Monash Alfred Psychiatry research centre

# Women's Mental Health Toolkit

## *for rural and regional health practitioners*

**Sarah Rotstein[1], Elizabeth Thomas[1], Anthony De Castella[1] & Jayashri Kulkarni[1]**

[1]Monash Alfred Psychiatry Research Centre, Melbourne, Australia

*The reported prevalence of mental illness in rural and remote Australia is similar to that of major cities but due to limited access to mental health services, there are increased rates of self-harm and suicide with remoteness.*[1]

**By supporting and upskilling GPs in their role in mental health care in their local communities, we can improve access and quality of mental health services in rural and remote Australia.**

[1] Department of Health, *Submission 30*, p. 22.

# Preamble

***The numbers of psychiatrists, mental health nurses and psychologists in rural/regional areas in 2015 were, respectively, 36%, 78% and 57% of those in major cities, with even poorer comparisons in remote areas.[2]***

Women in rural areas have poorer access to health services than women in the cities.[3] In addition, women in rural areas being less satisfied with health service provision.[3] Hence, it is important to upskill health practitioners so they can better provide women's mental health services in rural/regional areas.

This resource has been developed to assist rural and regional health practitioners in identifying and responding to women with mental illnesses.

***"Rural and remote GPs play a crucial role in providing and facilitating a range of mental health services for patients experiencing mental disorders and distress: a role that is frequently under-recognised and under-supported."[4]***

This toolkit contains guidelines for patient/client care, from a range of sources. This includes information on assessment, diagnosis and management of mental health in women.

***Providing mental health training for local health practitioners beyond core skill sets could improve identification of potential mental health conditions, and earlier referral to appropriate treatment.[4]***

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[2] National Rural Health Alliance, *Submission 37*, p. 14.
[3] Australian Longitudinal Study on Women's Health: Health in Rural and Remote Areas of Australia alswh.org.au/images/content/pdf/synthese_reports/ruralhealth_summary.pdf
[4] Accessibility and quality of mental health services in rural and remote Australia rdaa.com.au/documents/item/471

# Contents

# 1. Women's mental health

Mental illness has many gender-specific aspects that clinical research has not always addressed. There is a great deal of individual variation in the vulnerability to the effects of hormone shifts on mood and behaviour. This has led to the connection between the mind and hormones being somewhat discounted because it is not a universal experience. However, people rarely experience even the most obvious physical illnesses in exactly the same way, so why should we expect uniformity in the mental health impact of hormones?

Women have biological hormone shifts on a cyclical basis and in a major way during the menopausal transition. Women have 14 times increased prevalence of depression during the menopause[1] and often poorly treated with standard antidepressant therapies. Hormone treatments can provide better responses for this type of depression – but the link between depression and hormones is not often made.

In conditions such as schizophrenia, the age of onset and pattern of symptoms commonly seen is different for women and men[1]. Women and men may also respond differently to medications or other treatments. In addition, changes in the level of sex hormones such as estrogen are known to affect symptoms[2].

The hormone influence on mental ill health is only part of the many other factors that trigger or perpetuate mental ill health. Mental illnesses are due to a combination of biological, psychological and social factors. Hence, it is important to consider all factors when exploring mental health in women in order to gain a better understanding and provide effective treatments.

**Women's mental health should be a national health priority with better holistic understanding and treatments for our grandmothers, mothers, wives, partners, girlfriends, sisters, daughters, aunts and female friends.**

[1]Parry, B. L. (2008). Perimenopausal depression. *American Journal of Psychiatry*, *165*(1), 23-27.
[2]Abel, K. M., Drake, R., & Goldstein, J. M. (2010). Sex differences in schizophrenia. *International review of psychiatry*, *22*(5), 417-428.

# 2. Assessment

## Purpose of assessment

1. Make a working diagnosis

   Psychiatric conditions often declare themselves over time. It is therefore important not to foreclose early!

2. Basic case formulation

   Use a BPSL (biopsychosocial and lifestyle) framework consider predisposing, precipitating, perpetuating and protective factors.

3. Risk Assessment

   Risk of harm to self, others, financial, homelessness, carer burnout etc.

