MHCA – Bulletin no 3, 2012

Hi everyone,

Last week the team at the MHCA sadly said our goodbyes to Linda who has worked tirelessly to provide a wonderful service and support to so many carers, consumers, colleagues and service providers out there in the wide and varied world of mental health. The work that Linda has done through the Carer Engagement Project (CEP)has been so important which makes it so imperative for us to be able to find the right person to be able to fill her very large shoes (figuratively speaking of course).

In the meantime, I will make a valiant attempt to try and fill the void that Linda has left, by continuing to keep each of you abreast of the issues that I think might be important and interesting; including a mix of local and international research findings as well as any other interesting mental health related articles and stories. As background, I have been working at the MHCA in various roles for four and a half years and may well have met many of you through the various CEP, NGO or Minister's workshops that I have facilitated during that time.

Kind regards,
Rachelle

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1 Changes to Better Access

Minister for Mental Health and Ageing, Minister Assisting the Prime Minister on Mental Health Reform and Minister for Social Inclusion
Media release
1 February 2012

In the 2011-12 Budget, the Gillard Government brought in changes to the Better Access program to deliver a mental health package that better targeted and supported some of the most disadvantaged people in our community. The changes to Better Access allow us to rebalance our investments across new and innovative services that target and address mental illness throughout a person�even"s lifespan. While Better Access was neither designed nor intended to provide intensive services or ongoing therapy for people with severe and persistent mental illness, the Government acknowledges there are some people with more complex needs who have come to rely on the program for support. We recognise that reducing the number of rebatable sessions has caused some community concern and that the new services in our mental health package need to build further

capacity before they are fully able to provide care and support to those with more complex needs. We will therefore reinstate the additional 6 services under „exceptional circumstances‟ for a transitional period to 31 December 2012. The transitional period will provide sufficient time for our new mental health services to build capacity and effectively respond to people with more complex needs. The standard number of rebatable sessions under Better Access will remain at 10, consistent with the program‟s focus on people with mental disorders where short term interventions are most likely to be useful. However, this change means that eligible individuals can receive up to 16 services in the transitional period where „exceptional circumstances‟ apply. In addition, individuals will continue to be able to receive Medicare rebates for ten group therapy services per calendar year on top of their individual sessions. People with more severe and ongoing mental disorders can also be referred to Medicare subsidised consultant psychiatrist services (where 50 sessions can be provided per year), or to other specialised mental health services. Individuals will be eligible for an additional 6 allied mental health services under "exceptional circumstances" from 1 March 2012 until 31 December 2012.

http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr12-mb-mb005.htm

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2 Depression is an illness, not a life choice

Kim Lester
ABC
2 February 2012

On the few occasions that suicide is reported in the media - generally if the victim is famous or the act was committed in a particularly gruesome manner - there is one reaction that makes me want to scream.

"What a stupid thing to do."

Sure suicide is stupid, depression is stupid, and the public's understanding of mental illness is especially stupid. But a victim of suicide wasn't stupid, they just lost the battle.

No-one with a terminal illness would be called stupid for giving up the fight. For them it's a tough fight. They were brave to push on as long as they did. But depression is a private illness, the symptoms are mostly internal and many people don't like - or know how - to articulate it, so it's no wonder they don't understand why someone would take their own life.

I don't claim to know what goes through the mind of every person with a mental illness. I can only speak from my own experience, but that experience has given me an insight into why depression, if left untreated, can be fatal.

Have you ever had a nagging thought that just wouldn't go away? The harder you try to stop thinking it, the louder and more prevalent it becomes. What if that thought was an image. An image of self-harm? How would that thought make you feel? Sad? Angry? Desperate? How about relieved? Settled? Calm?

My experience of depression, which was diagnosed in 2003 during my final semester at university, manifested itself through obsessive thoughts. At first they were thoughts of self-harm. That was my way of expressing the anger and self-loathing I felt. I wanted to punish myself for what I thought I was. Or perhaps what I felt I wasn't and would never be.

