



Mental Health
Council of Australia

WEEKLY BULLETIN

No. 17 2012

BULLETIN NO. 17, 2012

Hi all,

I have added an additional article regarding suicide toll in ACT as Sebastian Rosenberg responded to the original article (see items 5 and 6).

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

Thanks,
Kim

National Articles

1. **Mental illness in men costs \$3b, says report**
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1. Mental illness in men costs \$3b, says report

Publication: Sydney Morning Herald (NSW)

Author: Amy Corderoy

30 May 2012

MENTAL ILLNESS in young men costs the Australian economy more than \$3 billion per annum, a new report to be launched by the minister for mental health today reveals.

The cost, which equates to \$387,000 lost each hour, is largely due to the unfilled potential of men who drop out of work or education while suffering their problems in silence, experts say.

The federal government covers about 31 per cent of the annual cost of mental illness in men and boys aged between 12 and 25 through direct health and welfare costs, says the report, *Counting the Cost: The Impact of Young Men's Mental Health on the Australian Economy*.

The rest is borne by individuals and businesses through reduced earning potential, lost productivity over time and other costs.

The minister for mental health and ageing, Mark Butler, said the report showed the tremendous scope of the mental health challenge facing Australia.

"The clear message from *Counting the Cost* is that we must intervene early and invest smarter to reduce the cost and impacts associated with young men's mental illness. We stand to gain from both a happier, healthier population and increased productivity," he said.

The chief executive of the Inspire Foundation, Jonathan Nicholas, said men were often resistant to getting help, and by the time they did they were in crisis. "The human cost of this is very significant, more young men die by suicide than on our roads," he said. "But what we are also showing [with this report] is there is also a very significant economic toll."

The report, produced by the Inspire Foundation and Ernst & Young with the Young and Well Cooperative Research Centre, found Australia loses more than 9 million working days a year



to young men with mental illness and on average they have an additional 9.5 days out of role per year.

Mr Nicholas said the findings should not discourage employers from hiring people with a mental illness, but rather highlight to them the importance of early intervention.

"This is likely to happen to one in four of us over our lifetimes ... it's actually an issue in your workplace right now," he said.

The report recommends men be supported to receive higher levels of education, that men with mental illness be helped to remain in work, and that current policy responses and investments in mental health be evaluated.

<http://www.smh.com.au/opinion/political-news/mental-illness-in-men-costs-3b-says-report-20120529-1zhex.html>

2. Mental Health not a dirty term

Publication: Sunday Age – Letters

27 May 2012

THE assertion by the Australian College of Specialist Psychologists that the term "mentally ill" is stigmatising - putting off a lot of people from getting help - is disappointing. Illness is not a dirty word. And mental illness as a term should NOT be avoided.

To try to separate some common mental disorders from the more severe mental illnesses - under the assumption they do not need biological treatments - is hardly a professional approach.

It risks further entrenching stigma against those with certain diagnoses. It also risks people with severe mood and anxiety disorders not accessing the treatments that are most effective - namely biological treatments including medication and electroconvulsive therapy.

DR RUTH VINE,
Victorian Chief Psychiatrist



Stifle the stigma

IN EXPRESSING concern that the term "mental illness" labels people with depression as "dangerous, crazy and violent", the Australian College of Specialist Psychologists perpetuates the same stigma against people with a psychotic illness.

Psychotic symptoms often co-exist with depression, and mental health professionals, whether psychologists or psychiatrists, should be collaborating to reduce stigma across the spectrum.

Singling out high-prevalence disorders as less severe has no clinical basis and belittles the role medication can play in conjunction with psychological therapies in treating these illnesses.

Instead of vilifying the term "mental illness", efforts to combat over-reliance on pharmacological treatments would be more usefully directed at improving access to affordable psychological care.

DR HANNAH McMILLAN,
Psychiatry Registrar, Prahran

Working together

IT IS of concern that Dr Jillian Horton of the Australian College of Specialist Psychologists seemingly fails to recognise that the crippling physical and cognitive symptoms of clinical depression and anxiety often require psychiatric diagnosis and drug therapy before the sufferer can successfully participate in and respond to psychological counselling.

Having suffered clinical depression, I have no problem with describing my experience as a mental illness. My GP initially referred me to a psychologist, who recognised that my symptoms made psychological treatment impossible. My GP then appropriately referred me to a psychiatrist who assessed me and prescribed medication, which ameliorated my symptoms enough to make the vital psychological therapy successful.



Psychologists should not see themselves as an alternative to a "medical model", but as part of a collaborative healthcare team. Any other approach is, at best, unprofessional, at worst irresponsible and dangerous.

