MENTAL HEALTH COUNCIL OF AUSTRALIA

NEWSLETTER
FEBUARY 2010

www.mhca.org.au

Contact:
Ph: (02) 6285 3100
Fax: (02) 6285 2166
Email: admin@mhca.org.au

Promoting the mental health of all Australians

Staff changes at the MHCA

2010 heralds some staff changes at the MHCA.

Deputy CEO Sebastian Rosenberg has moved on after many years here. Sebastian will remain as Senior Lecturer at the Brain and Mind Research Institute, Sydney Medical School, as well as being a Director with ConNetica Consulting. We wish him the very best and know that his commitment to the Mental Health Council and mental health in general will continue, albeit in other ways.

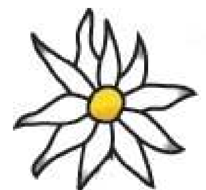
Melanie Cantwell is the new MHCA Deputy CEO. Mel has been here for over 3 years as Director, Policy and Projects. Melanie has already been a senior leader within the MHCA and is a logical choice to assume the broader responsibilities entailed in the Deputy CEO role.

Rachelle Irving has been promoted to fill the role of Director Research and Projects. Rachelle has performed remarkably well across a number of key project areas including very successfully managing the complexities of the NGO Grants Project which has now concluded. Rachelle came to us from the Institute of Criminology, has good policy and research skills and is well grounded having served as a police officer in QLD for almost ten years.

Here is a full list of current MHCA staff and their positions.

<u>MHCA</u>

David Crosbie	CEO
Melanie Cantwell	Deputy CEO
Rachelle Irving	Director, Projects and Research
Simon Tatz	Director, Communications and Marketing
Toni Maxfield	Corporate Services Manager
Natalie Soar	Corporate Support Officer
Anne Nelson	Finance Manager
Amy Waterford	Finance Officer
Corinne Dobson	Policy Officer
Linda Rosie (Mon - Wed)	Carer Engagement Project Manager
Kylie Wake	NMHCCF and National Register Executive Officer
Kim Harris	Admin/Project Officer - NMHCCF & National Register
Sue Thompson (pt)	Policy Officer
Liz Ruck (Tue - Thurs)	Policy Officer



Farewell lunch for Sebastian at Fuel, Manuka.

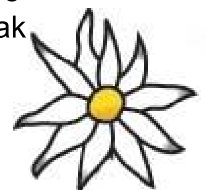
Australia and social inclusion

David Crosbie
CEO, Mental Health Council of Australia
(This article appeared in the *Canberra Times* on 26/01/2010)

If you go looking for social inclusion in the Rudd government policies and programs, you can find it, not in a single clump, but spread in patches across a range of areas. Senator Ursula Stephens (Parliamentary Secretary for Social Inclusion) and other Rudd government Ministers regularly highlight a record of achievement starting with the apology to Indigenous Australians through to increased pension payments, more public housing, more emergency relief, jobs programs, community innovation funds, more financial counselling, and so on.

These achievements are impressive and should be publicly acknowledged. They reveal a social inclusion agenda focused strongly on the economically marginalised, those most often served by a mixture of social services, prisons, homeless shelters, mental health and drug treatment services, employment programs and hospital emergency units. In all of these areas there is work to be done, important work that should be adequately resourced and unequivocally championed.

Early start / head start programs have merit, as do place-based interventions to stimulate regional economies, microfinance approaches to opportunity, and capacity building in our community-based organisations. Again these programs need to be strongly supported to the degree that they reduce economic marginalisation, break cycles of poverty and disadvantage, and diminish the need for social services.



But there is another dimension to the social inclusion agenda beyond the economically marginalised that has not attracted the same attention.

The mental health research tells us that it is not just the circumstances you find yourself in, but whether you feel your life has value and meaning that is the critical factor in personal and collective well being. In fact, recent research in the US has highlighted that the level to which people work productively, feel inclined to suicide, or suffer from a range of problems including ongoing illness, is best predicted by asking a few simple questions that identify how they feel about themselves and the world they live in.