It's important to note that I have lived a charmed life. My parents are happily married and now so am I. Growing up I always had a roof over my head, food in my belly, access to education, and save for the occasional overpriced skirt my mother refused to buy, I never wanted for anything. I've never experienced abuse, addiction or a major trauma. I am a straight, white woman who has never known prejudice. But I still developed depression.

I was experiencing relative success but I didn't trust it. I graduated university with distinction but as I saw it, the course was just too easy. I practically fell into my dream job, therefore I didn't believe I earned it. My colleagues were happy with my skills and progress, but I couldn't understand why. I just didn't believe I was worthy and for whatever reason the idea of harming myself offered a form of relief.

Then a colleague in another city completed suicide. It was a shock and a tragedy for everyone who knew him. I didn't know him well, but I was nonetheless affected.

After that my images of self-harm developed to images of suicide. I'm not sure why the suicide of someone I wasn't close to made me suicidal. I suppose it just made that form of self-harm a reality. I sought counselling and after several months of self-analysis I started to feel better. I began to look at my life and achievements with a more positive outlook. I believed I had recovered.

It was around this time that I moved to Canberra with my fiancé and I saw the move as an opportunity to leave my illness behind. A fresh start where no-one knew I was 'the one with depression'. I even felt ready to wean off my anti-depressants. With hindsight I can see what a bad idea that was. To think that I wouldn't be emotionally affected by a major upheaval in my life was, to return to my opening theme, pretty stupid.

Once again I found work with relative ease but in Canberra everyone seemed smarter, more cultured, and had so much more confidence than me. Once again my colleagues and employers were impressed by my abilities but I felt like a fraud.

Except this time I didn't have the support of my family and friends and I was sticking with my vow not to tell anyone in Canberra that I had depression.

Eventually I did start talking, to my colleagues, my fiancé and finally to a psychologist, and I have no doubt talking openly about my illness saved my life.

It's been about three years since I recovered and the issue of whether I should still be talking about it weighs on my mind.

It's one thing to say I suffered from depression. The illness has received a lot of publicity in recent years and people are becoming more comfortable with the term. But I'm more reluctant to say I suffered from suicidal tendencies, not because I'm ashamed, but because I worry about how uncomfortable it makes others feel.

Then I wonder, as someone who did win the battle, and desperately wants to see an end to the stigma surrounding mental illness, do I have a responsibility to be completely open about my experience? I want to say I share this story with courage and pride, that little time was spent worrying about the consequences, the stares I might get, the respect I could lose, but the irony is there is still a part of me who fears the stigma.

I believe politicians and celebrities like Andrew Robb and Jessica Rowe who have become the faces of mental health awareness are incredibly brave. I hope they have given ordinary people like me the courage to speak up as well. Not everyone has a national audience to speak to, but whether we are in the frame of mind to believe it or not, we are surrounded by people who care about us and want us to feel better.

If people could talk as openly with their friends and colleagues about their mental health as they do about their physical health, perhaps they would find it easier to talk to a doctor or a psychologist and that, at least in my experience, is the first step to recovery, and a longer, happier life.

http://www.abc.net.au/news/2012-02-02/lester-depression-experiences/3807652

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3 New diagnosis could confuse mental health care

Eleanor Hall & Emily Bourke
ABC – The World Today
30 January 2012

ELEANOR HALL: There's renewed debate over the clinical definition of depression and whether it should be extended to encompass the most severe symptoms of grief.
Mental health experts in the United States are considering bundling depression and bereavement together in the new diagnostic manual of mental disorders.
Experts here in Australia are warning that could medicalise normal human emotions as Emily Bourke reports.

EMILY BOURKE: To some the symptoms are the same but in the medical world grief and depression are regarded as very different beasts - but that might be about to change.
The American Psychiatric Association is updating its classification system known as the Diagnostic and Statistical Manual of Mental Disorders, or DSM.
Dr Allen Frances from Duke University says it's been proposed that grief and loss be considered as something much more severe.