MICHELLE GOLDSMITH, Eaglehawk

It's in the wording

AS A long-time sufferer of mental illness, I agree with the writer of your editorial "Mental illness is much more than a word game" (20/5), who concludes that "it would be better to remove the stigma from the concept of mental illness than to simply attach it to another set of words".

I suffer from schizophrenia, depression and anxiety. At job interviews I disclose my condition by saying that I suffer from mental illness. Were the Australian College of Specialist Psychologists to have its way, I would have to say "I suffer from a mental illness and two psychological disorders"! What would be my chances of getting a job, then?

GLENN HORNE, Forest Hill

<http://www.theage.com.au/national/letters/not-a-dirty-term-20120526-1zbuw.html>

3. Teenagers left to care for sick and disabled family members with little or no support

Publication: Courier Mail (QLD)

Authors: Amy Kelly and Jackie Sinnerton

27 May 2012

TEENAGERS caring for sick, delusional and suicidal family members are slipping through the cracks of a faulty government support system, forced to fend for themselves and risking their own future.

Experts are calling for an overhaul of support services, with many of the state's 60,000 "forgotten angels" exposed to mental and physical trauma.



"I have come across five year olds who have been the primary carer in the home," said Tim Moore, president of Carers Australia and a research fellow at the Australian Catholic University.

"Many children have to deal with parents or family members who are deeply depressed, maybe suicidal, and high on drugs or are delusional.

"Workers throughout the country are doing a great job but - unfortunately - there are too many hurdles in the system."

The most recent Australian Bureau of Statistics data show that only 4 per cent of young carers aged 15-25 were in education. And 60 per cent were jobless.

Brisbane psychologist and school counsellor Judith Locke told The Sunday Mail that children in these situations needed expert support. "My training in clinical psychology took me six years to be knowledgeable enough to cope with the responsibilities of assisting people with complex mental health needs. To put this responsibility on children would be an impossible task and should not be asked of a child under 16 or maybe even 18," she said.

Child psychologist Dr John Irvine said how a child coped with caring responsibilities varied greatly. "For some it stunts their own growth because they can't do things that other kids of their age do. They can become somewhat resentful and passively aggressive. But others flourish."

In his research into young carers, Dr Moore has found that only 10 per cent of surveyed young carers could identify a service or support that they could access more than once a month.

In other research, he found 80 per cent of support workers, including youth and mental health officers, said their key service response to a child caring for an adult with drug or alcohol issues would be to send them elsewhere.



The hand-balling of responsibilities was a problem, Dr Moore said.

"There needs to be an alignment of services all working for the needs of the family, not just the person needing care," he said.

Dr Moore said many young carers would have to drop out of school to access Centrelink allowances.

Research from Carers Australia shows that young carers report caring from pre-school age but most are 10 to 13. According to Carers Queensland acting chief executive John Kennedy: "I think every carer is an angel ... young or old."

Carers Queensland Services offer support for people aged 5-25 and acknowledges young carers' tasks include "interpreting and understanding psychological difficulties as well as bathing, feeding and toileting family members".

Young carers often report situations when they feel unsafe, particularly when their relative is prone to seizures or challenging behaviours. Many young carers end up with mental issues of their own and social isolation and poverty adds to that.

Carers Queensland chief executive Debra Cottrell said there was a reluctance to admit how many young carers there were. She said that while there had been a slow increase in awareness, some still believed that supporting them legitimised a system that was failing children.

"If the disability system was supported better, then it would be more likely that the physical and practical tasks young carers do could be purchased externally," she said. But she said many young carers took on caring roles out of love for the dependent person and that supporting them with appropriate funding and services to help them stay in school was vital.



Many Australian parents think their young carers do a better job than a professional care provider. There also is a strong bond, adding weight to the argument that keeping the family unit working together is vital.

There are a range of services to support young carers.

These include guidance officers, school-based nurses, school counsellors, youth support coordinators as well as learning support staff.

Federal Parliamentary Secretary for Disabilities and Carers Senator Jan McLucas said that young carers struggled to get the support they needed through the State Government's disability service system.

Senator McLucas's office said that, fundamentally, the issue came down to getting better in-home support services, including respite to support young carers.

A spokesman for the Queensland Minister for Communities, Child Safety and Disability Services Tracy Davis said while young carers were an issue of "considerable concern", funding for carers was a Commonwealth issue.

Queensland is acknowledging the efforts of its young carers with an invitation-only festival day at Movie World on Sunday, June 24.

For the love of my mother

IF Aiden Crozman could have just one wish, he would wish for his mum to be well.

The 13-year-old forgotten angel from Loganholme started doing small jobs for his mum when he was six. His responsibilities have grown over the years and he is now her primary carer.

