Mental Health Council of Australia

WEEKLY BULLETIN

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BULLETIN NO. 19, 2012

Hi all,

Wishing Kim all the best on her trip to Ireland, already she's met with the CEO of Mental Health Ireland ahead of the UN Conference and we're looking forward to hearing all about the conference on her return.

Please provide any feedback/comments on the Bulletin to me directly while Kim's away at policy@mhca.org.au.

Thanks,
Peter

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1. 2012/13 ACT Budget – Overview of Mental Health initiatives

Media release
Mental Health Community Coalition of the ACT
6 June 2012

The ACT Government has provided a further $1 million of growth funding for the mental health sector in the 2012-13 budget released 5 June 2012. The funding will be split 50/50 between the public and community mental health sectors as per usual over the last few years.

The new funding is allocated to the following areas:

Migrant and Refugee Mental Health:
Increased funding for Companion House MH program and a Transcultural MH Liaison Officer (upgraded to full-time) to be based in the Migrant Health Unit of ACT Health Directorate
Implementation of Comorbidity Strategy initiatives:
$50,000 to make the co-morbidity bus tours sustainable and progress other initiatives from the Comorbidity Strategy.
Post-Traumatic Stress Disorder:
Funding for Picking Up the Peaces PTSD support group.
LBGTI community:
Funding for A Gender Agenda, which also gets an extra $50,000 from general Health funding for counselling and volunteer services.
Compeer program:
Funding for continuation of this program.

There is also $2 million capital funding for design of a Secure MH Facility.

Other things to keep an eye out for include:

- $588,000 over two years for an upgrade of the AMC Crisis Support Unit
- $130,000 for design of a building for the Common Ground housing project
- $100,000 for community visitors in the disability sector

- $300,000 for recurrent funding for the Street Law homeless legal service
- $1,137,000 over two years for extending throughcare services for people exiting AMCX
- $448,000 next year for implementation of the equal pay case and community sector reform.

Indexation of community sector funding came out at 3.25% (-0.34% for the community sector reform co-contribution for organisations with funding above $150,000).

MHCC ACT comments:

The MH initiatives in this budget address a couple of gap areas and are most welcome. We recognise however that the amounts allocated to each initiative are small. There is also no funding to increase capacity in any other areas of the sector meaning many services will continue to struggle with unmet demand. While it is difficult to tell from the available figures, it appears that MH as a proportion of the total health budget fell again. Nonetheless the MH sector fared better overall than most other community sector subsectors.

We have already noted some other initiatives contained in the budget. We are concerned, however, at the seeming lack of funding for ATOD services, but note that some funding may flow to that sector from other initiatives.

http://www.mhccact.org.au/cms/index.php?page=policy_and_pubs#303

2. Mental health support service for children (WA)

ABC News Online
14 June 2012

The state and federal governments have announced plans to set up a 24 hour support service in Perth for children suffering from mental health issues.

The Federal Mental Health Minister Mark Butler says around 800 children with psychiatric problems are treated at Princess Margaret's emergency department each year, which is clogging up the system.

He says funding to be provided to the state government today will eradicate the need for children to be treated in hospital.

"The Australian Government is providing $13.5 million to fund a 24 hour acute response team that will be able to respond to the needs of those children, those teenagers and their families, without them needing to go to the emergency department," he said.

A total of $26 million will fund two projects that aim to divert young people with mental illness from hospital and fund more houses to accommodate people moving out of hospital.

http://www.abc.net.au/news/2012-06-14/mental-health-unit-set-up/4070282?section=wa

3. NSW Budget 2012

Senior Australian News and Research
12 June 2012

The New South Wales Treasurer Mr Mike Baird handed down a $60.552 billion budget for 2012-2013 today in the face of a difficult economic environment.

NSW's GST revenue has fallen by more than $5 billion and the Federal Government has also 'shifted' $690 million which has contributed to a Budget deficit in 2012-2013 of $824 million. The Budget provides for a number of areas associated with seniors interests, some of which are outlined below.

Ageing and disability support services
Supports services have been allocated $2.7 billion in the budget.
Accommodation and respite places for people with a disability will be increased for services to older people, people with a disability, their families and carers.
This includes an increase in disability funding of $178 million on the previous year.

A commitment to individualised funding packages coincides with $336 million to implement the second year of 'Stronger Together Two', the NSW Government's five year, $2 billion strategy to reform disability services.

$6 million will go to the NSW Ageing Grants Program to support services and projects that meet the needs of older people. This will coincide with the implementation of the NSW Ageing Strategy to be announced this year.

9,125 new places will be created in 2012-13 for people with a disability, their families and carers. This includes:

- 860 places for flexible respite options to support people with a disability, their families and carers in the community;
- 530 new supported accommodation places;
- an additional 300 places to increase community engagement for adults;
- 3900 additional decision support service places to improve access to local services and programs;
- 70 additional Aboriginal and family intensive support places.

The Budget commits $148.5 million for capital works including $70 million for improved alternative accommodation for people with a disability living in large residential centres. The capital works investment will provide high standards of living for people with a disability, providing a home environment, while being highly accessible to a community in which they can become involved.

