Mental Health
Council of Australia

WEEKLY BULLETIN

No. 29 2012

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BULLETIN NO. 29, 2012

Dear all

Lifeline Out of the Shadows - National World Suicide Prevention Day walks

Last year in conjunction with World Suicide Prevention Day – 10 September, Lifeline launched Out of the Shadows – an initiative those encouraged local communities across Australia to organise or participate in suicide prevention walks.

In 2012, Lifeline is once again running this national campaign to provide the broader community with an opportunity to unite with a shared commitment to the prevention of suicide, raise awareness for suicide prevention, acknowledge those lost and bereaved by suicide and encourage help-seeking.

As an organisation working within the Mental Health, Suicide Bereavement and Prevention space, Lifeline would like to invite you to join a walk or organise a walk in your local community.

Posters and flyers are also available upon request (marketing@lifeline.org.au) if you would like to display these within your offices.

More information is available on the website www.outoftheshadows.org.au.

Kind regards
Kim

National Articles

1. **Labours of love (WA)**
2. **Mental Health Consumer Reference Group Moves Forward (National)**
3. **Autism diagnosis rules to change (National)**
4. **Mental Health plan mooted (TAS)**
5. **Family key to youth drug abuse recovery (QLD)**

International Articles

6. **New Mental Health Care Bill gives agency and empathy to patients (India)**
7. **Help for Elders with Mental illness and Substance Use Disorders (US)**
8. **Mental Health Courts: Diverting Loss (US)**
9. **Obama orders better mental health care for vets (US)**
10. **Managing Mental Health at Work (US)**

1. Labours of love

Publication: The West Australian
Author: Tamara Hunter
30 August 2012

There are about 310,000 of them in WA and more than 2.5 million Australia-wide - and they're saving the Government a bundle.

If the unpaid carers sprinkled liberally throughout the towns and suburbs of Australia were to be paid for what they did it would bankrupt the nation, according to mental health carers' advocate Mike Seward.

"They have a very central and important role, one that is often overlooked and definitely undervalued," he says. "And it's done free of charge, out of love."

Not only that, but they're doing it at considerable risk to their own physical, emotional and financial wellbeing.

Numerous studies have pointed to the stress carers experience as they attempt - many working around the clock every day of the week - to meet the needs of loved ones who may be incapacitated by anything from age and dementia to mental-health issues, congenital disabilities, acquired brain injuries or other disabling conditions.

Liberal MP Craig Kelly, debating a motion about the proposed National Disability Insurance Scheme in Federal Parliament last week, likened the stress levels of single mothers of children with severe disabilities to those of combat soldiers.

Mr Kelly, who has a 16-year-old son with Down syndrome and autism, said he personally understood that for parents caring for a physically or intellectually disabled child, it was a lifetime's task.

"I understand that for most carers there are no days off, there is no sick pay, there is no holiday pay and there is no superannuation," he told Parliament.

"When carers grow old, they do so with the worry about what will happen to their children when they are too old or frail to nurse them. Many parents I know with kids with severe disabilities are on medication for depression. Divorce rates are high and studies show that

single mums who have kids with severe disabilities have the same stress levels as soldiers in combat."

Reports from the Australian Bureau of Statistics and other organisations highlight the financial disparity between carers and non-carers, with carers less likely to be employed than other people, with their career prospects, superannuation and other savings suffering as a result.

If they are employed, they tend to work fewer hours. At the same time, many face significant care costs, with extra money needed for medication, equipment and appointments.

Carers can also take a hit socially and emotionally, experiencing feelings of grief, loss, resentment, loneliness and isolation as relationships, friendships and their own health suffer. Many carers report satisfaction with the role and a closer relationship with the person they're caring for but, for others, anxiety and depression can be a hazard.

"It's a little-known fact that families and carers of people with mental-health issues have higher instances of depression and anxiety than people with mental-health problems themselves," says Mr Seward, who is the executive director of Mental Health Carers Arafmi (WA) Inc.

He says much of the stress centres on the struggle to get appropriate and timely services and support, with carers faced with a labyrinth of bureaucracy as they champion their loved one's needs.

"There are challenges in dealing with the various machines of bureaucracy and with funding. Stuff that is funded by one arm of government will require things to happen in one way and stuff funded by another arm will require different things."

Paul Coates, chief executive of Carers WA, says carers face a period of huge change, with a raft of health reforms, including the National Disability Insurance Scheme, the introduction of Medicare locals, and mental health and aged-care reform set to have a significant impact on carers across the board.