Mum Kathy, who suffers from chronic fatigue, is heavily reliant on her son to cook and clean the house or at times help her to the bathroom. At the age of 10, Aiden helped save her life. When Kathy's heart stopped he called the paramedics, who managed to resuscitate her.



Busting every myth about selfish teens, Aiden is happy to be on hand for his mum. and help out in the home. Aiden says he is now "about 75 per cent" responsible for Kathy's care, with occasional help from his 28-year-old sister and a government-funded community carer who comes once a week to bathe Kathy and clean the house.

Aiden receives about \$50 a week in benefits and Kathy is on a disability pension. Their combined income just covers household expenses and medication.

First thing every morning, Aiden calls out to see if his mum is OK and on weekends he stays close to home. "Usually I'm in the house, if I'm not I'm in the street, and I check on Mum every 10 minutes," he said.

Kathy says on bad days Aiden helps her to the toilet when he gets home. Aiden does not complain, but there is no doubt that like other "carer" families, he and Kathy would welcome extra help and support

WHAT'S NEEDED

- * Review of 25-hour rule limiting access to financial help to young carers in school or part-time work
- * No Wrong Door Policy implemented by all bodies. Too often vulnerable families find they have approached the wrong service and are turned away without information.
- * Services for kids and adults must align to ensure children's needs are met as well as those of the cared-for relative and family.

This would avoid a situation where a parent is given a bed in a facility but nothing is available for their child - resulting in both being unable to attend.

- * Take responsibility off the children. Allow access to education, work, community and social life.
- * Family, not individual, responses are required. Often young carers fall between the gaps because services are targeted at adults instead of the complete family unit.
- * Safety of the young people is paramount. Provide them with appropriate and responsive supports and assistance. This is the shared responsibility of schools, community groups and health and welfare services.
- * Increase awareness of the problem at schools.



HOME TRUTHS

- * 152,500 young carers in Australia are aged under 18.
- * 67% of 10-to-24- year-olds look after a parent.
- *60,000 young carers in Queensland.
- *4% of primary young carers aged 15-25 are in schools or learning institutions.
- *60% of young carers aged 15-25 are unemployed.
- *67% of those aged 10 to 24 years look after a parent.
- * Many thousands of young carers are hidden and not included in statistics.
- * Many spend an average 6.4 hours a day in caring duties for an average of six years.
- * Young carers may experience pain due to physical strain.
- * A possible outcome of significant caring is depression and low self-esteem.
- * Carers Queensland supports young carers aged five to 25.

<http://www.couriermail.com.au/news/sunday-mail/burden-of-a-young-angel/story-e6frep2f-1226367904339>

4. Prison health report released

Source: ABC news

24 May 2012

An independent review of South Australia's prison health service has recommended significant changes to the way care is provided.

The report contains 26 recommendations and was handed down to the Health Department last July, but has only just been released.

Dr Martin Dooland from the Central Adelaide Local Health Network says the most urgent recommendations involve treating drug and alcohol dependency and mental health problems.



"We have agencies that have specialists in those areas, highly qualified specialists in those areas, and rather than duplicate those in prison health the report recommends that the drug and alcohol specialists come into that arena to bring their specialty with them," he said.

Dr Dooland says a plan to introduce the changes will be completed by the end of the year. "They pointed to areas where our prison health service can develop to meet the more complicated needs of the prisoners. No one is satisfied that we're quite doing that yet," he said.

Earlier this year, the Salaried Medical Officers Association took the Health Department to the Industrial Relations Commission over concerns about a shortage of doctors in the prison system.

Andrew Murray from the association says under-resourcing has been a chronic issue for years.

"To suggest that a conversation now may start which presumably would turn into a budget submission sometime in the future I think simply isn't adequate and people have every right to say, 'Well you've had the report for 12 months. You've had plenty of time to prepare a Budget submission for 2012'," he said.

"I think the important thing however is that the money needs to be found because those services themselves will need to be supplemented to increase the resources they've got so that they can meet that corrections demand

<http://www.abc.net.au/news/2012-05-24/prison-health-review/4031524>



5. Revealed: our tragic hidden toll

Publication: The Canberra Times

25 May 2012

Thirty-seven people have committed suicide over the past six years during or after treatment by the territory's mental health system, and another 18 deaths are being investigated by the coroner.

Documents released to The Canberra Times under Freedom of Information have given the first snapshot of how many people on Mental Health ACT's client database have taken their lives since 2006. Two of those people were on a psychiatric treatment order, or forced mental health intervention, when they committed suicide.

While some people took their lives at a Mental Health ACT facility or during patient leave, the majority of suicides were not carried out by inpatients.

The figures reveal the majority of cases involved men, and those aged between 30 and 40 were the most likely to commit suicide. Of particular concern were young people between 15 and 25 and older people in their 90s who killed themselves, a clinician said.