Mental health

- $67 million over four years for works on the Missenden Mental Health Unit at Royal Prince Alfred Hospital with an expected completion date of 2015
- $40 million over four years for the NSW Mental Health Commission, which will be established on 1 July 2012 to improve the mental health system and ensure greater accountability
- $25.7 million to complete the construction of the Hornsby Hospital Mental Health Units

Health

- An extra 50,000 emergency department presentations, 30,000 additional acute inpatient services including an extra 2,000 elective surgery procedures and $10 million for additional intensive care services
- $64 million for 500 more nurses and over $4 million for more clinical nurse/midwife educators and specialists
- Major new hospital works: Blacktown/Mt Druitt, Bega, Hornsby Ku-ring-gai, Tamworth, Parkes and Forbes hospitals. New car parks at Blacktown, Nepean and Wollongong hospitals
- $45 million for health and medical research including $5 million for the new Medical Devices Seed Fund and a $5 million boost for the Medical Research Support Program

Family, community services

- $232 million for home and community care services to support people with a disability to continue living in their communities
- $134 million for specialist homelessness services to help break the cycle of repeat homelessness for 65,400 people
- $131 million for Aboriginal housing including 65 new dwellings and repairing and maintaining dwellings in the Aboriginal community housing sector
- $4.5 million over four years for Volunteering Strategy initiatives to make it easier for people to volunteer and to support current volunteers.

Cost of Living

On 1 July 2012, the Low Income Household Rebate will increase from $200 to $215. In addition, the Government will introduce the Family Energy Rebate of $75 per eligible customer, rising to $150 per eligible customer by 1 July 2014 at a cost of $83 million over the four years to 2015-16. Other energy assistance measures such as the Energy Accounts Payment Assistance Scheme take total energy assistance in 2012-13 to over $210 million. Families will receive increased assistance through the Low Income Household Rebate which rises to $215 from 1 July, increasing to $235 by 2014.

The Medical Energy Rebate will increase to $215 from 1 July, which will continue to increase in line with the Low Income Household Rebate.

The emergency voucher scheme – the Energy Accounts Payment Assistance Scheme (EAPA) - will also increase to $14.9 million for 2012-13 to help households stay connected to essential energy services during a financial crisis. The full set of Budget papers with details of provisions are available at http://www.budget.nsw.gov.au/home11

http://www.seniorau.com.au/index.php/more-seniorau-news/2480-nsw-budget-2012-seniors

4. Expert warns against child mental health checks

ABC News Online
12 June 2012

One of the most influential psychiatrists in the United States says the Federal Government's program to screen three-year-olds for mental health problems is "ridiculous" and potentially dangerous.

Australian preschoolers are set to be screened for early signs of mental illness as part of the Government-funded Healthy Kids Check, which would be voluntary for families.
The Australian Medical Association (AMA) supports the initiative but says the evaluations must focus on broad-based problems rather than individual things like fear of the dark or fear of monsters.

The Healthy Kids Check will be predominately conducted by GPs who will refer children with troubling behaviour to psychologists and paediatricians.

The program will cost $11 million over five years and is expected to identify about 27,000 children who would benefit from extra support.

But Professor Allen Frances, an Emeritus Professor at the Duke University, has raised concerns about the scheme.

Professor Frances was the chairman of the American Psychiatric committee that produced the current edition of the Diagnostic and Statistical Manual of Mental Disorders, which psychiatrists around the world call their bible.

He is highly critical of the latest edition of the manual and warns that if it is issued unamended it will "medicalise normality".

"My experience is that the hardest diagnoses in our field are in the youngest children," he said.

"Kids have developmental changes that are dramatic in a very short period of time. So, I would be the most cautious in doing anything psychiatrically with very young children.

"Parallel to that, the most adventurous of all the diagnosticians in psychiatry, are the child psychiatrists."

'Unintended consequences'

Psychiatrists supporting the program say early identification of mental illness is essential to properly treating it before it becomes extreme, but Professor Frances says that is not practical given the current knowledge base.

"There's absolutely no evidence at all that we can predict accurately who will go on to have a mental disorder," he said.

"There can be lots of unintended negative consequences to labelling children who essentially are normal and will grow out of whatever problem they have at that moment.

"I just got an email this morning from a mother in America whose child had been diagnosed as autistic. And the description in the report did not resemble her child at all.

"A label like 'autism' can be obviously devastating, but even less severe labels can have a dramatic effect on expectations, on the way the child feels about himself, his role in the

family. I would be very cautious about labels, especially in young children, especially because they're so likely to be wrong."

Professor Frances says there are many individual differences between children, and, except in very clear-cut cases, diagnoses are likely to be wrong.

"It's ridiculous to be doing it with three-year-olds," he said.

"But even with older children you have to be very, very cautious in making diagnoses in kids who are undergoing developmental challenges, [and] have different [rates] of growth."
He says the biggest single problem in the field is the push to medicalise behaviour to ensure medical treatment is funded.

"I think that the first six sessions or so, first six visits with a physician or psychologist shouldn't require a diagnosis," he said.

"I think that requiring a diagnosis from the very start leads to over-diagnosis and that diagnostic inflation leads to way too much treatment."

And he says although drugs can be very helpful for those who need them, they are unnecessary and, in some cases, dangerous for those who do not.

"There are all sorts of short-term side effects in terms of problems with sleep and eating," Professor Frances said.

"Some of the kids are going to have problems that may be worsened by stimulant drugs and the long-term effects are largely unknown."

Professor Frances is critical of the current edition of the Diagnostic and Statistical Manual of Mental Disorders and says the manual is expanding the boundaries of psychiatry at the expense of the shrinking realm of normal.

He is calling for psychiatrists to relinquish their monopoly on defining disease in the manual. "Psychiatric diagnosis is too important to be left with any small group or one profession," he said.

"And policy decisions, in Australia for instance, for the whole country may be determined by what's in the manual, what's not in the Manual.

"I don't think decisions this important should be made quickly or be made by just a small panel of experts. Experts are important in decision-making, but inherently have their own biases and their own pet ways of looking at things.

