MHCA – Bulletin no 4, 2012

Hi everyone,

Well, it's been a week since Linda left and I managed to get my first Bulletin out a day late, although hopefully I have redeemed myself by getting this one to you a day early. I'm on leave tomorrow for a few days from tomorrow, so I figured better sooner than later.

I have to say that I am quite enjoying compiling these articles for you each week as it allows me to spend some time to keep abreast of what is happening in the sector, both locally and internationally. In my review this week, I discovered a couple of interesting pieces that are a little bit older, but I thought you might find them interesting. On that note, I try to ensure that I'm not replicating any articles or research that Linda might have presented to you previously, so apologies if that happens occasionally.

There wasn't a huge amount reported locally this week, so you will see much of what I have included is international, although I have provided a link to a consumer/carer brochure which simply explains the reason that measurements are important in mental health – it is quite a useful resource. I have also included a link to some free mental health event promotion through the Australian and New Zealand Mental Health Association.

Where I have provided links to research findings, don't be put off by the often scientifically jargoned titles, the actual content is generally easy to understand and pretty cutting edge in terms of the latest developments in mental health research.

Kind regards,

Rachelle

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1 Mental health policy 'fails to show results'

Adam Cresswell
The Australian
31 January 2012

National attempts to improve mental healthcare have been challenged by a trio of health experts.

The three experts claim it is unclear whether patients have benefited from the $8 billion in new money allocated to improving the sector by state and federal leaders since 2006.

In a scathing critique of current policy, the three experts say mental health's share of the overall health budget is shrinking instead of rising. This is the reverse of the outcome sought by peak mental health organisations, which have long argued that the mental health share of the budget -- now 5 per cent -- should better reflect the 13 per cent share of the overall disease burden caused by mental illnesses.

The experts say a lack of centralised definitions and control means the current initiatives appear to be being dissipated in a "patchwork of jurisdictional investments, rather than a co-ordinated national effort to address the agreed priorities".

The three experts -- Sebastian Rosenberg, a senior lecturer at the University of Sydney's Brain and Mind Research Institute; John Mendoza, former chairman of the National Advisory Council on Mental Health; and Lesley Russell, a former adviser to Julia Gillard when she was shadow health minister -- make their arguments in an article published online yesterday by the Medical Journal of Australia.

They say there is no clear reason why Western Australia should dedicate to promotion, prevention and early intervention nearly a quarter of the $483.9 million it was allocated by the Council of Australian Governments under the 2006-2011 National Action Plan on mental health, when Queensland spent "almost nothing" on the same activity. "Similarly, WA spent four times as much as South Australia on Action Area 3 (participation in the community and employment), and the ACT allocated 20 per cent of its effort to workforce development, to which Victoria committed less than 1 per cent," they wrote.

Mr Rosenberg told *The Australian* that despite the billions poured into mental health by successive state and federal governments, and despite the $2.2bn allocated in the most recent federal budget, there was "a dearth of information about outcomes for people with a mental illness".

A spokeswoman for Mental Health and Ageing Minister Mark Butler said spending on mental health-related services had increased by an average of 4.8 per cent per Australian between 2004-05 and 2008-09, and the $2.2bn package was "the single largest investment in mental health in the nation's history".

Mr Butler helped to launch a report on people with psychotic illness late last year, which found significant improvements in their health and wellbeing, including a one-third fall in voluntary hospital admissions for mental health reasons over the past 12 years.

Allan Fels, chairman of the National Mental Health Commission, said Mr Rosenberg and co-authors had written "a very sensible article" and the lack of data and accountability were "a key reason" why the commission was established. "We are particularly interested in providing information about what's working well in the system, and what's not working," Professor Fels said.

http://www.theaustralian.com.au/news/health-science/mental-health-policy-fails-to-show-results/story-e6frg8y6-1226257718847

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2 How do we measure change in mental health?

Brochure: How do we measure change in mental health?

Australian Mental Health Outcomes Classification Network

The Australian Mental Health Outcomes Classification Network (AMHOCN) and the Royal Australian and New Zealand College of Psychiatrists recently collaborated on the development of a consumer focussed brochure to explain outcome measurement and how it is used in mental health services in Australia.

