MHCA – Bulletin no 2, 2012

Hello Everyone,

This week is a big week for mental health. The first meeting of the MH Commission is underway as I write. See item 1 and 2.

Chinese, Arabic, Greek and Italian mental health carers have the opportunity to complete the Mental Health Carers survey in their own language. The translated surveys are attached to this Bulletin. Please distribute to mental health carers who speak Chinese, Arabic, Greek and Italian. A much greater understanding of mental health issues related to CALD carers can be achieved by a wide and varied response, so please send the attached to your networks.

This week is also a big week for me, I am leaving the MHCA. I have enjoyed the work tremendously and would like to take this opportunity to thank all carers, consumers and workers in the field for their help and support over the last five years. Without your help, encouragement and work my job would not have been possible, so thank you for all the things you have taught me over this time. The MHCA will continue to produce the Bulletin and will sent to you on a regular basis.

Best wishes for the future,
Linda

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1 Open for Business: Australia's First National Mental Health Commission

Minister for Mental Health and Ageing , Minister for Social Inclusion , Minister Assisting the Prime, Minister on Mental Health Reform
Media Release
23 January 2012

The Minister for Mental Health and Ageing, Mark Butler, today launched Australia's first *National Mental Health Commission*. Today's launch marks a significant milestone in the rollout of the Gillard Government's mental health reforms and will give mental health the prominence it deserves at the national level. The Commission is led by the Chair, Professor Allan Fels and eight Commissioners, and will formally meet for the first time tomorrow to begin work on Australia's first National Report Card on Mental Health and Suicide Prevention. Speaking at the official launch in Sydney today, Mr Butler said, "The Commission will put Australia's mental health services under the spotlight. It will bring much needed transparency to our system – it will give us insights into service gaps, where we need to do more and where services are working and working well. "One of the Commission's first priorities will be to deliver the first annual *National Report Card on Mental Health and Suicide* Prevention – a key election commitment of the Gillard Government. This is important data that will allow us to monitor whether services are working effectively to deliver lasting outcomes for people

with mental illness." The Commission is one of the key components of the Gillard Government's $2.2 billion record mental health reform package. The Government has provided $32 million over five years for the establishment and operation of the Commission. "The new Commission will advocate for the needs of consumers and carers, which should be at the front and centre of policy making. We want to ensure these needs are given the priority they warrant by all levels of government," Professor Fels said. "Governments need to do better in mental health. We hope to help them do that by more clearly identifying the gaps in the system. "Our wide variety of relationships and our independence from the agencies that fund and deliver mental health services will give us a unique perspective from which to provide our public reports and advice."

http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr12-mb-mb003.htm

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2 Mental health gets new champion

Amy Corderoy
Sydney Morning Herald
Tue 24 Jan 2012

Allan Fels is used to caring for his daughter, who 17 years ago was diagnosed with schizophrenia. But now he will be caring for the nation's mental health as well. As the new chair of the first *National Mental Health Commission*, he will be responsible for making sure the bipartisan political support for improving mental healthcare in Australia is translated into action. The Commission, officially launched yesterday by the Minister for Health and Ageing, Mark Butler, will have its first meeting in Sydney today. Professor Fels, 70, said mental illness could devastate families. "It has been a very heavy burden on my wife especially, and on me and my other daughter," he said. "We, like many carers, are conscious of the long term problem of providing care as we age." Professor Fels, formerly an outspoken chair of the *Australian Competition and Consumer Commission*, said his experience would inform his work. "I'm very aware of what economists would call the demand side of the equation - the needs of the consumers and carers - and it's important that mental health is not just led from the supply side," he said. He will work with other prominent mental health advocates such as the executive director of the *Brain and Mind Research Institute*, Ian Hickie. But he said they could still be critical of government decisions. "The ACCC in my time was independent, it often publicly advocated change". While the advocacy will be passionate, Professor Fels said the Commission would have an equally important role as a dispassionate research and reporting body. It will also hold six meetings each year, with three in capital cities and three in rural and regional areas. Alan Rosen, who along with Professor Fels helped design the NSW mental health commission, said the national body would face challenges delivering on "a promising start". It would need to work with other mental health commissions. "The collective noun for Mental Health Commissions has not yet been coined but ... perhaps a 'hope' of commissions is apt," he wrote in an article for the journal *Australasian Psychiatry*. He said the federal body, based in Sydney with 6.5 full time staff, would need more resources, as well as the ability to force the government to deliver on promises by setting definite goals with strict time-frames.