The highest number of suicides in one year among those who had received mental health treatment was in 2007, when 11 died. That would represent just over a third of the territory's total suicides that year, according to the latest Australian Bureau of Statistics figures.

The latest available statistics for suicides in the ACT was 2010, when 35 people took their own lives. The territory has the third lowest rate of suicide in the country and sits just below the national average of 10.4 suicides per 100,000 people.

SupportLink chief executive Tony Campbell, whose team "sits in the room of the family at nearly every suicide", said some people were being let down by ACT's mental health



system. There would be value in a community-wide review into mental health services, both government and community, in the ACT.

“There is a system. Is the system fantastic? No. Could it work better? Yes,” Mr Campbell said.

“The best thing we can do is to make sure the systems are working in tandem with one another. “We’ve got a mental health system that probably could work with the community sector better.

“We’ve got a frustration where people are put into emergency departments after an attempted suicide and find themselves back out on the street the same day.” Clinical Services director and chief psychiatrist Peter Norrie said former patients often came back several years later, grateful for the support that had been given.

But Lifeline Canberra chief executive Mike Zissler said many families in the community felt they were not being treated well by the system because it was “overstretched” and “not well funded”.

According to the ACT Health Directorate, funding has increased over the past decade from \$27.4 million to \$82.6 million in 2010-11. Of that most recent figure, about \$10 million was spent on community sector mental health services.

Mr Zissler said that the funding ratio was too much in favour of acute mental health care – the buildings and professional staff in the hospital setting. He would like to see more money invested into the community sector and into families caring for the mentally ill.

“At times people just get lost in the system,” Mr Zissler said, adding community resilience needed to be built.

Mental Health ACT has a “no wrong door” policy, which aims to ensure people aren’t turned away when seeking help.



The ACT Mental Health Consumer Network said there were a lot of mental health support services in the ACT. But the network's executive officer Dalane Drexler said people still "fell through the cracks" because "they don't quite qualify for this service, they don't quite qualify for that service. People say I can't get support that I need when I need it," she said. "Ideally down the track they will get focused on the community side of things and have people properly supported in the community."

Lifeline Canberra has been calling for a suicide review committee in the ACT because it says: "We don't know enough about them, we don't respond to them, we don't really react to them".

Dr Norrie said the total number of suicides by people linked to Mental Health ACT at some point in their lives was small when compared to the number of people on the system's clinical records and followed a downward trend. He also said the numbers were hard to quantify because of the varying degree of contact they had with patients.

"The majority of suicides, as sad as this is, occur without any of us knowing," Dr Norrie said. "There are some people who suicide without pre-warning, no diagnosis, no contact with any services, not just with Mental Health, and no contact with their GP or Lifeline.

"For me as a clinician [the data obtained under FoI request] reaffirms that it is a very challenging area. "We would be working hard to do our very best to make sure that figure is as small as possible."

<http://www.canberratimes.com.au/act-news/revealed-our-tragic-hidden-toll-20120525-1zapj.html#ixzz1w7DKJQuI>



6. Suicide toll demands unified and frank response

Publication: The Canberra Times

Author: Sebastian Rosenberg

30 May 2012

Articles in this newspaper at the weekend regarding the impact of suicide on the ACT community impel us to take new action.

Suicide's impact is always reported as "hidden" or "secret". This is bizarre given that suicide now ranks as the leading cause of death for adult men under the age of 44 and adult women under the age of 34. The most recent Australian data (ABS, Causes of Death, 2009) reports deaths due to suicide at 2132; that is six a day or one every four hours.

Consensus is that this figure is an underestimate and that the real figure is more likely to be around 2500 deaths by suicide per year. For such a critical issue, the fact that the data is unreliable is shocking in itself.

Men in Australia are four times more likely to die by suicide than women and indigenous people are four times more likely to die by suicide than non-indigenous people. More people die from suicide than in road accidents, which is of course subject to a rolling array of state and federal public safety campaigns.

Similarly, the government and community have been convinced of the need to invest in public awareness campaigns about skin cancer, going right back to Slip Slop Slap. Skin cancer accounts for 1837 deaths a year, well below suicide.

Given the scale of the problem, it seems more than passing strange that The Canberra Times needed FOI documents for its recent report on the impact of suicide in Canberra.

Suicide is a health and social problem that demands immediate action.

Why is this not happening? Chestnuts like social and religious stigma are usually trotted out at this point to explain the community's reticence to engage in a discussion about a problem that also accounts for an estimated 180 suicide attempts per day; one every 10 minutes. It is also estimated that 249 people make a suicide plan every day.