The literature often uses the term 'languishing' to describe people who are struggling to find any sense of purpose or value in life. Languishing is contrasted with 'flourishing' which describes those people who find meaning in the challenge of life and their place in the world including all the ups and downs. Historically there are many other descriptions of similar categorisations. Many are grounded in whether or not people have grasped a spiritual meaning in life.

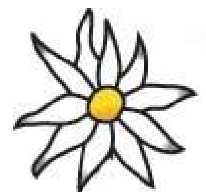
Languishing and flourishing are not terms we commonly use in Australia, but so powerful has been the impact of the underlying research that countries around the world are adopting and adapting this terminology.

In Scotland, for instance, they now call their mental health strategy 'Towards a Mentally Flourishing Scotland', while the UK has initiated a 'dual continuum model' of mental health in which flourishing and languishing are one of the two continuums, the other being mental health.

In most parts of Australia it is probably more acceptable to talk about sex, race, politics and religion than to talk about how you feel about yourself and your life. Consequently, we have an almost silent epidemic that is rarely discussed or acknowledged, an epidemic of isolation, disconnection, loss of satisfaction in life and in the world around us. This is not simply about economic marginalisation, mental health, whether people are outwardly happy or sad, extroverted or introverted, contrary or accommodating. It is about Australians who are languishing.

The good news is that languishing is not something that is permanent or cannot be overcome. In fact, innovative programs in Australia such as the Act-Belong-Commit campaign in Western Australia have shown how we can reduce the numbers of people languishing within our communities. This reduction means less crime, less problematic drug use, less hospital admissions, less mental illness, higher productivity and stronger communities.

The Act-Belong-Commit type of programs tend to be seen as health promotion initiatives, but their reach and benefit extends well beyond preventing illness and improving economic measures such as productivity. In practice, these programs form the basis of real social inclusion. Strategic investments in these areas are emerging as fundamental to the kind of society we live in.



While Australians have a lot to be very proud of as a prosperous and practical nation, our social inclusion agenda still has a way to go if we are to become a nation where difference is embraced, where people engage and communities flourish.

In a strong and fair Australia, how we feel about ourselves, each other and our communities needs to be the critical touchstone for social inclusion.

In The media – Haiti and mental health

Simon Tatz
Director of Communications and Marketing

The tragic visions of the Haitian earthquake have dominated the news – with truly horrific scenes of a country destroyed and a people left devastated. The media have covered the logistical and other problems in rescuing survivors and delivering essential medical aid, but there has been scant coverage of the immediate and ongoing mental health issues which millions of Haitians are and will experience.

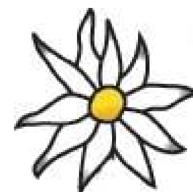
Our first glimpse into the mental health disaster that is Haiti will be seen through the experiences of rescue workers and aid workers. US news service ABC reported (18/1/10) that soldiers and volunteers risked “not just their safety, but the sanctity of their own minds” as they try to cope with the overwhelming demands for help.

America – which is providing the bulk of aid and relief – has experienced the 9/11 attacks and Hurricane Katrina, so there is experience in wide scale trauma. The commonly reported conditions for Americans in these disasters (and from returning Iraq and Afghanistan soldiers) include: depression, anxiety, emotional numbing, sleep difficulties and substance abuse.

While many of the doctors arriving in Haiti are experienced in disaster relief efforts and the impact of trauma, ABC quoted Dr. Carol North, a psychiatrist with the Veterans Affairs Medical Centre in Dallas and an expert in post-disaster mental health, who said that experienced aid workers, like Doctors Without Borders, may be tougher than the average citizen, but "That may not prepare them for the massive scope of severe injury, the many, many dead bodies … and people who are frantic. Nothing can prepare a human being for something that massive."

Dr North told ABC that there isn’t any way to tell which patients would require specialist care and attention for their mental health. "In the early stages of a disaster, everybody's upset, and it takes time for the dust to settle to see what is healing and what is developing into psychiatric illness. Really, the fist mental health interventions are to tend to people's physical needs."

Remember that Haiti is a country where Creole and French are the predominant languages and local customs and practices may render ‘western’ psychiatry and psychology as less than helpful.



