Find alternative coping strategies** - if using substances to cope with life or escape personal problems, other ways are needed to manage the situation and deal with life's stress and pressures. Dealing with other problems can make it easier to recover and not relapse.
5. **Deal with setbacks and keep going** - Recovery can be a long and difficult road. Expect some setbacks and don't focus on failures. Focus on plans and understanding triggers and how to best respond to them in future.

Evidence based psychological treatment guidance includes:

- Psychoeducation for child and family
- Cognitive behavioural therapy (CBT), which applies learning based approaches to modify behavior and cognitions and increases confidence and empowers families and children
- Groups such as Alcoholics Anonymous who offer 12 step approaches and support for family members /carers and programs for young people.

Two online sources of information and treatment options are:

https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services

https://www.lifeline.org.au

PE6a (iv) Behavioural and Relationship Disorders

This section will consider child and adolescent behavioural disorders and family relationship problems but not Juvenile Justice issues which are considered in PE3c ii.

A child's social development, like all other aspects of development, occurs primarily within a family context. Healthy nurturance by caregivers provides positive reinforcement for socially acceptable behaviours. Socially unacceptable behaviours are shaped by withdrawal of positive reinforcement and introduction of negative reinforcements. Along with this social learning there is a process of physiological maturation which underpins impulse control, affect regulation, planfulness, awareness of consequences and the differences between self and others. Secure attachment enables empathy and consideration for others to take priority over self-gratification. Insecure children have difficulty with these executive functions and require more positive reinforcement of acceptable behaviour and more systematic management.

Social learning is not a one-way process. One person's behaviour shapes another's whilst the latter's shapes the former's. A central task is to objectively view events to understand how behaviours are being reinforced. Understanding the "meaning" of behaviours enables a systematic change in what reinforces their continuation and what alternative reinforcement can produce more adaptive behaviour. This is as equally applicable to adult-adult communication as it is to adult-child.

The adult-adult principles are outlined in the following notes from the Relationships Australia website, found on https://www.relationships.org.au Many of these principles apply in families, parenting, sibling and friendship patterns.

> Some conflict in relationships is inevitable, but there are ways to handle it so it is not destructive to you individually or within family and social relationships. Relationships can become stronger if you can talk about differences and stress as a normal part of their relationship. Conflict can often be resolved and serious matters dealt with through respectful communication and a bit of give and take.
>
> The key questions are:
>
> - how can you manage not to hurt each other or your relationship when you have a row? and
> - how can you learn from the conflict?
>
> Avoiding conflict, or agreeing not to talk about the issue that caused the conflict, might provide short-term peace. However, it's better to sort out important relationships issues. Conflict is a symptom – if you patch things up without finding out what's at the bottom of your differences, you'll probably find yourselves in conflict again.
>
> People who express their anger without restraint often claim that their anger takes over, and that they can't help their actions. It may feel as if anger is beyond your control, but in reality everyone can learn to control their response to anger.
>
> Physical violence in intimate and family relationships is a serious criminal offence and is never acceptable as a response to conflict or provocation. If you feel unsafe, it is essential you get help. Get away if it is safe to do so, or call for help. Police Emergency 000
>
> If you find you are getting worked up and starting to argue, there are things you can do to prevent things getting out of hand:
>
> - if you are angry, it's usually better to say so, rather than pretend you are not. Admitting to feelings of anger helps to get it out into the open, so you can address the problem
> - a verbal attack on another when you are angry is unlikely to help the situation
> - it's ok to ask for 'time out' and encourage the other to do the same if either of you feels too angry or upset to talk about the problem. When you are calmer you can come back and try to sort things out
> - often there is something underneath the anger. It could be sadness, hurt, disappointment, or a sense of being let down or taken for granted. The underlying feeling will usually be a clue to the real issue that you and your partner need to work through

- you might both have to back down a bit and make changes. There may be an angle on the situation that you haven't considered. Compromising is not a sign of weakness, it's part of the give and take needed in a relationship
- apologise when you are able to, though don't make your partner wait as a punishment. Saying sorry doesn't mean you are accepting all the responsibility
- remember that the other did not 'make you angry'. He or she may have said or done something you didn't like, but *you* are angry - no-one forced you to feel that way. You can choose to learn how to react differently to things you don't like and be responsible for your own behaviour
- ask yourself what you can learn from the conflict. This could lessen the chances of a similar conflict happening again.