http://m.smh.com.au/national/health/new-mental-health-chief-informed-by-experience-20120123-1qe41.html

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3 Mental health reform roadmap needs work

Alan Rosen
Croakey.com
January 19, 2012

A draft of the *Ten Year Roadmap for National Mental Health Reform* has been released for comment and can be downloaded http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-t-roadmap

The document outlines five key directions:
1. Promoting Good Mental Health and Wellbeing and Preventing Mental Illness
2. Early Detection and Intervention
3. Putting Consumers and Carers at the Heart of Services and Supports
4. Supporting People to Participate in Society
5. Making Services Work for People – Access, Quality, Integration and Coordination.

A mental health reform advocate, psychiatrist Professor Alan Rosen, who has previously written about the roadmap for Croakey readers, has concerns about both the content and processes involved. The roadmap for mental health reform: Is the Federal Government trying to make a monkey out of us?

Alan Rosen writes:
The stated aim of the draft Ten Year Roadmap for National Mental Health Reform, released this week for comment, is "to guide future action and investment across Australia over the next ten years". Among others invited to do so, I provided detailed advice to the *Department of Health and Ageing* at a full day consultation in September, and in responding at length to two previous confidential drafts. There have been marginal attempts at improvement from earlier drafts through the addition of suggested short to long-term actions and possible indicators for monitoring these. The directions are essentially sound, but there are many stated, with no prioritising or timeframe for implementation. It is an in-principle statement.

Mark Butler, our federal Mental Health Minister, is quoted as saying, reasonably, that "it outlines what we intend to do over the long term and how we'll get there". In other words, "you have to start somewhere", but the trouble is that we have started here many times before.

That's all the Federal Government seems to do in mental health. It starts over and over with in-principle documents, but with little defined action or commitment, within living memory, to deliver proven cost-effective interventions and service delivery systems that would actually change lives for the better. The core problem is that they have still arrived at so-called "action" statements without any specific numeric goals, targets or timelines for achievement of any changes to the mental health service system over 10 years or any other period. It suggests some rough ideas for possible indicators to monitor progress on these mainly uncontroversial directions ("How will we know we are doing better?" sections) again, without specifying any actual baselines, or setting any targets or achievable threshold values. This is despite having received much advice mapping out what specific goals and targets are practically achievable in this timeframe (as per my previous Croakey posts).
It is still a roadmap with only the most vague of directions, and without any specific destinations. For example, there is no specifying of the need to roll out evidence-based effective interventions so they are accessible to all who need them wherever they may live, such as skill-enhancing family interventions, crisis and assertive community treatment teams.

DoHA commissioned only one small and gestural one-day highly selective Noah's Ark style consultation of stakeholder groups in September. The current exercise with this latest draft does not appear to be a real in-depth consultation of stakeholders, but only offers a Survey Monkey forcing stakeholders into easily codified responses. Having tried to fill it out, I found that is far too self-preoccupied and focussed on appraisal of the many motherhood statements already in the so-called

roadmap, and leaves little scope for providing alternative trajectories or any other overall strategies. The Survey Monkey is so long-winded and so time-consuming, that many initially well-meaning respondents with relevant expertise may lose concentration, or may run out of steam or waking time and abandon it. Such survey tools can be misused to provide officials with a misleading and simplistic way to gain and broadcast an illusory and false impression of broad agreement with their initial premises.

This use of the Survey Monkey, like the so-called roadmap itself, essentially commits no-one in their organisations (and certainly no Australian government or minister) to actually doing anything over the next ten years. So reform stalls yet again. Same old story. I do understand the multiple pressures that DoHA labour under and how many jurisdictional interests they consider that they have to balance, which is the main reason that they recently produced such bland and non-committal products as the 2nd national mental health policy and 4th national mental health plan, and presided over the downgrading and diluting of the national mental health service standards. In many ways with this "roadmap", they have essentially repeated the same exercise. So honestly, why bother? They should never have been given this task by CoAG in the first place, and it should never have been such a rushed job. It should have been conducted at arm's length as the first substantial task of the *Australian National Mental Health Commission*, which kicks off next week.