Providing culturally appropriate mental health care to so many people, and so many orphaned and injured young people in particular, is almost unimaginable.

The AMHE Relief Mission of the Haitian Physicians Abroad immediately noted 'acute depression' as a major health problem for survivors. The *Psychiatric Times reported* in mid January that volunteer teams of physicians were going to Haiti, however Dr Marc Vital-Herne said, "My viewpoint is that it is too early for psychiatrists to go to Haiti. Right now, the pressing needs are to rescue people and to treat the injured. But in the upcoming weeks, psychiatrists and other mental health professionals will be needed to help those traumatized by the tragedy."

Dr Vital-Herne also highlighted the mental health issues facing Haitians living abroad. "Many are experiencing emotional turmoil. Some feel impotent and overwhelmed. They want to be there in person, but it is impossible. Their family members in Haiti may be missing or dead and their family homes destroyed."

This makes the tragedy of Haiti even more immense – hundreds of thousands dead and millions traumatised and likely to face ongoing mental health and PTSD problems; and millions of Haitian people trying to cope with their own loss, anxiety and depression far removed from their community and the ability to provide any direct comfort or help.

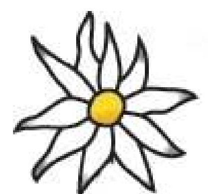
Time Magazine quoted Haitian-born psychologist Marie Guerda Nicolas of the University of Miami, who explained that Haitian people express what they feel differently to Westerners, and this must be considered in terms of mental health care. "There may be a lot of crying and wailing. [Survivors] may faint, they might fall down, but it doesn't mean they're not able to cope or function."

Marie Guerda Nicolas said that while people functioned "remarkably well" during a crisis, once the situation becomes more stable, PTSD symptoms appear. "The psychological impact doesn't occur until several months later. When things get quiet...you start to feel the impact and the sadness of the images you witnessed."

As *Time* brought to the fore, PTSD treatments, medication like antidepressants and cognitive behavioural therapies may be available and effective in the developed world, but in a society where there is no water, no buildings, no mental health facilities or any other semblance of infrastructure or society, it will be surviving family and friends who will have to cope with severe mental health issues.

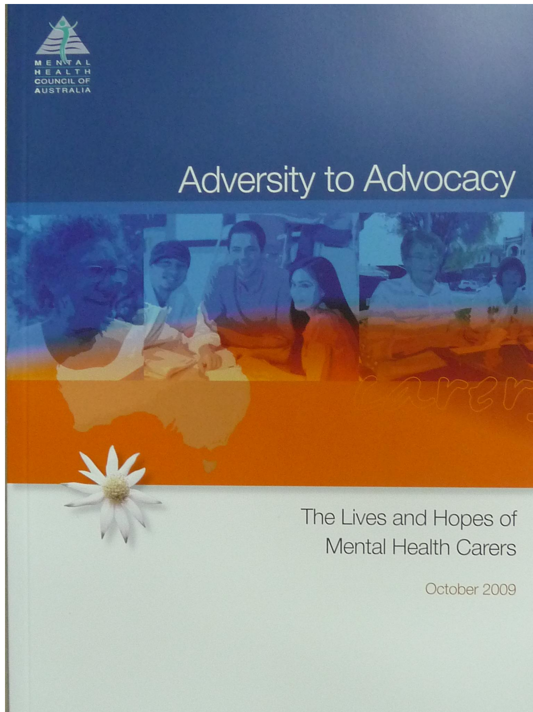
Haitian society has something called lakou, which basically means the extended network and family, friends and the 'neighbourhood'. Apparently this forms an essential component of their culture.

The people of Haiti will need all this and more over the coming months and years as the full impact of the physical and mental damage is dealt with.



Carer Engagement Project – Update

Linda Rosie –Carer Engagement Project Manager



The response to the release of the report *Adversity to Advocacy* has been very positive. The MHCA has received many requests for copies and some very favorable comments from those the report most concerns - mental health carers. Some examples are below:

Comments on the *Report Card*

Our group will wait with interest the posting on your website of the report Adversity to Advocacy but in the meantime the 'Report Card' is a wonderfully succinct and well expressed summary of the concerns we carers have regarding a dysfunctional mental health system and our place within it.