"The defining issue for carers is the impact that these health reforms will have on their lives and whether these reforms will provide more support for carers or less," he says.

http://au.news.yahoo.com/thewest/lifestyle/a/-/article/14706633/labours-of-love/

2. Mental Health Consumer Reference Group Moves Forward

Media Release - The HON Mark Butler MP
30 August 2012

The Consumer Reference Group tasked with guiding the establishment of a new mental health consumer organisation met for the first time today.

Minister for Mental Health Mark Butler said, once established, the new Organisation will be dedicated to representing the diverse views of mental health consumers to contribute to a more responsive and accountable mental health system.

“The new organisation will be critical to the successful implementation of the Government’s $2.2 billion National Mental Health Reform package,” Mr Butler said.

“It is critical that the voice of mental health consumers is represented to government in the delivery of new and existing programs and initiatives.”

Mental health consumers can already register their interest in the organization through the website - www.mhconsumer.org.au.

A communiqué will be released with outcomes following the meeting.

The Australian Government has invested $4 million over five years to establish and operate the new organisation as part of its landmark $2.2 billion national mental health reform package.

The Consumer Reference Group is chaired by Mr Ian Watts who has an extensive health care background and substantial experience in leadership and organisational roles.

The full membership of the Consumer Reference Group is:

- Mr Ian Watts (Chair)
- Dr Michelle Banfield
- Mr Michael Burge
- Ms Fay Jackson

- Mr Darren Jiggins
- Mr Keith Mahar
- Mr Lei Ning
- Mr Wayne Oldfield
- Ms Lorraine Powell
- Ms Emily Todorov
- Ms Lily Wu

For more information, contact the ministers office on 02 6277 7280

3. Autism diagnosis rules to change

Publication: The Australian
Author: Adam Cresswell
3 September 2012

Some children are likely to be cut off from support services

Thousands of children diagnosed with autism could lose access to thousands of dollars in federal support and other subsidies under changes planned for the manual of medical disorders used to guide psychiatrists worldwide.

Autism patient advocates say the first Australian research on the likely impact of the changes suggests 23 per cent of those who qualify as having a form of autism would no longer do so.

Many of those who fail the new test would be classified under a new diagnostic category, called ``Social Communication Disorder'' which, under current arrangements, would not qualify children for support under a federal government package introduced in 2008.

Several independent studies conducted in the US have found fewer children would qualify for an autism diagnosis under the new criteria, in contrast to field work done by the American Psychiatric Association which has predicted no such outcome.

The country's largest not-for-profit, autism-specific service provider, Autism Spectrum Australia (Aspect), which conducted the research, says the findings could hold dire implications for many families who, since 2008, have been able to access up to $12,000 in

funds over at least two years to help provide speech therapy and other treatments for children who are diagnosed before the age of six.

Other elements of the scheme allow autistic children to receive Medicare-funded treatment from audiologists, occupational therapists, psychologists, speech pathologists and others, provided a treatment plan has been drawn up by the time the child is 13.

Clinical psychologist Vicki Gibbs, manager of Aspect's diagnostic assessment service, said the new definitions, contained in the fifth edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, were likely to come into effect shortly after the DSM-5 was published in May.

Aspect's study, the first of its kind to be done in Australia, compared how 132 Australian children diagnosed with autism would have fared had they been assessed under the DSM-5.

The results showed 23.5 per cent failed to meet the new criteria, which will require children exhibit at least five out of a possible seven symptoms, instead of three as at present.

``I think it is unlikely (changes) would be applied to people with an existing diagnosis, until they are going into a situation where they are asked for an updated diagnostic statement,'' Ms Gibbs told The Australian. ``There could be some issue then.''

http://www.theaustralian.com.au/national-affairs/health/autism-diagnosis-rules-to-change/story-fn59nokw-1226463496296

4. Mental Health plan mooted

Publication: The Mercury, Hobart
Author: Matt Smith
30 August 2012

Housing, jobs and greater access to services should be the focus for tackling mental health issues, says the head of Australia's first National Mental Health Commission.

Commission chairman Allan Fels flew into Hobart yesterday to discuss concerns and suggestions surrounding mental health and suicide prevention in the lead-up to the release of Australia's first National Report Card on Mental Health and Suicide Prevention later this year.

Professor Fels said providers told him mental health services in Tasmania's rural and poorer regions were lacking.