"I think you need a wider purview, you need experts from the all the mental health disciplines. From health economics, from public policy, from primary care. The decisions shouldn't be made based on the narrow conception of how this particular expert would treat his next patient."

http://www.abc.net.au/news/2012-06-11/expert-warns-against-child-mental-health-checks/4064474

5. Government stands by child mental health tests

Nine News Online
10 June 2012

Mental Health Minister Mark Butler is concerned about possible over-reaction to clinical experts' advice after three-year-olds are screened under the new Healthy Kids Check program.

The program, which starts on July 1, will be predominantly managed by GPs who will refer children with troubling behaviour to psychologists or paediatricians.

Mr Butler admits there is always the danger of misdiagnosis or oversubscribing and says that's why child care experts have been spending months getting the program "precisely right".

"Parents can be confident that when they go to a GP or a practice nurse in a GP surgery to check that just before their child starts pre-school or steps into primary school, that they're developing in a way that we all hope and expect that they will be," Mr Butler told journalists in Adelaide.

He said the program was aimed at picking up problems early so they can be dealt with and allow the child to enter preschool and primary school in the best position possible.

He said this $11 million program is the latest addition to the government's $2.2 billion mental health reform package where children are checked for heart, eyesight and other physical health issues.

The mental health check itself will be mostly done by GPs under the Medicare system.

"The experts who have been designing this tool have made it very clear that their overriding objective has been to do no harm ... to provide a positive opportunity to families to take their children at that critical time of three years of age," Mr Butler said.

"Obviously, we need to make sure through the advice of the clinical experts that it's conducted in the best way possible and that there's not an overreaction.

"I'm very confident that the people we have around the table designing this piece of work have that absolutely at the front of their mind."

The government experts more than 27,000 children will benefit from additional support after being tested.

http://news.ninemsn.com.au/health/8481534/govt-stands-by-child-mental-health-tests

6. In sickness and in health

Sydney Morning Herald
10 June 2012

More and more Australians are being diagnosed with a mental illness. Are we pathologising normal states of mind, or are we really getting sicker?

Andrew Tierney was a quiet, introverted teenager. Socially awkward and prone to prolonged periods of sadness, he struggled to make friends.

At the time, he thought it was a normal part of growing up. Looking back, the 51-year-old sees it differently. ''I think I've gone through bouts of depression my whole life and just not realised it. Anything to do with mental illness was frowned upon when I was a kid. 'You can't have problems, just get over it' was the attitude,'' he says.

Diagnosed with clinical depression after a suicide attempt six years ago, he now believes that might have been prevented if he had had more support as a teenager. It may have helped him see the warning signs in his son Terry, who tried to take his own life at 14 after the death of his best friend in a car accident.

While Andrew's behaviour was dismissed as ''teen angst'', Terry's troubles were diagnosed as a mental health problem. He has since recovered after being prescribed antidepressants by a doctor and receiving counselling from headspace, the national youth mental health foundation.

The difference between Andrew's and Terry's experiences is that Terry, 19, lives in an Australia where the spotlight has never shone more brightly on mental illness.

The figures say that one in five of us will experience a mental disorder in any given year, and almost half will be afflicted in our lifetimes.

But as the focus on mental health intensifies, there is growing disquiet, much of it within the psychiatric profession, that in the push to raise awareness and reduce stigma, the pendulum may have swung too far in the opposite direction.

While the spotlight has helped reduce suicide rates and encouraged people such as Andrew and Terry to seek help, some fear the diagnostic bar is being set so low normal human behaviour, sadness and personality quirks are being classified as medical conditions. They argue this shift will spark false epidemics of psychiatric disorders and lead to more people being unnecessarily medicated.

''It's been to psychiatry's advantage to talk up these higher numbers. We know that governments are not going to be interested in doing something about a trivial or very rare condition,'' says Gordon Parker, professor of psychiatry at the University of NSW and founder of the Black Dog Institute. ''The figure that one in five will have an episode of depression is very evocative, and certainly makes a point that these mood disorders are common and that we should do something about them. But is it valid? Almost certainly no.''

Central to Parker's concerns is the rise of psychiatric drug use. In 2009-10, more than 13 million Medicare-subsidised prescriptions were written for antidepressants - an average increase of 1.3 per cent a year since 2005-06. Anti-psychotics have also increased to 2.6 million prescriptions a year, up 9.6 per cent over the same period. A recent analysis, showing these powerful drugs are being given to people aged more than 67 at twice the rate they're prescribed to younger people, has led experts to worry they are being used as a way to control behaviour in elderly dementia patients rather than as a therapeutic measure.

The broadening definition of mental illness has been a boon for the pharmaceutical industry, with the global psychiatric drug market now worth $80 billion a year, and tipped to climb to $88 billion by 2015.

It's a long way from the 1950s when the world's first antidepressant, Imipramine, was discovered and its manufacturer, Ciba-Geigy, worried there weren't enough depressed people for it to generate a profit.

Many mental health experts argue these drugs have helped save lives and that advances in treatment mean more serious illnesses such as catatonia and severe forms of schizophrenia are rarely seen today.

However, rising economic pressures and the psychological burden of chronic ''lifestyle'' diseases such as type two diabetes and obesity have created new triggers for mental distress, which can be treated like any physical ailment, with appropriate therapies.

''Our society's changed, we're busier than ever before, more women are working, workplaces are more stressful and expectations on workers are higher than they were in decades past. That has taken a significant toll on mental health,'' says Kate Carnell, chief executive of the national depression initiative beyondblue.

So all of this raises the question: are we any more mentally ill than we once were? Or has medicine simply blurred the boundaries between normality and disease?

Mental illness in Australia has only been recorded in a population-wide way in the past 10 to 15 years, making comparisons with previous generations problematic.