If you want to find out more about Relationships Australia courses that focus on managing anger phone 1300 364 277.

Similar principles underpin the management of child and adolescent behaviour disorders although the younger the child the lesser expectation of internalised controls and the greater reliance on adult-child power imbalance and capacity for limit-setting and application of positive reinforcements.

Childhood behavioural disorders occur commonly in primary school aged children but can also be seen in pre-school children. There are varying degrees of disruptive behaviour disorders recognised by mental health services, with varying degrees of seriousness of outcomes and responsiveness to intervention. The whole life trajectory of the young person is at risk. The spectrum ranges from disruptive behaviour disorder, oppositional defiant disorder, and conduct disorder through to antisocial personality disorder. Early behavioural problems may reflect poor socialisation or responses to stressful environments but may also include other clinically significant predispositions such as mood and anxiety disorders, attention deficit hyperactivity disorder or developmental disorders of autism spectrum or language processing which impair the child's capacity to meet expectations. It is important to undertake proper assessment of underlying difficulties.

In general, children with seriously disruptive behaviour have less satisfactory school progress and social relationships than children with normal behaviour. This tends to persist and result in poor educational outcomes, less stable partnerships, lower socio-economic levels and higher rates of involvement in welfare and justice systems.

Childhood behavioural disorders can significantly affect other members of the immediate and extended family. Teachers and parents can become frustrated, feel helpless and inadequate because they can't change the child's behavior and often feel that their children's behavior is a reflection of their poor parenting. Siblings can become embarrassed and ashamed of the behavior and reluctant to bring their friends home. Battles at school and home often ensue with blame by each party of the other – typically parents blame each other, the child, the school and the child feels unheard and without options to change his/her behaviour.

If the child's disruptive behaviours manifest in delayed development in one or more areas the psychologist is likely to assess cognitive function and developmental markers. This can be very important in identifying children who have learning disabilities which may be affecting their academic performance and their capacity to learn. Many children show behavioural difficulties in association with such delays in areas of functioning. If a learning disability is identified different ways of learning will be planned so that the child's strengths can be the focus. This pattern may also be relevant in Autism Spectrum Disorders.

Treatment plans may include psychoeducation for parents which seeks to empower them with understanding of strategies which can be tried to help the child and how to discuss these with their child if relevant and monitoring success again with the child having an active role if possible. Working with the teacher /school as a partnership will also be important.

Cognitive behavioural interventions may be helpful with the child if the child is receptive and motivated, but not likely to succeed if the parents or teachers are wanting the child to do this but the child is not ready or open to this. Battles about behaviour should be avoided as far as possible.

Children with behavioural or relationship difficulties are likely to become more challenging in the context of family stress, notably poverty, relationship difficulties between parents, illness in the family, migration. Generally supporting the family to strengthen is important. Research shows that early intervention can have major beneficial effects in improving the outcome as compared to children who are not helped. In general, the earlier the intervention, and the less well-established the behavioural disturbance is at the time of intervention, the better the chance of satisfactory outcome.

A pilot program for children with disruptive behaviour has been trialled in some Victorian state primary schools with significant success. The program CASEA (CAMHS and schools early action) has been implemented in schools serviced by four metropolitan (Austin Health, Southern Health, Royal Children's Hospital, and Eastern Health) and four rural (Gippsland health, Bendigo Health, Ballarat Health, and North Eastern Health) mental health regions. The program involves a series of small group 'play sessions' in which the rules of social behaviour are explored and reinforced. The principles communicated in the sessions are carried over to the daily classroom activities. Concurrently, parent groups explore the principles of behaviour modification.

The research literature and results are published by the Mental Health Branch of the Victorian Health Department.