``In low-income areas there are major problems with access to services,'' Prof Fels said.

``One of the reasons is that the system encourages psychologists and psychiatrists to be in better-off areas even though the demand for their services is very strong in low-income areas.''

Prof Fels said a big focus for all governments should be on employment opportunities for people suffering with mental illness.

``We are going to undertake an initiative to give people a better chance at getting jobs in the future,'' he said.

``Employers are not very well educated on how to deal [with people with common mental disorders] so we are going to talk a lot more to employers about doing more to employ them.

``We need to educate and train employers.''

Housing was another important issue facing people with mental health issues, Prof Fels said.

``If people don't have stable, secure and reasonable accommodation then many of the treatments just don't work.

``Rehabilitation is not going to work if you don't know where you are going to sleep that night or you are living in sub-standard or temporary accommodation.''

Prof Fels said the National Report Card on Mental Health and Suicide Prevention would provide data highlighting the regions in Australia that need more services the most.

5. Family key to youth drug abuse recovery

Publication: Courier Mail
By Michelle Henderson
29 August 2012

Young people are more likely to recover from drug and alcohol problems if they can resolve any conflicts with their families, a snapshot of Victorian youth shows.

The study of 150 adolescents aged between 16 and 21 receiving drug and alcohol treatment revealed cannabis was the most commonly used substance, with 56 per cent using the drug.

This was followed by 19 per cent who consumed alcohol, 13 per cent who used heroin and other opioids, while five per cent used stimulants such as amphetamines.

Associate Professor David Best from Turning Point Drug and Alcohol Centre, which carried out the study, said many of the young people used four or more drugs.

More than half - 55 per cent - had been diagnosed with a serious mental health disorder.

The study found 77 per cent were not employed or undertaking any education or training.

It also showed 37 per cent had lived on the streets and 36 per cent reported conflict with their families.

Assoc Prof Best said the most problematic young people were those with significant family conflict problems.

This group had the least resolved drug and alcohol problems by the end of the study, which ran from 2009 to 2011.

Assoc Prof Best said while researchers could not conclude that family conflict caused those youths' problems, there was no question it was an underlying factor throughout treatment at drug and alcohol services.

"The group of young people who seek treatment in this area have complex problems and it's not entirely clear that alcohol and drug use is their primary problem," Assoc Prof Best told AAP.

Young people who experienced an improvement in their family relationships were more likely to show the greatest improvement in their alcohol and drug use, he said.

"Young people's drug and alcohol treatment is effective and does lead to significant improvements," Assoc Prof Best said.

"However, the magnitude of the improvement is markedly greater where there's an improvement in domestic stability and family situation."

He said engaging young people in education or employment was also vital for a full recovery, and drug and alcohol treatment programs needed to improve their links with these other services.

The Youth Cohort Study research will be presented at Turning Point's annual symposium in Melbourne on Wednesday.

http://www.couriermail.com.au/news/breaking-news/family-key-to-youth-drug-abuse-recovery/story-e6freono-1226460341454

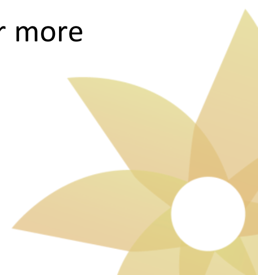
6. New Mental Health Care Bill gives agency and empathy to patients

Publication: The Times of India
4 September 2012

Emphasising patients' own will, the new Mental Health Care Bill prepared by the law and health ministries takes a step in the right direction. The proposed Bill seeks to ensure that patients suffering from mental health ailments don't get lodged in hospitals or asylums for more than six months and are not given electric shocks without their consent. Seeking close government supervision of mental health centres, the proposed Bill attempts to raise India's 25-year-old law on mental health treatment to standards set by the United Nations. The proposed Bill further calls for six-month jail terms for persons who might violate these norms.

These are welcome moves. Studies estimate over two crore Indians suffer from mental health problems. However, this medical area remains a subject of dread, shame and silence amongst many Indians, obfuscated by erroneous notions of 'madness' caused by magic, karma, etc. These are utterly outdated ideas. Many mental health issues are caused by chemical imbalances, curable through therapies and medication. However, uninformed fears lead to mental health becoming a taboo for public discussion, patients left without proper treatment, abandoned or even unscrupulously bundled off to institutions where they're kept out of society's sight. Such care is frequently unregulated - and often, evident from instances of chaining and sterilisation, brutally handled.