Ten years is a fine time-span for a national reform program with real goals and achievable targets. We had time to build this up steadily by in-depth national grass roots consultation with several public drafts if necessary.

If this latest draft and its survey methodology are any indications, this 10-year roadmap has been a futile exercise and a wasted opportunity. We are all capable of doing a lot better than this. Over to you, developing mental health commissions of Australia.

PS: If you plan to complete the Survey Monkey, which closes on February 1, I suggest you first read my recent Croakey posts, *Don't rush the road map for mental health reform* *http://blogs.crikey.com.au/croakey/2011/11/29/dont-rush-the-roadmap-for-mental-health-reform/* and *Suggesting some long-term goals for mental health reform*. http://blogs.crikey.com.au/croakey/2011/12/01/suggesting-some-long-terms-goals-for-mental-health-reform/

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http://blogs.crikey.com.au/croakey/2012/01/19/mental-health-reform-roadmap-needs-work/

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4 Magic mushrooms may help with depression, say leading scientists - UK

Active ingredient could allow sufferers to relive happier times, says team including former government adviser David Nutt

A drug derived from magic mushrooms could help people with depression by enabling them to relive positive and happy moments of their lives, according to scientists including the former government drug adviser, Professor David Nutt. Two studies, for which scientists struggled to find funding because of public suspicion and political sensitivity around psychedelic drugs, have shed light on how magic mushrooms affect the brain. Nutt, from *Imperial College London*, was sacked as a government drug adviser after claiming tobacco and alcohol were more dangerous than cannabis and psychedelic drugs such as ecstasy and LSD. He believes prejudice and fear have prevented

important scientific work on psychedelic drugs. Research began in the 1950s and 60s but was stopped by the criminalisation of drugs and stringent regulations which made the work costly. "Everybody who has taken psychedelics makes the point that these can produce the most profound changes in the state of awareness and being that any of them have experienced," said Nutt. The drugs had been used for millennia, he said, since psychedelic mushrooms grew in the Elysian fields of Greece. Aldous Huxley wrote The Doors Of Perception about the insight such drugs gave him into the life of the mind.

The studies, led by Robin Carhart-Harris, also of *Imperial College*, looked at the effect that psilocybin, the active ingredient in magic mushrooms, has on the brain through the use of a magnetic resonance imaging (MRI) scanner. The first study on healthy volunteers, published in the journal Proceedings of the National Academy of Sciences (PNAS), surprised the researchers. They had assumed the drug might increase activity in certain parts of the brain. Instead, it decreased it in the "hub" regions which link different areas. "This loss of connectivity might mean consciousness is less constrained by inputs from the outside world via the senses, which could explain why people can imagine things very vividly," said Nutt. The 10 men and five women who volunteered experienced changes in visual perception, extremely vivid imaginings and changes in their perception of time and of size and space. The MRI scans showed lowered bloodflow to regions linked to the ego, the sense of self and personality.

A second study, to be published on Thursday in the British Journal of Psychiatry, gave volunteers cues to remember positive events in their lives such as their wedding or performance in a play. Their recollection became very vivid. "It was almost as if rather than imagining the memories, they were actually seeing them," said Carhart-Harris. "This could be very useful in psychotherapy, for instance in people with depression who find it very difficult to remember good times and are stuck in the negative." The team are now hoping to do a further study which will involve giving psilocybin to depressed people who are undergoing psychotherapy, in the hope that it will allow them to relive times of past happiness. The studies showed that psilocybin worked on the same areas of the brain as the SSRI antidepressants such as Prozac, as well as talking therapies and meditation as carried out by skilled practitioners. But the advantage over pills, the team believes, is that the positive effect could be long-lasting.

http://www.guardian.co.uk/society/2012/jan/23/magic-mushrooms-psilocybin-depression-drug

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5 Poverty and mental disorders: breaking the cycle in low-income and middle-income countries - UK