4. Guide Treatment

## Screening questions

| Sample screening questions | |
|---|---|
| **Depression** | Do you have a depressed /low mood?<br>Do you still experience pleasure? |
| **Anxiety** | Do you feel excessively anxious?<br>Are there any situations that make you feel especially anxious? |
| **Mania** | Have you ever had a period of a few days – weeks when you haven't needed to sleep but had lots of energy and felt really good (or irritable)? |
| **Psychosis** | Do you hear any voices or whispers?<br>Do you every watch TV or listen to radio and feel there are special meanings for you specifically?<br>Do you feel that people are trying to hurt or harm you? |
| **Eating Disorders** | • S – Do you make yourself **S**ick because you feel uncomfortably full?<br>• C – Do you worry you have lost **C**ontrol over how much you eat?<br>• O – Have you recently lost more than 6.35 kg (**O**ne pound) in a three-month period? |

| | |
|---|---|
| | • F – Do you believe yourself to be **F**at when others say you are too thin?<br>• F – Would you say **F**ood dominates your life?<br>• Are you satisfied with your eating patterns?<br>• Do you ever eat in secret? |

HEADS mnemonic for psychosocial assessment

**H**ome

**E**ducation/Employment

**E**ating

**E**motions

**A**ctivities

**D**rugs & Alcohol

**S**exuality

**S**elf-harm and Suicidality

## History taking

- History of presenting episode
- Symptoms screen

  ✓ Depression

  ✓ Anxiety

  ✓ Psychosis

  ✓ Mania symptoms (past or present)

  ✓ Organic causes – for example: history of head trauma, seizures, signs of thyroid dysfunction, recent viral infection, anaemia
- Impact of hormones on mental health.

  Patients can have a cyclical pattern to their symptoms or worsening at time of perimenopause.
- Risk assessment questions

  ✓Overtly ask about suicidality and deliberate self-harm
- Screen for psychosocial factors (e.g. HEADS mnemonic in adolescents)
- Substance use

- Symptoms screen

  ✓ Alcohol

  ✓ Illicit substances

  ✓ Cigarette smoking

  ✓ Caffeine
- Medical history and current medications

  ✓ Especially hormonal medications e.g. oral and in-situ contraceptives
- Developmental history

  ✓ Ask about abuse and sexual assault
- Forensic history
- Collateral history from family, other health professionals and schools – with consent

**Physical examination**

The primary aim of the physical examination is to assess for signs of organic causes of psychiatric symptoms and signs of physical deterioration secondary to psychiatric symptoms or psychotropic medications.

Examination may include:

- Vital signs
- Body Mass Index (height and weight)
- Assess for co-morbid eating disorder or medication side effects
- Signs of polycystic ovarian syndrome including, hirsutism (e.g. acne on face, neck or back and excessive hair growth)
- Signs of thyroid dysfunction
- Signs of anaemia
- Signs of mononucleosis including enlarged cervical lymph nodes
- Signs of self-harm (e.g. cutting on arms or ligature mark)
- Signs of physical abuse