Congratulations on putting together the information so coherently – after a plethora of reports this summary from the MHCA shines like a beacon!

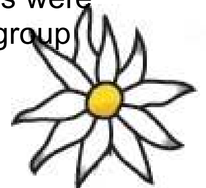
Comments on *Adversity to Advocacy*

> *I was most impressed by the report… So much of it resonates with my experiences and those of my friends who are also mental health carers. Now the question is how are we going to convert this knowledge into action where it really counts? It is imperative that your good work is acted upon...*
>
> *We were very pleased indeed with the report which is an excellent summary of all our concerns, constantly expressed over the last ten years or more.*

The ongoing impact of the report can only be guessed but the following short email comment reflects a number of comments received over the last two years:

> *…went to a support group meeting this morning & they really snapped up all the copies (Report Card) I brought home with me. We're organising a planning meeting to see where to go with it from here.*

During the course of delivery of the workshops over 2008 and 2009, comments from local coordinators were positive and also active and forward looking. Local groups were spurred on to seek dialogue with their local mental health service, including one group who set up further meetings to discuss and write their own report to the state government.



Informal and formal carer support groups have been established. In one workshop location, mental health services requested the top issues from the workshop in their particular area so they could establish a working group of carers and MH professionals to work through the carer issues. To help mental health carers continue the support gained through the project the MHCA is setting up a listserv to enable isolated carers to communicate with other carers who share similar issues, if not locations.

Planning for the ongoing reporting of carer issues on an annual basis is well underway and information has been sent out to mental health carers who were not part of the CEP workshops. This will increase and continue in the upcoming months. The MHCA anticipates a steady flow of carers wishing to be part of the ongoing monitoring and reporting of mental health carers.

Campaigning for Mental Health: Some Effective Strategies

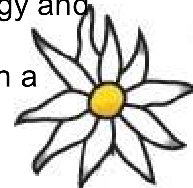
Sue Thompson –Policy Officer

Last May, the MHCA established a new working group to develop a National Mental Health Promotion Strategy. Since its inception, this group has been charged with the task of recommending an effective mental health promotion strategy. Preliminary findings have found that there is a need for both a ‘top-down’ policy approach together with ‘bottom-up’ community action. Reviews of health promotion interventions indicate that the most effective employ multiple strategies on many levels. These include components that: develop a comprehensive strategy; establish infrastructure to support implementation; link different sectors such as mental health and public health; and produce a tolerant environment in which to implement policies.

One study tried to apply these criteria to Australia and found that this country was a worldwide leader in developing health promotion policy and projects, but lagged behind others in terms of implementing evidenced-based practice, engaging stakeholders from other sectors and reducing discrimination.

One of the more common forms of conveying mental health promotion messages is through mass media campaigns. Many tend to focus more on the ‘bottom-up’ approach by appealing to the general public directly, and they can achieve positive outcomes. Evidence indicates that campaigns are especially effective when they involve more than one form of media, and include community-based components and/or direct interventions.

Also, further research has shown that in media campaigns, narrative advertising aimed at engaging participants in so called ‘real-life’ experiences, rather than using argument advertising, resulted in greater sympathy towards those suffering from certain mental illnesses. And there are two important structural features of narratives: chronology and causality. For example, a narrative message can present a real-life story of an individual, giving the audience an opportunity to watch that real-life story unfold in a series of advertisements.



By contrast, argument advertising often has no plot or characters, therefore depriving viewers of the ability to connect and empathise with a personally.

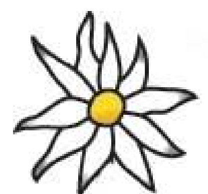
One successful campaign is ‘Like Minds, Like Mine’ in New Zealand where celebrities talk about their experiences living with mental illness. The current campaign focuses on encouraging people to behave in ways that are supportive of people with mental illness. To date, ‘Like Minds, Like Mine’ has had four campaigns with distinct strategies designed to build on the previous one. The first strategy involved famous people with experience of mental illness in the aim of ‘normalising’ mental illness. Strategy two continued on from strategy one by showing famous people with experience of mental illness engaging with other famous people. Strategy three moved into the realms of ‘everyday’ people by involving non-celebrities and the fourth strategy – currently being used in New Zealand – builds on this by featuring a particular personality, namely a chap called Aubrey and the people in his life.