The new Bill therefore targets two vital aims. It seeks to accord dignity and agency to patients of mental health issues while enabling their families to take responsible, well-informed choices. And by supervising care properly, it moves towards making mental health a far more



normal, accountable and openly discussed zone of medical practice - and social experience - than it has been.

http://timesofindia.indiatimes.com/home/opinion/edit-page/NewMental-Health-Care-Bill-gives-agency-and-empathy-to-patients/articleshow/16239329.cms

7. Help for Elders with Mental Illness and Substance Use Disorders

Publication: American Society on Ageing
By Willard Mays

Our country is aging rapidly and is not prepared to meet this population's healthcare needs. This is especially true of older persons with mental illnesses and-or substance use disorders. The workforce necessary to address such an onslaught of mental health issues does not exist and is projected to fall even shorter in the future. Thirteen years ago in "Mental Health: A Report of the Surgeon General," Dr. David Satcher predicted the issue would become a "…major public health problem." Unfortunately, little has been done to address it.

In response, Congress requested the National Academies Institute of Medicine (IOM) convene a committee to determine the mental health needs of older adults and to make policy and research recommendations to develop a competent and well-trained workforce. The Committee on the Mental Health Workforce for Geriatric Populations was formed with Chair Dan Blazer, M.D., Ph.D., of Duke University, and included several members of MHAN, including past Chair Fred Blow, Ph.D., Steve Bartels, M.D., and myself. The IOM Report, "The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?" was released this past July.

Some of the report's key findings include:

- Approximately 8 million, or about one in five of today's older adult population has one or more mental health or substance use disorders. About 2 million have a serious mental illness. Depressive disorders and behavioral problems related to dementia are the most prevalent. Also, older veterans have more mental health issues and substance use disorders than does the general population.

- In addition to aging, the nation is becoming more diverse, which means increasing numbers of Asian, Hispanic-Latino and African-American elders with mental health and substance use disorders.
- As baby boomers age there will likely be increased use of illicit drugs.
- The workforce is not prepared in numbers, knowledge and skills to address current or future needs. Current educational, training, certification and licensing requirements are insufficient and inconsistent.
- Only a minority of older adults with mental health and substance use disorders receive specialty care, and the care provided in other settings, such as primary care, is often inadequate.

Two of the most important conclusions of the report are that there is a “conspicuous lack of attention” to preparing the workforce to care for older adults with mental illness and substance use disorder, and that many of the challenges that must be overcome in developing such a workforce are fundamental and entrenched in numerous public and private systems of care, coverage policies and reimbursement levels. The following is a summary of IOM recommendations.

Recommendation Number One addresses the lack of coordination between federal agencies in developing and strengthening the mental health and substance use disorders workforce for the geriatric population. The Committee found there were numerous programs and initiatives spread across multiple federal agencies, with little evidence of overall planning, coordination or even information sharing. Congress previously authorized, but failed to fund, the National Health Care Workforce Commission to address these issues. The IOM report urges Congress to fund the Commission. If that does not happen, the Committee recommended that the Secretary of the Department of Health and Human Services (HHS) move as quickly as possible to designate an alternative body.

Recommendation Number Two focuses on agencies within the HHS, and urges the Secretary to ensure they assume responsibility for building the capacity and facilitating the deployment of the geriatric mental health and substance use disorders workforce. Specific recommendations are provided for individual agencies, including the following:

- **Centers for Medicare and Medicaid Services (CMS).** Medicare and Medicaid are the largest funders of mental health and substance use disorders services for older adults. Unfortunately, current coverage policies, reimbursement levels and payment systems present major barriers in attracting professionals to the field, sustaining the current workforce and making appropriate services available for covered individuals.

Although a number of evidence-based practices exist, providers struggle to figure out how to get reimbursed for services under the current payment system. CMS is urged to consider alternative payment methods. It is also recommended that CMS take steps to encourage integration between behavioral health and primary care settings. Additionally, CMS should increase oversight of the Pre-Admission Screening and Resident Review (PASRR) and Minimum Data Set (MDS) programs for nursing home applicants and residents. These programs can be valuable resources in determining appropriate placement, providing critical information for planning care and assisting in discharge planning.

- **Substance Abuse and Mental Health Services Administration (SAMHSA).** SAMHSA currently has only one grant program specifically for older adults, the Older Adult Mental Health Targeted Capacity Expansion (TCE) Grant Program, and it plans to end it. The Report recommends that SAMHSA restore the funding and continue the TCE Program. While neither the Mental Health nor the Substance Abuse Prevention and Treatment Block Grant Programs requires that money be spent on serving older adults, it is recommended that states, at a minimum, be required to report data on what they are spending on older adults and what services are being provided.