There is in fact nothing as stigmatising as poor care. With only 13 per cent of young men receiving any care at all for their mental illness, there is surely little surprise that suicide takes such a massive toll.

Suicide is not hidden. The community knows its cost only too well. Rather, it is suppressed. Hushed inquiries and FOI requests muzzle media engagement, along with strict press guidelines on reporting designed to address the "copy cat" phenomena.

It is time to confess that this hyper-sensitive approach has got us nowhere and is allowing one of the great social and health problems facing the Australian community to grow unchecked.

People who know will tell you that one of the key markers of a person's likelihood of committing suicide is recent contact with a mental health service. Key message: stay away.

On the other hand, there is also a proportion of suicides which involve people who have never had any contact with mental health care. This is one of many paradoxes that deserve further investigation and engagement by the community.

The federal government's suicide prevention activities in Australia operate under the romantic rubric "Living is for Everyone", a program that could not be characterised as a co-ordinated national awareness campaign.

While (as usual) Australia has had successive and competing state and national suicide prevention plans, current efforts typically dole out small parcels of funding to myriad community and professional groups with minimal co-ordination and almost no evaluation. A thousand flowers wilt.

Other countries are now embarking on much more sophisticated national mental health and suicide prevention strategies. These are not advertising campaigns but multi-layered community engagement plans and programs.



New Zealand's "Like Minds Like Mine" program has been evaluated as having impact. Communities have a chance to discuss and own the problem rather than it being the subject merely of whispers.

Against this backdrop is the most recent health budget which showed that Commonwealth outlays on health have now reached \$61billion, or a 37per cent increase on 2007-08 levels. Though last year's funding for mental health was welcome, this year there is practically nothing.

Meanwhile the rate of increase to the overall health budget continues largely unabated. Mental health's share of the overall health budget is in decline.

It is time to cast off the cloak of secrecy which has surrounded suicide in Australia. The community now deserves a frank and honest discussion about suicide, its causes and some solutions.

We don't know everything and the tiny amount Australia spends on suicide prevention research is scandalous. But there is very promising data on extremely effective programs from overseas. We cannot afford to delay their introduction and evaluation here.

It's a matter of life and death.

Sebastian Rosenberg is a senior lecturer at the Brain and Mind Research Institute, University of Sydney.

<http://www.canberratimes.com.au/opinion/suicide-toll-demands-unified-and-frank-response-20120529-1zh4x.html>

7. PM eyes national bully law

Publication: Herald Sun Sunday

Author: Peter Rolfe, State politics reporter

27 May 2012



A LAW passed after the death of a Victorian teenager has inspired a national review of bullying at work. Yesterday Prime Minister Julia Gillard announced an inquiry into the practice that could see state legislation used Australia-wide.

Brodie's Law, named for waitress Brodie Panlock who committed suicide in 2006 after being bullied, will see workplace bullies jailed for up to 10 years.

Ms Gillard, who described bullying at work as, a "silent epidemic", said: "One way we could add to what we're doing is to take Brodie's law nationally and to have common national laws to deal with bullying at work."

Brodie's mother, Rae Panlock, backed the review into the nature, causes and extent of workplace bullying and consider proposals to prevent it.

"It's been a long, hard road and it's just wonderful that so many people are united in this particular cause," Ms Panlock said.

The Productivity Commission estimates the cost of workplace bullying at up to \$36 billion a year.

<http://www.heraldsun.com.au/news/more-news/pm-eyes-a-national-bullying-law/story-fn7x8me2-1226367911524>

8. PTSD therapy reaches soldiers in the field

Publication: Dayton Daily News (USA)

Author: Andrew McGinn

27 May 2012

Just days after a suicide attack in Afghanistan like the one in April that killed three Ohio Guardsmen and wounded five others, another fight begins — for a soldier's mental health.

In battlefield interviews from Afghanistan with the Dayton Daily News, two military mental health providers revealed how they're trying to get the jump on post-traumatic stress before a veteran comes home.



“There’s now a much bigger emphasis on prevention and early intervention,” said Army Capt. Donell Barnett, a clinical psychologist whose combat stress-control unit operates the Warfighter Restoration Center at Bagram Airfield near Kabul.

Still, prospects for completely warding off PTSD — an illness that may take months or even years to develop — aren’t good.

“We thought we could prevent the whole of PTSD,” Barnett said. “The consensus now is that you can’t prevent neurobiological responses, but you can prevent it from being worse than it would be otherwise.”

In other words, there’s no cure for nightmares and flashbacks — only a way to manage them. “We do lessen the severity of the situation,” Barnett said.

The lessening of anxiety begins 24 to 72 hours after a critical event — that lethal suicide attack in April, for example — when a behavioral health officer like Maj. Maria Kimble, of the Ohio Army National Guard, makes contact with the affected unit.