MHYFVic advocates that this proven initiative of preventive mental health should immediately be made available in **all** primary schools and that research be undertaken for possible implementation in pre-schools. The future costs to the community of a behaviourally impaired life trajectory can be immense, and the savings by a favourable improvement far outweigh the costs of the program. This is an extremely important health initiative not only because it can improve the life of individuals but also the lives of current and future families and friends.

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PE6a (v) Eating Disorders

Eating disorders are characterised by disturbances of eating behaviours and a core psychopathology centred on food, eating and body image concerns. Eating disorders are associated with notable quality of life impairment and impact on home, work, personal, and social life. Eating disorders also frequently co-occur with other mental health disorders, particularly anxiety disorders and depression.

PHYSICAL WARNING SIGNS INCLUDE:

- Rapid or sudden weight loss, or frequent changes in weight,
- Loss or irregularity of menstrual periods,
- Dizziness, fainting and/or fatigue/disturbed sleep,
- Lanugo, Dry/brittle hair, skin, nails,
- Gastrointestinal disturbances, Signs of frequent vomiting, Dehydration,
- Changes in heart rate (slow), Changes in blood pressure (low), Oedema,

- Changes in body temperature (low), Sensitivity to the cold, Reduced cognitive capacity.

PSYCHOLOGICAL WARNING SIGNS INCLUDE:

- Preoccupation with body shape, weight and/or appearance, Negative body image / body dissatisfaction,
- Fear of gaining weight, Heightened sensitivity to comments or criticism weight/appearance/exercise,
- Low self-esteem, Anxiety or depression, Obsessive behaviours, Suicidal thoughts or behaviours
- Preoccupation with food or food related activities, Heightened anxiety around mealtimes,
- Rigid thinking, Increased changes in mood, irritability, Feeling a lack of control,

BEHAVIOURAL WARNING SIGNS INCLUDE:

- Dieting behaviour, Avoidance of eating/ excuses, Eating very slowly, Deceptive behaviour around food.
- Changes in food preferences, Rituals around food, Preoccupied with food planning/ preparation,
- Evidence of vomiting or laxative abuse, Evidence of binge eating,
- Excessive or compulsive exercise patterns, Repetitive or obsessive body-checking behaviours,
- Change in school or work performance, Social withdrawal, Changes in clothing style.

Several variants are described:

Anorexia nervosa was described first in 19th century medical reports, to include self-imposed or maintained weight loss such that the person is underweight (for age and height) and associated overvaluation of shape and weight. This condition is characterised by intense fear of gaining weight/ becoming fat or persistent behaviour that interferes with weight gain. In addition, there is a disturbance in body image and /or undue influence of body weight or shape on self-evaluation and/or persistent lack of recognition of the seriousness of the low body weight. Two subtypes of anorexia nervosa are specified: restrictive type (with or without compulsive exercise); and binge eating/purging type, with binge eating (uncontrolled overeating) and purging (vomiting, laxative or diuretic misuse).

Bulimia nervosa and **binge eating disorder** were not described until the 20th century. Bulimia nervosa and binge eating disorder are both defined by having regular and recurrent sustained binge eating episodes. The amount of food eaten is larger than what most people would eat in a similar time period under similar circumstances. There is also a sense of lack of control overeating during the episode.

People with bulimia nervosa also compensate for binge eating with regular extreme weight control behaviours (such as purging). As they do not engage in such compensation regularly, people with binge eating disorder are likely to be overweight or obese. Self-evaluation is unduly influenced by body shape and weight and the binge eating and inappropriate compensatory behaviours both occur weekly or more frequently over a period of three months. Anorexia nervosa is not present in this condition. The bingeing and purging occur in cycles.

Binge eating disorder in the absence of recurrent inappropriate compensatory behaviours is associated with three or more of the following:

- Eating much more than normal,
- Eating until feeling uncomfortably full,
- Eating large amounts of food when not feeling physically hungry,
- Eating alone out of embarrassment, feelings of disgust, guilt, depression after a binge.