Abstract

Growing international evidence shows that mental ill health and poverty interact in a negative cycle in low-income and middle-income countries. However, little is known about the interventions that are needed to break this cycle. We undertook two systematic reviews to assess the effect of financial poverty alleviation interventions on mental, neurological, and substance misuse disorders and the effect of mental health interventions on individual and family or carer economic status in countries with low and middle incomes. We found that the mental health effect of poverty alleviation interventions was inconclusive, although some conditional cash transfer and asset promotion programmes had mental health benefits. By contrast, mental health interventions were associated with improved economic outcomes in all studies, although the difference was not statistically significant in every study. We recommend several areas for future research, including undertaking of high-quality intervention studies in low-income and middle-income countries, assessment of the macroeconomic consequences of scaling up of mental health care, and assessment of the effect of

redistribution and market failures in mental health. This study supports the call to scale up mental health care, not only as a public health and human rights priority, but also as a development priority.

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2811%2960754-X/abstract

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6 Legal coercion: the elephant in the recovery room - Scotland

Mary O'Hagan
Tuesday, 17 January 2012

In a specially commissioned article for SRN, international mental health leader with lived experience, Mary O'Hagan, critically challenges the use of legal coercion in a world where the recovery approach and human rights are accepted norms. In the last ten to fifteen years the recovery philosophy has become a centrepiece of mental health policy and practice models in many English speaking countries (Compagni et al, 2006). At the same time rates of compulsory interventions in many of these countries have increased (Director of Mental Health, 2006; de Sephano and Ducci, 2008; Burns and Dawson, 2009; Lawton-Smith, 2010).

The four cornerstones of a recovery approach are hope and belief in people's potential, self-determination over their lives, the choice of a broad range of services, and equal participation in their communities. Legal coercion, through mental health legislation, empowers selected mental health professionals with support from the police and the judiciary to detain people in hospital, treat them without their consent, place them in solitary confinement (seclusion), and in many jurisdictions to compel people to take treatment in the community. Legal coercion erodes all the cornerstones of the recovery philosophy, yet it remains a core response in our mental health systems.

Discrimination is the biggest single barrier to recovery and it pervades the justifications, criteria and processes involved in legal coercion in mental health. Misplaced community fears that mad people are violent and unpredictable automatons have been a major driver for mental health legislation. In most jurisdictions the legal criteria for compulsory interventions include dangerousness to self or others. There is growing concern that these criteria create double standards for justifying the loss of liberty – one for people diagnosed with mental illness and one for the rest of the population. When it comes to danger to self, critics note that general health service users have the right to refuse treatment with dangerous consequences to themselves, but mental health service users do not (Hoyer, 2008; O'Brien, 2010; Ryan, no date; Burns and Dawson, 2009). When it comes to danger to others, critics state that the criminal justice system has no power to take a person's liberty away before they have committed a crime, so why should the mental health system be given these powers (Campbell, 1994; Szmuckler, 2000; Hoyer, 2008; Ryan, no date).

Behind these double standards sit some implicit assumptions about the incapacity of people who use mental health services. Studies have shown however, that psychiatric and general hospital inpatients have similar rates of incapacity (Okai et al, 2007; MacArthur Research Network, 2001). In recent times incapacity has become an explicit criterion in some mental health legislation, and some commentators have advocated for generic incapacity legislation that would enable compulsory interventions for general health service users as well as mental health service users. Some of these advocates however, propose a different threshold for incapacity in mental health than in general health, such as not being in agreement that one has an illness and might benefit from treatment (Ryan, no date), as well as a different capacity test to capture the 'complex and subtle' loss of capacity thought to be peculiar to people with a diagnosis of mental illness (Dawson and Szmuckler, 2006). It's clear this would not resolve the problem of discrimination in the criteria, but just shift its focus.

Modern mental health laws provide more avenues for people to challenge their involuntary status, but the review processes and decisions are usually stacked against the consumer. People applying to be released from compulsory status often find these processes disempowering and weighted towards medical opinion (Topp, 2008). The success rate for people making such applications in Commonwealth mental health review tribunals is between 1% and 10% (Shah and Heginbotham, 2010; Mental Health Review Tribunal, 2010; Director of Mental Health, 2010). In some jurisdictions people may be left on compulsory orders indefinitely.