ALLAN FRANCES: Feelings of sadness, loss of interest, loss of energy, loss of appetite, difficulty sleeping and this lasted for up to two months after losing a loved one, well that would be natural. In the new system that is being suggested after two weeks of these symptoms you get a diagnosis of major depressive disorder.

EMILY BOURKE: The idea has divided the medical profession in the United States and mental health experts here are wary.

Frank Quinlan is from the Mental Health Council of Australia.

FRANK QUINLAN: Something like 20 per cent of the population in Australia will experience some form of depression at some point in their lives. The vast majority of those people won't experience any assistance at all so it is really important that people seek help. We don't want to see all of these problems lumped into one basket. Just because somebody has a diagnosis of depression, it doesn't necessarily mean they need medication. It doesn't necessarily mean that their life is going to be completely turned upside down.

IAN HICKIE: I think the trouble is it threatens to undermine the wider credibility of clinical psychiatry when we just confuse a whole lot of different states that we already have good understanding of

how to approach those disorders and provide appropriate support.
EMILY BOURKE: Professor Ian Hickie is from the Brain and Mind Institute at Sydney University. He says even though grief can evolve into depression, changing the definitions could be a step backwards.

IAN HICKIE: Some people who have experienced a loss may go on to develop something that is more akin to a depressive illness over time and much more importantly, might become actively suicidal or might be likely to benefit from specific psychological care. And on one level I think that is what it is trying to address.

I think however at the wider level people will see it as a nonsense to mix up understandable normal mood states which are best supported by family and support and normal mechanisms from those that require any specific professional intervention.

EMILY BOURKE: He also points to differences between the American and Australian health systems when it comes to mental health care.

IAN HICKIE: In the United States what tends to happen is the applying of medical labels to a whole range of psychological states in order that you can get health care. We don't have that problem in Australia and in most other health systems.

Another characteristic of the United States is that wider use of medicines in a number of situations than elsewhere in the world and importantly in Australia with changes in the Medicare system, we now see greater access to psychological therapies which is a really good thing.

So nobody in the Australian setting will be rushing to prescribe medicines inappropriately to people who are in the middle of an acute grief state but there are situations where people are suicidal, where people are on their own, where people are developing major sets of problems where provision of appropriate psychological care may well be the best way to deal with that situation. And that would have happened using a normal grief label, it will happen in the future and I think common sense will prevail in Australia no matter what route the Americans choose to go down.
EMILY BOURKE: The DSM5 will be published next year.

ELEANOR HALL: Emily Bourke with that report.

http://www.abc.net.au/worldtoday/content/2012/s3418303.htm

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4 National Study Shows Majority Of Self-Harming Adolescents Don't Receive A Mental Health Assessment During Emergency Room Visit

Medical News Today
Nationwide Children's Hospital
1 February 2012

A national study of Medicaid data shows most young people who present to emergency departments with deliberate self-harm are discharged to the community, without receiving an emergency mental health assessment. Even more, a roughly comparable proportion of these patients receive no outpatient mental health care in the following month. These are the findings from a study conducted by researchers at Nationwide Children's Hospital that appears in the Journal of the American Academy of Child & Adolescent Psychiatry.

Deliberate self-harm is one of the most common reasons for an emergency department visit by young people in the United States. Eighty to 90 percent of young people who deliberately harm themselves meet criteria for at least one psychiatric disorder, most commonly mood disorders. The National Institute for Clinical Excellence has advised that all patients presenting to emergency departments with an episode of deliberate self-harm should receive a mental health evaluation before discharge.

"Emergency department personnel can play a unique role in suicide prevention by assessing the mental health of patients after deliberate self-harm and providing potentially life-saving referrals for outpatient mental health care," said Jeff Bridge, PhD, principal investigator in the Center for Innovation in Pediatric Practice of The Research Institute at Nationwide Children's Hospital and lead study author. "However, the coordination between emergency services for patients who deliberately harm themselves and linkage with outpatient mental health treatment is often inadequate."

