Mental Health
Council of Australia

WEEKLY BULLETIN

No. 5, 2012

Phone: (02) 6285 3100 | Fax: (02) 6285 2166 | Email: admin@mhca.org.au | www.mhca.org.au

BULLETIN NO. 5, 2012

MHCA – Bulletin no 5, 2012

Hi everyone,

I have included a real mix of national and international articles, research and stories this week. A few of the research findings that I have presented may be related to particular ethnic groups or nations, but I am sure that many of you will find them interesting and relevant on either a personal or professional level.

Some of you may not be aware that Trieste in Italy has long been regarded as a 'leader' in shifting from the traditional hospital-centric mental health system to one which is made up of community-based healthcare services. While looking for some interesting stories and updates on how Trieste is going, I found the Trieste Mental Health Department website which contains a plethora of information including data, links and stories. I read one particularly captivating story by a nurse which, although long, is worth the read. It is interesting to hear the perspective of a service provider who is feeling overwhelmed and frustrated by an inefficient system. It certainly highlighted to me that consumers, carers and service providers are probably often experiencing the same frustrations, just from different sides of the fence – and that this is the case regardless of where you call home!

Kind regards,

Rachelle

---

1. Carers still struggling

Health Reporter
Cheryl Critchley
9 February 2012

While some find their job fulfilling, one in two primary carers have their sleep interrupted and many feel worried and depressed.

Research shows carers are devoted to their loved ones and often enjoy their role, but the challenges they face are still enormous and often impact on their health and wellbeing.

The recently updated ABS report *Caring in the Community, Australia, 2009*, found only 24 per cent of primary carers found their role satisfying.

More than a third of primary carers said their physical or emotional well-being had changed, and 40 per cent of those caring for 40 hours or more per week frequently felt worried or depressed.

One in four primary carers had also lost touch with friends due to their role.

On the positive side, 36 per cent of primary carers found their role brought them closer to the person to whom they provided the most help. Almost 20 per cent said the relationship was strained.

Primary carers are those aged 15 and over who identify themselves as providing the most informal help with core activities to either a person with a disability or to a person aged 60 years and over.

This covers a range of roles such as domestic work, shopping, transport, bathing, hygiene, feeding, dressing and medication management. They also provide emotional support, often assuming an advocacy role.

Carers Australia CEO Ara Cresswell said while things had improved with National Carer Strategy and the 2010 Carer Recognition Act, many people still didn't realise just how big the sacrifice was.

She said careers were Australia's "invisible health workforce" and the foundation of our aged, disability, community, mental health and palliative care systems. "Without carers these systems would simply collapse," she said.

"In 2010, the replacement value of the care provided by Australia's 2.6 million carers was $40.9 billion per year … 3.2 per cent of GDP."

The ABS found a higher proportion of women than men were carers (13 per cent compared to 11 per cent). Of the total, 29 per cent were primary carers and women were twice as likely as men to be a primary carer.

Some (six per cent) have been in the role for 25 years or more, and two thirds of those spent 20 hours or more on it each week. Almost 30 per cent had carers for 2-4 years, and 12 per cent for less than two years.

While 85,500 carers had used respite, 98,300 reported a need for it. Of those, 62,600 had never used it.

Many carers themselves are disabled. Almost 870,000, or one third, also have a disability, which is much higher than the 16 per cent rate for non-carers.

Ms Cresswell said carers needed greater respite opportunities and greater flexibility in choosing a system that meets their needs and those of their loved one.

“We recognise that budgetary circumstances are tight, at least in the short-term, but what might be possible is the trial of more flexible respite services, phased in perhaps over the next one or two years,” she said.

Those looking after a loved one are eligible for a range of support payments including the carer payment, allowance and supplement.

But Ms Cresswell said many still faced financial insecurity and constraints on their participation in the paid workforce, which often meant lower than average incomes and savings.

“Caring can be a rewarding experience, deepening friendships and relationships,” she said.

“It can also however be physically and emotionally demanding, potentially affecting the carer’s health and wellbeing.

“Carers can experience reduced physical, mental and emotional health once caring commences and over time the effects may be intensified.”

http://www.healthreporter.com.au/news/2012/02/09/carers-still-struggling/

---

2. Educational drug website launched

Health Reporter
15 February 2012

SYDNEY – An educational drug website has been launched that includes details of the safest ways in which to inject drugs.

The Australian Drug Foundation (ADF) has compiled the large collection of drug educational materials, which is aimed at teachers, health workers and parents.

Featured on the website are sections including “The Safer Injecting Handbook”, “Take Control of Your Drinking And You May Not Need To Quit”, and “What Drug Is That?”.

