Mental Health Council of Australia

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BULLETIN NO. 27, 2012

Hi all,

Please provide any feedback/comments on the Bulletin to me at kim.harris@mhca.org.au

Kind regards
Kim

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1. High Court clears way for plain packaged cigarettes to be sold in Australia

Publication: The Australian
Author: Nicola Berkovic
15 August 2012

The High Court decision upholding the government's plain packaging laws for cigarettes showed that big tobacco can be "taken on and beaten", Attorney-General Nicola Roxon said.

The Gillard government has claimed a historic court victory over the tobacco giants today, paving the way for cigarettes to be sold in plain packaging by December.

Ms Roxon said the decision to uphold world-first plain packaging laws was a watershed moment for tobacco control around the globe.

“Tobacco companies should now stop trying to stymie this reform internationally and get on with implementing this important change,” she said after the ruling.

“The message to the rest of the world is big tobacco can be taken on and beaten. Without brave governments willing to take the fight up to big tobacco, they’d still have us believing that tobacco is neither harmful nor addictive.”

At a later media conference Ms Roxon said: "Many other countries around the world... will take heart from the success of this decision today.

"Governments can take on big tobacco and win and it's worth countries looking again at what the next appropriate step is for them.''

The big tobacco companies had argued the plain packaging laws amounted to an acquisition of their valuable trademarks without proper compensation.

The laws mandate that cigarettes be sold in drab olive-green packs and bans all commercial logos. Packs will be distinguishable only by printed brand names in a standard font and size.

A majority of the High Court this morning rejected the tobacco companies' challenge to the laws.

In a statement this morning the court said: “At least a majority of the Court is of the opinion that the (Tobacco Plain Packaging) Act is not contrary to s 51(xxxi) (of the Constitution).”

The tobacco companies have been ordered to pay the commonwealth's legal cost, which Ms Roxon said had run into the millions of dollars.

"I am very happy that tobacco companies will be paying that amount rather than taxpayers," she said.

Ms Roxon and Health Minister Tanya Plibersek said the government would not be applying the laws to other products.

"This is a measure that is for tobacco it is not a measure that is for other products," Ms Roxon said.

The full reasons for the decision, which was being watched closely around the world, will be published later in the year.

British American Tobacco spokesman Scott McIntyre said the company was disappointed in the court's decision, but would comply with the law.

"Although the (law) passed the constitutional test, it's still a bad law that will only benefit organised crime groups which sell illegal tobacco on our streets," McIntyre said in a statement.

"... The illegal cigarette black market will grow further when all packs look the same and are easier to copy."

Ms Roxon said the plain packaging laws were a vital preventative public health measure, which removed the last way for tobacco companies to promote their products.

"This decision is a relief for every parent who worries about their child picking up this deadly and addictive habit," she said.

The major tobacco companies, British American Tobacco Australia, Philip Morris, Imperial Tobacco and Japan Tobacco, will now turn their sights overseas, where they have launched separate legal challenges to the government's laws.

The tobacco companies have filed an international arbitration claim based on the Australia-Hong Kong bilateral treaty and begun a World Trade Organisation dispute process via member countries Ukraine and Honduras.

Under the laws approved by federal parliament last year, the plain packs must be used from December.

Jonathan Liberman, director of the McCabe Center for Law and Cancer, told reporters outside the court that the ruling would inspire other countries to take the same measures against tobacco companies.

"It shows to everybody that the only way to deal with the tobacco industry's claims, saber rattling and legal threats is to stare them down in court,'' he said.

"It's a fantastic decision for public health in Australia."

Anti-smoking organisations chorused their delight at the decision, which the Australian Council on Smoking and Health said would have global ramifications.

Its president Mike Daube, who chaired the government's expert committee that recommended plain packaging, said global tobacco companies opposed plain packaging ferociously because they knew other countries would follow Australia's lead.

"We know from the companies' own internal documents that packaging is a crucial part of their marketing,'' Professor Daube said in a statement.

"They have now lost their last means of promoting smoking to adults and children. This truly is a life-saving victory for public health.''

2. Plain reality: High Court ruling, a victory for a healthier nation

Press Release - The Royal Australian College of General Practitioners (RACGP)
16 August 2012

The Royal Australian College of General Practitioners (RACGP) applauds the High Court's ruling to mandate plain packaging of all tobacco products.

The victory serves as a prime example of Australia leading the world in preventive care, supporting healthier communities.