In an effort to examine the quality of the emergency mental health management of young people who are discharged to the community after an act of deliberate self-harm, Dr. Bridge and colleagues examined Medicaid Extract files throughout the country for children ages 10 to 19.

They found that in this Medicaid population, most young people who presented to the emergency departments with deliberate self-harm were discharged to the community as opposed to inpatient care. Only 39 percent of all patients who are discharged to the community received a mental health assessment while in the emergency department.

Dr. Bridge says without more detailed information on whether the deliberate self-harm occurred with or without a suicidal intent it is impossible to exclude the possibility that some discharged patients are at relatively low risk, although deliberate self-harm is the main risk factor for completed suicide. The greatest risk of suicide occurs in the period immediately after an episode of deliberate self-harm.

"Our findings suggest that the decision to provide emergency mental health assessment is dictated less by the clinical characteristics of individual patients and more by staffing patterns or established emergency department evaluation protocols," said Dr. Bridge. "This study highlights the need for strategies to promote emergency department mental health assessments, strengthening the training of physicians in pediatric mental health and adolescent suicide prevention and timely transitions to outpatient mental health care."

Consistent with previous research of adult patients on Medicaid who present to emergency departments after self-harm, recent mental health treatment emerged as the most powerful predictor of follow-up outpatient mental health care. Nonetheless, only about one half of patients who had visited the emergency department for a mental-health-related reason up to 60 days before, received a mental health assessment during their self-harm incident visit. "This association and the lack of an association between emergency mental health assessment and follow up care suggest that a portion of the follow up mental health visits simply represent ongoing mental health care rather than new emergency-department-driven referrals," said Dr. Bridge.

Co-authors of the study include Steven C. Marcus, PhD, from the Philadelphia Veterans Affairs Medical Center and the University of Pennsylvania; and Mark Olfson, MD, MPH, from the New York State Psychiatric Institute and the College of Physicians and Surgeons of Columbia University.

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http://www.medicalnewstoday.com/releases/240976.php

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5 Implementation of mental health service recommendations in England and Wales and suicide rates, 1997—2006: a cross-sectional and before-and-after observational study

While et al
The Lancet
Early Online Publication
2 February 2012

Background
Research investigating which aspects of mental health service provision are most effective in prevention of suicide is scarce. We aimed to examine the uptake of key mental health service recommendations over time and to investigate the association between their implementation and suicide rates.

Methods
We did a descriptive, cross-sectional, and before-and-after analysis of national suicide data in England and Wales. We collected data for individuals who died by suicide between 1997 and 2006 who were in contact with mental health services in the 12 months before death. Data were obtained as part of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. When denominator data were missing, we used information from the Mental Health Minimum Data Set. We compared suicide rates for services implementing most of the recommendations with those implementing fewer recommendations and examined rates before and after implementation. We stratified results for level of socioeconomic deprivation and size of service provider.

Findings
The average number of recommendations implemented increased from 0·3 per service in 1998 to 7·2 in 2006. Implementation of recommendations was associated with lower suicide rates in both cross-sectional and before-and-after analyses. The provision of 24 h crisis care was associated with the biggest fall in suicide rates: from 11·44 per 10 000 patient contacts per year (95% CI 11·12—11·77) before to 9·32 (8·99—9·67) after (p<0·0001). Local policies on patients with dual diagnosis (10·55; 10·23—10·89 before *vs* 9·61; 9·18—10·05 after, p=0·0007) and multidisciplinary review after suicide (11·59; 11·31—11·88 before *vs* 10·48; 10·13—10·84 after, p<0·0001) were also associated with falling rates. Services that did not implement recommendations had little reduction in suicide. The biggest falls in suicide seemed to be in services with the most deprived catchment areas (incidence rate ratio 0·90; 95% CI 0·88—0·92) and the most patients (0·86; 0·84—0·88).