If people with a diagnosis of mental illness were subject to legal coercion under generic incapacity legislation on an equal basis with other members of the community, it is unlikely that the community would tolerate an increase in use of coercion and the unfair appeal processes for general health service users; it is far more likely that its use among mental health service users would drastically decrease and the appeal processes would become fairer.

Rates of legal coercion in mental health vary enormously over time, between jurisdictions and within jurisdictions. For instance there is a 20 fold variation in compulsory detention rates between the highest and lowest European Union countries (Zinkler and Priebe, 2002). Compulsory intervention rates have increased significantly in many Northern European countries and in New Zealand and Australia in the last 20 years (Director of Mental Health, 2006; de Sephano and Ducci, 2008; Burns and Dawson, 2009; Lawton-Smith, 2010). These variations show that the rates are driven by factors outside the criteria in the legislation, such as poor services and growing pressures to manage risk (Bindman et al, 2002; Ducci & de Stephano, 2008; Lawton-Smith, 2010). People from socially deprived groups are also more likely to be subject to legal coercion.

There is still no consensus in the evidence that compulsory community treatment improves clinical or personal recovery outcomes (Kisely, 2009), and very little research has been done on the effectiveness of compulsory inpatient detention (Hoyer, 2008). The most common compulsory intervention is antipsychotic medications. These can cause life-shortening conditions, and their introduction in the 1950s has not increased clinical recovery rates in people diagnosed with schizophrenia, according to longitudinal studies (Warner, 2004).

Compulsory interventions can cause significant physical and psychological harm but can they also save people from death and peril? Occasionally perhaps, but one commentator has calculated that it would take 85 community treatment orders to prevent one admission and 238 of them to prevent one arrest (Molodynski et al, 2010). Another has claimed that the state would need to deprive the liberty of many thousands of mental health service users to possibly prevent one homicide (Szmuckler, 2000). There is clear evidence that mental health experts' predictions of risk are unreliable.
What do the people subject to legal coercion think of it? The limited research suggests they are often ambivalent, with complaints about loss of freedom on one hand but acceptance if it on the other (Dawson, 2003; Wallsten et al, 2008; McKenna et al, 2004; Jarrett et al, 2008). Clinicians routinely use their legal coercion powers to ensure people have priority access to services when demand exceeds supply. The acceptance some service users express may be in response to getting a more reliable service. It may also echo the paradoxical Stockholm syndrome, where people experience, or at least express, gratitude to those who deprive them of their freedom.

A major 'game changer' in the area of legal coercion has been the *UN Convention on the Rights of Persons with Disabilities*, passed in 2006. Article 14.1 states that 'the existence of a disability shall in no case justify a deprivation of liberty'. United Nations officials have interpreted this to mean that legal coercion in mental health probably is not allowed under the Convention (United Nations

Human Rights Council, 2009). Member states appear to be slower in coming to this fairly obvious conclusion.

The recovery philosophy and recent developments in human rights should be rocking the foundations of legal coercion in mental health as we know it. Instead, legal coercion remains the elephant in the recovery room. All of us who support recovery and human rights need to voice our objections and develop a vision for a new regime within the following outlines. The mental health system shifts its orientation towards preventing crises rather than reacting to them. It develops services that facilitate recovery, works in collaboration with service users, and offers advance directives and choices for people in crisis. Society no longer tolerates discrimination and demands that all mental health and general health service users are treated equally when it comes to non-consenting interventions.

Society also expects that offenders with mental health problems will receive the same level of support for recovery in the criminal justice system as people do in the mental health system.

http://www.scottishrecovery.net/Latest-news/legal-coercion-the-elephant-in-the-recovery-room.html?dm_i=1DZ,NR3A,13QIWV,1X3D0,1

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7 Beating the blues

Peter Jean
Canberra times
24 Jan, 2012

Kate Carnell has no intention of replacing Jeff Kennett as the public face of beyondblue when she starts work as chief executive of the national depression and anxiety initiative at the end of March. Ms Carnell will divide her time between Canberra and Melbourne as she uses her trademark enthusiasm to lead the not-for-profit organisation into a new phase after it suffered a difficult 2011. The ACT's former Liberal chief minister said she would probably have a higher public profile than some previous beyondblue chief executives but that would not diminish the public role of founder and chairman Mr Kennett. ''That doesn't mean in any way Jeff will take a lower profile. Beyondblue wouldn't be beyondblue if it wasn't for Jeff. It was Jeff's idea,'' she said.