Professor Claire Jackson, RACGP President, said smoking still remained the behavioural risk factor responsible for the highest levels of preventable and premature death, despite smoking rates continuing to fall in Australia.

"From December (2012), it is hopeful the introduction of drab olive-brown packs sporting large health warnings will discourage new smokers from starting the habit, whilst reminding current smokers of the detrimental health effects associated with lighting up," Professor Jackson said.

Professor Jackson highlighted the important role general practitioners (GPs) continued to play in reducing smoking rates through education and support.

"While smoking rates have steadily declined in Australia, we have not won the battle yet. We know that spending just a few minutes talking to patients about quitting smoking can lead to behavioural change – a step that may result in increasing life expectancy up to 10 years.

"The High Court's decision to mandate plain packaging on cigarettes will further support the vital work GPs currently undertake in our communities to put an end to the uptake and continued smoking rates in Australia," Professor Jackson concluded.

The RACGP recently released an updated smoking cessation resource, *Supporting smoking cessation: a guide for health professionals 2011*, incorporating a number of significant new developments in both the science and practice of cessation support providing health professionals with a valuable resource to help patients keen to stop smoking.

http://www.racgp.org.au/media2012/48006

3. RACGP launches redeveloped 'GP Psych Support' website

Press Release - The Royal Australian College of General Practitioners (RACGP)
15 August 2012

The Royal Australian College of General Practitioners (RACGP) has recently launched a redeveloped website, 'GP Psych Support', offering an advisory service for GPs wanting specialist guidance from a psychiatrist in regards to managing the mental health issues of patients in their care.

The newly redeveloped website further enhances accessibility and usability of the existing GP psych support service that has been managed by the RACGP to GPs, GP registrars and International Medical Graduates (IMGs) Australia-wide, since 2006.

Associate Professor Morton Rawlin, GP Psych Support Advisory Group chairman, said the free support service remains a highly valued resource for GPs responsible for providing high quality mental healthcare delivery in every state and territory throughout Australia.

“General practice provides whole patient, coordinated, ongoing healthcare for people with mental health conditions as diverse as depression, social phobia, bereavement, postnatal depression, anxiety disorder, sleep disturbance and bipolar disorder.

“Given the crucial role GPs play in the delivery of early intervention and prevention mental health services, it is vital that support continues to be readily made available to GPs seeking specialist advice on particular mental health matters from medication issues, to general patient management advice,” A/Professor Morton said.

The new GP Psych Support website offers improved usability, function and simple registration making access to the service more streamlined for GPs seeking patient management advice within 24 hours.

GPs with RACGP gplearning/QI&CPD website login details will be able to login to the redeveloped GP Psych Support website using the same login details. Non-members of the College can still use the service, but must have their identity as a GP verified before using this service by calling the RACGP helpdesk on 1800 284 789.

GP Psych Support is an initiative funded by the Department of Health and Ageing as part of its Better Outcomes in Mental Health Care program. The service allows GPs the flexibility to submit enquiries and receive advice within 24 hours from a psychiatrist via phone, fax or secure website.

To access the website visit: www.psychsupport.com.au.

http://www.racgp.org.au/media2012/47997

4. Call to reduce death rates for persons with mental ill health

Media Release: activate: mind & body initiative, Queensland Alliance for Mental Health, General Practice Queensland and Queensland Health.
14 August 2012

People with mental illness have higher death rates from preventable diseases than the general population.

One of the United States' leading health professionals will be in Queensland next month to address local doctors and service providers on how to reduce growing early death rates for the mentally ill.

Dr Joseph Parks is renowned in the United States for his work in mental illness and extensive research into the growing gap in death rates for people with severe mental illness.

Dr Parks will present his findings and take part in a discussion panel at a free forum hosted by the activate: mind & body initiative, Queensland Alliance for Mental Health, General Practice Queensland and Queensland Health on 5 September.

"While it has been accepted for a number of years that people with a mental illness die younger than those in the general community, recent research suggests that the rate of serious morbidity (illness) and mortality (death) amongst those with a mental illness has accelerated," Dr Parks said.

"In fact, people with serious mental illness are now dying 25 years earlier than the general population."

The increase in illness and death rates was largely due to treatable conditions that were more readily addressed among the general population, such as smoking, obesity, substance abuse, and lack of access to general medical services.

Dr Parks said he had identified a range of initiatives that could be implemented by both private and public health care providers that would help close the gap between mental health patients and the general community.

These included prioritising the issue as a public health problem; introducing better tracking of illness and death rates in the mental health community; implementing established

standards of care such as prevention, screening and treatment; and improved integration of mental health and physical health services.