Interpretation
Our findings suggest that aspects of provision of mental health services can affect suicide rates in clinical populations. Investigation of the relation between new initiatives and suicide could help to inform future suicide prevention efforts and improve safety for patients receiving mental health care.

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61712-1/fulltext

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6 How a parent's education can affect the mental health of their offspring

McGill University
Medical News Today
29 January 2012

New research sheds light on cycle of low socioeconomic status and depression

Could depression in adulthood be tied to a parent's level of education? A new study led by Amélie Quesnel-Vallée, a medical sociologist from McGill University, suggests this is the case.

Drawing from 29 years of data from the National Longitudinal Survey of Youth 1979 (NLSY79), Quesnel-Vallée and co-author Miles Taylor, an assistant professor in the Department of Sociology at Florida State University, looked at pathways between a parent's education level and their children's education level, household income and depressive symptoms.

The team found that higher levels of parental education meant fewer mental health issues for their adult children. "However, we also found much of that association may be due to the fact that parents with more education tend to have children with more education and better paying jobs themselves," explained Quesnel-Vallée. "What this means is that the whole process of climbing up the social ladder that is rooted in a parent's education is a crucial pathway for the mental health of adult children."

These findings suggest that policies aimed at increasing educational opportunities for all, regardless of social background, may help break the intergenerational cycle of low socioeconomic status and poor mental health. "Children don't get to choose where they come from. I think we have a responsibility to address health inequalities borne out of the conditions of early childhood," said Quesnel-Vallée.

http://www.medicalnewstoday.com/releases/240852.php

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7 Atypical antipsychotic more effective than older drugs in treating childhood mania, but side effects can be serious

Geller et al.
National Institute of Mental Health
11 January 2012

The antipsychotic medication risperidone is more effective for initial treatment of mania in children diagnosed with bipolar disorder compared to other mood stabilizing medications, but it carries the potential for serious metabolic side effects, according to an NIMH-funded study published online ahead of print January 2, 2012, in the *Archives of General Psychiatry.*

Background
Childhood bipolar disorder is a relatively rare but seriously impairing condition. It is also associated with an increased risk of substance use disorders and suicide. To treat symptoms of mania, a key symptom of the disorder, medications such as mood stabilizers or antipsychotics are often prescribed. However, no prior study has addressed the question of which medication to try first.

In the Treatment of Early Age Mania (TEAM) study, Barbara Geller, M.D., of Washington University in St. Louis, and colleagues randomized 290 children ages 6-15 years diagnosed with bipolar I disorder (having mixed or manic symptoms) to treatment with lithium, divalproex sodium or risperidone for an 8-week trial. None of the children had taken an anti-manic medication before. Lithium has been used to treat bipolar disorder for many years. Divalproex sodium is an anticonvulsant mood stabilizer commonly prescribed to treat bipolar disorder as well. Risperidone is an atypical antipsychotic that has been approved by the U.S. Food and Drug Administration for the treatment of mania in youth age 10 and older.

Results of the Study
After eight weeks, 68.5 percent of the children taking risperidone showed improvement in manic symptoms, compared to 35.6 percent of those taking lithium and 24 percent of those taking divalproex sodium. Overall, 24.7 percent discontinued the trial, but more children taking lithium—32.2 percent—discontinued the trial compared to those taking risperidone (15.7 percent discontinued) or divalproex sodium (26 percent discontinued.)

However, those taking risperidone also gained more weight than those on the other medications—an average of more than 7 lbs compared to around 3 lbs for those taking lithium and 3.7 lbs for those taking divalproex sodium. Those taking risperidone were also more likely to experience other metabolic side effects, such as an increase in cholesterol levels, compared to those on the other medications.

Significance
The researchers concluded that risperidone was significantly more effective than lithium or divalproex sodium for initial treatment of childhood mania. In addition, the children were less likely to discontinue the drug compared to those taking lithium or divalproex sodium, indicating a higher tolerance for it. This finding is consistent with other studies that have compared second-generation antipsychotics like risperidone to placebo in treating childhood mania.