Ms Carnell said she had been involved in health care throughout her adult life after suffering from anorexia as a teenager. ''It [anorexia] started the process of me being obviously interested. Once you've been there you sort of know what it's like,'' she said. Ms Carnell ran several pharmacies in Canberra, was health minister and later served as chief executive of the Australian General Practice Network. She has combined her current duties as head of the Food and Grocery Council with serving as a director and deputy chair of beyondblue. Ms Carnell said her passion for mental health issues had made it hard to say no when she was approached by the beyondblue board about filling the vacant chief executive position. ''It's something I'm passionate about. It's why I'm on the board, it's why I've been involved in mental health issues for most of my life,'' she said. ''So when you're given an opportunity to be totally engrossed in something you're passionate about, it's hard to say no.''Ms Carnell said her priorities at beyondblue would include increasing its work on anxiety. ''We've got some work to do around anxiety. People don't necessarily know the difference with depression,'' she said. ''They don't understand that anxiety can be treated,'' she said.

http://www.canberratimes.com.au/news/local/news/general/beating-the-blues/2430149.aspx

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8 Family ties helping teenagers rise above anorexia

Jill Stark
Sunday Age
Sun 22 Jan 2012

An intensive in-home treatment is achieving remarkable results, writes Jill Stark. It was a battle of wills. Gripped by an illness that made every mouthful torture, Lucy Caldwell begged her parents not to make her eat. "She used to say at meals, 'It's like you're asking me to throw myself out of a plane without a parachute,"' Lucy's mother, Belinda, recalls. But the hospital had warned Belinda and her husband, Rob, to expect this. This was not their daughter. It was anorexia talking. They had to show the illness they were in control. If it took her three hours to eat, that's how long they sat there.

For six months, the Caldwells supervised their 17-year-old daughter's every meal in their Mont Albert home. There were tears, yelling and a bowl of yoghurt hurled across the room. Showers were supervised to stop her purging. Belinda slept next to Lucy, ensuring she didn't succumb to a compulsion to exercise. It was gruelling, but it worked, and this intensive, in-home therapy, known as family-based treatment, is revolutionising the way children and teens are treated. At the Royal Children's Hospital, admission rates have dropped by 56 per cent since the treatment started in 2008. Of the 83 per cent who complete the six-month program, 97 per cent fully recover.

The results have astounded the eating disorders team, who say it has ended the revolving door for patients admitted for refeeding through a nasal gastric tube, discharged for outpatient psychological therapy, only to fall ill again. Some were hospitalised 20 times a year. The average illness duration was seven years. Now, by involving the whole family, recovery in six months to a year is common. Readmission rates have dropped by 75 per cent. More than 200 patients have been through the program _ the youngest was nine. "Before, we were not really focused on cure because we saw that so infrequently for those who were very unwell. Cure is now completely expected," says Professor Susan Sawyer, director of the *Royal Children's Hospital's Centre for Adolescent Health*. "Anorexia is something that really takes over the young person's mind. Now, families talk about getting their kids back," she says.

The program is largely supported by a grant from the Baker Foundation, but its future hinges on $3 million in recurrent funding, promised by the Coalition government in the 2010 state election. A spokeswoman for Minister for Mental Health Mary Wooldridge said the Coalition had spent $400,000 on capital works for the program and it remained committed to its promise. At the core of the treatment, also known as the Maudsley approach, founded at the Maudsley Hospital in London in 1985, is removing blame from parents and patients. They are taught to externalise the illness and make anorexia the common enemy.