He also serves as President of the Medical Director's Council of the National Association of State Mental Health Program Directors. He practices psychiatry on an outpatient basis at the Family Health Centre, a US federally funded community health centre servicing uninsured patients in the Columbia area.

5. Aggression and Sibs

Source: Siblings Australia
22 June 2012

This time, I am going to raise a topic that causes me some discomfort – the aggression that some siblings experience from a brother or sister with disability. It is a very sensitive issue, one that is not easy to discuss. Certainly, I don't want to add to the stigma experienced by people with disability, but I know many families are struggling with this issue and are at a loss to know how to manage it, especially given current service systems.

Of course, the vast majority of children with disability do NOT show aggressive behaviour. However, over the last 13 years as I have run workshops for providers, parents and siblings, the issue of sibling aggression has come up from time to time. I have talked about it with policy makers and government officials. However, given the sensitivities and complexity, the evidence is very anecdotal and little notice is taken.

In recent times, my concern has risen as I hear more and more of these stories – a child in traction for considerable time with a broken leg, episodes of choking, being thrown across the room, stitches, repeated visits to the emergency room, older siblings trying to protect younger ones. And I hear of many children who are in a perpetual state of anxiety.

All brothers and sisters might cause harm to another from time to time in the normal jousting of siblinghood. But this is different. It is an ongoing threat and an ongoing source of stress.

It is an issue that families are very hesitant to talk about it – and understandably so – they fear that the family might be broken up if they talk to authorities – either the sibling or the child with disability might be taken away from the family.

Recently I had an email from a teen sibling who is being physically harmed by her brother – I suggested she talk to her school counsellor, but she didn't want to do that as last time, after giving some of the details, she became afraid they would take her away from her family so she stopped talking.

And of course it isn't only physical abuse that does the harm. One sibling shared that her brother continually punches her in the arm and tells her she is 'fat and ugly'. Over and over.

So where to from here? First, more research needs to be done to better understand the issue and assist families. As a starting point, Siblings Australia set up a short survey which did not ask for any personal details. We understood the need for privacy and anonymity to ensure people would feel comfortable being honest. We heard from parents, siblings and service providers. T his is just a small sample, but over 100 parents told us about the aggression toward a sibling. We also heard from many siblings (of all ages) and service providers.

The responses to the surveys certainly reinforced what we have been saying for a long time. There needs to be more support for families to ensure all members are able to be safe and secure. Sometimes people with disability have behaviours that are difficult to manage. These may be due to a number of factors such as their sensory difficulties, medication, and/or intellectual disability. Families need assistance to both manage the behaviour but also to deflect the aggression and protect themselves.

A very draft report of the findings from the surveys is available. I encourage you to comment on the report and also spread the word about its findings. I am hoping that the report will lead to serious discussion about the issue, and how it might be addressed, whilst accounting for the needs of all members of the family. A final report will then be developed.

http://siblingsaustralia.org.au/blog-article.php?entry=2012-06-1-aggression-and-sibs

6. New evidence supports PTSD treatment

Source: news.com.au
By: Michelle Henderson
15 August 2012

Drug abuse should not be a barrier to psychological treatment for people also suffering post traumatic stress disorder, an Australian study suggests.

The study found that people with post-traumatic stress disorder (PTSD) and substance abuse issues benefited from treatment involving exposure to traumatic memories, called prolonged exposure therapy, while simultaneously treating their drug use.

Lead author Dr Katherine Mills from the University of New South Wales said the study results were important because people with drug problems were often excluded from PTSD treatment.

"Currently, a majority of people with substance use disorders are excluded from receiving PTSD treatment as there is a widely held view that patients need to be abstinent before any trauma work, let alone prolonged exposure therapy, can be undertaken," said Dr Mills, from the university's National Drug and Alcohol Research Centre.

"However, this is often very difficult for patients to achieve as their trauma symptoms tend to resurface when they stop using."

"Our positive findings indicate that by using an integrated treatment program such as this, the many Australians who suffer from both of these conditions can be treated successfully."

Most previous trials of PTSD treatment excluded people with substance dependence, despite evidence that trauma exposure among this group was almost universal, according to the study published this week in the Journal of the American Medical Association.

Dr Mills said it was difficult to treat both mental health and substance use disorders as each condition exacerbated the other.

The study randomly assigned 103 patients to either the integrated therapy or a control group, where participants received standard treatment for substance use only.

All participants had experienced multiple traumas.

