Mental Health
Council of Australia

NEWSLETTER

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The Road Ahead?

Frank Quinlan, MHCA CEO

Ever since the former Prime Minister John Howard announced a $1.9 billion investment in mental health, readers of some mainstream media could be forgiven for thinking that the mental health sector is pre-occupied with the role key mental health advocates play in achieving reform. In *The Australian* (13/2/12) we saw further coverage of a dispute amongst academics regarding the relative efficacy of depression medications and treatments, and the appropriate declaration of pharmaceutical company involvement in research.

This public feuding appears to have more to do with the role academics play in political advocacy than it does with significant mental health reform. Academia is structured to produce conflict – thesis/antithesis, gathering and interpretation of evidence, view and counter view. That this struggle to find the truth only occasionally spills out of the academic journals and into the mainstream press is evidence itself that the arguments are not usually central to the main policy debates of the day.

In mental health, "Big Pharma" is not "Big Tobacco". Many people experiencing mental illness lead happier, richer, more resilient and more productive lives because of the medication they take. Clear protocols and procedures which guide our engagement with the Pharmaceutical Industry must be adhered to, to offer protection against undue influence.

The big questions in mental health policy, investment and research have little to do with the role of pharmaceutical companies and even less to do with the research being conducted by most of the academic sector.

There are three big questions that should be the focus of our critical attention.

First, will the new National Mental Health Commission (established by the last budget), be able to bring the mental health sector to account? The Mental Health Commission will report to the Federal Parliament within the year, and the sector has high hopes that the Commission will identify and quantify the gaps and failures in our current systems. Only such a systematic audit can guide effective future investment. The Government has established a formidable group of Commissioners and an excellent team of public servants to support them. But the proof will be in the pudding, and the sector awaits the Commission's first report card with high hopes.

Second, will governments (Liberal and Labor, state, territory and Commonwealth) be able to give practical meaning to the aspirational commitments of the recent Council of Australian Governments? Last year the Prime Minister and the Premiers agreed to develop a Ten Year Road Map for National Mental Health Reform. This historic agreement has the potential to guide investment and reform across the sector for a

decade to come, but the sector was largely disappointed by the lack of detail contained in the first draft plan. COAG agreements have a dangerous potential to be negotiated down to the lowest common denominator. Agreements can end up including only what is acceptable to the least committed of the governments at the table. All eyes will be on the next version of the Ten Year Roadmap to see if the excellent vision and objectives of the first draft are matched by real goals, targets and deliverables.

Third, will spending across the mental health sector be systematically increased over the next decade to address the chronic underfunding that has created the present crisis? Disputes about the relative merits of this or that program risk being as salient as an argument about what kind of tyres should be fitted to a car that has no engine. Once our car has a functioning engine and a full tank of petrol, then we can determine which tyres give us the best performance. The mental health sector receives about half the funding that it needs to deliver quality services to all Australians. Only a long term, committed campaign will overcome this.

As long as disputes at the periphery of mental health distract us from these core questions we risk being placed back in the political “too hard basket”, and that would set back the cause of mental health reform for another generation.

Mental Health in Immigration Detention Centres

In late 2011, Kim Ryan, CEO of the Australian College of Mental Health Nurses, initiated a campaign calling for better mental health care for people in Australia’s immigration detention centres.

Almost 50 of Australia’s leading mental health and health organisations issued a media statement calling on the Federal Government to immediately launch an independent investigation into the standards of mental health care in Australia’s immigration detention centres.

The campaign gained momentum in November 2011 when a report in Fairfax newspapers revealed that the company paid to provide mental health services in detention centres admitted “that prolonged detention of asylum seekers has created high demand for psychiatric services which its staff can't meet.”

This provided further evidence that the Federal Government must urgently review the standards of mental health care in all immigration detention centres.