Going by British and American studies, which show exponential increases in mental disorders during the past 50 years - particularly depression and anxiety - researchers extrapolate that it's likely to be similar in Australia.

The most commonly referenced modern-day snapshot is the Bureau of Statistics' 2007 National Survey of Mental Health and Wellbeing, which found that one in five people aged 16 to 85 had experienced a mental disorder in the 12 months prior to the survey - marginally up from the 18 per cent recorded in the 1997 survey.

A further 25 per cent had been diagnosed with a mental disorder in their lifetime. All up, that's 45 per cent, or more than 7.2 million Australians who meet the criteria for a diagnosable mental illness.

It's an alarming number that has been used as a call to arms. The Gillard government last year invested a record $2.2 billion in mental health services - almost a quarter of it into youth programs such as headspace, founded by former Australian of the Year Professor Pat McGorry, who frequently quotes figures from the 2007 survey showing 26 per cent of 16 to 24-year-olds will suffer a mental disorder in any given year.

Arguably, without McGorry's impassioned lobbying, mental health would still be in the shadows, but Parker warns the figures don't tell the whole story.

''I suspect that 90 per cent of the suggested increase in prevalence we are seeing for mood disorders like depression is due to the lowering of the bar for diagnoses and destigmatisation making more people coming forward with lower levels of severity who in the old days would have soldiered on,'' Parker says. ''The risk now is of including normal states of sadness and depressed mood as diseases and thus pathologising normal reactions to abnormal situations … The downsides are people get misdiagnosed and given medication that's inappropriate and may have significant side effects.''

The 2007 survey grouped respondents into three categories. Fourteen per cent of people were found to have anxiety disorders such as post-traumatic stress disorder and panic disorder, 6 per cent had mood disorders, which include conditions such as depression and bipolar syndrome, while 5 per cent had experienced substance abuse disorders including ''harmful alcohol use''. Using these criteria, critics claim, a binge drinker could arguably be counted as mentally ill.

The survey also classified low levels of depressed mood for relatively short periods as a depressive episode.

McGorry acknowledges the need for better data, but denies prevalence rates have been exaggerated. He points out that services are facing unprecedented demand and two-thirds of people with mental health problems still go untreated.

''Some people just want to put their head in the sand and dismiss mental ill-health as the 'worried well', that they should just draw on their own resilience and only seek help if things get really, really severe. But when the person's becoming disabled they've got a right to seek help. It doesn't mean that they should be immediately channelled into the serious mental illness category and given medication but they do deserve an assessment and non-stigmatising help and that's what the national reforms are trying to do,'' McGorry says.

Nobody denies the burden of mental illness is substantial. More Australians die each year from suicide (2100) than on our roads (1300.) Mental disorders are responsible for one in four new disability claims, and cost 4 per cent of the nation's gross domestic product.

But diagnosing psychiatric problems is an inexact science. Barbara Hocking, executive director of SANE Australia, says that unlike physical conditions such as cancer or heart disease, there are no clear biomarkers for mental illness that can be picked up by diagnostic screening such as X-rays, brain scans or blood tests.

This, she says, means mental illnesses are more likely to be misdiagnosed than other health problems. But at the opposite end of the spectrum it can lead to under-treatment.

''We see it time and time again, in the early stages when you're told no you're not sick enough go away, which is counter to everything that happens in any other health area,'' Hocking says. ''The rule of thumb we always use is if whatever you're experiencing is bad enough to stop you doing what you need to do in your day, if it stops you getting out of bed to make the kids' lunches before you go to school, if it stops you getting to work and doing the things you usually enjoy then it's worth getting help.''

At the heart of the debate is the changing definition of mental illness and the contentious document that is used globally to diagnose disorders. The Diagnostic and Statistical Manual of Mental Disorders (DSM), produced by the American Psychiatric Association, has grown from a 130-page booklet of about 60 broad illnesses in its first edition in 1952 to a 900-page tome listing more than 300 disorders.

A draft of its fifth edition, due to come into practice next May, proposes a range of new disorders and drops the diagnostic threshold for many existing conditions. It has caused an international outcry, with 51 health groups including the American Counselling Association, the American Psychological Association and the British Psychological Society calling for an independent review.

The draft document has also sparked a bitter divide within the psychiatric community, with the debate as much about the ideological future of the profession as it is about the nature of mental illness.

The most strident critic of DSM-5, American psychiatrist Allen Frances, who developed the previous edition in 1994, has called it a ''dangerous public health experiment'' that would inappropriately inflict the label ''mental disorder'' on millions of people now considered normal.

Among the proposed conditions are ''disruptive mood dysregulation disorder'', which could turn children's tantrums into an illness, and ''mild neurocognitive disorder'', which could see the natural forgetfulness of ageing become a treatable disease. Criminal behaviour such as rape could be redefined as mental illness, with ''paraphilic coercive disorder'', or arousal from sexual coercion, being considered as a new condition.

It will also be easier for a boisterous child to meet the diagnosis for attention deficit hyperactivity disorder (ADHD), as the number of symptoms needed to meet the diagnosis has been halved. There has been a global epidemic of the condition since it was added to the DSM in 1987. It follows a trend which has seen diagnostic categories expand with every new edition.

Most notably, while once depression was broadly divided into two types - melancholic depression, which was seen as a disease and had no obvious cause, and reactive depression, sparked by stressful life events - DSM-3, released in 1980, essentially created one condition that varies by severity.

Thus, critics argue, the bar was lowered, and mild or moderate sadness was lumped into the same category as what was once considered clinical depression.

It's a blunt instrument that on its own does not consider personality type or differentiate between transient unhappiness triggered by personal circumstances such as marriage difficulties or job loss, and a depressive illness with a biological root.