Kimble, of Massillon, is the only mental health provider for the roughly 1,500 deployed guardsmen of the 37th Infantry Brigade Combat Team, which lost those three soldiers, all from the Columbus area, in April. The brigade contains numerous soldiers from the Miami Valley.

As part of “traumatic event management,” Kimble first gathers everyone involved for a confidential debriefing, in part to alleviate guilt.

“They seem to be very useful in getting some closure,” said Kimble, herself a recipient of a Bronze Star. “Soldiers have always been very open with me. They always get very emotional.”

Because everybody responds to trauma differently, Kimble is a proponent of providing soldiers with self-care.



She gives soldiers journals, encourages art therapy and massage therapy, if possible, and offers a yoga workshop five days a week. “Anything I can think of,” she said. She also passes out stress balls. “Lots of stress balls,” she said.

The approach to dealing with combat stress in the post-Sept. 11 era differs from the Vietnam War, Barnett said, when mental health providers would have been posted at a major hospital.

“Once a service member is separated from their unit,” he said, “it sets them up to start questioning themselves. They’re removed from that natural support group. By keeping them closer to the fight, you don’t make them outcasts. “When it’s treated closer to the fight, we see much better improvement.”

The Warfighter Restoration Center works with referrals from every branch of service. There, troops embark on a voluntary, three-day program covering such topics as anger management and sleep hygiene, along with more personalized care, Barnett said.

The stigma of mental illness is lessening, he said, out of sheer necessity. More service members are seeking help because they’re seeing the link between personal problems and multiple deployments.

“We’ve come to a place where it’s unavoidable,” he said. “We’ve been at war for so long.”

Key to treatment at the restoration center is a therapy dog — a yellow Lab named Major Timmy. “Everybody loves to pet Major Timmy,” Barnett said, “and that sparks the conversation. That’s been hugely successful. I was sceptical of it at first until I got here. He is a rock star.”

Of the troops that complete the program — Barnett’s unit has treated more than 100 in the year they’ve operated the center — 97 percent return to duty, he said, with a 25 percent reduction in stress symptoms.



While antidepressants can be prescribed for service members while they are still in the field, he said, the preferred first step is having the service member go to a restoration center. “The concept is to give them enough of a break so they can complete the deployment successfully,” he said. His team also goes on “walkabouts” in the field, just talking to soldiers.

Kimble, of the Ohio Guard, said she unfortunately isn’t able to track what happens when a soldier returns home. She can only pass out stress balls now and hope for the best.

“As a therapist, I feel helpless,” she said. “I’m helping them, sometimes only to send them back into the same environment where they might experience even bigger trauma.”

<http://www.stripes.com/news/ptsd-therapy-reaches-soldiers-in-the-field-1.178675>

9. Campaign calls for open investigations into deaths of mental health patients

Source: The Guardian (UK)

Author: Yvonne Roberts

26 May 2012

Campaigners are fighting for investigations into the deaths of mental health hospital patients – of which there are on average one a day in England and Wales – to be independent and open to scrutiny.

The move follows an inquest into the death of Janey Antoniou, a leading mental health campaigner who had influenced many organisations including Mind, the Royal College of Psychiatry and Rethink Mental Illness.

Janey, 53, was diagnosed with schizophrenia at the age of 30. She campaigned tirelessly, acting as an advocate for those using mental health services and becoming a trainer with services such as the police. She died in 2010 in her room at Northwick Park hospital in Harrow, London.



The jury at an inquest earlier this month found that her death was inadvertent "following self-harming by use of ligature". While the jury commended staff for trying to "build sincere and trusting relationships" with her, it was highly critical of other issues, including the hospital's risk management.

An investigation was conducted by Central and North West London NHS Foundation Trust, the same trust that had responsibility for Janey's care. Its findings have not been made public. Objections made by her husband, Dr Michael Antoniou, over lack of independence were rejected by the trust. This is now the subject of judicial review proceedings.

There were 3,628 deaths in mental health detention (501 self-inflicted) between 2000 and 2010, accounting for 61% of all deaths in state custody. The proportion of deaths recorded from "natural causes" is also exceptionally high.

Antoniou's judicial review is funded by the Equality and Human Rights Commission. "Anyone detained against their will in an institution is in a very vulnerable situation," said John Wadham, the commission's general counsel. "An independent investigation would ensure that anyone culpable is identified and dealt with, and lessons are learned that could reduce the chances of other people dying."

Since 2004, deaths in police custody have been investigated by the Independent Police Complaints Commission (IPCC), while deaths in prison are investigated by the Prisons and Probation Ombudsman (PPO). In both instances the family is closely involved: a liaison officer is appointed, written updates are provided, and the investigation report and underlying documents are disclosed.