There have been a number of media stories and reports reinforcing the critical need for a pool of mental health professionals able to treat the complex range of mental health issues experienced by people in detention. The newspaper report about the International Health and Medical Services (IMHS) – which is funded to provide health services in immigration detention centres – shows that they are failing to provide the necessary health services. Fairfax reported that:

> *"IHMS has only one psychiatrist on staff, used on a casual contract basis in the months of May, September and October. Although outside psychiatrists are used, detainees can wait up to six weeks for treatment ... IHMS also said detainees with complex mental health issues need to be in cities such as Sydney, Melbourne or Perth. According to immigration data, the remote Curtin desert centre and Northern detention centre, in Darwin, have the highest incidence of detainees diagnosed with a mental illness."*

Mental health/health organisations are genuinely concerned that the Government and its contracted service provider are not providing adequate mental health care to people in detention centres at a time when incidents of self-harm and suicide have increased, and riots, protests, and hunger strikes have become common.

It is clear that conditions inside immigration detention centres are unacceptable. The mental health crisis in the immigration detention system is rapidly worsening and these conditions cannot be allowed to continue.

The demand by Australia's leading mental health organisations for an immediate investigation into mental health services in detention centres has so far gone unanswered by the Federal Government

This campaign is supported by:

- Australian College of Mental Health Nurses
- Australian Nursing Federation (ANF)
- Australian Medical Association (AMA)
- Royal Australian & New Zealand College of Psychiatrists (RANZCP)
- Mental Health Council of Australia (MHCA)
- Brain & Mind Research Institute (Prof Ian Hickie)
- Orygen Youth Health (Prof Pat McGorry)
- National Mental Health Consumer & Carer Forum (NMHCCF)
- Australian Psychological Society (APS)
- ConNetica (Prof John Mendoza)

- SANE Australia
- Professor Louise Newman
- Royal College of Nursing Australia
- Lifeline Australia
- Australian College of Psychological Medicine
- Mental Health Research Institute
- Catholic Social Services Australia
- The Mental Health Association of Central Australia
- ACT Mental Health Consumer Network
- Mental Illness Fellowship of Australia
- Mental Illness Fellowship NQ
- Multicultural Mental Health Association of Australia
- GROW
- Crisis Support Services
- Neami Limited
- Norwood Association Inc
- Alcohol and Other Drugs Council of Australia
- Queensland Voice for Mental Health
- Australian Association of Social Workers
- Reconnexion
- The Royal Australian College of General Practitioners
- Carers Australia
- Suicide Prevention Australia
- Australian Infant, Child, Adolescent and Family Mental Health Association Ltd
- Council of Remote Area Nurses Australia
- Psychotherapy and Counselling Federation of Australia (PACFA)
- Cooperative Research Centre for Young People, Technology and Wellbeing
- Australian Practice Nurses Association
- Black Dog Institute
- Mental Health at Work
- Headspace
- Occupational Therapy Australia
- The Joy Project
- National Enrolled Nurse Association of Australia
- On Track Community Programs
- Corporate Diagnostics
- The Australian Association of Family Therapy

Report highlights level of stigma from health professionals

Rachelle Irving, Director of Projects and Research

In late 2011, the Mental Health Council of Australia released the results of a landmark study which showed that the levels of stigma experienced by mental health consumers seeking treatment from mental health and other health professionals are similar to the levels of stigma reported in the general population.

The publication *Consumer and Carer Experiences of Stigma from Mental Health and Other Health Professionals,* identified the scope and nature of stigma experienced by mental health consumers. This revealing and groundbreaking research shows that the views held by health professionals providing mental health services may not differ to those of the wider community.

Rachelle Irving, the Director of Projects and Research, conducted the research and wrote the published report.

While it may seem unthinkable that health professionals would stigmatise Australians with a physical condition such as cancer or a heart condition, mental health consumers often encounter stigmatising attitudes from health professionals. This stigma is likely to have a profoundly negative effect on consumers, limiting treatment and recovery.

The Mental Health Council of Australia report shows the results of a quantitative and qualitative survey of stigma and discrimination experienced by Australian mental health consumers who have sought help from health professionals and as it is perceived by their carers. The report finds that many consumers are subjected to stigmatising attitudes from various health professionals. Some of the key findings show that:

- across diagnostic categories, almost 29% of consumers reported that their treating health professional had shunned them;
- these figures rose to over 54% and 57% for consumers with post-traumatic stress disorder and borderline personality disorder respectively;
- over 34% of consumers had been advised by their health professional to lower their expectations for accomplishment in life; and

- over 44% of consumers agreed that health professionals treating them for a physical disorder behaved differently when they discovered they had a mental illness.