This type of ''check-list'' diagnosis, says Parker, and the notion that all forms of depression respond to medication, has led to time-poor GPs reaching for the prescription pad rather than delving more deeply into a patient's problem.

''I've treated a perfectionistic school teacher who had been at the school for 30 years and he was publicly demeaned by the headmaster and he felt invalidated. A week later he went to a GP and was put on an antidepressant. He was referred to us 18 months later when he'd had 22 differing medications and two courses of electroconvulsive therapy. His depression was no better; in fact it was worse. He would have been in a much better place if the headmaster had prescribed him an apology,'' Parker says.

Chris Tanti, chief executive of headspace, concedes over-prescribing is a concern, but says those experiencing ''normal'' human anguish can become gravely ill and should be treated. ''People can be catatonic, they won't talk for months because they lose their spouse. I think about that as a serious problem. Yes, the DSM does create a paradigm that has its limitations but what's the absence of that? The absence of that is chaos.''

Parker favours a screening program for mood disorders that is less about the severity of symptoms and more about the fundamental nature of the problem. He's developed a detailed online assessment program, which patients can fill in on their own time, with the results then sent to their GP. This, he says, removes some of the problems of ''six-minute medicine''.

For Andrew Tierney, labels are irrelevant. He's just thankful his son got the help he needed before it was too late. And he wonders how different things may have been if his own teenage problems had not been dismissed as trivialities.

''What might seem insignificant to us can be huge for a kid, like a break-up or being picked on. The public perception needs to change to recognise that these kids have got problems. We need to give them help instead of saying, 'you're not sick', and then two weeks later the child's dead and we're saying, I don't know why it's happened.''

Recognition key to recovery

Lucinda Napper's world slowly began to close in around her when she was in the first year of her law degree.

Then 19, she did not comprehend what was happening but she knew she was desperately unhappy.

''I was just really, really sad all the time,'' she said.

''I stopped wanting to go out. I stopped wanting to communicate with my friends and my family. My uni work suffered. It was like the whole world was inaccessible … It was very isolating and scary and quite emotional.''

Napper, now 26, was suffering from depression but it took her almost 2½ years to realise what was wrong and seek treatment.

''When you have a normal emotional reaction to something in your life - where your dog has died or your parents are going through a divorce - then of course it makes sense to have negative emotions,'' she said. ''But when everything in your life seems fine, which it did in mine, there didn't seem any reason for me to be so sad.

''I just had no idea that you could have these kinds of feelings which weren't due to some kind of external event. I thought I was pathetic and not very good at living. That was the worst bit of the experience. It wasn't just the sadness and the lack of energy and the isolation. It was how guilty I felt that I wasn't able to enjoy my beautiful young life, as my mother put it.''

It was her mother who suggested she visit the family's doctor, who referred her to a psychiatrist, who treated her with cognitive behavioural therapy and a six-month course of anti-depressants.

''It made a massive difference. I know not everyone has been as lucky as me in their treatment but it was absolutely spot on for me. I felt like I was myself again.''

Having experienced depression, Napper realises there is much misunderstanding about the condition in the community.

''I have heard of people who have been misdiagnosed or haven't been diagnosed … that's quite concerning,'' she said. ''People shouldn't be scared of being sad. Depression is quite different.''

http://www.smh.com.au/national/in-sickness-and-in-health-20120609-202q2.html

7. How a shy boy is learning to conquer his anxiety

Sydney Morning Herald
10 June 2012

If Deborah Smith could have taken her son Tyler to the doctor for an emotional wellbeing check at the age of three, it would have saved her a lot of worry. Tyler, now four, had been reluctant to interact with adults from a young age.

Mrs Smith, of Epping, originally assumed it was just shyness but once he started pre-school she realised it was more serious.

''When he was younger, I thought it was normal and age-appropriate that he wasn't talking to adults,'' she said. ''As he got older, I realised that compared with other kids, he was really shy towards adults. It got to a point where he wouldn't even talk to other family members, like grandparents and aunts and uncles. He started preschool and the staff told me that he would rather miss out on things than ask an adult. At lunch time, if there weren't enough chairs to sit on, he wouldn't eat lunch rather than have to ask a teacher for a chair. He would rather go hungry than have to talk to an adult. That's when I started to really worry.''

Last year Mrs Smith joined a long-running research project into childhood anxiety at Macquarie University's Centre for Emotional Health. Through the program, she learned that Tyler suffered from both shyness and anxiety. After 12 months of strategies, including cognitive behavioural therapy that exposes him to the social situations that can cause him anxiety, Mrs Smith is pleased with his progress.

Associate Professor Jennifer Hudson, from the centre, said clinical anxiety was the most common mental health problem in preschoolers, with up to 10 per cent affected. She welcomes the July 1 introduction of widespread mental health assessment for preschoolers, saying: ''Anxiety in the preschool years is most likely to predict anxiety in adolescence and adulthood. We know that if we target it early in life, we can treat it and prevent other mental health problems from developing later in the child's life.''

Mrs Smith agrees. ''If I had been able to take Tyler to the GP to have an assessment at the age of three, it would have highlighted that there was a problem and it was something that needed to be addressed.'' When her daughter, 23-month-old Harlee, turns three she will be happy to have her emotional health assessed.

http://www.smh.com.au/national/health/how-a-shy-boy-is-learning-to-conquer-his-anxiety-20120609-202qb.html

8. But who looks after the carers?

Judith Cameron, The Guardian
12 June 2012

GPs are at last realising that giving support early on can reduce the strain on those who care for family or friends.