Those who received the integrated therapy had a significantly greater reduction in PTSD symptoms than those in the control group over the nine-month period.

There was also no increase in substance use among those who revisited their trauma during therapy.

The most commonly used substances by patients included benzodiazepines, cannabis and alcohol followed by heroin, amphetamines, other opiates, cocaine, hallucinogens and inhalants.

http://www.news.com.au/breaking-news/national/new-evidence-supports-ptsd-treatment/story-e6frfku9-1226450532157

7. Peer support to help residents

Source: Taranaki Daily News
By: Nadia Stadnik
17 August 2012

A new centre for New Plymouth residents battling mental health and addiction problems will be staffed with carers who have “walked the walk” themselves.

Workers at Harmony House Te Whare Marire in Whalers Gate, which opens today, are people who themselves have experienced mental health problems or addiction.

Harmony House is the first such "peer-supported" respite centre in the city.

"The message we're trying to get across with this is we've walked the same walk; everyone's story isn't the same but the journey to recovery is,” team leader Karen Wehle said.

“We’re not there as counsellors, we're there to let people rest, and families also. It's a place of safety for them.”

Ms Wehle, a trained mental health support worker, said she has had her share of struggles with “mental unwellness”.

“Having peer support from people who had had their own experience of a mental illness or addiction gave me hope and encouragement rather than service providers who had not experienced it themselves,” she said.

The new centre has three floors and four bedrooms and will cater for anyone aged from 16 to 65.

It will be staffed by a team of about 10 volunteers, most with Witt's Mental Health Support Worker Certificate, and one person will be on duty 24 hours, seven days a week.

Like Minds Taranaki manager Gordon Hudson said he was pleased the project had got off the ground.

“It is a first for Taranaki, putting, as it does, people with personal experience of mental illness at the forefront of ownership and decision making - where it belongs," Mr Hudson said.

“There is an acknowledged real need in Taranaki for peer-led and peer-managed services for people with experience of mental illness.”

Taranaki District Health Board mental health and addiction services support the centre's concept and the Health Ministry had acknowledged the need for it, Mr Hudson said.

Ms Wehle hoped Harmony House would be a benefit to the community as a whole and help reduce prejudice surrounding mental illness.

“I think there's still a lot of stigma and discrimination around mental health, although it is getting better.”

http://www.stuff.co.nz/taranaki-daily-news/news/7494823/Peer-support-to-help-residents

8. Mental health of a war-torn Somalia

Source: www.aljazeera.com
Author: Nazanine Moshiri
18 August 2012

What happens to the mental health of a nation when it is devastated by war and poverty?

A walk through the corridors of Mogadishu's Habeeb psychiatric hospital will give you a pretty good idea.

Patients have a vacant look in their eye; they are either laughing sporadically, or just staring into space. Many are just lying down motionless.

According to the World Health Organisation one in three Somalis suffers from mental illness.

The energetic, eccentric Abdirahman Ali Awale, known as Habeeb, runs the institution. He is a nurse who does the work of a psychiatrist. There are dozens of new arrivals here every day.

Abdirahman introduces me to one young woman brought in by her family, who say she is violent, and shouts and laughs without reason. She is not eating or drinking. She weighs only 34kg, and could be anorexic. I ask him what can be done for her?

"Well, we can give her medication, a bed, and food."

She is extremely lucky her family is understanding enough to have brought her here. Abdirahman tells me many Somalis will blame her condition on "magic, or the evil bad eye, or punishment from Allah".

He says what they really need is "love, support, and food".

Many of the people being treated have experienced beatings, torture, or have witnessed members of their family or friends being killed in front of them.

It sounds incredible, but Abdirahman believes that no-one who has lived through the war in Somalia has "good mental health".

He has treated 15,000 people since he opened his doors in November 2005. He would treat a lot more if he could, but he doesn't have enough beds.

He starts crying; he says: "This state of affairs brings me to tears, seven or eight times a day."

War and hunger aren't the only reason for this crisis. Khat chewing is a tradition that dates back thousands of years. It is a plant, which contains a compound with effects similar to those of amphetamines; you can find it in the Horn of Africa and in places like Yemen.

The armed group al-Shabab bans khat consumption, so since their fighters left Mogadishu, the streets of the capital have become a haven for khat chewers.

Recent research from the National Institute on Drug Abuse says that "at the end of a khat session, the user may experience a depressive mood, irritability, loss of appetite, and difficulty sleeping".