## Investigations to consider

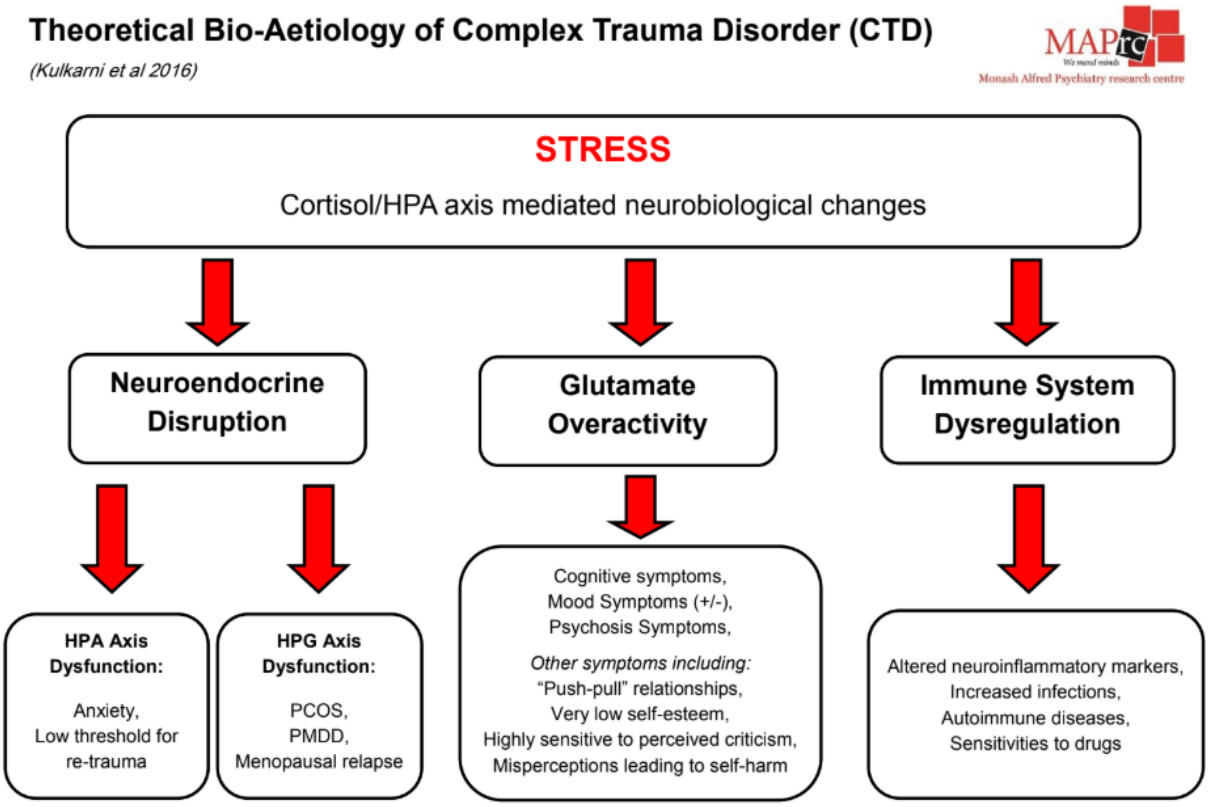
| Investigation | Rationale |
|---|---|
| **FBE, UEC, LFTs** | General health workup. Some medications can cause derangement of these tests. |
| **Iron, Folate, B12, Vitamin D** | Deficiencies can cause depression symptoms |
| **Thyroid Function Tests** | Abnormalities in thyroid function can cause psychiatric symptoms |
| **Fasting glucose, cholesterol and triglycerides** | To assess baseline in preparation of starting psychotropic medications |
| **Hormone levels** | Consider if signs/symptoms of polycystic ovarian syndrome |
| **Inflammatory markers (CRP and ESR)** | To investigate for chronic or acute inflammatory/infective illness |
| **EBV serology** | May be warranted if suspicion of EBV infection |
| **Hepatitis screen or other blood borne illnesses as indicated** | To investigate for other causes of psychiatric symptoms |
| **Anti-NMDAR, Anti-VGKC, AntiGAD antibodies** | To investigate possible autoimmune encephalitis as cause for psychiatric symptoms (especialy psychosis) |
| **ECG** | As a baseline prior to commencing psychotrpic medications |
| **EEG** | Consider electroencephalogram in atypical presentation |

| | |
|---|---|
| **MRI brain with contrast** | For other organic neurological causes (especially important in the presence of focal neurological signs or any neurological symptoms on history) |
| **βHCG** | If history indicates possible pregnancy. Especially relevant if planning to commence medications. |
| **STD (sexually transmitted diseases) screening** | Should be considered if the patient is sexually active |
| **Urine Drug Screen (UDS)** | We would be reluctant to request a UDS on an outpatient. Ordering a UDS will threaten the rapport with your patient. |
| **Psychometric testing & other screening tools** | Ideal to have these assessments (although not always practical) they are useful to highlight cognitive deficits in keeping with your diagnosis |