In his judicial review statement, Dr Antoniou says the trust did not keep him informed, interview him or his family, or ask for any input from him. He was told the trust would not be disclosing documents, nor did it offer any support or advice. The experience left him "dazed" and "distressed".



Paul Bowen QC, a barrister at Doughty Street Chambers who appeared for Antoniou at Janey's inquest and has acted for a number of families in similar circumstances, said: "It is plainly not possible for a trust to be, and to be seen to be, 'independent' in investigating a death which may have been caused or contributed to by failures of its own staff or systems."

An article 2 investigation must be initiated by the state, independent, effective, open to public scrutiny, reasonably prompt and involve the family. Deborah Coles, co-director of the charity INQUEST, said: "This is a blatant injustice. Too many deaths of very vulnerable people are not being properly investigated by a number of trusts. They are not being held to account. More rigorous robust and transparent investigations play a critical role in learning lessons to safeguard the lives of others."

A Department of Health spokesman said: "The coroner's inquest is the place where an independent assessment is made of the circumstances of the death of an inpatient."

<http://www.guardian.co.uk/society/2012/may/26/campaign-deaths-mental-health-patients?newsfeed=true>

10. Changes to Mental Health Diagnosis Could Impact Caregivers

Publication: The Huffington Post (USA)

Author: Leann Reynolds

27 May 2012

How mental health professionals diagnose their patients could be changing and therefore affect patients, families, and caregivers after 2013.

According to the American Psychiatric Association:

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the standard classification of mental disorders that is used by mental health professionals in the United States. It is intended to be applicable in a wide array of contexts and used by clinicians and researchers of many different orientations (e.g., biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems). The Diagnostic and Statistical Manual of Mental



Disorders, Fourth Edition (DSM-IV) has been designed for use across clinical settings (inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care), with community populations. A wide range of health and mental health professionals, including psychiatrists and other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, and counselors can use it. It is also a necessary tool for collecting and communicating accurate public health statistics.

Anticipated changes to the DSM (now commonly referred to as the DSM-5) will go into effect in May 2013 and have been generating a fair amount of controversy.

"It's complicated for family members," said Ken Duckworth, Medical Director of the National Alliance on Mental Illness. "They want to make sure people are getting help."

Changes to the DSM-5 will be the first to the manual in 17 years, and might affect everything from research and treatment to insurance coverage.

One of the more hotly-debated changes is in the autism diagnosis. The proposed changes include a recommendation for a new category called autism spectrum disorder which would incorporate several previously separate diagnoses, including autistic disorder, Asperger's disorder, childhood disintegrative disorder and pervasive developmental disorder not otherwise specified.

"For some people it may enlarge their access to treatment," said Darrel A. Regier, M.D., M.P.H. and Director for the Division of Research at the American Psychiatric Association and Vice-Chair of the DSM-5 Task Force and Director of the American Psychiatric Institute for Research and Education.

Across websites devoted to autism and in other public forums, people have been expressing fear and concern that eliminating specific autism diagnoses might eliminate access and treatment for loved ones. The goal of the proposed changes is have more accurate diagnoses -- not just of autism, but many mental disorders -- and therefore better treatments.



Considering that studies have shown that family caregivers are at a higher risk for depression than non-caregivers, it's also important to note proposed changes to how major depression is treated by clinicians.

"I think caregivers are at an increased risk for depression because of the persistent stress level they are under" said Dr. Regier.

The DSM-5 will highlight a link between depression and anxiety, a combination that can mean a patient is at an increased risk for developing a "treatment-resistant illness" and higher risk for suicide. "The DSM does not specifically have treatment guidelines," said Dr. Reiger. "It helps clinicians recognize what is clinically meaningful when prescribing a course of treatment."

To learn more about the DSM-5 proposed changes, visit the site www.dsm5.org.

http://www.huffingtonpost.com/leann-reynolds/dsm-5_b_1536244.html?view=print&comm_ref=false

11. Families need help to cope with loved one's illness

Source: thestar.com (Canada)

Author: Ian C. Dawe

28 May 2012

Mental health recovery is a journey of healing and transformation that enables a person with a mental health problem to live a meaningful life in a community of their choice while striving to achieve their full potential. Too often, however, the emotional and practical problems experienced by the relatives of people with severe mental disorders are not a major focus of attention for mental health services.

The impact of mental illness on families can be dramatic and long lasting.

More than 60 per cent of those with a first episode of major mental illness return to live with families following their hospitalization; with further hospitalizations that number only drops an additional 10 per cent to 20 per cent. In dealing with a relative with dementia, care



is provided at home by family caregivers for an average of 3.7 years before clinical assistance is even sought.