At Habeeb Hospital, Abdirahman says the impact is far more worrying. He tells me "there is a link between khat and psychosis".

Although the World Health Organisation describes Habeeb Hospital as one of the health facilities that implements WHO Somalia's Chain Free Initiative.

We found people, even one child being chained, apparently "for their own good". It is clear the hospital does not have enough staff to look after the violent patients.

I left Habeeb thinking about Somalia's political transition which could be just days away. Discussions about politics, security, and famine are crucial, but the Somali people don't just need food and jobs. They also must to heal the mental wounds of the past.

http://blogs.aljazeera.com/blog/africa/mental-health-war-torn-somalia

9. Mental illness driving people out of the workforce

Publication: Waikato Times (NZ)
Author: Nicola Brennan-Tupara
16 August 2012

A big proportion of people claiming benefits have mental problems, writes Nicola Brennan-Tupara.

Mental illness is driving more and more Waikato people to leave work and go on the benefit, recent figures show.

Figures for the end of June show 43 per cent of the 4642 Waikato people on the sickness benefit were on it because of a psychological or psychiatric condition.

Just under 30 per cent of the 7171 people on the invalids benefit also list such conditions as a reason they couldn't work.

That's a 5 per cent, and 4 per cent, increase, respectively, since June 2007 and dwarfs all other reasons for being on those benefits.

A single person can get up to $204.96 a week on the sickness benefit, or $256.19 for the invalids benefit. A sole parent gets $336.55.

In total, 26,000 Waikato people were receiving some form of benefit.

Work and Income regional disability adviser Sue Bristow said the increase was most likely due to a better understanding and acceptance of mental illness in the community.

She said mental illness, for some people, was just as debilitating as a physical injury.

While she said many people with mental health conditions succeeded in a work environment, for some it was a hinderance.

"It's like any incapacity; it does make it more difficult and can establish barriers to employment."

Ms Bristow did not think it was easier to get a sickness benefit due to a mental illness, than a physical condition.

Like all of the other conditions, a person claiming a benefit for a psychological disorder had to have a medical certificate from their GP, or another registered medical practitioner.

She said a client had to fill certain criteria before that medical certificate would be given and would then be reassessed after four weeks; then eight and 13 weeks.

After one year they had to undergo an extensive assessment by Work and Income themselves.

In the Waikato, 48 per cent stayed on the sickness benefit for less than a year.

She said the figures showed mental illness was definitely affecting a lot of people - from depression right up to psychotic disorders.

Mental Health Foundation chief executive Judy Clements said several barriers had pushed up the numbers of those on the benefit.

One was a person's own fear of returning to work, the other some employers' wariness to hire people with mental health issues.

"Those are barriers and of course unemployment levels are higher than they were, so that pushes those figures up as well."

The foundation was working with both sides to reduce the barriers and get people back in to work.

"The majority of people with mental health issues want to work."

She said working also aided their recovery.

http://www.stuff.co.nz/waikato-times/news/7488098/Mental-illness-driving-people-out-of-the-workforce

10. Mental Health Taboo in the Ethiopian Community: Interview with Dr. Welansa Asrat

Publication: Tadias Magazine
By Tadias Staff
20 August 2012

The latest news of suicides and murders in the Ethiopian community, including the tragic killings of a Dallas couple who were gunned down outside their house last week as they returned home from working at their popular Ethiopian restaurant, is raising the question: Is this the consequence of our taboos about mental illness?

“Although the negative stigma associated with mental illness is prevalent throughout the world, it remains particularly relevant in Ethiopian culture where it is believed to be a result of possession by evil spirits or a sign of weakness,” says Dr. Welansa Asrat, a Psychiatrist practicing in New York City. “Due to the unacceptability of such a stigma, many Ethiopians deny their mental suffering and never get the necessary treatment, which can then result in disastrous outcomes such as suicides or homicides.”

In the Texas case, police documents show that the suspect, also an Ethiopian immigrant, was allegedly motivated to assassinate the parents of an 18-month-old baby because he “felt disrespected.”

What are the social pressures that drive people to this type of irrationality?

According to Dr. Welansa concerns associated with culture-shock or adjustment issues increase the likelihood of developing psychological problems.

“The loss of one’s culture, lack of social support, isolation and loss of self-identity experienced by immigrants are known risk factors of mental illness,” Dr. Welansa said in a recent interview with TADIAS.