As background, AMHOCN was established by the Australian Government in December 2003 to provide leadership to the mental health sector to support the sustainable implementation of the outcomes and casemix collection as part of routine clinical practice. AMHOCN aims to support states and territories and to work collaboratively with the mental health sector to achieve the vision of the introduction of outcomes and casemix measures. As such, many of you would not have heard of AMHOCN, but the brochure that they have jointly developed may be quite useful to consumers, carers and service providers who understandably struggle to understand how questionnaires might fit into the bigger picture of mental health care.

The brochure has been prepared for consumers and carers to help them better understand what is involved and why a health professional may ask you to fill out a form about the service/s that you receive. It aims to simplify and explain what 'outcome measures' are as well as hopefully answering some questions that a consumer or carer might have.

I'm not sure how widely this document has been circulated so I thought it might be a useful resource to many of you. If by chance you cannot download this document (as it is in PDF), please contact AMHOCN by email (info@amhocn.org) or telephone (02 9840 3833). Failing this, please drop me an email and I'll print a copy and post it out to you.

http://amhocn.org/static/files/assets/35eebd75/OMP_Resource_-final_doc.PDF

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3 Integrating tobacco cessation into mental health care for posttraumatic stress disorder

McFall et al
The Journal of the American Medical Association
2010 Volume 304(22) pages 2485-2493

Context - Most smokers with mental illness do not receive tobacco cessation treatment.

Objective - To determine whether integrating smoking cessation treatment into mental health care for veterans with posttraumatic stress disorder (PTSD) improves long-term smoking abstinence rates.

Design, setting, and patients - A randomized controlled trial of 943 smokers with military-related PTSD who were recruited from outpatient PTSD clinics at 10 Veterans Affairs medical centers and followed up for 18 to 48 months between November 2004 and July 2009.

Intervention Smoking cessation treatment integrated within mental health care for PTSD delivered by mental health clinicians (integrated care [IC]) vs referral to Veterans Affairs smoking cessation clinics (SCC). Patients received smoking cessation treatment within 3 months of study enrollment.

Main Outcome Measures - Smoking outcomes included 12-month bioverified prolonged abstinence (primary outcome) and 7- and 30-day point prevalence abstinence assessed at 3-month intervals. Amount of smoking cessation medications and counseling sessions delivered were tested as mediators of outcome. Posttraumatic stress disorder and depression were repeatedly

assessed using the PTSD Checklist and Patient Health Questionnaire 9, respectively, to determine if IC participation or quitting smoking worsened psychiatric status.

Results - Integrated care was better than SCC on prolonged abstinence (8.9% vs 4.5%; adjusted odds ratio, 2.26; 95% confidence interval [CI], 1.30-3.91; *P* = .004). Differences between IC vs SCC were largest at 6 months for 7-day point prevalence abstinence (78/472 [16.5%] vs 34/471 [7.2%], *P* < .001) and remained significant at 18 months (86/472 [18.2%] vs 51/471 [10.8%], *P* < .001). Number of counseling sessions received and days of cessation medication used explained 39.1% of the treatment effect. Between baseline and 18 months, psychiatric status did not differ between treatment conditions. Posttraumatic stress disorder symptoms for quitters and nonquitters improved. Nonquitters worsened slightly on the Patient Health Questionnaire 9 relative to quitters (differences ranged between 0.4 and 2.1, *P* = .03), whose scores did not change over time.

Conclusion - Among smokers with military-related PTSD, integrating smoking cessation treatment into mental health care compared with referral to specialized cessation treatment resulted in greater prolonged abstinence.

Nicotine dependence inflicts a disproportionate toll on individuals with mental illness, adversely affecting quality and length of life. Posttraumatic stress disorder (PTSD), a prevalent mental disorder, is highly associated with smoking (45%) and unsuccessful quit attempts. Individuals with PTSD smoke more heavily than smokers without PTSD and use tobacco to regulate mood and psychiatric symptoms. Tobacco dependence likely contributes to the high mortality, morbidity, and health care costs of persons with PTSD.