As Kathleen Griffiths, the Director of Depression and Anxiety Consumer Research unit and the ANU said of this report: “This level of stigma is dangerous and unacceptable.”

When the report was made public, Frank Quinlan, CEO of the Mental Health Council of Australia said: “The MHCA is calling on all health professions to examine their approach to mental illness and ensure people experiencing mental illness and their carers receive the same level of non-judgemental care and concern as people with any other health condition.

“The attitudes of health care providers can have a direct impact on the recovery and resilience of people experiencing mental illness and these results suggest we have a long way to go.

The ABC’s flagship current affairs program, the *7.30 Report*, featured the findings of this survey in an extensive feature aired on 22 December 2011.

What was particularly interesting about the study findings is that care received by the diverse health professions is quite varied. For example, when survey participants were asked about examples of particularly good care they had received - general practitioners, psychologists and psychiatrists were cited with similar frequency.

However, when consumers were asked about experiences of particularly poor care – only general practitioners and psychiatrists were commonly referred to as the treating health professionals. This study was not investigating this matter specifically, and as such further work needs to be done to establish the variance in positive and negative experiences that consumers are having, depending on the profession of the person treating them. One possibility is that undergraduate and postgraduate health and allied health programs have varying emphasis on mental health issues. In other words, it may be that some medical schools have a number of core and elective mental health specific subjects, while others may not.

To answer this question, the MHCA is currently undertaking a national scoping exercise to establish the mental health curriculum content of every undergraduate and post graduate course in the areas of medicine, nursing, mental health nursing, psychiatry, psychology, social work and counselling. Such a study has not been undertaken previously and should provide some useful information not only for this project, but to inform the work of the various health professional and workforce planning groups.

The results of this phase of the project are expected to be completed by May 2012.

For a copy of *Consumer and Carer Experiences of Stigma from Mental Health and Other Health Professionals go to www.mhca.org.au or contact the MHCA.*

Why don't we talk about suicide?

Simon Tatz, Director of Communications

On 28 November 2011, Welsh football star Gary Speed, who represented his country in 85 internationals, was found dead at his home in Huntington.

ABC news reported that "Wales football manager Gary Speed died on Sunday at the age of 42." The report added: "There are no suspicious circumstances surrounding the death."

It was left to listeners to surmise that this was a suicide. The BBC, in contrast, reported that "the 42-year-old was found hanged."

(In late January 2012, an inquest into Gary Speed's death ruled that he died by hanging but the coroner said: "the evidence does not sufficiently determine whether this was intentional or accidental". The coroner said Mr Speed may have "nodded off" while sitting with a cable around his neck on the stairs in the garage of his home.)

The Australian media generally does not report the taking of a life as suicide, nor does it report the method. Typically the media use the euphemism 'there were no suspicious circumstances' to mean a suicide. This was also how cricket commentator Peter Roebuck's death was originally reported.

The next day, 29 November 2011, ABC news reported that British film director Ken Russell "passed away peacefully in his sleep on Sunday afternoon" at age 84.

The difference in reportage is significant. So as to distinguish a death by natural causes (or accident) the public must be told that Ken Russell died peacefully with no suspicious circumstances.

There are very good reasons why media guidelines recommend that method of suicide, location and other details are not reported. The British media provided the full story, yet here we continue to treat suicide as a subject not to be fully reported on and discussed publicly. It is not the fault of the media, they are responding to well-intentioned and well-founded guidelines on reporting suicides.

Yet every day on the news we are told precise details about how people die. In the same week as Gary Speed and Ken Russell died, the media reported in detail about multiple road fatalities, an electrocution of an Australian in Bali, an Australian woman who died in an inferno on an Indian train, the young man who tried to jump from his

hotel balcony into a swimming pool and missed, the trial of an alleged ‘honour killer’ and so on.

These too must cause grief and pain to relatives and friends and readers. There is a difference that needs to be explored. There is a difference between people suffer from acts of violence or accidents in that their situation fell upon them rather than them making a conscious decision to end their life. Yet almost nightly on the news grim and horrific footage of car accidents are shown; perhaps footage that may shock drivers to slow down, to not drink, to not drive when overtired. The reporting of death, with the exception of suicide, is prime media fodder.