# 3. Diagnoses in brief

## Complex Trauma Disorder (aka Borderline Personality Disorder)

- A serious pervasive disorder that results from early life traumatic experiences
- Characterised by the presence of psychological and social symptoms/behaviours (not all are required for the diagnosis) including low self-esteem, difficulties with intimacy, cognitive symptoms, impulsivity, chronic suicidality/self-harm and low threshold for re-trauma




*Clinical Practice Guideline - Borderline Personality Disorder*
nhmrc.gov.au/about-us/publications/clinical-practice-guideline-borderline-personality-disorder

## Major Depressive Disorder

Five or more of the following symptoms have been present during the same **2-week period** and represent a change from previous functioning: at least one must be depressed mood or anhedonia[1]

- Depressed mood most of the day, nearly every day
- Anhedonia (loss of ability to feel pleasure) or marked loss of interest in activities
- Significant weight loss/gain or appetite increase/decrease • Insomnia/hypersomnia
- Psychomotor agitation/retardation
- Fatigue
- Feelings of worthlessness or inappropriate guilt
- Poor concentration or indecisiveness
- Recurrent thoughts of death or suicide

*Clinical practice guidelines for mood disorders*
ranzcp.org/practice-education/guidelines-and-resources-for-practice/mood-disorders-cpg-and-associated-resources

Note, depression occurring around the menopausal transition, known as **Perimenopausal Depression**, has a different clinical presentation compared with other types of depression. Anger, irritability, poor concentration, memory difficulties, poor self-esteem, poor sleep and weight gain make up this depression.

*Perimenopausal depression scale: MENO-D*[2]
The Meno-D can be completed as a self-report scale or completed by a clinician. The general reference point for each item is the individual's pre-menopausal level or state.
maprc.org.au/about_depression

[1]American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub.
[2]Kulkarni, J., Gavrilidis, E., Hudaib, A. R., Bleeker, C., Worsley, R., & Gurvich, C. (2018). Development and validation of a new rating scale for perimenopausal depression—the Meno-D. *Translational psychiatry*, *8*(1), 1-9.

## Anxiety Disorders

Anxiety is another umbrella term that encompasses a number of different diagnoses that are characterised by a disrupted fear response.

Generalised Anxiety Disorder[1]

- Excessive anxiety and worry, occurring most days for at least 6 months, about a number of events or activities

Panic Disorder[1]

- Recurrent unexpected panic attacks
- A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes

Social Anxiety Disorder[1]

- Marked fear or anxiety about at least one social situation in which the individual is exposed to possible scrutiny by others

*Clinical practice guidelines*

ranzcp.org/practice-education/guidelines-and-resources-for-practice/anxiety-disorders-cpg-and-associated-resources

*Depression, anxiety and stress scale (DASS)*[2]

The DASS is a 42-item self-report instrument designed to measure the three related negative emotional states of depression, anxiety and tension/stress.

psy.unsw.edu.au/dass/

[1]American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub.

[2]Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour research and therapy*, *33*(3), 335-343.

## Schizophrenia

- A chronic disorder with a propensity for acute psychosis and negative/cognitive symptoms
- Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of acute symptoms (or less if successfully treated) and may include periods of prodromal or residual symptoms[1]
- During prodromal/residual periods, the signs of the disturbance may only include negative/cognitive symptoms[1]

*Clinical practice guidelines*
ranzcp.org/practice-education/guidelines-and-resources-for-practice/schizophrenia-cpg-and-associated-resources

## Eating Disorders

Eating disorders are characterised by a persistent disturbance of eating behaviours and associated thoughts, attitudes and emotions that significantly impair physical health or psychosocial functioning

Anorexia Nervosa

- Severe restriction of energy intake, fear of weight gain, belief need to lose weight[1]

Bulimia Nervosa

- Binge eating episodes with compensatory methods to reduce weight gain[1]

Binge Eating Disorder

- Binge eating episodes without compensatory methods[1]

*Clinical practice guidelines*
ranzcp.org/practice-education/guidelines-and-resources-for-practice/eating-disorders-cpg-and-associated-resources

[1]American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub.