Limited access to tobacco cessation treatment is a barrier to quitting smoking in many health care settings. Smokers are infrequently referred to specialized tobacco cessation clinics, and those referred often fail to attend or drop out prematurely. Although primary care clinicians screen for tobacco use, they usually do not provide treatment to aid quitting. Psychiatrists deliver cessation counseling to patients who smoke at only 12% of visits. In the US Department of Veterans Affairs (VA), which enrolls more than 1.5 million veterans with mental illness, including more than 400 000 with PTSD, the majority of smokers reported not receiving tobacco cessation treatment during the previous year. An effective service delivery approach is needed to improve access to tobacco cessation treatment for patients with PTSD and other psychiatric illnesses.

Nicotine dependence is a chronic, relapsing addiction that responds best to intensive treatment extended over time. Mental health clinicians are well positioned to deliver intensive cessation treatment to smokers undergoing psychiatric care for PTSD owing to frequent visits attended by these patients. Integrating tobacco cessation into psychiatric care allows for monitoring of smoking status and reapplying cessation treatment to relapsers. Integrated cessation interventions also can address exacerbation of smoking by psychiatric symptoms, severe withdrawal symptoms experienced by smokers with mental illness, and possible deterioration in mood following quit attempts. Integrating treatment of substance use and other psychiatric disorders in a single clinical setting has been widely advocated but only preliminarily studied as an effective service delivery approach.

Our multisite randomized controlled effectiveness trial hypothesized that integrating smoking cessation treatment into mental health care would improve long-term smoking abstinence rates in veterans with PTSD compared with referral for specialized cessation treatment. Smoking cessation treatment sessions and use of tobacco cessation medications were examined as mediators of treatment effects. We also evaluated whether psychiatric symptoms worsened from participating in integrated smoking cessation treatment or stopping smoking.

http://jama.ama-assn.org/content/304/22/2485.full?sid=c1fb1caf-34c8-418d-ab28-872e0e74ece1

4 Free mental health training & event promotion

Australian and New Zealand Mental Health Association

I just came across this article with the Australian and New Zealand Mental Health Association. I know that some of our subscribers are part of NGOs that might be hosting various mental health training and this might be one avenue for you to be able to promote your event:

If you conduct any training or educational seminars in the mental health sector, the Australian and New Zealand Mental Health Association can promote them for you (at no charge) to our members and the 6000 people who visit our site each month.

We have launched an online education database, where you can enter the details of your Seminar or Workshop. It can link to your website, registration page and email address.

Further details about registering to promote your event or to look at what the ANZMHA does more generally can be found here: http://anzmh.asn.au/

5 5 innovative ways mental health care is more accessible

Miranda Scotland
CTV News
7 February 2012

The mental health community is working to make treatment more accessible to Canadians through technology, art and changes in care.

Currently, only one-third of Canadians who need mental health services actually receive them, according to a survey done by Statistics Canada. Stigma and lack of nearby treatment centres often keep those with mental illness from getting the help they need.

Just 50 per cent of Canadians would tell friends that they have a family member with mental illness while 72 per cent would discuss diagnoses of cancer, according to a Canadian Medical Association report.

Still every Canadian at some point in their life will know someone with a mental illness, whether it be a friend, family member or colleague.

So through YouTube videos, cellphone apps, art and building redevelopments the mental health community seeks to encourage more to be open about mental health and get help.
Here are five innovative efforts making mental health treatment is more accessible to Canadians:

Louis H. Lafontaine Hospital

A filmmaker has released a series of YouTube videos that follow two mental health patients from their arrival at Lafontaine hospital until they are reintegrated into the community. The six episodes of 'Key 56' introduce Sebastien, who has schizophrenia, and Michele, who suffers from bipolar affective disorder. The patients struggle with being involuntarily confined, finding housing and handling mental health relapses.

Royal Ottawa Health Care Group

For Canadians in rural areas accessing specialized health services often means travelling for hours by car or even by plane. But the Royal, a specialized mental health centre, is helping to alleviate this stress through modern technology and telecommunications. Telepsychiatry allows Royal physicians to connect with their patients face-to-face, no matter where the person is, using live video consultations. Physicians in outlying communities can also use the technology to do video consultations with mental health professionals. Telepsychiatry allows Royal staff members to reach out to a wider number of people and provide help to patients who otherwise may not have received treatment.