I didn't know the term "carer" when I first became one in 1999, but I soon felt the effects of isolation, anxiety and depression that are commonplace when looking after someone else long term. Caring for my young adult daughter, I felt I had fallen into a parallel world where my tedious role lacked definition and was merely a necessary extension of parenting. I wrote about my experiences in the Who cares? column for Society Guardian and was subsequently invited on to the inaugural Standing Commission on Carers set up by the last government. With a rapidly ageing population, it realised that the nation's army of unpaid carers was integral and required support to continue its vital work.

It is estimated that one in three adults will become a carer in the next 10 years, with over 20% caring for more than 50 hours a week, and most doing so without outside assistance.

Like me, many carers don't think of themselves as such, yet if they are unable to cope, it could lead to an emergency situation, with the person they care for having to be admitted into hospital.

A survey released next week for Carers Week will show that many carers are indeed buckling under the strain. However, evidence suggests that when carers are supported early in their role, crises can be avoided.

The GP surgery is the obvious place to identify and signpost carers towards appropriate services, but historically it has been difficult to engage doctors with the issue of carer support. Their role was to look after the sick patient not the person caring for the patient. I had frequent contact with my GP's surgery about my daughter's illness, but didn't consider that my own health was relevant.

In recent years, though, I have witnessed first-hand how doctors have come round to acknowledge the importance of supporting carers. This is particularly the case with younger

family doctors, who recognise that by helping carers, everyone benefits: the person being cared for, the carer and the primary healthcare team.

Win-win situation

Dr Sachin Gupta, a GP in Welwyn Garden City, is typical of this new generation of GP. He says: "By keeping carers healthy we can reduce referrals to secondary care and hospital admissions. This is a win-win situation for GPs, carers, the people they care for and the NHS. I came into this profession to make a difference to the lives of people and this is a great opportunity to do so."

Gupta is one of an initial group of nine GPs who have been recruited regionally by the Royal College of General Practitioners (RCGP) to champion the needs of carers. They work with liaison workers from the charity network Carers Trust and carer ambassadors from Carers UK to strengthen local links between GP surgeries and support services, and to share best practice.

When I became involved with the RCGP four years ago in an initiative funded by the Department of Health to support carers in general practice, it was already working with the Princess Royal Trust for Carers (now Carers Trust) to produce an action guide. My role, along with two practising GPs, was to use the guide's material in a series of nationwide workshops for primary healthcare staff to demonstrate the benefits of engaging with carers.

At the first workshop in Hertfordshire, where my GP colleague knew several of the participating doctors, our presentation was welcomed. A fortnight later in Lancashire, the reception was quite different, and doctors were adamant that the last thing they needed was the additional burden of carers. Surely, they argued, carers were the responsibility of council social care services, not the health service. This became a common theme during subsequent workshops, particularly from older, male GPs.

But by generating discussion through a series of case studies, we always succeeded in demonstrating the mutual benefit of identifying and supporting carers. After all, it is the carer who carries out the doctor's recommendations and knows the patient better; by recognising the carer as an expert partner in the patient's treatment plan, the doctor has a valuable aid, we argued.

Since 2008, each workshop has taken us a step closer to breaking down the divide between primary care staff and carers. Much of the support that carers need cannot be provided by the GP practice, but, once identified, a carer can be signposted to appropriate services. To this end, many practices now appoint a carers' lead – a member of staff who facilitates the identification of carers and acts as a conduit between the GP surgery and local services. As well as Carers UK and Carers Trust, there are other agencies that offer carer support, including Age UK and Action for Children as well as illness-specific groups. Service provision varies widely but carers' leads have contact with what is available locally.

In Worcestershire, a county-wide GP-based carer support service launches next week following a successful pilot in three areas. The service was commissioned and will be provided by Worcestershire Association of Carers, which will place carer support advisers within surgeries, providing one-to-one support for carers and signposting them to appropriate services. There will be 6.5 full-time advisers working across 68 GP practices.

Issues with capacity

Helen Garfield, project officer at the joint commissioning unit at Worcestershire county council acknowledges that the service may have issues with capacity. She says the money awarded by the primary care trust and managed by the three Worcestershire clinical commissioning groups also has to enhance the services that carers will be referred to.

"We have expanded our 24-hour phone information and support helpline for carers, and increased our flexible breaks service, which will allow more carers to receive up to four hours per week replacement care. It was a delicate balancing act," she explains, between funding the advisers and building the capacity of countywide services that could experience a huge rise in demand.

The scheme was showcased at a national carers' conference in Birmingham earlier this year at which I was pleasantly surprised to hear care services minister Paul Burstow talk as though he genuinely believed in the imperative of better support for carers through primary care.

Let's hope this isn't just talk, because more is needed, including designated financing for regular health checks for carers. Although available in some areas, health checks are not

routinely offered despite research suggesting that carers experience increased mortality. Carers neglect their own health needs in favour of those they care for, resulting in a high prevalence of depression and muscular strain along with a greater risk of many physical illnesses including stroke.

There is still a lot for primary healthcare teams to learn, and many of the GP champions are new to post, but the enthusiasm from this predominantly young group of doctors is encouraging. As Becky Steed, a GP champion from Nottingham, says: "For every person with a long-term physical or mental health condition there is almost certainly a carer too. If we can recognise their needs as well as the person that they care for, we can help to safeguard their health and hopefully make life a little easier for all concerned."

If such positive attitudes had been evident when I was looking after my daughter I might not have felt so marginalised or impotent. Instead, I might have recognised that being her carer as well as her mother was a dual role, and important.

http://www.guardian.co.uk/society/2012/jun/12/but-who-looks-after-the-carers?newsfeed=true

9. First Nations, poor kids turn to ERs for mental health care

The Canadian Press
11 June 2012

Children and teens from First Nations communities and families on welfare were more likely to use hospital emergency departments for mental health crises than other kids their age, a new study reports.