ADF CEO John Rogerson says young people need to be given tools that promote informed decisions about drug and alcohol use.

“Every secondary school in Australia is required to teach drug education, so it’s important that schools and health workers have access to the latest, quality-checked information and learning tools,” Mr Rogerson said in a statement on Tuesday.

“As a community, we need to better equip young people to challenge the role that alcohol and other drugs play in their lives.”

The Australian Drug Foundation is an independent, non-profit body that has been educating about the negative impact of drug and alcohol consumption for more than 50 years.

The ADF Shop website including its shop can be found at www.adf.org.au.

http://www.healthreporter.com.au/news/2012/02/15/educational-drug-website-launched/

---

3. Programs and resources for carers and consumers

NPS – National Prescribing Service – for a medicinewise Australia

Published 24 August 2011

The below information gives you links to a number of programs and resources for consumers and carers. The link at the bottom of the section will give you direct access to the range of articles and fact sheets in relation to bipolar disorder, dementia, schizophrenia and mental health generally.

Bipolar disorder

For information on bipolar disorder go to:

Beyondblue

Beyondblue is a national, independent, not-for-profit organisation working to address issues associated with depression, anxiety and related disorders in Australia.

The Black Dog Institute

The Black Dog Institute is an educational, research, clinical and community-oriented facility offering specialist expertise in mood disorders - a range of disorders that include depression and bipolar disorder. The Institute is attached to the Prince of Wales Hospital and affiliated with the University of New South Wales.

Dementia

For information about:

- antipsychotic use for behavioural symptoms of dementia
- advice about non-pharmacological behavioural management techniques

- support for carers

Alzheimer's Australia

Alzheimer’s Australia is the peak body for people with dementia and their families and carers. It provides advocacy, support services, education and information.

Additional Alzheimer's Australia resources and links of interest:

- Drugs used to relieve behavioural symptoms of dementia
- Update Sheet – Risperdal: What is it?
- Fact sheet – Therapies and communication approaches (includes validation therapy, music therapy and reminiscence)
- Update Sheet - Drugs used to relieve behavioural and psychological symptoms of dementia
- National Dementia helpline: **Ph 1800 100 500**

Dementia Behaviour Management Advisory Services (DBMAS)

DBMAS is a nationwide network of services funded by the Australian Government as part of the dementia initiative. DBMAS is managed by different organisations in every state.

National Dementia Behaviour Advisory Service: **Ph 1800 699 799** (depending on the state you are calling from, you are connected to the service provider in that state)

Mental health

Activate mind & body

Activate mind & body, a collaboration between Queensland Health and General Practice Queensland that aims to improve the physical and oral health of people with severe mental illness. The website has information for people with mental illness, carers, GPs and other mental health service providers.

Better Health Channel

Better Health Channel was established by the Victorian State Government in 1999. The website provides health and medical information to help individuals and their communities improve their health and wellbeing.

Additional Better Health Channel information:

- Information on antipsychotics (endorsed by SANE)
- Information on bipolar disorder (endorsed by SANE)
- Information on schizophrenia (endorsed by SANE)

Lifescripts program

The Lifescripts initiative provides general practice with evidence-based tools and skills to help patients address the main lifestyle risk factors for chronic disease: smoking; poor nutrition; alcohol misuse; physical inactivity; and unhealthy weight. The initiative assists with the provision of tailored advice to patients on modifying their lifestyle

Resources from the Lifescripts program such as self-assessment forms and action plans may be useful for supporting behaviour change.

Sydney South West Area Health Service (SSWAHS) consumer brochure

Consumer medicine brochure on antipsychotic medications from SSWAHS. Includes information on how to take antipsychotics, precautions to take and common side effects.

Schizophrenia

For information on:

- schizophrenia and bipolar disorder
- antipsychotic treatment.

SANE Australia

A national charity working for a better life for people affected by mental illness.

Call the SANE Helpline **1800 18 7263** or email helpline@sane.org or visit the website

Additional SANE resources and links of interest:

- Mind + Body initiative of SANE Australia, promoting physical health and wellness with a range of resources available for individuals and non-government mental health organisations.

http://www.nps.org.au/health_professionals/tools/consumer_resources

---

4. Effect of an Advocacy Intervention on Mental Health in Chinese Women Survivors of Intimate Partner Violence - a randomized controlled trial

Tiwari et al
The Journal of the American Medical Association
2010 Volume 304(5) pages 536-543

Abstract

Context Intimate partner violence (IPV) against women can have negative mental health consequences for survivors; however, the effect of interventions designed to improve survivors' depressive symptoms is unclear.

Objective To determine whether an advocacy intervention would improve the depressive symptoms of Chinese women survivors of IPV.