However, the researchers caution that risperidone is associated with adverse metabolic effects that can increase the risk for diabetes and cardiovascular problems. They note that many children responded to low doses of the medication, suggesting that clinicians should be conservative when determining how to dose the medication. A lower dose may minimize the potential for serious side effects. The researchers also caution that because diagnostic measures for childhood bipolar disorder are not always consistent across studies, and because the validity of such a diagnosis in younger children is under debate, TEAM findings may not generalize to patients diagnosed using other measures.

http://www.nimh.nih.gov/science-news/2012/atypical-antipsychotic-more-effective-than-older-drugs-in-treating-childhood-mania-but-side-effects-can-be-serious.shtml

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8 Naturally produced protein could boost brain repair

Hannah Isom
Medical Research Council
10 January 2012

Scientists from the Medical Research Council (MRC) have discovered that a protein produced by blood vessels in the brain could be used to help the brain repair itself after injury or disease.
The protein, called Betacellulin (BTC), was found to boost brain regeneration in mice by stimulating the organ's stem cells to multiply and form new nerve cells. The findings, published in the journal PNAS, suggest that BTC could enhance future regenerative therapies for conditions such as stroke, traumatic brain injury and dementia.

Although most nerve cells (neurons) in the adult brain are formed in the womb and soon after birth, new neurons continue to be generated throughout life by stem cells. These neural stem cells are housed in two small 'niches' of the brain and supply new neurons to the olfactory bulb, responsible for our sense of smell, and the hippocampus, which is involved in forming memories and learning.

The niches produce a range of signals that control how fast the stem cells divide and the type of cell they become. Stem cells in these areas normally produce neurons, but in response to a brain injury such as stroke they tend to produce more so-called glial cells, leading to the formation of scar tissue. Dr Robin Lovell-Badge from the MRC's National Institute for Medical Research (NIMR), who led the research, said:

"The stem cell niches in the brain are not fully understood, but it appears that many factors act in concert to control the fate of the stem cells. We believe these factors are finely balanced to control precisely the numbers of new neurons that are made to match demand in a variety of normal circumstances.

"But in trauma or disease, the stem cells either can't cope with the increased demand, or they prioritise damage control at the expense of long-term repair. We hope that our new findings can add to the arsenal of exciting approaches coming out of stem cell biology that might eventually lead to better treatments for damaged brains."

The researchers studied the effects of BTC, which is produced by cells in the blood vessels within the stem cell niches, on the rate of neuron formation in mice. They found that BTC signals to both the stem cells and to dividing cells called neuroblasts, triggering their proliferation.
When extra Betacellulin was given to the mice, there was a significant increase in both stem cells and neuroblasts in their brains, leading to the formation of many new neurons. In contrast, when mice were given an antibody that blocks BTC activity the production of new neurons was suppressed.

As BTC leads to the production of new neurons, rather than glial cells, this protein could improve the effectiveness of regenerative medicine treatments aimed at repairing damage to the brain.
Professor Jim Smith, Director of the NIMR, said:

"Regenerative medicine has the potential to unlock new treatments for many human diseases that currently have no effective cures. This study is an important step towards our goal of moving beyond the replacement of tissues and organs to the exploitation of the intrinsic repair and regenerative potential of the human body."

This work is still far from the clinic as further experiments are needed to explain the normal role of BTC in the brain and to explore in animals the effects of BTC on damaged brains alone, or together with transplanted neural stem cells.

http://www.mrc.ac.uk/Newspublications/News/MRC008417

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9 Emergency Management Trauma and Resilience

Victorian Council of Social Service
Insight – Issue 5
December 2011

Few of us who live in Victoria will forget the summer of 2008-09 which began with its terrible toll in heatwave deaths and culminated in the tragedy of the 2009 Victorian Bushfires. Not quite two years later came the floods of 2010-11 – their death toll, thankfully, was far less but they traumatised many new communities and some that were still recovering from bushfires and the slow ache of enduring drought.