The rates were highest among First Nations youth, followed fairly closely by children from families on welfare. Children from other low income families -- those which qualified for a provincial government subsidy -- were next.

Children whose families didn't receive any government subsidies turned to emergency rooms for mental health care at the lowest rates of the four groups.

First Nations girls were about three times more likely to go to the emergency department for mental health care than girls from families didn't receive government subsidies. And with First Nations boys, the rate was about four times higher, according to the study, published this week in the Canadian Medical Association Journal.

"We were expecting differences but we weren't expecting to see such gaps," said lead author Amanda Newton, an assistant professor of pediatrics at the University of Alberta.

Newton and her co-authors looked at records for emergency room use in Alberta hospitals only. She said it would be useful to see if similar patterns emerged in other jurisdictions, but her findings can't be used to predict what is happening in other parts of the country.

The data are interesting and a possible sign of problems. But because of the type of study this is, Newton and her colleagues cannot say whether children from First Nations or welfare families have higher rates of mental health problems.

The children from families who aren't of First Nations origin and don't receive government subsidies may have mental health problems at the same rate as the other groups.

But they may be getting care elsewhere -- through psychologists, psychiatrists or through mental health programs -- and therefore may be less likely to get to the type of crisis that necessitates an emergency room visit. If Alberta kids and teens didn't use the emergency department for mental health care, they would have been invisible to these researchers.

Nor can Newton and her colleagues say for sure that First Nations children and teens are showing up to emergency departments because they lack adequate mental health resources in their communities.

It could well be that there are services, but they aren't effective, she said. Alternatively, there may be such a stigma about using such services in the community that First Nations kids avoid them, then turn to emergency departments when problems reach a head.

"We really need to use this study as a jumping off point to ask much more particular questions and not just assume that we need more services," Newton said.

Children and teens who turned to the emergency department for mental health care suffered a spectrum of problems, from attempted suicides to accidents caused by drinking or drug use. But the majority of complaints were about anxiety and stress.

Still, the pattern with First Nations children was different from the others, the study said.

"We found that more First Nations children presented to emergency departments for disorders secondary to substance abuse and intentional self-harm than other children, and that, compared with other children, First Nations children returned more quickly to the emergency department and had a longer time before visiting a physician in the post-crisis period," the study said.

In fact, the median time to a follow-up appointment with a doctor was 79 days for First Nations children and teens.

Newton and her colleagues started the work as part of a grant from the Canadian Institutes of Health Research to see how Alberta emergency departments were being used.

After poring over six years worth of data on Emerg visits, they noticed a high usage for mental health care among children and further that there appeared to be differences in usage rates that were gender and socio-economically based.

First Nations girls aged 15 to 17 had the highest rate of visits -- 7,047 per 100,000 children -- followed by First Nations boys -- 5,787 visits per 100,000 children. The study said First Nations children make up about six per cent of all children under 18 in Alberta.

The lowest rates were found among boys (1,323 per 100,000) and girls (2,144 per 100,000) from families who didn't receive any government subsidies.

Newton said it's important to find out more about why children are turning to emergency departments for mental health care and what happens after they do.

"Because being in a crisis doesn't feel good. Going into the emergency department and waiting for several hours to see someone for an assessment is probably not how families and kids want to spend their time," she said.

"The emergency department is a critical piece in terms of access to services. But asking questions about what happens before and after are also equally critical."

http://ottawa.ctv.ca/servlet/an/local/CTVNews/20120611/First-Nations-poor-kids-turn-to-ERs-for-mental-health-care-120611/20120611/?hub=OttawaHome

10. Meditation hope for mental health

UK Press Association
12 June 2012

A month of meditation training alters brain wiring in ways that could open the door to new treatments for mental disorders, research has shown.

Scientists looked at the effects of integrative body-mind training (IBMT) on two groups of university students.

After just four weeks, or 11 hours, of training scans showed physical changes in the brains of the volunteers.

Nerve fibres, known as "white matter", became denser, providing greater numbers of brain-signalling connections. At the same time there was an expansion of myelin, the protective fatty insulation surrounding nerve fibres.

The effects were seen in the anterior cingulate cortex region of the brain, which helps regulate behaviour. Poor nerve activity in this part of the brain is associated with a range of mental problems, including attention deficit disorder, dementia, depression, and schizophrenia.

The study, reported in the journal Proceedings of the National Academy of Sciences, built on previous research based on magnetic resonance imaging (MRI) scans that first flagged up brain changes induced by IBMT. Scientists revisited results from two 2010 studies, taking a closer look at what the scans revealed.

One involved 45 US students from the University of Oregon; the other 68 students from China's Dalian University of Technology. The researchers found greater density of axons, or nerve fibres, after two weeks of IBMT training, but no change in myelin formation.

After a month both increases in axon density and myelin were seen. Students undergoing IBMT also reported improvements in mood, experiencing reduced levels of anger, depression, anxiety and fatigue. They also had lower levels of the stress hormone cortisol.

Study leader Professor Michael Posner, from the University of Oregon, who carried out the original US research, said: "This study gives us a much more detailed picture of what it is that is actually changing. We did confirm the exact locations of the white-matter changes that we had found previously. And now we show that both myelination and axon density are improving.

"The order of changes we found may be similar to changes found during brain development in early childhood, allowing a new way to reveal how such changes might influence emotional and cognitive development."

http://authorjaenwirefly.wordpress.com/2012/06/12/meditation-hope-for-mental-health-the-press-association/

11. Adolescent mental disorders have repercussions for addiction

Piriya Mahendra, News Medical (US)
8 June 2012

Adolescents with mental health disorders are significantly more likely to become addicted to prescription opioid pain relievers than those without mental disorders, experts say.