Design, Setting, and Participants - Assessor-blinded randomized controlled trial of 200 Chinese women 18 years or older with a history of IPV, conducted from February 2007 to June 2009 in a community centre in Hong Kong, China.

Intervention The intervention group (n = 100) received a 12-week advocacy intervention comprising empowerment and telephone social support. The control group (n = 100) received usual community services including child care, health care and promotion, and recreational programs.

Main Outcome Measures - Primary outcome was change in depressive symptoms (Chinese version of the Beck Depression Inventory II) between baseline and 9 months. Secondary outcomes were changes in IPV (Chinese Revised Conflict Tactics Scales), health-related quality of life (12-Item Short Form Health Survey), and perceived social support (Interpersonal Support Evaluation List) between baseline and 9 months. Usefulness of the intervention and usual community services was evaluated at 9 months.

Results - At 3 months, the mean change in depressive symptom score was 11.6 (95% CI, 9.5 to 13.7) in the control group and 14.9 (95% CI, 12.4 to 17.5) in the intervention group; respective changes at 9 months were 19.6 (95% CI, 16.6 to 22.7) and 23.2 (95% CI, 20.4 to 26.0). Intervention effects at 3 and 9 months were not significantly different (P = .86). The intervention significantly reduced depressive symptoms by 2.66 (95% CI, 0.26 to 5.06; P = .03) vs the control, less than the 5-unit minimal clinically important difference. Statistically significant improvement was found in partner psychological aggression (−1.87 [95% CI, −3.34 to −0.40]; mean change at 3 months, 1.5 [95% CI, −1.0 to 3.9] in the control group and 0.3 [95% CI, −0.7 to 1.4] in the intervention group; mean change at 9 months, −6.4 [95% CI, −7.8 to −5.0] and −8.9 [95% CI, −10.6 to −7.2]) and perceived social support (2.18 [95% CI, 0.48 to 3.89]; mean change at 3 months, 6.4 [95% CI, 4.9 to 7.8] and 9.2 [95% CI, 7.7 to 10.8]; mean change at 9 months, 12.4 [95% CI, 10.5 to 14.3] and 14.4 [95% CI, 12.7 to 16.1]) but not in physical assault, sexual coercion, or health-related quality of life. By end of study, more women in the intervention group found the advocacy intervention useful or extremely useful in improving intimate relationships vs those in the control group receiving usual community services (93.8% vs 81.7%; difference, 12.1% [95% CI, 2.1% to 22.0%]; P = .02) and in helping them to resolve conflicts with their intimate partners (97.5% vs 84.1%; difference, 13.4% [95% CI, 4.7% to 22.0%]; P = .001).

Conclusion - Among community-dwelling abused Chinese women, an advocacy intervention did not result in a clinically meaningful improvement in depressive symptoms.

http://jama.ama-assn.org/content/304/5/536.full?sid=62b84925-412f-4033-a9e6-079235fdd9a9

---

5. Failure to identify and address mental health problems costing NHS billions

Centre for Mental Health – United Kingdom
9 February 2012

People with long-term conditions, such as diabetes or heart disease, are two to three times more likely to experience mental health problems than the general population. However, a systemic failure to identify these problems and provide effective support is resulting in poorer outcomes for patients and could be costing the NHS billions, says a report published today by The King's Fund and Centre for Mental Health.

Where a mental health problem is identified alongside a physical health illness, the two have traditionally been treated separately with services designed around conditions rather than patients. A growing volume of research evidence suggests that more integrated approaches, with closer working between professionals responsible for patients' mental and physical health, can improve outcomes while also reducing costs.

Researchers found that by exacerbating physical illnesses, co-existing mental health problems substantially increase the costs related to care for long-term conditions. Overall, £1 in every £8 spent on long-term conditions is linked to poor mental health, equating to £8–13 billion of NHS spending each year. For example, co-existing mental health problems can lead to:

- increased hospitalisation rates – patients with chronic lung disease spend twice as long in hospital if they also have a mental health problem

- increased outpatient service use – diabetes sufferers with mental health problems access double the amount of outpatient services as those with diabetes alone

- less effective self-management – poor mental health means that people with heart disease or other long-term conditions are less likely to look after their physical health, take medication as intended and attend medical appointments

Not only do associated mental health conditions carry a significant financial cost for the NHS, the report shows they also contribute to poorer clinical outcomes for patients and lower quality of life. For example, studies have shown:

- depression increases mortality rates after a heart attack by 3.5 times

- children with diabetes are more likely to suffer retinal damage if they also have depression

- co-existing mental health problems can have a greater effect on quality of life than the severity of the physical illness

There are also wider financial implications for individuals, families and the economy. People with both a long-term condition and a mental health problem are less likely to have a job than those with a physical illness alone; take twice as many sickness days; and are more likely to rely on informal care, which in turn leads to family members taking time off work.