While still not yet considered mainstream, increasing evidence suggests it is becoming the gold standard of care. Professor Sawyer says the shift came after the hospital experienced a 300 per cent rise in admissions for eating disorders between 2004 and 2006. Unlike traditional treatment, the psychological drivers of the illness are not dealt with until the patient puts on weight. Clinical nurse consultant Stephanie Campbell says that when someone is malnourished their mind is too starved to engage in psychotherapy. "So it's all about weight restoration. It's getting the parents on board and empowering them to refeed . . . At the beginning patients will say that 80 to 90 per cent of my thoughts are about eating or food, it's all consuming. And at the end of the six months, they'll say maybe 10 per cent."

Families attend regular sessions to record weight gain and discuss how conflict at mealtimes can be resolved. Family therapist Maria Ganski says the physical consequences of the illness -including heart

problems and death in 20 per cent of cases - are stressed to give parents motivation to carry on with what is a test of love and endurance. "The parents put up with screaming, yelling, scratching, being assaulted. It's probably one of the only illnesses where they don't appreciate the help they're given because they don't want to get better," Ms Ganski said. Troy Holland, 17, said he was always skinny but "just kind of stopped eating" about 18 months ago. He said the therapy was "full on". The Sunbury teenager is now eating independently but still remembers mealtimes during the program as an ordeal. "I hated it because the amount of food I was having to eat in a week would have been the same amount that I would have eaten in three or four weeks. It was a lot of food and it was really stressful."

For Lucy, who started family therapy last February after being hospitalised when anorexia left her so weak she had a life-threatening heart-rate of 35 beats per minute, it was a hard road but she is now back at school. "Logically, I knew what they were doing was right but it was just a compulsion. It was kind of like two parents. They're telling you to do something and at the same time anorexia's telling you to do something else," she says.

Path to recovery -Traditional treatment
Largely hospital based. Inpatient admission for re-feeding through nasal gastric tube, then outpatient sessions of individual psychological therapy and group therapy with other eating disorder patients to determine the root cause of the illness. Parental involvement considered unnecessary.

Family-based treatment
Intensive in-home treatment involving the whole family that puts parents at the centre of their child's care and gives them complete control over refeeding to restore weight to healthy levels.

http://www.theage.com.au/victoria/family-ties-helping-teenagers-rise-above-anorexia-20120121-1qbcy.html

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9 Mental Health Consumer Reference Group

Expressions of Interest – Mental Health Consumer Reference Group

The Australian Government is inviting mental health consumers across Australia to express their interest in becoming a member of a *Consumer Reference Group* (CRG). The CRG will provide advice to an auspicing body to assist with the establishment of the new national mental health consumer organisation. This will include advice on: strategic directions for the consumer organisation; building an inclusive and diverse membership base; and setting up appropriate mechanisms to ensure consumers are involved throughout the process. The new national mental health consumer organisation will be supported under an auspice arrangement whereby an existing well-established non-government body will set up the infrastructure for the new organisation. It is intended the new organisation will function independently after a period of around two years. A non-government organisation to act as an initial auspicing body will be announced in the coming months.

The final report of the scoping study to inform the establishment of a new peak national mental health consumer organisation and the Australian Government's response to the report's recommendations will be important reference points for the CRG and the auspice body in establishing the new organisation. The *Department of Health and Ageing* is responsible for coordinating the national call for expression of interest (EOIs) through an on-line process and initially convening the CRG until it transfers to the auspice body. Mental health consumers interested in applying can read the CRG EOI Kit. This kit provides information that will assist with preparing your EOI and contains:

- An Overview including Roles and Position Responsibilities;
- Selection Criteria;
- How to apply, including lodgement process;
- Tips in completing this EOI;
- A checklist that covers steps you need to complete, write and submit your EOI.

Your EOI must be lodged by 4pm AEDT Monday, 20 February 2012

Return to the Department's Mental Health - Consumer and Carer partipation web page.
EOI Applicant Kit (rtf 425kb)
EOI Applicant Kit (pdf 115kb)
http://healthjobs.nga.net.au/cp/index.cfm?event=jobs.jati&returnToEvent=jobs.home&jobID=3e99b413-12a5-4c7e-8ff5-6d3dc7ebae62&audienceTypeCode=HID

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10 Stressed for success

David Wilson
Sydney Morning Herald
Sat 21 Jan 2012

Australians' long working hours are an unnecessary health hazard, writes David Wilson. Frantically busy? Stress has been called "today's essential badge of status and success". In fact, stress sparks such awe that analysts talk of "stress envy". Stress envy means the office workaholic verging on burnout could be treated as a role model. Apparently, it is impressive to be wedded to 24-hour connectivity. Apparently, it is cool to multitask like a maniac, yapping into a mobile phone while grappling with social media updates and directing the intern. Such intense displays of commitment can be seen as bragging because they show the showoff is in demand - a winner. From the stress-envy angle, only losers loaf. The heroic overachiever's idea of relaxing is pursuing a part-time MBA (Manic Busy Agitated) and skimming alpha-dog blogs about hacking your inner success geek.