In its 9th survey report, the ‘Like Minds, Like Mine’ campaign found that one-third of the peopled surveyed reported having changed their behaviour in relation to people with mental illness.

The ‘see’ me campaign in Scotland found that in the first four years of its campaign, a public attitudes survey revealed a 57 per cent decline in derogatory terms used by the media, and that there was hard evidence that ‘see me’ had helped to better informed the community which had become less fearful and more caring towards people with mental health problems. ‘See me’ drew on experiences from existing campaigns such as ‘Like Minds Like Mine’ in New Zealand, ‘Mind Out for Mental Health’ in England, the World Psychiatric Association’s Open the Doors’ campaign, and others. By taking stock of the evidence, a campaign was devised which integrated high profile publicity with ongoing local activity. Personal testimonies from those with first-hand experience of stigma were found to be a power tool. First-hand accounts in the media of how stigma affects individuals are believed to be some of the most effective ways of influencing people’s attitudes, second only to actually knowing someone with a mental health problem; and this is key to the ‘see me’ campaign.

Programs that do not involve the media are less common, but can still be effective in terms of attitude change. Studies have found that direct contact with individuals with mental illness is associated with more positive attitudes. There is also evidence that school-based programs can improve mental literacy among adolescents. Some of the strongest evidence comes from studies of educational interventions for carers and family members of people with mental illness.

Relating physical health with mental health is another opportunity to convey mental health promotion messages, especially in areas where resources are scarce. An efficient strategy has been to incorporate mental health promotion within existing health promotion programmes that are already well received in the community. Not only does this save on resources, but it also brings mental health promotion activities into mainstream health.



Yet another area is improving mental health literacy among the indigenous community. One such project in the Northern Territory aims to address the different cultural needs but adapting mental health information through the development of mental health stories. These stories focus on personal strengths and family support, using local artwork and images, local language, metaphors, and music. Positive feedback and encouragement has been given to the story telling project, thus highlighting the importance of incorporating the needs of the target group with the sharing of information.

There is still no consensus on what works best, and often it is the case that different strategies work for different settings, though there is consensus that mental health promotional messages and anti-stigma campaigns make a difference, however great or small they may be.

Healthy public policy, along with healthy community attitudes are requisites for mental health promotion. Recent research focuses on interventions that place the individual within the wider community.

However, the connection between the 'top-down' approach and the 'bottom-up' approach still needs to be strengthened if the holistic and positive definition of what mental health means is applied successfully. Nevertheless, the evidence is extremely positive and proves that mental health promotion is a necessary component to any strategies that seek to reduce the risk factors that contribute to poor mental health and enhance the protective factors that contribute to good mental health, as well as producing overall health, social, and economic benefits.

NMHCCF and MHCA National Register of Mental Health Consumers and Carers

The NMHCCF finished 2009 with a flurry of activity – an issues paper, the Business Plan and multiple Advocacy Briefs were completed, and two new working groups were established. In 2010 NMHCCF members look forward to further progressing NMHCCF Forward Plan 2009-2011 objectives.

Submission on new national peak mental health consumer body

In December 2009, the NMHCCF and MHCA provided a joint response to the *National Scoping Study to inform the development of a New Peak Mental Health Consumer*

Organisation Discussion Paper in December 2009. This submission can be found in the 'Publications' section of the NMHCCF website– www.nmhccf.org.au.

NMHCCF members strongly support the development of a new national peak consumer organisation; they also note that it is best practice to have both a national peak and state/territory peak mental health consumer organisations. The NMHCCF encourages all jurisdictions to develop and/or provide ongoing funding to state/territory peak mental health consumer bodies.