In Long-term conditions and mental health: the cost of co-morbidities, researchers review the available evidence on the interaction between mental health and long-term conditions and offer examples of innovative practice from the UK and abroad to combat the problems associated with the co-existing conditions. They conclude that a more integrated approach will help the NHS to make savings, improve patient outcomes, and meet its targets on productivity improvement.

Chris Naylor, the report's lead author and Fellow at The King's Fund said: "The prevailing approach towards improving care for people with long-term conditions is at risk of failing unless we look at patients' needs as a whole, including their mental health needs. To achieve this, mental health provision cannot simply be tacked on to physical care but needs to be an integral part of it."

Centre for Mental Health chief executive Sean Duggan said: "Failing to support the mental health of people with long-term physical conditions is costing the NHS billions of pounds at a time it can ill afford to spend money unwisely. Untreated or poorly managed mental ill-health among this group is cutting lives short, reducing quality of life and increasing health inequalities. Responding better, by contrast, will save lives, increase fairness and cut costs."

http://www.centreformentalhealth.org.uk/news/2012_the_cost_of_co-morbidities.aspx

---

6. Mental health and employment - job well done: Employment and mental health problems, a guide for funders

Benedict Rickey, Iona Joy & Esther Paterson
February 2012

Mental health is key to everyone's well-being. It affects our relationships, our work and our overall happiness. But at any one time, one in six people are suffering from mental health problems. This costs society £67bn every year—as much as the government has recently spent bailing out UK banks.

The economic cost of mental health problems is mainly down to unemployment, sick leave and poor performance at work. Job well done is a guide for funders keen to reduce these huge costs and improve lives. It identifies effective charities and approaches helping people with mental health problems get back to work, at a time when soaring unemployment and tighter public spending mean private funding is needed more than ever.

Private funding can improve the lives of people with mental health problems by helping them find jobs and make the most of their work. But there is also a part to play for social investors, businesses, and charities. This is a challenging and complex area, but there is very real potential to help thousands of people with mental health problems to lead healthy and productive lives.

http://www.philanthropycapital.org/download/default.aspx?id=1178

---

7. Report shows 7.5 million children live with a parent with an alcohol use disorder

Substance Abuse and Mental Health Services Administration (SAMHSA)
United States research
16 February 2012

SAMHSA is a public health agency within the Department of Health and Human Services. Its mission is to reduce the impact of substance abuse and mental illness on America's communities.

A new report shows 7.5 million children under age 18 (10.5 percent of this population) lived with a parent who has experienced an alcohol use disorder in the past year. According to the report by the Substance Abuse and Mental Health Services Administration (SAMHSA) 6.1 million of these children live with two parents—with either one or both parents experiencing an alcohol use disorder in the past year.

The remaining 1.4 million of these children live in a single-parent house with a parent who has experienced an alcohol use disorder in the past year. Of these children 1.1 million lived in a single mother household and 0.3 million lived in a single father household. This study is done in conjunction with Children of Alcoholics Week, February 12-18, 2012.

“The enormity of this public health problem goes well beyond these tragic numbers as studies have shown that the children of parents with untreated alcohol disorders are at far greater risk for developing alcohol and other problems later in their lives,” said SAMHSA Administrator Pamela S. Hyde. “SAMHSA and others are promoting programs that can help those with alcohol disorders find recovery – not only for themselves, but for the sake of their children. SAMHSA is also playing a key role in national efforts to prevent underage drinking and other forms of alcohol abuse.”

SAMHSA offers an on-line treatment locator service that can be accessed at www.samhsa.gov/treatmentor by calling 1-800-662-HELP (4357).

There are many resources available to help children with a parent who has an alcohol problem. The National Association for Children of Alcoholics (http://www.nacoa.org) provides information and resources for professionals who may be in a position to help these children and their families. More resources are available at: http://www.samhsa.gov/prevention.