"I just had the most productive week ever," wrote blogger Kaihan Krippendorff in a December 22 Fast Company post about maximising potential. Krippendorff then explained how to "rip out of the gates in 2012 on fire". "Imagine if every week were your best week ever," the go-getter urged.
In similar spirit, profiles of tycoons breathlessly highlight their type-A, high-pressure seven-day weeks and 20-hour days. "Meet Clive Palmer: busy one day, frantic the next," says a November 11 BRW magazine profile of the mining magnate billionaire.

In the quantity-over-quality climate, frantic effort is portrayed as exemplary proof of that buzzword trait, "passion". The rise of reverence for zeal marks an epic shift. Back in the tweedy age of elegantly unemployed gentlemen, prestige hinged on being above toil. Attended by servants, aristocrats took pride in bludging in an echo of the classical age. Then, slaves enabled classy Greeks and Romans to devote their "careers" to areas including philosophy and art. Now, in the quick-fire smartphone age, stress rules. One in two Australians is experiencing a level of stress that could cause illness, according to a report produced by the mental health group Lifeline. The Lifeline report, which rates work as the top national cause of stress, also says 93 per cent of Australians were stressed in 2011 - up from 90 per cent in 2010. Australia's stress levels apparently rise every year, inching towards the 100 per cent mark.

Stress has its virtues. According to the so-called "Goldilocks principle", just to stay alert and interested you need to experience some of it. Still, stress is toxic. It triggers the "fight-or-flight" response, causing cortisol to surge through your bloodstream as you perch at your desk, absorbing

the poison that impairs your immune system. After that, you become vulnerable to everything from depression to cancer. Whether stressful quantity-over-quality bustle even offers the boon of boosted productivity is doubtful. Just look at the Dutch. The Netherlands' residents are the most leisurely workers in the *Organisation for Economic Co-operation and Development*. The average Dutch worker puts in fewer than 1400 hours a year, compared with 1855 hours for Australians. Still, the Netherlands boasts low unemployment and the second-highest gross domestic product per capita in Europe. Just to underline its gift for effortless excellence, the Netherlands regularly ranks among the world's happiest countries and boasts an enviably high living standard. Hence the talk of a "Dutch miracle".

Australians, however, remain dependent on work for their identity, it seems. Tourism Australia says Australians need a holiday because they stockpile leave entitlements, further harming their health. So the next time you hear the gung-ho office hero brag about being "crazy-busy" all the time, resist the urge to feel envy. Stress is sad.

How to keep calm and carry on

Effective management of stress and excitement hinges on perception adjustment, psychologist Dr Joann Lukins says. She says we need to see that many dynamics are beyond our control. Think, for example, of the random ways in which others react to our actions. Think of that byword for unpredictability, the weather, and the global financial crisis of 2008. Still, when a challenge emerges, we have choices, Lukins says. To start with, we can dodge or change the source of stress by extending deadlines and delegating responsibilities, among other options. "Or we can accept that the stress is something we need to deal with," she says.

Then we should build resistance: eat well, exercise and enlist social support to make us resilient. Finally, we need to lighten up. "There is oodles of research supporting an optimistic outlook over a pessimistic one," Lukins says. She recalls an interview with long-distance runner Cathy Freeman, who said she was glad to get pre-race butterflies. To Freeman, butterflies meant her body was ready to race. Less-positive athletes might read them as anxiety, with career-damaging results. For more advice on coping with stress, contact the Resilience Institute, 9509 2881, resiliencei.com, or Lifeline, 13 11 14, www.stressdown.org.au

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Ongoing - Mental Health Carers Forum

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