Marked distress regarding binge eating is present and the binge eating occurs at least weekly for three months or more.

Other specified feeding and eating disorder Symptoms characteristic of an eating disorder predominate, cause clinically significant distress or impairment but do not meet the criteria for diagnosis of a disorder in the eating

disorders diagnostic category. This may include atypical anxiety nervosa where there is normal weight, low level bulimia nervosa (frequency / duration). Binge eating disorder (low level/limited duration), purging disorder and night eating syndrome.

Orthorexia This refers to an obsession with healthy food, where there is fixation on quality rather than quantity of food to an excessive degree. This can start with 'healthy" eating and progress to elimination of whole food groups.

Avoidant restrictive food intake disorder (ARFID) which, like binge eating disorder, and in contrast to anorexia nervosa and bulimia nervosa, is not characterised by body image disturbance.

WITHOUT TREATMENT, EATING DISORDERS MAY RESULT IN:

- Slowing of growth and delay of puberty, Infertility,
- Brain changes that can lead to cognitive problems,
- Social withdrawal and isolation, Other mental health problems,
- Loss of bone density (osteoporosis), Loss of tooth enamel from vomiting,
- Complications from overweight and obesity, including diabetes,
- Heart failure and death can occur in anorexia and bulimia.

EVIDENCE BASED TREATMENTS:

- Family-Based Treatment (FBT) / Maudsley Model For young people with Anorexia Nervosa
- Cognitive-Behavioural Therapy (CBT-E)
- Other treatment options for adults with Bulimia Nervosa and Binge Eating Disorder:
    - CBT-E (AN);
    - Specialist Supportive Clinical Management (SSCM) for AN;
    - Interpersonal Psychotherapy (BN)
    - Mindfulness based therapies (ACT; DBT),
    - Cognitive Analytic Therapy (CAT);
    - MANTRA;
    - Cognitive Remediation Therapy;
    - Motivational Enhancement Therapy (MET);
    - Schema Therapy;
    - Guided Self-Help

TREATMENT REFRRALS: PUBLIC/COMMUNITY

- Refer client based on MH Catchment area
- Child/Adolescent/Youth Mental Health Service (CAMHS) (CYMHS)
- Adult Mental Health Service (AMHS)
- Local Hospital / Emergency Department Acute paediatric/adult medical care
- Eating Disorders Victoria www.eatingdisorders.org.au
- Headspace •12-25 years

REFERRALS PRIVATE SECTOR (FEE FOR SERVICE)

- Eating Disorders Victoria (EDV)
    - Psychology Service, Abbotsford
    - Inpatient / Outpatient / Day Program Services
- The Melbourne Clinic, Richmond
- The Geelong Clinic
- Delmont Private Hospital, Glen Iris

- Private clinicians, Psychologists (APS), Dietitians (DAA)
- Mindful Moderate Eating Group (MMEG), Swinburne University School of Psychology, Hawthorn
- Clinic for Healthy Eating and Weight (CHEW), Australian Catholic University School of Psychology, East Melbourne
- Recovery is Possible for Everyone (RIPE) Group, Body Positive Australia, Hawthorn

A recommended reference for this topic is provided by the Royal Australian & New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders Aust NZ J Psychiatry 2014 4:48:977.

Other information came from Eating Disorders Victoria. This group offers telehealth nurse, peer mentoring program, psychology and dietetics, education, primary health, support groups and stories of recovery.

PE6a (vi) Psychotic Disorders

Psychotic disorders are uncommon in children. Most begin in young adulthood but some in adolescence and very rarely in younger children. They are characterised by thought disorder, abnormal interpretation of reality, impaired executive functioning and affect, often accompanied by negative symptoms of self-neglect and social withdrawal. The thinking disorders will often include delusions and hallucinations.

Although psychosocial factors contribute to the form of a psychotic illness, the underlying biological disorder is shown by familial studies to be predominantly genetic. However, the non-compliance with usual inheritance patterns, the failure to identify 'necessary' genetic markers, and the role of exogenous factors such a stressors, all imply a significant role for epigenetic factors.