The report entitled, Data Spotlight: Over 7 Million Children Live with a Parent with Alcohol Problems, is based on data analyzed from SAMHSA’s 2005-2010 National Survey on Drug Use and Health (NSDUH). NSDUH is a scientifically conducted annual survey of approximately 67,500 people throughout the country, aged 12 and older. Because of its statistical power, it is the nation’s premier source of statistical information on the scope and nature of many substance abuse and behavioral health issues affecting the nation. The report is available at:http://www.samhsa.gov/data/spotlight/Spot061ChildrenOfAlcoholics2012.pdf.

http://www.samhsa.gov/newsroom/advisories/1202151415.aspx

---

8. Changes in mental health services and suicide mortality in Norway: an ecological study

Håkon A Johannessen, Gudrun Dieserud, Bjørgulf Claussen and Per-Henrik Zahl1

BioMedCentral Health Services Research
2011 Volume 11 Page 68

Abstract

Background

Mental disorders are strongly associated with excess suicide risk, and successful treatment might prevent suicide. Since 1990, and particularly after 1998, there has been a substantial increase in mental health service resources in Norway. This study aimed to investigate whether these changes have had an impact on suicide mortality.

Methods

We used Poisson regression analyses to assess the effect of changes in five mental health services variables on suicide mortality in five Norwegian health regions during the period 1990-2006. These variables included: number of man-labour years by all personnel, number of discharges, number of outpatient consultations, number of inpatient days, and number of hospital beds. Adjustments were made for sales of alcohol, sales of antidepressants, education, and unemployment.

Results

In the period 1990-2006, we observed a total of 9480 suicides and the total suicide rate declined by 26%. None of the mental health services variables were significantly associated with female or male suicide mortality in the adjusted analyses ($p > 0.05$). Sales of antidepressants (adjusted Incidence Rate Ratio = 0.98; 95% CI = 0.97-1.00) and sales of alcohol (adjusted IRR = 1.41; 95% CI = 1.18-1.72) were significantly associated with female suicide mortality; education (adjusted IRR = 0.86; 95% CI = 0.79-0.94) and unemployment (adjusted IRR = 0.91; 95% CI = 0.85-0.97) were significantly associated with male suicide mortality.

Conclusions

The adjusted analyses in the present study indicate that increased resources in Norwegian mental health services in the period 1990-2006 were statistically unrelated to suicide mortality.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3078842/

---

9. Join a carer focus group - Mental Illness - 23 February 2012

Apologies to the majority of you who don't reside in Victoria, but I thought this was a good opportunity for those living in Melbourne to be able to take part in a carer-specific focus group. I will include Notices from other jurisdictions if I come across them.

The Victorian Auditor-General Office is holding an audit of carer support programs and has requested the Victorian Mental Health Carers Network to hold a Carer Focus Group for carers of people with a mental illness.

Join the discussion to talk about what support carers need and your experiences of what support is available. Support may include: carer involvement in treatment and care planning and decision making; information and education; peer support, respite and other support groups.

The focus group will be situated in the Melbourne CBD. Join in from 10.30am for morning tea followed by the session to run 11.00am - 12.00pm.

Places are limited. For further details or if you are interested in participating in the VAGO focus group please contact David White, Victorian Mental Health Carers Network on 8803 5501 or david.white@carersnetwork.org.au

Contact Name: David White, Victorian Mental Health Carers Network

Contact Email: david.white@carersnetwork.org.au

Contact Phone: 8803 5501

Event Date: Thursday, 23 February 2012

http://www.carersouth.org.au/news/join-carer-focus-group-mental-illness-23-february-2012

10. 5 out of 89 in four hours

Paola MARCHINO
True story from a service provider as found on the Trieste Mental Health Department website
Retrieved 16 February 2012

Monday morning, 7 o'clock – the alarm clock rings. It's time for me to get up. "No, I can stay a bit longer, the alarm will ring again," I say to myself. Ten minutes later, the alarm clock rings again and I slowly get up, slowly go to the bathroom and slowly get ready for breakfast.

Everything has to be done calmly – it's the only time of the day I can allow my brain and body to go slow, marvellously slow!

I listen to the news on TV, then go and have a shower. I realise that I should hurry up because the service opens at nine o'clock and by then I have to be at work with a smile on my face, ready to give a warm welcome to 70-80 people. I need to avoid making mistakes in administering narcotics to participants; I must be careful of the authenticity of toxicological assessments, make sure that data are correctly put in the computer and prevent other colleagues from making mistakes. I must be vigilant in adhering to certain procedures, particularly those whose omission could lead to the cancellation of the therapeutic programme and pay attention to what participants say. I also have to answer the phone and to colleagues who keep on entering the room. Even if they don't speak, I can easily guess from their expression that what they mean is: "Well, then? How long will it take you? There's people queuing outside!" I would like to reply "Leave me alone!", but in the end I decide to smile and answer "Just a minute, I'll call you as soon as I've finished with him!"

I come out of the shower, dry my hair and apply some moisturiser automatically because I'm too busy thinking about how to best get organised at work. Monday morning is dreadful for everyone – the participants are eager to get in because they are in a hurry and everything seems urgent. The only thing I can do is hope that my colleagues – four or five if I'm lucky – have arranged a training psychologist answering the phone for them and are therefore relaxed enough to create an atmosphere of collaboration rather than tiredness, frustration and aggressiveness.