## Polycystic Ovary Syndrome

Rotterdam criteria[1] for diagnosis requires at least 2 of the following:

- Menstrual irregularity

  Oligomenorrhoea or amenorrhoea, or irregular bleeding
- Hyperandrogenism

  Clinical signs of hyperandrogenism or biochemical findings of hyperandrogenism
- Polycystic ovaries (one or both on Ultrasound)

  *Ultrasound is not recommended for those within 8 years of menarche*

## Premenstrual Dysphoric Disorder

Mental health and physical symptoms in the final week before menses that start to improve within a few days of onset of menses and become minimal in subsequent weeks. Mental health symptoms can include[2]:

- Affective lability
- Irritability, anger or increased interpersonal conflicts
- Depressed mood, feelings of hopelessness or self-deprecating thoughts
- Anxiety, tension or feeling 'keyed up' or on edge

## Premenstrual Syndrome

- Somatic, behaviour or psychiatric disturbances in **second half of the cycle that do not meet criteria for PMDD**
- Psychiatric symptoms are not required for the diagnosis

*Additional clinical practice guidelines and resources for practice can be found here:*

ranzcp.org/practice-education/guidelines-and-resources-for-practice

[1]Eshre, TR, & ASRM-Sponsored PCOS Consensus Workshop Group. (2004). Revised 2003 consensus on diagnostic criteria and long-term health risks related to polycystic ovary syndrome. *Fertility and sterility*, *81*(1), 19-25.

[2]American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub.

# 4. Management

## Treatment summary

| Crisis planning and management | Psychological | Biological | Social/Lifestyle |
|---|---|---|---|
| Monitor for risks e.g. suicide and accidental death from deliberate self-harm, to others | Proper psychoeducation for patient and family | Cease or change any medications that could be worsening mental health e.g. many of the hormonal contraceptives, stimulants in anxiety | Assess and manage any current risks to patient safety (e.g. ongoing abuse) |
| Crisis management e.g. psychiatric triage or admission, staying with family | Structured psychotherapy e.g. CBT (anxiety/ depression), DBT/ MBT (CTD) | Psychotropics as indicated to treat the specific condition – see RANZCP clinical practice guidelines for details | Support occupational and academic achievement (e.g. liaison with school, university or work) |
| Develop a safety plan and share with patient, family and carers | Family Therapy – as appropriate | Utilise hormonal strategies in setting of premenstrual or perimenopausal worsening of symptoms | Provide support and psychoeducation to family and carers |
| | Longer term psychodynamic psychotherapy – if history of trauma | Novel treatments targeting glutamate for CTD including memantine (current treatment trial at MAPrc) | Encourage healthy lifestyle practices including diet, exercise and avoidance of substances |
| | | Treat psychiatric, addiction and physical health co-morbidities | Link patient/family with support groups |

## General management principles

- **Trust -** the most important part of the therapeutic relationship
- **'Being with'** – is an underrated therapeutic tool
- **Boundaries -** adhere to them with kindness and empathy
- **Breaks, transitions and endings** – can be times of escalation of symptoms. Provide plenty of warning and make clear plans
- **Hope -** sometimes all we can do is hold the hope
- Managing your **own emotions** – Be aware of transference/countertransference
- **Looking after yourself and supervision** – It is reasonable to reduce your case load of challenging patients, seek peer support and supervision from senior or psychiatrist colleagues

## Starting antidepressants

- Antidepressants take **at least 2 weeks** to demonstrate a partial effect and **4 – 6 weeks to exert maximal effect.**
- In the initial few days to 2 weeks, patients may experience **prominent initiation symptoms** including agitation, escalating anxiety, nausea, insomnia and headaches.
- It is important to **inform patients of the initiation side effects** and explain that if they experience these symptoms they should be short-lived.
- Antidepressants have been associated with an increase in suicidality in adolescents. **Monitor for risks closely.**
- Antidepressants can precipitate mania. **Monitor for signs of a 'manic switch'** and to avoid antidepressants if there is a strong likelihood that your patient has bipolar depression.

Biological management of PMDD: Antidepressant medication can be used as intermittent or continuous therapy and/or hormonal strategy.