Apps

Suffering from mental illness? There's an app for that, several in fact. Patients can now use a smart phone, iPad or iPod to learn about mental illnesses, evaluate their mental wellness and track their mood. For instance, the American made app Stop Panic & Anxiety Self-help comes with audio to coach the user through panic attacks, articles on cognitive-behavioural therapy, emotional training exercises and relaxing sounds. Another app called Mental Illness provides information on anxiety, schizophrenia, dementia and many other illnesses. Nonetheless, none of these apps can replace traditional therapy.

Building Redevelopments

Some of Canada's mental health hospitals are moving away from older models of care and redeveloping their sites to reflect those changes. In Toronto for instance the Centre for Addiction and Mental Health (CAMH) is integrating into the neighborhood around it. By making the hospital a part of the community the centre hopes to reduce stigma and discrimination against those with mental illness. The change is part of CAMH's plan to part from the traditional model of care, which keeps patients isolated from the outside world, and focus instead on integrating the patient back into the community. Meanwhile, in British Columbia health authorities are closing Riverview mental hospital so smaller practices can be created across the province. By decentralizing care they are hoping to make it easier for individuals to access treatment facilities.

Aboriginal Youth Comic

The Healthy Aboriginal Network produces a series of comics that address health and social issues including addiction and mental illness. The network is one of the many programs partnering with Opening Minds, an initiative to reduce stigma and discrimination associated with mental illness. One of the comics, called Just a Story, follows two siblings as they struggle with family issues that affect their mental health. Wendy suffers from generalized anxiety disorder and Adam has anger issues. Luckily Wendy's teacher recognizes something is wrong and encourages her to see the school counselor. Wendy then inspires her brother to get help too.

For more information about the above mentioned innovations contained in this story, click on this link: http://www.ctv.ca/CTVNews/Health/20120207/5-psychiatric-care-innovations-120207/

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6 County unveils bold health plan for poor - public, private agencies collaborate on integrated care system, one of first of its kind

Joe Goldeen
Recordnet.com staff writer
7 February 2012

Imagine a health care system that provides you with medical attention when you need it, superior treatment and seamless coordination between your primary care doctor and a specialist?

It already exists.

But for thousands of chronically sick, disenfranchised poor San Joaquin County residents the concept is nothing but a pipe dream.

Until now.

Four public and private agencies that work with the same underserved populations have embarked on an ambitious collaboration to provide an integrated system of primary care, mental health, specialty care, clinical and community preventive services and support for disease self-management. At the same time, members of this safety-net partnership expect to see long-term cost savings and healthier outcomes for the ethnically diverse population they serve.

Their strong collaboration has earned the county group $1 million in grant funding to move forward with its plans.

"They have come to the table ready to find creative solutions. Kudos to San Joaquin," said Peter Long, president and CEO of the Blue Shield of California Foundation that provided a $500,000 grant toward one of two major projects initiated by the partnership.

The partnership members include Community Medical Centers, Health Plan of San Joaquin, San Joaquin County Behavioral Health Services and San Joaquin General Hospital.

The Blue Shield Foundation grant will help fund - along with a $748,000 commitment from the partners - a safety net Health Information Exchange system that is expected to go live by Oct. 31.

By the end of the year, physicians at the health clinics, hospital and behavioral health sites expect to be able to coordinate care for patients receiving both psychiatric and primary care services. The Health Information Exchange will allow them to access joint-care plans and exchange progress notes and other documents.

According to Long, San Joaquin County's grant proposal was one of just two out of 26 submitted statewide that was funded. Los Angeles County received the other.

"We think this is a very big deal. San Joaquin's proposal to have an integrated information system for their low-income population is the most innovative and is really transformational. If they can pull this off, identify a person across the system, it is going to be very powerful. It is one of the boldest projects we've seen. It is exactly what we want to fund as a health funder," Long said.

The partnership received a second grant of $500,000 from the Community Clinics Initiative, a collaboration between Tides Foundation and The California Endowment to help fund - along with $220,000 from San Joaquin General and Health Plan of San Joaquin - the Health Home Innovation project.