Another reason cited for not reporting on method and location of suicides is the possibility of ‘copycat’ suicides. There is international research showing that report of ‘means’ can result in an increase in that choice of suicidal method. However, I doubt there are many people who are not familiar with the concept of hanging, or poisoning, using a gun or leaping from a building or bridge.

Australia’s suicide rate is horrific. According to Lifeline, suicide is the leading cause of death for women aged 15 to 34 and for men aged 15 to 44. Almost none of these are reported. Over one million people worldwide take their own life every year.

So why don’t we report on suicides in the same way we report on other deaths?

One reason is that suicide isn’t like other deaths because the individual has control over it. It’s been put to me by mental health experts that if you report a suicide, you can’t control who is listening, how they interpret it, what their state of mind is and how they might respond to it. This line of argument points out that if a person has a number of risk factors present and they are contemplating suicide, listening to a detailed report or using the internet about a suicide could trigger impulsive behaviour which will lead to their death.

This is why reporting needs to be done responsibly and with a balance of help and assistance provided to support people who might be at risk.

I’d add another factor - that suicide shocks us and we don’t fully understand it. We grapple to come to terms with why some within our midst, especially someone loved and respected, chooses to take their own life. The coverage on the BBC website is illustrative:

> *Ryan Giggs said Gary Speed was "one of the nicest men in football".*
>
> *His former Wales teammate, Robbie Savage, tweeted: "The world has lost a great man in Gary Speed I'm devastated spoke to him yesterday morning why ! Why. Why !! I'll miss him so much x”*

Suicide is tragic and shocking. It challenges some religious beliefs about the sanctity of life. It also challenges the mental health system and the biomedical model that more mental health services can prevent suicides. For many, the taking of a life is seen as a rejection of love, support, caring and ability to prevent. 'Why?' is the question always asked.

Because we often don't understand *why*, we struggle to bring out in the open *how* and *when* and other factors which might help us understand.

The actions and behaviours perpetrated or engaged in by humans can and should be analysed and discussed by humans. We should be able, and indeed willing, to look at human behaviour and human actions, at what we do to ourselves and others and seek to understand and learn more about both ourselves and our fellow human beings.

The example of genocide studies is relevant here. In genocide studies the minutiae and mechanisms of mass murder are studied in remarkable detail. In order to understand the actions of the Nazis, the Turks, the Rwandans and other genocidaires we seek to understand their mindset, systems of governance and the precursors that lead to the extermination of millions and what made some people perpetrators, others bystanders and many victims. Genocide academics and scholars of the Holocaust have produced enormous bodies of research on the mechanisms of extermination. Every aspect of these crimes against humanity has been dissected and subjected to dissertations so that other humans might understand and learn about what humankind is capable of doing – and then seek ways to prevent them ever happening again.

Why did some Rwandan mothers pick up machetes and hack to death their neighbours and their neighbours' children? How did people who lived and worked together become not just murderers but perpetrators of some of the most mind-boggling horrors ever recorded?

And why do some people leap from bridges or hang themselves? Research tells us that many people who take their own life do not want to die, they just find the unbearable pain of living too much. This is where mental health and medical models are needed as they play a life-saving role. Yet I don't think we always know *why*, so the approach to reporting and understanding of suicide is conducted with caution. However well-meaning media guidelines are, we are not openly discussing why people take their lives, how and where and when. These are important and indeed critical questions.

The Bureau of Statistics (ABS) provides informative data that I believe should be given greater attention. From the most current ABS information we know that:

> *hanging (including strangulation and suffocation) which was used in half (51%) of all suicide deaths. Poisoning by drugs was used in 12% and poisoning by other methods (including by motor vehicle exhaust) was used in 16% of suicide deaths. Methods using firearms accounted for 7% of suicide deaths. The remaining group (Other) comprised 14% of suicide deaths and included deaths from drowning,*

jumping from a high place, and other methods. Suicide deaths using firearms have more than halved over the last ten years, from 389 deaths in 1995, to 147 deaths in 2005.

Method of suicide is important to know because it explains why, for example, people in urban centres tend not to hang themselves while farmers and those with access to firearms often use this methods to take their own life. This has implications for legislatures and the way we control firearms in Australia. It has been shown that the gun buyback scheme contributed to the decline in firearm use as a means of suicide.