The gradual onset of symptoms possibly attributable to other causes can delay identification, but referral for assessment is indicated when the young person shows:

- Significant behavioural change without apparent cause,
- Deteriorating self-care
- Deteriorating academic performance
- Bizarre ideas
- Confusion of fantasy with reality
- Emotional inappropriateness, including excessive suspicion

The following guidelines are from the Royal Australian and New Zealand College of Psychiatrists, relating to the management of established cases, which of course are predominantly adult. The management of younger children will, of course, be significantly modified to be age appropriate. Schooling, for example, may need to be modified in a similar way to that of children with autism spectrum disorders.

Galletly, C. et al. "RANZCP clinical practice guidelines for the management of schizophrenia and related disorders" ANZ J Psychiat 2016 : 50 (5): 1-117.

This guideline provides recommendations for the clinical management of schizophrenia and related disorders. It includes the management of ultra-high-risk syndromes' first-episode psychoses and prolonged psychoses, including psychoses associated with substance use. It takes a holistic approach, addressing all aspects of the care of people with schizophrenia and related disorders' not only correct diagnosis and symptom relief but also optimal recovery of social function.

What is schizophrenia?

Schizophrenia is a complex disorder of brain function with wide variation in symptoms and signs, and in the course of the illness. The experiential *'core'* of schizophrenia has been described as a 'disturbance involving the most basic

functions that give the normal person a feeling of individuality, uniqueness and self-direction' (World Health Organization [WHO], 1992). The deficits in neurological, psychological and social function that manifest in the various syndromes of schizophrenia appear to have a number of genetic and environmental causes.

Schizophrenia is the most common and most important disorder within a spectrum of clinically similar (and possibly genetically related) conditions, which include schizoaffective disorder, schizotypal disorder and acute transient psychotic disorders. The term 'schizophrenia' includes a range of clinical presentations and personal experiences that result from complex interactions between genes and the environment and are influenced by the person's reaction to their experience of the disorder.

Variation in the incidence and prevalence of schizophrenia between populations is greater than was once believed. As many as 1% of people meet diagnostic criteria for the disorder over their lifetime. Schizophrenia often has profound effects on people with the disorder and their families. In terms of the global burden of disease and disability, schizophrenia ranks among the top 10 disorders worldwide.

Clinical presentation and diagnosis.

There is currently no validated biological marker of schizophrenia. The diagnosis is made by identifying the symptoms and signs of the disorder, which include delusional beliefs, hallucinations, disorganized thinking and speech, cognitive impairment, abnormal motor behaviour and negative symptoms. While neuroimaging and cognitive testing may help to rule out alternatives, such as schizophrenia-like manifestations of other disorders affecting brain function, schizophrenia is essentially a clinical diagnosis. The syndrome of schizophrenia, as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and International Classification of Diseases (ICD) classification systems, can be diagnosed with a high degree of inter-rater reliability. However, the validity of the syndromal diagnosis is currently under examination due to the variation in the course and clinical presentation of the disorder.

Since the onset of psychotic symptoms is often preceded by a prolonged period of disturbance of cognition, affect and behaviour, the importance of a thorough exploration of the person's developmental history and premorbid personality cannot be overestimated. Among the presenting symptoms, those of particular importance for the diagnosis include persistent delusions and hallucinations, incongruent or blunted affect, and interruptions in the train of thought. Characteristic 'first-rank' symptoms (thought insertion, withdrawal or broadcasting, hallucinatory voices commenting on the person's behaviour and passivity experiences) may be present but are not pathognomonic for schizophrenia. Depressive symptoms and anxiety are common. In differential diagnosis, one should consider other primary psychotic disorders as well as a range of neurological and systemic medical conditions. The differentiation of schizophrenia from substance-induced psychotic disorders may be particularly difficult and should be based on a careful review of the temporal relationship between drug taking and the emergence and persistence of psychotic symptoms.