The community sector has played, of course, a pivotal role in response and recovery in each of these emergency events. It also came under extreme pressure to step up to new demands in very short timeframes while still maintaining long-standing services and supports, to manage new or competing funding and administrative arrangements, and to look after its own staff – many of whom were not just dealing with the trauma of others, but experiencing it themselves.

Many of our traditional communities, already vulnerable, faced new challenges and trauma from these disastrous events, and people who had never dealt with a counsellor or community sector agency in their lives suddenly found themselves in need. That those who had lived through other disasters were re-traumatised only underscored the complexity and long-term impact of such events.

The impact has also, of course, been greatest in rural and regional areas of Victoria, which already face major social, economic and climatic challenges and include some of the most disadvantaged communities in the state. The Victorian Council of Social Service has sought to draw out the lessons and challenges for the community sector from these events, to look at where the risk falls most heavily. This edition of *Insight* is part of that focus, aiming to highlight what works and what doesn't as the State Government begins to reshape its emergency management arrangements and as we mark new anniversaries of these recent disasters.

We feature insights from Ruth Wraith, who has led psychosocial care particularly for children and young people in so many major disasters since the 1983 Ash Wednesday fires; Penelope Hawe from the University of Calgary, who was invited by the Department of Human Services soon after the 2009 Bushfires to explore the scope for community recovery; Deputy Premier and Emergency Minister Peter Ryan, who had barely set up his office before he had to deal with the new emergencies; and journalist and academic Denis Muller on a timely investigation into the role and impact of the media in a disaster.

We canvass the views of many community sector leaders about what they did and learnt in a range of disasters; explore where philanthropy can do things that government can't; look at what sorts of programs work; and reflect on how other emergencies – like the everyday and ongoing crises experienced by people who are homeless – don't attract the same responses and resources.
Finally, because summer is also about taking time out and putting our heads in a different space, we return in this edition with more *Insight* Fiction, featuring the work of award-winning young Melbourne author Tom Cho.

http://vcoss.org.au/documents/VCOSS%20docs/insight/VCOSS_Insight05.pdf

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10 Mental health patients release second album of uplifting music

CTV News Montreal
30 November 2011

MONTREAL — From blues to gospel to soul to Christmas Carols, music is about making people feel. And who better to sing about feelings than people in therapy?

That was the thought process behind the creationof Le Groupe MusiArt, a choir of mental health patients who performed Tuesday night in support of a new album.

Formed 13 years ago by outpatients at the MUHC Dept. of Psychiatry, the choir helped pull Elinor Cohen from a dark place.

"I just feel that when I sing with everybody it's like a family and I forget all my problems," said Cohen. "When I sing, I don't have to think of anything that makes me sad."

The songs on the group's second album of original music, Perception, reflect feelings about relationships, pain, and recovery.

Choir director and psychologist Dr. Marie-France Boudreault says the power of the choir extends well beyond the aural impression of the ten tracks.

"It brings a sense of accomplishment, it brings self esteem," said Boudreault. "It's good for thinking, it's good for being together."

The group has toured France and the Maritimes, and spent the past three years working on their latest recording.

MusiArt has always wanted to entertain an audience, but members hope those who hear their music also come away with a better understanding of mental health issues.
"People in the communities will see that even if you have had difficulties and you've had some mental health issues doesn't mean that you cannot be productive and that you cannot be creative," said Boudreault.

As Cohen said, "singing just lifts me up."

http://montreal.ctv.ca/servlet/an/local/CTVNews/20111130/mtl_song_111130/20111130/?hub=MontrealHome

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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

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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 rachelle.irving@mhca.org.au Rachelle Irving, Deputy CEO, Mental Health Council of Australia
Tel (02) 6285 3100
www.mhca.org.au

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