“When the immigration is involuntary in nature and occurs after traumas such as war, torture and other forms of human rights violations, the individual is that much more vulnerable to mental illness.” She added: “Additional risk factors such as new minority status, language barriers, financial hardship, unemployment, difficulty negotiating educational and occupational systems, discrimination and changing gender roles can overwhelm an individual’s capacity to cope with his or her circumstances and result in a full-blown episode of depression, Post-Traumatic Stress Disorder (PTSD), anxiety disorders or psychosis, with or without suicidal or homicidal behaviors.”

Dr. Welansa notes that there are protective factors such as minority integration, social participation, social support, adaptability, and positive relationships, which can minimize the likelihood of a full-blown mental disorder. “It is the cumulative effect of multiple risk factors combined with an absence of protective factors that increases an immigrant’s risk of mental illness,” Welansa says. Additional factors affecting mental health include one’s biological and psychological makeup.

When it comes to violent crimes within the Ethiopian community, Dr. Welansa points out, however, that it is not as widespread as it seems and could be put under control.

“Despite the historical misconception that immigrant communities have higher crime rates, studies now show that immigrants are, in fact, less prone to violent crimes than native-born Americans,” she said. “In his study on this issue, Harvard sociologist, Robert Sampson showed that first-generation immigrants were 45% less likely to commit violent crimes, and second-generation immigrants were 22% less likely to commit violent crimes.” She added: “This pattern held true for non-Hispanic, black and white immigrants.”

Regarding the Ethiopian community, Dr. Welansa said there are studies that show that the close knit and communal nature of our culture may play a protective role in preventing mental illness.

“The first study that looked at mental health in the Ethiopian community in North America was conducted in Toronto in 2004,” Dr Welansa said. “The study looked at the frequency of depression and the risk factors involved in the occurrence of depression in the Ethiopian immigrant community.” She added: “The study found that the rate of depression in the Ethiopian community in the Toronto area was only slightly higher (9.8%) than the rate within the general Canadian population (7.3%). However, the rate (9.8%) was 3 times higher than the estimated rate in south eastern Ethiopia, which highlights the extent to which immigration increases one’s risk of depression.” The study corroborated the psychological stages of immigration that have been previously documented, starting with an initial period of elation, moving to a state of depression and ultimately to a recovery period.

“The researchers believe that the initial elation is due to the strong social support that is initially available from their ethnic group and that depression sets in as this support wanes over time,” Dr Welansa said. “Most eventually make it to a recovery period, which occurs when they have become fully acculturated, but some spiral downward into a state of despair.”

The patterns noted in this study suggest that social connections and programs that promote ethnic identity likely protect an immigrant from depression. However, further research is required to substantiate the protective role that ethnic identity plays in preventing depression.

“The one form of violence that is higher in immigrant communities is domestic violence against women,” Dr. Welansa said, citing NYC Mayor’s Office to Combat Domestic Violence, which found that young, foreign-born women have the highest risk of being killed by their partner of any group of women in NYC. “One study found that foreign-born women accounted for 51% of intimate partner homicides in New York City,” she said. “The study also showed that married immigrant women experienced higher levels of physical and sexual abuse than unmarried women.”

She added: “Domestic violence advocates cite three barriers that prevent immigrant women from seeking help: lack of information regarding the law and available services; culturally ingrained tendency towards preserving their family or community reputation combined with a sense of shame in divulging their family issues; and fear of the authorities.”

What is Dr. Welansa's advice to our community leaders, as well as cultural and religious organizations on how to contribute to help alleviate the various traumas associated with migration?

Dr. Welansa suggests developing educational programs that promote mental wellness and strengthen protective factors such as good parenting, literacy, problem-solving skills, social management skills and stress management, which can be taught and reinforced in community programs.

Implementing measures that address risk factors such work-related stress, discrimination, academic failure, chronic pain, substance abuse & poor work skills, are also important focus points prior to the onset of mental illness.

Additionally, individuals and families can be encouraged to use suicide hotline services that can provide emotional support for those experiencing emotional distress and provide referrals to mental health care workers in their area.

Dr Welansa said: "For those requiring psychotropic medications (antidepressants or antipsychotics), it is worth knowing that the liver enzyme that metabolize most psychotropics do so at an ultra-rapid rate for 20-30% of individuals with Ethiopian or Arabian genetics. For those who are ultra-rapid metabolizers, a higher dose of an anti-depressant or anti-psychotic would be required for the medication to achieve therapeutic efficacy and alleviate the targeted symptoms."

http://www.tadias.com/08/20/2012/mental-health-taboo-in-the-ethiopian-community-interview-with-dr-welansa-asrat/