The concept of staging

Staging is routine for many medical conditions. Over the last decade, a clinical staging model for mental illnesses has been developed, which proposes that the course of illness is a continuum. Clinical staging models assume that treatments offered earlier in the course of an illness have the potential to be safer, more acceptable, more effective and more affordable than those offered later. Interventions can be evaluated in terms of their ability to prevent or delay progression from earlier to later stages of illness and can be selected by the individual with schizophrenia and their clinicians on the basis of defined risk/benefit criteria.

At all stages, the therapeutic relationship is the foundation of clinical care. Time must be spent building trust and good communication. This is just as important for people with unremitting illness, as it is for those early in the course of the disorder. It is essential to take a respectful approach, provide accurate information and address the person's questions

and concerns. People with thought disorder, or other difficulties with conversation, are generally capable of meaningful communication and will often appreciate the opportunity to express their point of view and participate in clinical decision-making.

Comorbid substance abuse, which is very common among people with schizophrenia, can complicate the presentation and worsen outcomes.

The pre-psychotic or prodromal stage

Before the emergence of positive psychotic symptoms that are sufficiently severe and persistent to justify a diagnosis of schizophrenia or First Episode Psychosis, most people show a prolonged period of symptoms and increasing disability. This is commonly termed the 'prodrome' in retrospect, and the 'ultra-high-risk mental state' or 'at-risk mental state' prospectively. The pre-psychotic or prodromal stage is associated with evidence of changes in brain structure, probably reflecting active neurobiological processes. The neuropathological basis of these changes remains unclear.

The potential benefits of identifying and proactively treating individuals at risk of psychosis are significant because much of the psychosocial disability that becomes entrenched in the subthreshold period, prior to FEP, is difficult to reverse even when the core symptoms remit with effective treatment. People are also at risk of suicidal behaviour during the pre-psychotic or prodromal stage.

The ultra-high risk or at-risk mental state typically affects young people, usually aged between 14 and 35 years. It is characterised by a change in subjective experience and behaviour that is persistent and often progressive (although it may fluctuate in severity).

First Episode Psychosis

FEP is defined as one week or more of sustained positive symptoms above the psychosis threshold for delusions and hallucinations in particular. There are a range of diagnoses captured here with about 60% falling within the schizophrenia spectrum at this point although more 'graduate' later. The purposes of early intervention in FEP are to ensure the safety of the young person and others, to reduce the duration of untreated psychosis as much as possible and to preserve and restore function, thereby reducing the disability associated with psychotic illness. Management of FEP requires a holistic, systematic approach which involves a comprehensive range of pharmacological and psychosocial interventions.

Persistent/established illness

A significant proportion of people who have one episode of psychosis will go on to have more episodes or continuing disability. Naturalistic follow-up studies show that the early years after entry to treatment are often characterised by a turbulent early course, which can reduce ultimate levels of recovery. Relapses are common, with about half of people with FEP relapsing during a three-year follow-up period. Young people, in particular, find it difficult to accept the lifestyle change of taking medicines daily, especially if they have substantially recovered. Non-adherence to antipsychotic medication is a major risk factor for relapse during this period.

Relapses are disruptive and may contribute to an increased chance of treatment resistance. A substantial minority of people experience a 'stormy' early course of illness. Deaths from both suicide and natural causes occur at a much higher rate than in the general population. Secondary consequences such as persisting and worsening substance use and dependence, vocational failure, family stress and relationship breakdown are common. There is a serious risk of marginal lifestyles, homelessness and committing minor criminal offences. It is essential that high-quality, intensive care is continuously and assertively provided during this period. Recovery from an acute relapse can take longer than after the initial episode.

Severe persistent or unremitted illness

Clinical remission in schizophrenia is not uncommon, based on the findings of studies that have applied objective criteria, but a substantial minority of people with schizophrenia have persisting disabling and distressing symptoms. Apparent treatment resistance should be a trigger to reassess the treatment plan.

The recovery paradigm has reframed concepts of outcomes to include the subjective views of the person living with schizophrenia. The therapeutic approach at this stage is guided by a person-centred value system of a 'life worth living'.