Initially, the emphasis will be on poor patients who visit four targeted safety net clinics in the county and have been identified as having a specific chronic disease and a mental-health disorder.

"We chose the combination of diabetes and depression to focus on and show some improvements," said Dr. Paul Mascovich, Behavioral Health Services' medical director.

Through a combination of new technology and staff coaching at the four clinics to integrate the patient's primary and mental health care, the goal will be to improve the quality of that care and prevent the targeted patients from requiring emergency care or hospitalization. Patient data will be shared openly among all participating clinic sites.

"The staff will work in teams at the clinics to improve the health of the entire population. Each patient will have a personal physician in the clinic, who will work with a nurse, a social worker, a mental-health provider, health educators and community educators. They will support chronic care self-management, which has proven to be very effective," said Dr. Dale Bishop, medical director with Health Plan of San Joaquin.

Bishop said that the new Health Information Exchange "will make the Health Home more effective. We are working on quality and payment reform, because building Health Homes isn't free." Health Plan is working on a payment system to reimburse providers for the costs they incur to implement Health Homes, he said.

"Savings have been shown from other systems around the country. It's called medical cost offset. We're hoping to show the same thing," Mascovich said.

The assumption is that some patients use less medical care if they are able to get mental-health services. That decrease in cost of medical care may be greater than the cost of mental-health services.

Jane Stafford, Community Clinics Initiative managing director for Tides Foundation that co-funded the grant, said San Joaquin's "was one of the strongest proposals we have seen. Certainly, I think, it was in part the power of these folks coming together. I think there was something about their energy that produced a really compelling proposal about how they prepare to serve the population in San Joaquin County."

Stafford, who is based in San Francisco, toured some clinic sites in the county and walked away humbled.

"The physicians and staff we engaged with in this process really listen to the stories of the kind of care they are providing. With this infusion of funds, the direction is really up. I'm hopeful about what will follow," she said.

http://www.recordnet.com/apps/pbcs.dll/article?AID=/20120207/A_NEWS/202070322

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7 Hope for those with a depressive disposition

Rachel Maddux
Lund University, Sweden
Science Daily
27 January 2012

Good news for the 13 per cent of the population with depressive personality traits: their negative outlook does not have to be permanent. This has been shown by psychologist Rachel Maddux in new research from Lund University in Sweden.

Depression is a serious and sometimes devastating health problem which affects millions of people worldwide. In her previous work with depressed patients, Rachel Maddux often felt frustrated that treatments were not helpful for all of those diagnosed with depression. The main focus of her thesis therefore asked the question: why is it that some people are helped but others are not?

Her hypothesis was that those with depressive personality traits -- chronic melancholics -- are more difficult to treat, especially when they suffer from depression. These people generally feel down and worried, have low self-esteem and are dissatisfied with their lives and environment.

Rachel Maddux found that 13 per cent of residents in Lund have these personality traits.

"This is a very large number, but the results are in line with other studies carried out in the US and Canada."

The next study looked at how many of those who seek help from a psychologist have depressive personality traits -- a large portion, 44 per cent. These people were more seriously ill than other patients when they sought specialist help, according to Rachel Maddux.

Contrary to what she had believed, psychotherapy -- both cognitive-behavioural and psychodynamic therapy -- helped the depressive personality types as much as those without the disposition.

"The interesting thing was that therapy not only improved the depression itself, it also ameliorated the pervasive depressive traits," says Rachel Maddux.

She cannot say whether the effect is maintained over time. However, she thinks the study indicates that therapy is good for people with this characteristic manner of depressive thinking and behaviour, even if they are not suffering from acute depression.

The main issue for Rachel Maddux's research still remains: why aren't all those diagnosed with depression helped by the treatment they receive? Why do antidepressants or talk therapy work for some but not others?