NMHCCF Advocacy Briefs

NMHCCF members have developed advocacy briefs for consumers and carers to enable them to better understand and comment on key issues in mental health. The NMHCCF has completed six advocacy briefs:

- Supported Housing and Homelessness
- Privacy and Confidentiality
- Duty of Care - Duty to Care
- Mental Health Facts and Figures
- Mental Illness and Intellectual Disability
- Employment

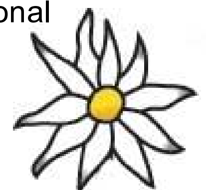
These advocacy briefs are available in the 'Publications' section of the NMHCCF website.

Joint National Register/ NMHCCF Workshop

Planning for the 2010 National Register of Mental Health Consumers and Carers and NMHCCF two-day workshop has begun. The workshop will be held 29-30 April 2010 at the Holiday Inn, Melbourne Airport and builds on previous annual workshops to provide participants with training, skills development and networking opportunities.

Mental health consumer and carer representatives

Members of the NMHCCF and National Register of Mental Health Consumers and Carers have experience working as representatives and have undergone training in leadership, advocacy, policy development, communication and a range of other relevant topics. Members have the skills and expertise to meet the needs of organisations requiring a consumer or carer representative that can work effectively at the national level.



If you require a mental health consumer or carer representative to sit on a committee, Board, or in another similar role, more information is available at http://www.mhca.org.au/consumers-carers.

Take 10 to feel tops in 2010

1. **Start with the right fuel**

   A healthy breakfast, no matter what time of day you get up, can help you think clearer, improve concentration, have more energy and may make you less likely to overeat later in the day.

2. **Move to feel good**

   Moving stimulates your body to release feel-good hormones (endorphins). The more you move the better you will feel. Look for every opportunity to move more.

3. **Sleep for brighter moods and better choices**

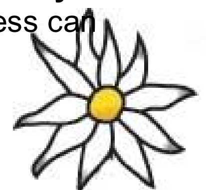
   People who are tired and don't get enough sleep are more likely to overeat and make unhealthy food choices. Do yourself a favour and get 6-8 hours of sleep each night.

4. **Mind your mind**

   Your mind is your most powerful tool to manage your mood and your food. Focus on your success and congratulate yourself for taking positive steps (in any area). Remember, each meal and snack is another opportunity to make a positive healthy choice.

5. **Watch out for portion distortion**

   Before eating or drinking, look at the amount. **Is it enough for 1 or 2? Are you really that hungry?** Overeating or drinking can leave you feeling sluggish and the excess can add extra kilos.



6. **Snack smart**

   Skipping meals or snacks leaves you running on empty, and feeling irritable and tired. You are also more likely to overeat when you next eat. Try healthy snacks such as fruit, yoghurt, wholegrain crackers with cottage cheese, a hard-boiled egg or a handful of nuts (about 10 nuts).

7. **Clear fluids for a clear mind**

   Swap sugar laden soft drinks for water to reduce excess kilojoules. Too much caffeine can make you anxious and jittery. Limiting caffeinated drinks may help you relax, sleep and feel calmer.

8. **Get fishy**

   Healthy fats such as those found in **oily fish** (salmon, tuna, mackerel), **grains and some plant oils** (sunflower, safflower) may improve mood. Other great mood foods include whole grains, green leafy vegetables, fruit, dairy products (low fat), lean red meat, eggs and nuts. These foods are good sources of vitamins & minerals linked to improved moods when eaten regularly.

9. **Celebrate your successes**

   Celebrate your successes and reward yourself (with non-food rewards). Making and maintaining change isn't easy. If you have an incentive you're more likely to persevere. Choose rewards that motivate you, make you feel good and are a little indulgence just for you.

10. **Recruit your support team**

    Everyone needs support to maintain healthy habits. Find at least one person (friend, family member, work colleague, health professional) who will support and cheer you on. An Accredited Practicing Dietitian (APD) can provide individual, expert advice and support to help achieve your goals. Visit 'Find an APD' on the Australia's Healthy Weight Week website **www.healthyweightweek.com.au** to find an APD in your area.

Eat *better*, feel *better*, move more **NOW!**