- **Health Resources and Services Administration (HRSA).** HRSA plays a critical role in the education and training of the workforce for the geriatric population, and the Committee recommended that the grants and programs that HRSA funds should devote sufficient attention to the geriatric mental health workforce. This includes Geriatric Education Centers, Comprehensive Geriatric Education Program institutional awards, Geriatric Academic Career Awards career development grants, and the National Center for Health Care Workforce Analysis.

- **Administration on Aging (AOA).** The 2006 reauthorization of the Older Americans Act (OAA) authorized, but did not require, the AOA to develop grant programs for projects

to increase public awareness of older adult mental health disorders, provide mental health screening, remove barriers to diagnosis and treatment, plus encouraging coordination with community mental health centers and other community-based providers. Although no funding has been specifically dedicated for these projects, some states have used other OAA funding for programs to achieve some of these objectives. The report recommends this become a higher priority.

- **Recommendation Number Three** encourages organizations responsible for accreditation, certification and professional examination, as well as state licensing boards to modify their standards, curriculum requirements and credentialing procedures to require professional competence in geriatric mental health and substance use disorders for all relevant professions.
- **Recommendation Number Four** urges Congress to appropriate funds for the Patient Protection and Affordable Care Act (ACA) workforce provisions that authorize training, scholarship and loan forgiveness for people who work with or are preparing to work with older adults who have mental health or substance use disorder conditions. This funding should be targeted to programs with curricula in geriatric mental health and substance use disorders and directed specifically to workers who make a commitment to caring for older adults with such conditions.
- **Recommendation Number Five** points out the paucity of data that exists and asks DHHS to direct a responsible entity to develop and coordinate implementation of a data collection and reporting strategy for geriatric mental health and substance use disorders workforce planning and development.

The IOM Report and recommendations present a real opportunity for governmental agencies, professional organizations, academic institutions, advocacy organizations and other stakeholders to work collaboratively to develop and implement solutions. The issues are complex and numerous, and addressing them will require sustained effort across multiple agencies and systems. We must do our part to make sure it doesn't become just another report on the shelf!

http://www.asaging.org/blog/help-elders-mental-illness-and-substance-use-disorders

8. Mental Health Courts: Diverting Loss

Source: Homelessness Resource Centre
Author: Wendy Grace Evans

Description: Many communities are establishing mental health courts to better serve the needs of people with mental illness who are charged with crimes. The result is a model that offers healthier paths to recovery and higher-quality, more cost-effective services. Melissa Knopp, Esq., Manager of the Specialized Dockets Section of the Supreme Court of Ohio, discusses the establishment of a mental health court in her community.

Content: "The mental health movement started with those of us who noticed that we were able to see mental health issues with more clarity once people were clean from drugs," says Melissa Knopp, Esq. Melissa is the Manager of the Specialized Dockets Section of the Supreme Court of Ohio. She has been working with drug court cases since 1995 for trial courts, drug court programs, and the jurisdictions that handle all mental health cases.

There had been attempts to procure mental health services within the drug court system before, but it became clear that drug courts were not equipped to address the complex nature of mental health issues. The courts realized the need for a separate mental health court docket, as mental health court issues require different sanctions.

Stigma was also a prevalent concern. Melissa says that other defendants would question why those drug court defendants facing both mental health and substance use issues sometimes did not go to jail, yet they did. This kind of stigmatization within the system provided additional reinforcement to the idea of creating a separate mental health docket. Melissa explains that people struggling with substance use issues face a different set of challenges than people struggling either with co-occurring disorders or with mental health issues.

The process for establishing mental health courts took time. There was early interest in 2000 and, in 2001, Melissa was designated as the Special Docket Program Manager. At this time, Justice Evelyn Stratton became very interested in mental health issues. She created an advisory committee and worked tirelessly to establish mental health courts. Melissa worked closely with her, and they partnered with the National Alliance on Mental Illness and colleagues from the criminal justice system. They presented a best practice called the Crisis

Intervention Team (CIT), which showed police officers how to identify mental illness and to teach de-escalation skills through the use of role play.

The screening process for individuals to enter mental health court includes an assessment of both legal and clinical eligibility. To be legally eligible, the case must involve a probationary offense or be a diversion case, which depends on the type of crime. Diversion cases allow individuals who qualify to be diverted from jail to programs that support more specific mental health needs.