"But now I know that there is hope for those with depressive personality," says Rachel Maddux. "The next step will be to study other factors that could affect the outcome of treatment; biology, childhood and development, trauma, etc."

http://www.sciencedaily.com/releases/2012/01/120127140011.htm

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8 Assessment of a multi-assay, serum-based biological diagnostic test for major depressive disorder: a Pilot and Replication Study

Papakostas et al
Molecular Psychiatry 2011
Science Daily
1 February 2012

The initial assessment of a blood test to help diagnose major depressive disorder indicates it may become a useful clinical tool. In a paper published in the journal *Molecular Psychiatry*, a team including Massachusetts General Hospital (MGH) researchers reports that a test analyzing levels of nine biomarkers accurately distinguished patients diagnosed with depression from control participants without significant false-positive results.

"Traditionally, diagnosis of major depression and other mental disorders has been made based on patients' reported symptoms, but the accuracy of that process varies a great deal, often depending on the experience and resources of the clinician conducting the assessment," says George Papakostas, MD, of the MGH Department of Psychiatry, lead and corresponding author of the report. "Adding an objective biological test could improve diagnostic accuracy and may also help us track individual patients' response to treatment."

The study authors note that previous efforts to develop tests based on a single blood or urinary biomarker did not produce results of sufficient sensitivity, the ability to detect the tested-for condition, or specificity, the ability to rule out that condition. "The biology of depression suggests that a highly complex series of interactions exists between the brain and biomarkers in the peripheral circulation," says study co-author John Bilello, PhD, chief scientific officer of Ridge Diagnostics, which sponsored the current study. "Given the complexity and variability of these types of disorders and the associated biomarkers in an individual, it is easy to understand why approaches measuring a single factor would not have sufficient clinical utility."

The test developed by Ridge Diagnostics measures levels of nine biomarkers associated with factors such as inflammation, the development and maintenance of neurons, and the interaction between brain structures involved with stress response and other key functions. Those measurements are combined using a specific formula to produce a figure called the MDDScore -- a number from 1 to 100 indicating the percentage likelihood that the individual has major depression. In clinical use the MDDScore would range from 1 to 10.

The initial pilot phase of the study enrolled 36 adults who had been diagnosed with major depression at the MGH, Vanderbilt University or Cambridge Health Alliance in Cambridge, Mass., along with 43 control participants from St. Elizabeth's Hospital in Brighton, Mass. MDDScores for 33 of the 36 patients indicated the presence of depression, while only 8 of the 43 controls had a positive test result. The average score for patients was 85, while the average for controls was 33. A second replication phase enrolled an additional 34 patients from the MGH and Vanderbilt, 31 of whom had a positive MDDScore result. Combining both groups indicated that the test could accurately diagnose major depression with a sensitivity of about 90 percent and a specificity of 80 percent.

"It can be difficult to convince patients of the need for treatment based on the sort of questionnaire now used to rank their reported symptoms," says Bilello. "We expect that the biological basis of this test may provide patients with insight into their depression as a treatable disease rather than a source of self-doubt and stigma. As we accumulate additional data on the MDDScore and perform further studies, we hope it will be useful for predicting treatment response and helping to select the best therapies."

Papakostas adds, "Determining the true utility of this test will require following this small research study with larger trials in clinical settings. But these results are already providing us with intriguing new hints on how powerfully factors such as inflammation -- which we are learning has a major role in many serious medical issues -- contribute to depression." Papakostas is an associate professor of Psychiatry at Harvard Medical School.

http://www.sciencedaily.com/releases/2012/02/120201120930.htm

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9 Breaking the stigma of mental illness in the workplace

CTV

Canada AM
7 February 2012

Mental health problems and illnesses are the leading cause of workplace disability in Canada. Paula Allen, the vice president of organizational solutions with Morneau Shepell in Toronto, reveals what's being done to create healthier workplaces and break the stigma around mental health issues.

Overall how are companies in Canada dealing mental health in the workplace?

"Employers are doing better, but I think we have reached a milestone where employers have to take the next step," according to Allen.

"They need to have resources for employees. Rather than just paying workers to take time off, they should pay for resources to help employees," she said.

"There is also still a stigma with mental health. Very few employers have strategies to deal with this. Stigma is a very big issue. The other side of the coin is knowing what to do about it," said Allen.

Mental health is so important because it affects overall health…

"There's no question about it," according to Allen.

According to a recent conference board study, 44 per cent of employees have had mental health issues. It also affects all employers.