I get dressed, put on the make up and run off. It's 8.30. Ten minutes later, at work, I meet Giacinta who is reading the messages left by the colleagues of the Sunday shift.

Her remark "Good morning Paola" shows she is quite relaxed. I answer with the same energy and start to work. I check that everything is in order and make sure we have enough drugs in the drawer and narcotics in the strong-box. According to my calculations, two 8-mg tablets of buprenorphine are missing. I curse and say to myself: "...that's a nice Monday start!". I do not have the time to check possible mistakes because it is nine o'clock and the surgery starts, so I put the notebook under the phone and postpone the problem till later in the morning.

Participant: "Good morning, I need eighty milligrams of methadone."

"Hello," I answer, trying to remember his name while skimming through the list, "well, the list shows ninety milligrams."

He says aggressively: "Yes, I know, but I want eighty. The doctor must have forgotten to write it down. It's always the same old story!"

"Do you have a minute, so that we can double-check it?"

Participant: "I have to go to work and don't have time to waste."

"OK, take eighty mg if you want to, but it would be better if you speak with your doctor to agree on the dosage."

The door opens and a colleague enters and tells me to be quicker. I nod and the door closes. I ask the participant no more questions and go on.

"Next, please!" I say.

"Hello Paola, how are you?". He says while sitting himself down.

"I'm all right, and you?". I answer while writing and not even looking at his face.

"Fairly well. Listen, I need to take the doses for two days".

"Well, do you need to do the urine test?"

"I knew you would ask me to!"

"It's my job. I'm actually doing you a favour by reminding you, since you always forget it!"

"Yes, I know, but not today, I don't feel I have to pee."

"All right, then. In the meantime, take these" I say, passing him the tablets.

"Thanks". He puts the tablets under his tongue. "I'll go now, bye."

"No, wait! You know you have to wait a while and then..."

“But there are people waiting outside.”

“Of course, but I cannot let anyone come in while I’m treating you. So stay here a bit. Besides, I need to double-check if you are actually taking the dosage and the tablets need time to melt, as you know”.

The phone rings. It is G, who asks if it is possible to have the methadone delivered at home because she has a temperature. So, while she goes on telling me about all her illness and emphasising that she needs the methadone immediately because she feels sick, I concentrate on better understanding why she has lately begun to ask for unreasonable requests. In the meantime, while colleagues keep on entering and leaving the room, talking loudly, the guy sitting in front of me takes advantage of the situation and leaves. Another one comes in immediately. I keep listening to G’s requests and try to reassure her, explaining that she is not in danger of any methadone withdrawal syndrome. She keeps asking me to go to her place immediately, but I answer I cannot because I am in the pharmacy, and tell her I will report her phone call to the afternoon-shift group so that they will certainly ring her. I come across convincingly enough and manage to end the conversation. In the meantime, the guy sitting in front of me is showing signs of impatience and my colleagues are still talking loudly. They enter the room to see what I have got up to.

I look at the guy. I know him quite well, as he is cared for by my group. His face is rather drawn, his eyes are bulging out. I ask him how he is but he does not feel like talking. In the meantime, I’m distracted by the thought of the people outside and by the colleagues opening the door continuously. He asks for the methadone and leaves, hardly saying goodbye.

I barely notice my colleague Elena arriving. She apologises for being late and she asks me repeatedly who’s next.

With the two of us, the work should be easier, but it is not and I do not understand why.

The pharmacy is not very large and its structure is meant to let the participants stay at one end of the room. Sometimes it gets full with two or even three participants, each one of whom talk to a different staff member about his/her personal situations.

The next participant is E. She does not seem well at all, but Elena has already involved the doctor in a problem with another participant therefore I try to listen to the girl’s requests, even though I immediately realise the situation can’t be solved by me in a few minutes. So, I apologise with a shy smile and tell her I will be available later on if she needs to talk. She answers “OK, I’ll call you”, but I think she won’t. My thought is interrupted by a colleague who self-confidently enters the pharmacy, as if everyone was waiting for her to arrive, and asks for the dosage of a participant who is waiting in another room. The girl I was talking to leaves.

Then, checking the list, I realise that my colleagues have forgotten to account for the dosage administered, so I look at Elena and she looks back at me enquiringly, adding: “We cannot work at such a pace”.

I do not answer. I know she is right, but what can we do about it? I try to remember the names of those who came in and double-check if they have actually been registered. I decide to postpone the problem and say: “Elena, let’s go ahead with the three people waiting outside. Then we’ll concentrate on the list”.