***'Evidence does not support the use of pharmacotherapy as first-line or sole treatment for BPD'[1]***

### Hormonal treatments

Only prescribe after **excluding contraindications** (such as past history of venous thromboembolism, hormonally responsive cancer, migraine with visual aura or hypertension) and **monitor regularly** for complications (e.g. breastscreen, pap smears, fasting lipids).
Situations when hormonal treatments may be warranted:

1. **Clear worsening of symptoms associated with the premenstrual period.**
   We recommend oestradiol and nomegestrel (Zoely) taken continuously with 4 days of placebo/break every 3 months
2. **Exacerbation of symptoms linked to the perimenopausal period**
   Hormone Replacement Therapy e.g. tibolone, transdermal oestrogen PLUS conjugated progesterone

***Zoely is one of the few combined oral contraceptive pills that has not been associated with depression***

### Managing your own well-being

In order to ensure that you are able to provide the best quality of care for these patients, it is important to maintain your own well-being.

- Be aware of your own emotional responses to certain patients and their behaviours.
- Know about and comply with your practice/organisation's safety protocols
- Seek support from peers or professionals, such as a counsellor, support group, or psychotherapist, if you find that you are feeling overwhelmed or burned out.
  - Resources for physician support are listed on page 20.
- Offer support to colleagues when necessary, and generally contribute to a workplace ethos of support and staff care.
- Recognize that caring for patients with trauma may trigger your own traumatic

[1]Clinical practice guideline for the management of borderline personality disorder. nhmrc.gov.au/about-us/publications/clinical-practice-guideline-borderline-personality-disorder

experiences.

- Trust your own instincts about your safety
    - Seek police support if you feel your safety is being threatened
- Recognize the value of the work you are doing! Small improvements in symptoms can have a significant impact on the patient's overall quality of life, even if the benefits are not apparent in a clinical setting.

## 5. Take-home points

1. Perform an appropriate medical work-up
2. Obtain a thorough psychiatric history
3. Employ pharmacologic management strategies as appropriate
4. Consider other non-pharmacological management strategies, including lifestyle changes and environmental factors
5. Be mindful of your own well-being

# 6. Further resources

| EMERGENCY LINE |
|---|
| **Please call 000 if you feel that you, or someone you know, is in immediate danger.** |

| 24/7 National Crisis Services | | |
|---|---|---|
| **Name** | **Contact** | **About the service** |
| **LIFELINE** | *Tel*: 13 11 14<br>*Website*: lifeline.org.au | Crisis support and suicide prevention service, available over phone or online chat |
| **Kids Helpline** | *Tel*: 1800 55 1800 | Telephone counselling service for children and young people between the ages of 5 and 25 |
| **Suicide Call Back Service** | *Tel*: 1300 659 467<br>*Website*: suicidecallbackservice.org.au | Counselling service for people at risk of suicide, people concerned by someone else's risk of suicide, people bereaved by suicide, and professionals caring for suicidal clients, offering telephone, online chat and video chat support |
| **1800 RESPECT** | *Tel*: 1800 737 732<br>*Website*: 1800respect.org.au | National sexual assault, domestic and family violence counselling service available through phone and online chat |
| **MensLine Australia** | *Tel*: 1300 789 978<br>*Website*: mensline.org.au | Telephone, online chat and video chat counselling service for men in crisis |
| **Beyondblue** | *Tel*: 1300 22 4636<br>*Website*: beyondblue.org.au | Telephone and online chat service that provides counselling and information for people suffering from mental health illness |

| 24/7 Victoria Telephone Crisis Services | | |
|---|---|---|
| **Name** | **Phone Number** | **About the Service** |
| **Sexual Assault Crisis Line** | 1800 806 292 | Telephone crisis counselling service for people who have experienced sexual assault |
| **Safesteps** | 1800 015 188 24 | Family violence telephone response service |
| **Suicide Line** | 1300 651 251 | Telephone counselling service providing professional support to people at risk of suicide, people concerned by someone else's risk of suicide, and people bereaved by suicide |