"Some companies will say we don't have time or resources for this or that they are a high-performance work environment. But you need people to be at their best. If you're not mentally healthy you won't be as productive as you want to be," said Allen.

Ultimately, mental health in the workplace is a business necessity from a cost point of view.

"It's very true that good employees are an employer's asset," said Allen.

"It's very difficult to differentiate between physical and mental when it comes to productivity, so all should be covered," she said.

Where do employers begin to change things?

"We need to be very specific. You want to remove the stigma around mental health," said Allen.

"In terms of building a safe workplace, understanding where you have risk is a starting point. Not every workplace has the same needs, so it's about what features are good for your employees," she said.

Many of us come to work everyday and sit beside a coworker who we often spend more time with than our families. How can we look out for one another?

"Employees need to look out for one another," said Allen.

"Don't be afraid to ask if there's something you can do or notice that something is different. The worst thing you can do is ignore changes. Be human. Say that you care."

More on mental health in the workplace:

- In a study by the conference board of Canada conducted in June of 2011, a total of 44 per cent of employees surveyed reported experiencing a mental health issue.
- According to this report, many people who experience mental health issues face incredible challenges in the workplace. Many are misunderstood, shunned and underutilized.
- Many employees remained concerned about disclosing a mental issue to an employer. They fear disclosure would jeopardize their future success in their organizations
- A committee of health and safety professionals has been created by the Canadian Standards Association (CSA) to develop a voluntary national standard for mentally healthy workplaces. The standard will aim to help Canadian employers support their employees. According to the government, Canada is the first country in the world to develop such a standard. It will be ready in the fall of 2012.

http://www.ctv.ca/CTVNews/CanadaAM/20120207/mental-health-in-the-workplace-paula-allen-120207/

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10 Completing the unfinished revolution in mental health - The physical health of patients with mental illnesses

Javed Latoo
British Medical Journal
24 November 2011

We now recognize that patients with mental illnesses have higher rates of physical health morbidity and mortality when compared with the general population. Furthermore, life expectancy is reduced by at least 10 years. The side effects of psychotropic medication, lifestyle, and poor access to physical healthcare are among the aetiological factors(1). Difficulty in comprehending health care advice and/or carrying out required changes in lifestyle, poor compliance with treatment, unawareness due to cognitive deficits or reduced pain sensitivity (induced by antipsychotic medication), poor communication and deficient social skills, all account for the shortened life-span of these patients. Sometimes physical symptoms are misinterpreted as psychosomatic and together with poor quality of care, unequipped teams, and lack of continuity of care, it is not surprising that psychiatric patients are forgotten.

Service-provision needs to clearly delineate where the responsibility of physical health lies between mental health and primary care. Poor resourcing of mental health limits the ability of psychiatrists to focus beyond their own speciality. Reforms in mental health have led to reduced inpatient resources leading to shorter and infrequent hospital admissions and thus less emphasis on physical health. Increased emphasis is placed on community care yet the management of physical health issues by community mental health teams may be poor because of inadequate training and learning. A greater effort to increase awareness of the problem among primary care and mental health care providers is needed. We would recommend that psychiatrists need to play a leading role in highlighting

discrimination and stigmatisation of patients with mental health problems. Education and training of mental health professionals needs to be improved with mandatory training in acute medicine and training to update knowledge of recognising physical illness and performance of basic medical tasks.

Community mental health teams and outpatient clinics need to be appropriately designed and equipped to assess physical health monitoring. Financial Initiatives such as CQUIN(2) can be used by the commissioners to improve the physical health of psychiatric patients by mental health providers. It is vital that trainees become more aware of the interaction between mental health disorders and various physical illnesses because of the high morbidity rates. Legislative changes to address the discrimination faced by people with mental illness and learning disabilities need to be made. The Disability Right's Commission(3) has already recommended appropriate physical health care screening for example, annual physical health checks, and the government's health inequality agenda should incorporate these conditions into its indicators of disadvantage.

http://www.bmj.com/rapid-response/2011/11/24/re-completing-unfinished-revolution-mental-health

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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 at rachelle.irving@mhca.org.au *or by phone on 6285 3100.*

www.mhca.org.au