Clinical eligibility assessments take 10 to 14 days and must determine that a person has a severe mental illness; only individuals with Axis I diagnoses (as defined in the *Diagnostic and Statistical Manual of Mental Disorders*) qualify for mental health court. The individual must also be found competent to stand trial.

Once the reports are completed, the court treatment team and an outside advocacy group assess whether or not the person is appropriate for the program. The judge and defense council are informed as to the person's eligibility for the specialized docket program. The mental health court's diversion program then provides community supervision, community treatment, court hearings, and access to appropriate medications.

Mental health courts are critical to a system that has been placing people with untreated mental illnesses in jails, Melissa says. Jails were filling up in the 1980s after people were released from institutions, yet appropriate services were not available to them in the community. "Jails are not healthy places for people without mental illness," says Melissa, "and they are definitely not healthy places for people who do live with mental illness."

Diversion courts have also helped people to stay on their medications and have lowered hospital costs. "If the altruistic reasons won't convince people of the benefits of mental health courts, then the financial reasons certainly hit home. This is the most intensive treatment we have, and the judges really like these programs because they are actually seeing people improving and not just getting locked up," says Melissa.

Melissa understands that it is difficult for case managers who have heavy caseloads to have one or two people who may require much of their time. She says mental health courts can help service providers save time and save lives.

‘I talk to a lot of homeless service providers and case managers about our mental health courts, and I suggest that they speak to the judges and start a conversation with them if they are working with people who experience mental illness with criminal charges in their community,” she says. Many times, sanctions from the court can provide opportunities to prevent relapses because of the community and team approach. And engaging individuals with the court can assist providers to keep them out of the hospital and to foster more sustainable connections with the people they work with.

http://www.nrchmi.samhsa.gov/Resource/View.aspx?id=54968&AspxAutoDetectCookieSupport=1

9. Obama orders better mental health care for vets

Source: Army Times
Author: Patricia Kime
31 August 2012

President Obama has signed an executive order aimed at reducing the rate of suicide and mental health disorders in veterans and troops by improving access to behavioral health care.

Addressing soldiers at Fort Bliss, Texas, on Friday, Obama said the initiative is part of an overall effort to maintain U.S. military superiority.

“We may be turning a page on a decade of war, but America’s responsibility to you has only just begun,” Obama said. “Just as we give you the best equipment and technology on the battlefield, we need to give you the best support at home.”

The order directs cabinet agencies, including the departments of Veterans Affairs, Defense, Health and Human Services and Education, to work together to expand suicide prevention efforts and to fill vacancies for mental health jobs.

The “Improving Access to Mental Health Services for Veterans, Service Members and Military Families” order also includes actions to improve access to mental health services for service members and veterans, including enhanced partnerships with community providers, increased VA staffing, and mental health research.

“If you are hurting, it’s not a sign of weakness to seek help; it’s a sign of strength. And we are going to help you remain strong — ‘Army Strong,’ ” Obama said, referencing the service’s advertising slogan in his speech before more than 5,000 service members at the 1st Aviation Support Battalion hangar at Fort Bliss.

Under the directive, VA must expand its veterans’ crisis line capability by 50 percent by Dec. 31 and ensure that veterans who identify as being a danger to themselves or others connect with a trained mental health professional within 24 hours.

VA also is required to partner with DoD in developing and implementing a nationwide year-long suicide prevention campaign aimed at veterans.

The order also authorizes VA to expand programs based on veterans helping veterans, directing the department to hire 800 more peer-to-peer counselors, and it also directs VA to work with HHS to establish a pilot program that leverages community mental health resources to reduce the waiting times veterans often face when seeking mental health services.

VA has faced criticism for not doing enough to help veterans who need mental health treatment.

A report in April from VA’s own inspector general said officials inflated success rates for providing timely services for veterans, reporting that 95 percent of new patients seeking mental health treatment received full evaluations for care within the department’s required window of 14 days, when the IG found that just 49 percent were seen within that time frame.

Most faced an average wait time of 50 days, according to the IG.

VA Secretary Erik Shinseki said the executive order shows Obama’s commitment to veterans.

“The president’s historic initiatives and budgetary support will have a positive impact on the lives of veterans and their families for generations to come,” Shinseki said.

A worsening problem

Mental health concerns have plagued the military since at least 2004, when services’ suicide rates started rising. About 18 veterans a day commit suicide, according to VA estimates.