A colleague comes in and says: “Shit, there are no cars available! I have to go to the General Hospital with L. Where can I find the car keys?”.

“In the cabinet” I answer.

“There are no keys there”, he says.

“Have a look in room 4. You’ll find the afternoon shift’s keys”, I say. I then turn to a new participant who has to collect his medical report and who is ready to go to the toilet to have his urine tested. I’m very brisk with him. While Elena is dealing with the last participant, I start checking the list, hoping nobody will come in and interrupt me. The colleague who was searching for the car keys comes in again, cursing because he has not found them yet. I look at him and answer in a sharp tone “Look, I can’t do anything for this problem. Do you want the keys of MY car?”.

He smiles, and maybe thinks I’m dealing with too many things at a time.

The door opens and a voice says: “Can we let T come in?”.

“No, there is a mismatch. I’ll call him as soon as I’ve finished”, I answer resolutely without taking my eyes off the list.

“All right!” the voice says. The door closes.

Once I have finished checking and updating the list, I let the next one come in.

“Hi, my doctor wants me to have my urine tested and to collect the results.”

“Hello, can you remind me which group you belong to? Who’s your doctor?”

“Doctor Tania.”

“It’s the third group, then.”

Meanwhile, Elena reports to doctor Gianni his list of participants. He answers in a raised voice, “I cannot do everything! My nurses – your colleagues – haven’t done anything, so now it’s up to me...but I need time because I’m doing other things that are just as important.”

While I am filling in the referral form for the guy sitting in front of me, I think that Doctor Gianni’s nurses can’t physically do everything – nor know what he has in his mind – and that he can do things himself without shouting that much. The guy waiting in front of me observes the scene and smiles. We must seem all pretty mad to him. I show him the way to the toilet.

The smell of urine fills the air. Someone hasn’t flushed and someone else has missed the toilet. Having to observe a urine test – what a sight! In order not to make mistakes, the men’s toilets are also equipped with mirrors that are similar to those used at crossroads with poor visibility.

The guy tells me: “There’s plenty of people today, isn’t there?”

He has the relaxed tone of someone who’s having a coffee with a friend and is used to be watched over without feeling uneasy by my presence.

“Yes, a lot” I answer with an almost indifferent tone.

“How come?”

“It’s Monday morning. There are lots of urine tests and appointments, and they all concentrate here. What about you?”

“I’m not too bad, I’ve got some relapses from time to time, but everything is under control”.

Such conversation takes place in a toilet, with him trying to pee in the glass and me standing two metres behind him, trying not to look at the mirror but paying attention to the noise of the urine dropping into the glass.

“How’s your child?”

“Well, he’s growing, he’s lively, he attends the nursery school... Sorry, I need to concentrate, otherwise I cannot pee.”

After a while I can hear the unmistakable noise, then he hands me the glass and says “here you are”. He goes on with what he has just started doing. I take the sample and close the door saying goodbye. I do not have the time to think about anything else when I see the fed-up looks of three or four people who have been waiting for five minutes. As I enter the pharmacy with the next participant, we suddenly hear shouts and doors slamming. It must be someone who does not feel well or who has not got what he was asking for. I can hear the voices of some colleagues trying to answer him and to cool him down, while the upset participant goes on shouting. Elena and I exchange an inquisitive look, we do not know what to do, we are ready to go out, but then we hear them speaking in a lower tone and order seems to be re-established. We think “thank goodness. We didn’t really need someone starting to break things or to attack someone! At least we don’t need to call the police”.

We keep up this pace and do not realise that time is passing by, nor do we take a break to have coffee or a glass of water. We don’t even go to the toilet. I realise that it’s one o’clock just when A comes in. He always arrives after he has closed up his shop for lunch. I say “It’s one o’clock. Thank goodness! Are there any other people waiting outside?”

“Two more people.”

“Thanks. You know what I mean, don’t you? I mean, with your job!”

“Yes I know what you mean, but there are always some latecomers... like me, for example.”

“You have a good reason for being late! Usual dosage?”

“Yes,” he answers “and I’d also like to have the urine tested today.”

“That’s a miracle! And ... how will it be?”

“Opiate-negative, and I’m sure about that because I haven’t used the drugs for more than one week.”

"That's what you say all the time. But today I want to trust you. You can go to the toilet, Alessandro is coming with you."

Alessandro, a doctor working with us, isn't very happy about its duty but he complies anyway. I am pretty fed up to be the urine woman.