| Other Phone and Online Support Services | | | |
|---|---|---|---|
| **Name** | **Contact** | **Hours** | **About the Service** |
| **Blue Knot Helpline** | *Tel*: 1300 657 38<br>*Website*: blueknot.org.au | Mon to Sun 9am-5pm EST | Phone support for adult survivors of trauma and their caregivers, staffed by trained trauma-informed counsellors. |
| **eheadspace** | *Tel*: 1800 650 890<br>*Website*: eheadspace.org.au | Mon to Sun 9am-1am EST | Phone and online support service for young people age 12-25 with mental health concerns |

| | | | |
|---|---|---|---|
| **SANE Helpline** | *Tel*: 1800 187 263 | Mon to Fri 10am-10pm EST | Mental health information and referral service. |
| **WIRE Women's Information and Referral Exchange** | *Tel*: 1300 134 130 | Mon to Fri 9am-5pm EST | Information, support and referral service for women. |

| Resources for Physician Support | | |
|---|---|---|
| **Name** | **Contact** | **About the service** |
| **Royal Australasian College of Physicians** | *Tel*: 1300 687 327 | Free 24/7 telephone counselling service for fellows and trainees |
| **Blue Knot Foundation** | *Website*: blueknot.org.au | Resources and information about caring for patients with a history of trauma for healthcare providers |
| **Black Dog Institute** | *Website*: blackdoginstitute.org.au | An institute that provides workshops, online training modules, and other online resources to provide mental health education and training for health professionals |

| Resources for Rural Support | | |
|---|---|---|
| **Name** | **Contact** | **About the service** |
| **Rural Workforce Agency Victoria** | *Website*: www.rwav.com.au | Supports general practitioners to pursue a rural career in Victoria through a free recruitment service and professional development opportunities |
| **Rural Doctors Association of Victoria** | *Website: r*dav.com.au/ | RDAV is the peak advocacy body representing the interests of rural doctors and their communities in Victoria |
| **Royal Australian College of General Practitioners Rural** | *Website*: racgp.org.au/the-racgp/faculties/rural | RACGP Rural supports and advocates for GPs working in our rural and remote communities |
| **NSW Rural Doctors Network** | *Website*: nswrdn.com.au | A network that assists suitably skilled and qualified GPs, nurses and allied health professionals to pursue careers in remote, rural and regional NSW |

| Resources for Caregiver Support | | |
|---|---|---|
| **Name** | **Contact** | **About the resource** |
| **Carers VIC (Victoria branch of Carers Australia)** | *Tel*: 1800 242 636<br>*Website*: carersvictoria.org.au | Telephone counselling and online resources for caregivers of people suffering from mental or physical illness or disability |
| **Mind Australia Carers Helpline** | *Tel*: 1300 554 660 | Telephone service for caregivers, offering counselling and information about support groups and other resources for caregivers |
| **Grow Together** | *Tel*: 1800 558 268<br>*Email*: national@grow.org.au | Program for caregivers of people with mental illness, helping to develop supports and coping skills in their roles as carers |

| | | |
|---|---|---|
| **Family Connections Program** | *Website*: bpdaustralia.com/family-connections-1 (Register online) | Free 12-week course for family members of people with BPD, offering education on DBT strategies, how to care for their loved ones with BPD, and how to manage their own well-being |
| **The Bouverie Centre** | *Tel*: (03) 9385 5100<br>*Website*: bouverie.org.au | Healthcare center providing family therapy and resources for families where a family member is suffering from mental illness, substance abuse, or a traumatic history |

| **Specific services for marginalized populations in Victoria** | | |
|---|---|---|
| **Name** | **Contact** | **About the service** |
| **The Healing Foundation** | *Tel*: 02 6272 7500<br>*Website*: healingfoundation.org.au | Aboriginal and Torres Strait Islander organization supporting local projects and providing online resources/information for patients and physicians to promote indigenous healing |
| **QLife** | *Tel*: 1800 184 527 (Mon-Sun 3pm-12am EST)<br>*Website*: qlife.org.au | Counselling and referral service for LGBTI people, including peer supported telephone and online chat, as well as online resources and information |
| **Mental Health in Multicultural Australia** | *Website*: mhima.org.au | A national organization promoting mental health care for culturally and linguistically diverse minority populations, including information about culturally competent services/resources in Australia |