The Army in July faced its worst month for suicides in at least three years; 26 active duty soldiers and 12 Army National Guard or Army Reserve members were suspected or confirmed to have died by suicide.

The Marine Corps suffered eight suicides in July, bringing its total for the year to 32 — matching its total for all of 2011.

This year, 55 Air Force members have committed suicide, while the Navy has had 39.

According to Rand Corp. think tank, nearly 19 percent of service members deployed to Iraq or Afghanistan meet diagnostic criteria for either post traumatic stress disorder or depression.

To improve medical care for affected individuals and families, Obama's order also establishes a task force of representatives from DoD, Education, the Domestic Policy Council, National Security Staff, the Office of Management and Budget, the Office of Science and Technology Policy and the Office of National Drug Control Policy.

The panel, known as the Military and Veterans Mental Health Interagency Task Force, will "make recommendations to the president on additional strategies to improve mental health and substance abuse treatment services for veterans, service members and their families," according to a release.

Since the order was announced, veterans and advocacy groups have thrown their support behind the president.

"Today, more American service members die by their own hands than at the hands of our enemies, which is why the [Veterans of Foreign Wars] is proud to see our commander-in-chief taking action to address this national crisis," VFW National Commander John Hamilton said.

Paul Sullivan, managing director for veterans outreach for the law firm Bergman and Moore, said he was "pleasantly surprised."

"As commander in chief, he is sending a very strong, anti-stigma, pro-treatment message, essentially saying it's the best thing to do, go in and get treatment," Sullivan said. "Second,

he's saying that DoD and VA are going to be ready when they show up, if a veteran is having mental health symptoms and they reach out for treatment."

'Too little, too late'

Some critics — including Republican presidential nominee Mitt Romney — have wondered what took so long.

"We applaud President Obama for finally getting serious about veterans' mental health," Romney spokeswoman Andrea Saul said. "Unfortunately, his actions are too little, too late. Instead of taking conclusive action to stop this national tragedy, the president proposes more toothless bureaucratic task forces and public relations campaigns.

"Governor Romney will act decisively. He will double the number of mental health care providers for veterans overnight by opening the military's Tricare network for our transitioning warriors," Saul said.

"For the past two years, this committee and Congress have been pushing the Obama administration to take the very actions the president has only now outlined in this executive order," said Rep. Jeff Miller, R-Fla., chairman of the House Veterans' Affairs Committee. "The funding has been there, the will of Congress has been there. What has been lacking is leadership from the president to use the substantial resources Congress has provided to him for these purposes."

Former Marine Corps Sgt. Geoffrey Ingersoll attributed the rise in suicides to the grueling operations tempo of the past decade and said in an email to Military Times that no new "facilities, booklets or cheesy internal military videos aren't going to prevent anything."

"It's too late. Though we appreciate and acknowledge the effort, the damage is already done, Mr. President," said Ingersoll, who served as a combat photographer in Iraq.

http://www.armytimes.com/news/2012/08/military-obama-orders-better-mental-health-care-for-vets-083112w/

10. Managing Mental Health at Work

Source: The Wall Street Journal
By Melissa Korn
28 August 2012

John Binns, a partner in the consulting practice at U.K.-based Deloitte LLP, assumed his career "would be finished" after he took a two-month leave in 2007 to treat a severe bout of depression.

When he told his bosses, they assured him that they would support any effort to get him back to health and working again, encouragement that the 54-year-old Mr. Binns calls "massively instrumental in speeding up my recovery." Still, milder symptoms had festered for nearly a year before a worsening of his condition forced him to come forward.

"There was no culture of talking about mental health or recognizing that some of our best and brightest people, statistically, would have a mental-health issue," he says.

That's not uncommon, and it's becoming problematic for companies as an increasing number of adults seek treatment for psychiatric disorders. While firms appear eager to support employee wellness initiatives, managers are wary of getting too deeply involved in staffers' private health issues. Firms can open the door by offering free, confidential hotlines or generous leave policies, but they can't force employees to volunteer details of their conditions.

Most workers have at least a few colleagues who struggle with depression or anxiety. More than one in four American adults has a diagnosable mental-health disorder, and one in 17 has a serious disorder such as schizophrenia or bipolar disorder, according to the National Institute of Mental Health. But chances are their co-workers—and managers—have no idea who they are.