A longitudinal analysis of 59,077 adolescents and young adults aged 13-24 years showed that those with mental health disorders were significantly more likely to be prescribed

opioids for chronic back pain, neck pain, headache, or arthritis/joint pain than those without mental health disorders.

Adolescents with mental health disorders were also significantly more likely to become long-term opioid users than those who did not have a mental health disorder, report Laura Richardson (University of Washington, Seattle, USA) and team in the *Journal of Adolescent Health*.

Overall, 321 (0.5%) patients were long-term opioid users, 16,712 (27.4%) were no-nchronic opioid users, and 42,584 (72.1%) did not use opioids. Long-term opioid use was defined as receiving more than 90 days of opioids within a 6-month period, without a gap of more than 30 days in opioid use within the first 18 months after qualifying pain diagnosis.

Long-term opioid use was significantly more common among men than women (OR=1.59), and in individuals older than 20.8 years than younger individuals (odds ratio [OR]=1.33). Long-term opioid use was also predicted by living in a poor community (median household income 75.1% in 2000; OR=1.65), but fewer residents who had attended college (<54.8% in 2008; OR=0.63).

After controlling for demographic and clinical factors, individuals with pre-existing mental health diagnoses were at a significant 2.36-fold increased risk for subsequently receiving long-term opioids versus no opioids.

Furthermore, participants with pre-existing mental health conditions were at a significant 1.8-fold increased risk for receiving long-term opioids versus non-chronic use.

"There are a number of reasons why adolescents and young adults with mental health issues are more likely to become long-term users of opioids," commented Richardson in a press statement.

"Depression and anxiety might increase pain symptoms and lead to longer treatment, and physicians may see depressed patients as being more distressed and may be willing to treat pain symptoms over a longer period of time."

Doctors should screen for mental health disorders before starting medications and consider referring patients with depression or anxiety for counselling or other mental health treatment, she added.

http://www.news-medical.net/news/20120608/Adolescent-mental-disorders-have-repercussions-for-addiction.aspx

12. Difficult to Improve Teens' Impression of Mental Health

Psychcentral Online
8 June 2012

While everyone seems to agree that adolescents often have a negative opinion of mental illness — a perception that prevents many teens from obtaining the care they need — the means to overcome the dilemma remains elusive.

Researchers at Case Western Reserve note that the relative dearth of data regarding stigma in this age group makes tackling the topic particularly tough.

Not only is adolescent mental health stigma rarely studied, but even less is known about the accuracy of measures used to assess it.

Melissa Pinto, Ph.D., R.N., KL2 Clinical Research Scholar and an instructor of nursing at the university's Frances Payne Bolton School of Nursing comments: "We need to find a reliable and valid way to measure the presence of stigma associated with mental illness among adolescents."

In a new study, published in the *Journal of Nursing Measurement*, Pinto and her colleagues sought to begin the process by testing an existing self-survey measure, the "Psychometric Evaluation of the Revised Attribution Questionnaire (r-AQ) to Measure Mental Illness Stigma in Adolescents," among more than 200 teenagers in the southern United States.

During the testing, researchers learned that young people troubled by mental health conditions are often so concerned about the perceptions of peers and others important in their social network that they forgo treatment that is beneficial.

Young people pick up cues about what is acceptable and unacceptable from those around them, Pinto said. If teens believe friends will distance themselves if their struggles with mental illness become known, they will endure the consequences and risks of disease without asking for assistance. But if peers seem accepting, then chances increase that teens with mental illness will seek help.

The researchers administered the self-report survey to 210 students between the ages of 13 and 18 from southern public and private high schools. The survey measured an important component of stigma, the emotional reaction to a person with mental illness.

This is important because emotional reactions to persons with mental illness are associated with how easy or difficult it is to socially interact with others and discriminating behaviors. Administering the survey again, the results were validated with another group of students.

“The Revised Attribution Questionnaire” was found to be a reliable and valid measure among this group of adolescents. Having measures of that reliable and validity give us confidence when we do interventions with teens to decrease stigma that changes we are see are actually changes and not an artifact of the measure. Specifically, this measure holds promise to be used in intervention studies to determine if our interventions work, Pinto said.

She added that it is the first time the Revised Attribution Questionnaire is found to be both reliable and valid in assessing stigma associated with mental illness in adolescents.

The idea behind changing attitudes about mental illness is to get teens help they need. “If untreated, illnesses, like depression and mood disorders, tend to reoccur and become chronic,” Pinto said.

Mental illness often begins before the age of 25. If an adolescent denies or hides the disease, they can suffer negative consequences as they may drop out from school, develop a substance abuse problem, accidentally become pregnant, struggle at work, and even contemplate suicide.

“Mental illness is like other diseases, with treatment, people can recovery. Creating a social culture where people feel comfortable getting treatment and talking about the illness with others who can support them is vital initial steps that can help people get better,” Pinto said.

http://psychcentral.com/news/2012/06/08/difficult-to-improve-teens-impression-of-mental-health/39876.html

Ongoing - Mental Health Carers Forum

If you are a carer and would like to talk with other mental health carers about issues of concern to you please complete the form at:

http://www.mhca.org.au/carerform/index.php

The email is sent every week and contains items which may interest mental health consumers, carers and service providers and which otherwise they may not be able to access. Thank you for subscribing to this MH email if you wish to unsubscribe please contact kim.harris@mhca.org.au Kim Harris, Carer and Consumer Project Officer, Mental Health Council of Australia. Tel (02) 6285 3100

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