It is ten past one and more people arrive. I walk out of the pharmacy reminding my colleagues the service is closed. There are always some latecomers or some colleagues who kindly ask "would you be so kind as to deal with this person, since you are still here? I've got something else to do...", but I answer rudely: "Today yours truly doesn't feel like being kind and has got other things to do herself and would like to finish her work in peace and within her working hours!"

The colleague, surprised by my reaction, mutters: "Sorry, I'll do it myself".

Elena and I try to clear our minds. There is obviously an inconsistency between the list and the actual methadone in stock. We start skimming through the various lists. I am irritable and cannot concentrate, so I say: "I'll go to the toilet and have a glass of water, so when I come back I'll be able to concentrate better." So does Elena.

Walking out of the pharmacy, I look at the faces of the colleagues who have spent the morning in the waiting hall and ask them how many people have come in today. Giacinta answers "Eighty-nine in total!"

"Bingo!" I answer and go and have something to drink.

Five minutes later I come back to the lists. I feel relieved. We start again from where we left off and find some mistakes, until Elena points out she has to leave because her working hours are over. She is a part-time worker. She says she is sorry for leaving me in such a mess. I reassure her, saying I will sort it out.

Finally I'm alone in the pharmacy and can concentrate on my work, but after a few minutes I notice I have been surrounded by other colleagues, some needing the lists, some looking for documents they cannot find, some talking on the phone and some who have just arrived to start the afternoon shift. I am about to burst out screaming. I am on the verge of a nervous breakdown.

Fortunately someone comes to rescue me and sits down next to me to help me in my work.

We finish the morning work two and a half hours late. By now, it's four in the afternoon.

I'm sick, exhausted, embittered, frustrated by an assembly-line job where you do not have the time to talk to any patient. The concept of properly receiving a patient and listening attentively to their needs is one that everybody described when I began working here. I've been spending the whole morning working with adrenalin flooding through my veins, running the risk of making mistakes in drug administration. I did not have the time to better estimate if a certain dosage suits a participant or not. How many people expressed problems, discomfort, inadequacy during these last four hours? Many.

How many times did I react adequately? Never. I can improve. I have always tried to meet the participants' requests, but I have not always achieved it. I haven't given enough time to listen to anybody and I have not helped anybody approach a problem in the right way. I have always given a rather quick, brief and apparently resolutive answer with the wrong tone. I have always considered the participant as a drug addict rather than a person. In other words, I have adopted the quickest approach. I have seen the person as a number rather than a human being. I have not listened to people's most intimate needs. I have merely met the need of the moment, but that was only a false need. Therapy yes or no, more or less methadone, urine test required yes or no, positive or negative urine tests etc. Above all, my working conditions have not been professional at all.

I should require to work professionally, to be acknowledged for the work I have been carrying out and to have time to think about what I am doing.

I should leave work with the feeling I have done a good job in terms of quality rather than quantity.

This day-to-day uncertainty has been demotivating me and as a result I have been going to work with less energy and enthusiasm.

Another certainty I have is that we are all caught up in a whirl where anyone tries to do the least he/she can. We, the nurses, are particularly good in justifying ourselves, maintaining the problem lies in the top management. Top managers have their responsibility but it's our fault not to make them aware of the problems we are facing. This flawed system is creating a negative situation. We will have to pay for not facing the problem, for not coping with our ineptitude, for succumbing to the overwhelming power of an excessively bureaucratic system and for not realising the negative impact of such system.

It's seven o'clock in the evening, I'm home at last. I look around, have so many things to do – washing, ironing, cooking, ringing Alessandra and see how she and her children are, ringing Bruna (I haven't heard from her for ages) and Cris to arrange for a coffee and a chat. I wish I could invite friends for dinner. I wish I could make a list of the Christmas gifts. I wish I could read a good book.

I WISH, I WISH, I WISH, but I am so exhausted and deprived that I do not do anything and the only diversion I allow myself is cooking a quick dinner, lying down on the couch in front of the TV and watching a not-too-serious programme or film, which is not difficult to find nowadays. Maybe I should choose a film which is able to relax my mind and to take me to a refreshing sleep that usually arrives before the end of the stupid film. But it does not matter. The ending is usually far too predictable.

http://www.triestesalutementale.it/english/archive.htm

Ongoing - Mental Health Carers Forum

If you are a carer and would like to talk with other mental health carers about issues of concern to you please complete the form at: http://www.mhca.org.au/carerform/index.php

---

The email is sent every week and contains items which may interest mental health consumers, carers and service providers and which otherwise they may not be able to access. Thank you for subscribing *to this MH email- if you wish to unsubscribe please contact Rachelle Irving at rachelle.irving@mhca.org.au or by phone on (02) 6285 3100.*

www.mhca.org.au