The clinician's role is to establish a mutually respectful therapeutic relationship and optimise the management of potentially treatable factors such as unrecognised depression, inadequate psychosocial rehabilitation, poor adherence to prescribed medicines, substance use, medication side effects, differential responses to medicines, drug interactions and suboptimal drug therapy. The clinician also needs to work in partnership with primary care physicians and NGOs to ensure physical health and non-clinical needs are adequately addressed.

Long-term Treatment

The recovery paradigm

Recovery-oriented practice is based on the central importance of the lived experience and the perspective of the person with mental illness. Distinctions can be made between clinical recovery (which includes lessening of symptoms), functional recovery and personal recovery. Personal recovery has been described as a unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even within the limitations caused by illness. The concept of personal recovery draws on constructs of hope, self-identity, meaning and personal responsibility. For the individual, gaining knowledge about the disorder and the available treatment options, developing illness self-management skills and taking responsibility for his or her own treatment are all important.

Recovery-oriented services emphasise peer relationships, social networks, person-centred (strengths-based) assessment and recovery planning. People are encouraged to take up new challenges. Risk can be reduced through the use of relapse prevention plans and advanced health directives, along with the development of self-management skills to prevent unnecessary crises and minimise the loss of personal responsibility during periods of crisis.

Recovery is a concept relevant to all stages of illness, beginning as soon as there is a need for care (in the prodromal or ultra-high-risk period) and continuing through the first episode and the critical period. Recovery is a key goal in real terms and not merely in the sense of acceptance of persistent illness or adapting around it to have a meaningful life (critical though this is for many people). Clinicians should aim for recovery for everyone, and across all stages, as there are often late remissions or improvements.

Interventions essential to community-supported recovery include supporting people in early prodromal or symptomatic stages, responding quickly to requests for assistance, providing meaningful support, planning together with individuals and carers, listening to family members, facilitating connections with peer support networks and professional advocates, ready access to suitable facilities and helping people stay in their own accommodation.

Antipsychotic medicines treat the symptoms of schizophrenia but not its underlying causes. In the absence of new treatments, these medicines remain the cornerstone of both acute and maintenance therapy for schizophrenia. All antipsychotic medicines derive their effect on positive symptoms of psychosis from the blocking of dopamine receptors.

The management of acute behavioural disturbance

The management of the acutely disturbed psychotic person requires calm strategies that protect the safety and dignity of all concerned. The first step should be to try to engage the person and understand what is driving their agitation. Sometimes simple measures such as orienting and explaining what is happening can be enough to defuse the situation. The opportunity should be taken to perform a cognitive screen to exclude delirium/intoxication and also, where possible, physical examination, blood tests, urinary drug screen and an electrocardiogram (ECG).

Attention should be paid to the physical environment, such that stimulation is reduced and safety ensured. Objects that might be thrown or used as weapons should be removed, where possible.

There is a growing evidence base to support the use of psychotherapy and psychosocial strategies for psychosis. These should be provided along with optimal antipsychotic medication. There is clear evidence for CBT for psychosis and cognitive remediation, with an emerging evidence base for other therapies. This trend is likely to continue, given clinicians' appreciation of the limits of pharmacotherapy in addressing all the domains of schizophrenia and the current focus on person-centred, individualised care.

The therapeutic relationship is the cornerstone of effective treatment. All clinicians working with people with schizophrenia need psychological skills. Services should ensure that clinicians can spend time delivering psychological therapies. People living with psychosis may have experienced many losses, traumas and hardships, and rejection by others and by society. Clinicians must acknowledge these painful aspects of the person's life and respond empathically. A promising new possibility is to draw on techniques from positive psychology to enhance positive mental health and wellbeing.

Family support and psychoeducation.

Families of people with schizophrenia experience tremendous distress, grief and chronic day-to-day stress, which can be extreme and result in significant risks to their health and wellbeing. These issues have generally been neglected by services and by many health professionals - yet effective support for families is crucial, since for many people with schizophrenia, survival and recovery depend on their family relationships.

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