Intentionally or not, "corporations encourage a climate of keeping things under wraps," says Dr. Jeffrey P. Kahn, a clinical associate professor of psychiatry at Weill Cornell Medical College in New York.

The Americans with Disabilities Act requires that companies provide "reasonable accommodation" for employees with disabilities. For someone with a diagnosed mental

illness, such accommodations may include anything from offering flexible work hours to allow for weekly therapy sessions, to reassigning the employee to a role with fewer deadlines. The HR office coordinates the effort, generally without ever telling the boss why such accommodations are being made.

Prudential Financial Inc. offers an employee assistance program, training for managers to spot distress among employees, health clinics that screen for mood instability and more. Still, the company recommends employees stop short of telling managers about their diagnoses, says Ken Dolan-Del Vecchio, vice president of health and wellness. "We don't want managers to be acting as surrogate counselors," he says.

Meanwhile, DuPont DD is training managers to identify signs of distress in workers, though conversations with a boss about a diagnosis "would never be encouraged," says Paul W. Heck, global manager of employee assistance and WorkLife services. Managers who do identify distress are asked to remind employees of the assistance program, which can offer free counseling.

Deloitte's Mr. Binns brought together a group of company executives and mental-health experts in late 2008 to create Mental Health Champions, which taps unofficial confidants for employees struggling with mental-health or emotional problems. Mr. Binns estimates that 50 to 60 people in his office seek help each year. The "champions" aren't trained medical professionals, but they can provide details on available support and managing disclosure.

Complicating such efforts are employees' fears that disclosing a mental illness will derail their careers—a valid concern.

Details about a serious mental illness are fair game when researching a job candidate, says Dr. Patricia Cook, chairman and CEO of Cook & Co., a Bronxville, N.Y., executive search firm. Such psychological troubles are "reasons for red flags," she says, and can raise questions about potential future success.

Mentions of depression or obsessive compulsive disorder, which Dr. Cook, a licensed psychologist, calls "diagnostic titles du jour," are a bit less worrisome.

Symptoms of some disorders may even be helpful in the office, some say. A person with obsessive-compulsive disorder, for example, could be seen as a perfectionist with a few quirks.

Dr. Cook once considered a candidate for an executive-level position whose prior supervisor alerted her to a diagnosis of schizophrenia. The candidate was eliminated from the shortlist; she says she provided an "ego-acceptable excuse" without disclosing specifically that it was because of his mental illness.

Rep. Jesse Jackson Jr. (D., Ill.) is facing calls to withdraw from the November ballot following his announcement earlier this month that he suffers from bipolar disorder. Mr. Jackson withheld details of his diagnosis for months, possibly because he was haunted by the political implosion of Thomas Eagleton, whose depression helped kill George McGovern's 1972 presidential aspirations.

Dr. Kahn once treated a manager who didn't submit insurance claims for his therapy sessions, fearing the details would make their way back to his employer. Upon receiving a promotion to a more senior position, the man finally sent in those claims. Executives may be more comfortable disclosing their mental-health histories, Dr. Kahn says, because they see themselves as "immune from adverse effects, which they largely are."

Dr. Rich Chaifetz, CEO of employee assistance program provider ComPsych Corp., says client companies are only told how many employees utilize the service, or how often. They might break down the population by gender, age or issues with which they're dealing, but employers aren't told who called in, or what they sought help with.

Federal and local laws protect people with disabilities, including serious mental illnesses, but employers "can always comment on somebody's actual observed performance, behavior [and] interactions in the workplace," says Katharine Parker, co-head of the employment law counseling and training group at Proskauer Rose LLP.

Gabe Howard worked in information technology at a large Ohio company when he was diagnosed with bipolar and anxiety disorders in 2004, spending several days in the hospital after having suicidal thoughts. Thinking his leave wasn't unlike time off for surgery or family needs, he openly discussed the reason for his absence.

The fallout was immediate: One co-worker said that Mr. Howard would have succeeded at committing suicide had he really wanted to die; another accused him of ditching work. He was eventually let go after supervisors complained about his absences and even questioned his diagnosis. He now works as a mental-health advocate and speaker.

Bob Carolla, director of media relations for the National Alliance on Mental Illness, recommends against disclosing a mental-health issue to a manager, if possible, and certainly not in a job interview. "It's not a skill or part of the qualifications that an employer is looking for," he says.

Most of the time, anyway. Fifteen years ago, when Mr. Carolla was hired by NAMI, his own history with depression, he says, was "a big selling point."

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