In the area of child and adolescent mental illness, we know that while family structure and economic stability are important determinants of family burden most, if not all, families deal with complicated “grief” reactions when faced with sick children. They struggle with the question of whether or not they should have done things differently. They experience profound feelings of guilt and often live in fear of stigma and the perceived disapproving views of other parents.

Whether because of a mistaken historical belief that family relationships were actually to blame for mental illness or because of laws that are designed to primarily protect the privacy of individuals living with mental health problems, family members have frequently been shut out of the treatment and recovery process. As a result, family members often feel helpless when they are denied access to information about the care and treatment of a loved one and understandably frustrated when information they want to share is ignored or dismissed.

Many studies document the real distress and burden in families: the additional caregiving demands (helping, supervising, financial aid) and loss of own activities (work, social and/or leisure roles) as well as the subjective experiences and emotional responses of the family caregiver.

In a system that is increasingly oriented to recovery and well-being, families must be helped to build on their strengths, survive their crises, meet their challenges, and enhance the quality of their lives. They need to be respected and valued for their input and perspectives. They also need help to remember that the person they love is still there — despite the illness — so that they can find joy in the person’s strengths and successes.

It is important that families not only have assistance navigating the health care system to optimally seek treatment for their loved one, but also that they have support services available to help them cope with the realities of their loved one’s illness.



Mental illness is truly a societal issue, not an individual one. It is only through building a receptive and integrated network of support and services that individuals and their loved ones will experience a real sense of recovery and genuine and realistic hope for the future.

Ian C. Dawe, MHSc, MD, FRCP, Physician-in-Chief, Ontario Shores Centre for Mental Health Sciences

<http://www.thestar.com/living/article/1193978--ian-c-dawe-families-need-help-to-cope-with-loved-one-s-illness>

12. Ending the stigma

Publication: The Fiji Times (Fiji)

Author: Avinesh Gopal

28 May 2012

MENTAL health problem is just one of the non-communicable diseases affecting some people in the country.

With the Mental Health Decree 2010 in place now, work is being done on the better treatment of mental health patients and their acceptance back into society.

Considering that it's a problem affecting some people like many other problems, The Fiji Times highlights for you today on what is being done by the authorities for those with mental health problems.

HEALTH is wealth. And there is no health without mental health, as often stated by doctors.

While many people are of sound mental health, there are a few among us with problems. These people with mental health problems are often ridiculed or laughed at by others or shunned by their relatives and friends.

However, with measures implemented by the Ministry of Health, there is now hope for better treatment for these mental health patients.

According to statistics on mental health issues in Fiji, there are 504 registered cases in the Northern Division, 2656 in the Western, 292 in the Eastern and 7285 in the Central divisions.



There were 378 admissions of mental health patients to the St Giles Hospital in Suva last year.

Of these, 24 per cent were from the greater Suva area, 23 per cent from Nasinu, 17 per cent from the west and 11 per cent from Rewa.

Eight per cent of those admitted to the hospital last year were from corrections centres, 6 per cent from Naitasiri/Tailevu, five per cent from the Northern Division, four per cent from Namosi and 2 per cent from the Eastern part of the country.

The highest or 116 of those admitted to the hospital last year were between 40 and 50 years old.

There were 12 admissions of patients below 20 years old, 114 people between 21 and 34 years, 44 between 35 and 39 years old, 79 between 51 and 64 years old and 13 were more than 65 years old.

According to the St Giles admission registry for this year, a little over 80 people admitted so far were iTaukei, followed by about 20 Fijians of Indian descent and about 15 from other races. The majority of those admitted to the hospital so far this year were men.

However, the Mental Health Decree 2010 provides a platform and makes it mandatory that a holistic approach be adopted to address mental health issues in the country.

It includes decentralising mental health services in the country, which has resulted in the opening of stress management wards in the three divisional hospitals in Suva, Lautoka and Labasa.

While commissioning the Central Community Mental Health Hub earlier this month, Health Minister Dr Neil Sharma said decentralisation had made mental health services accessible, affordable and acceptable to the people of Fiji.



- It is much more acceptable because service is provided in general hospital and the community which tends to reduce stigma which is associated with mental hospital and mental illness, he said
- The management of people with mental illness in the community allows the people to receive treatment in their own environment and the least restrictive environment possible.
- This allows them to be readily accepted by the family and the community compared to when they have to leave their home and get admitted to the hospital.

Dr Sharma said the Health Ministry was fully committed to supporting the development of the mental health services in the community and make these services readily available and acceptable to the people of Fiji.

<http://www.fijitimes.com/story.aspx?id=202437>

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

www.mhca.org.au