In every aspect of reporting there are risks and dangers. There are risks and dangers in social media, in young people influenced by the media and in copycat behaviour. Yet when six to seven Australians are taking their life every day, we should seek to understand this, to bring it out in the open, to engage young people, Aboriginal and islander communities, refugees and migrants, those in high risk groups and the nicest family men we never even 'suspected' of harbouring suicidal ideation.

There's a saying that 'suicide is everybody's business'. This is why we need to re-think how we report and discuss it.

A foray into social media: Bumpy beginnings

Kate Judd, Project and Policy Officer

It has been a little over 18 months since the MHCA launched itself into the social media scene by establishing a Facebook (FB) and Twitter page, and developing a new and improved content-driven website. We, like many other organisations, have taken up social media with the intention of figuring out over time how it might fit in with our broader communications and consultation strategies. Social media experts often warn against this ad hoc approach and instead encourage not-for-profits to properly research and plan their social media strategy. Indeed, this is the most sensible and strategic way to enter into the online world, but not particularly ideal for an organisation like ours that is still trying to figure out whether it is worthwhile dedicating finite resources to managing an online presence, and whether there are enough people online who are motivated and interested enough to stay engaged with the work we do.

Consequently, our foray into the virtual world has been typified by a series of peaks and troughs with semi-frequent bursts of energy, information sharing and communication with our online stakeholders and at other times, a deafening online silence - if there is such a thing! It certainly hasn't been the most perfect approach to establishing our online profile, and we are still very much learning how to use social media to advance the work of the Australian mental health sector and raise the profile of mental health in the Australian consciousness.

The increasing public profile of mental health in Australia, and the momentum gained through last year's Commonwealth Budget commitments generated near-perfect conditions for establishing and expanding our online reach. We have successfully recruited more than 600 followers on Twitter, nearly 1300 likes on our Facebook pages and more than 50 survey responses from young mental health carers (13-18yo) via our Young Carers Project FB survey application. Furthermore, a little less than 10 per cent of referral traffic to our website comes from our Facebook pages. Sometimes we wonder whether we are deserving of such encouraging statistics given the ad hoc way in which we have approached our online presence.

What we do know, however, is that despite these small successes, we still have a lot to learn. Some of the bigger questions that remain unanswered relate to how we can generate genuine and interesting discussions about mental health in the virtual world, and promote better mental health outcomes for all Australians. Should we start a blog? Should we plan and implement an online mental health promotion or anti-stigma campaign? Can we use social media platforms for consultation purposes? How do we integrate our traditional and social media communications strategies effectively? What role will social media and online technologies play in mental health treatment into the future? And how much is all of this going to cost?

As we, along with the rest of the world, move deeper and deeper into the digital age, it is becoming increasingly evident that we can't afford to ignore social media and online technologies. If we don't start attempting to answer all these questions, we are going to be left behind in the analogue world, and will miss out on the new and innovative opportunities for health promotion and stakeholder engagement that social media and online technologies present.

Perhaps you have some ideas or thoughts on what the Australian mental health sector should be doing with social media or online technologies? Perhaps you have some answers to our questions? We are always interested to hear your thoughts, criticisms and encouragement and with our expanding social media presence, there are many and varied ways in which you can give us an earful or two. We want to hear them! And we want to hear them in both the digital and analogue worlds, online and offline.

Centrelink, Human Services and DEEWR – an update on employment participation and mental health

Liz Ruck, Policy Officer

Centrelink engagement

Mental health consumers and carers have long called for Centrelink services to interact with them in a more respectful, empathetic way and with better informed more useful information. These requirements should be obvious – they are after all included in existing service charters – but consumers and carers are aware that it can take some finessing to get these sorts of principles into action. Importantly, the Department of Human Services (DHS) is beginning to find out that working more closely with consumers and carers is the key, but translating this into practice is slow.

In response to the Australian Government Ombudsman's report *Falling Through the Cracks, Centrelink, DEEWR and FAHCSIA: engaging with customers with a mental illness in the social security system*, DHS has established the Mental Health Issues Working Group to propose strategies for Centrelink to improve its service delivery. The working group includes representatives from a number of MHCA member organisations as well as a consumer and carer representative.

The MHCA has also been invited by DHS to partner in a trial of interventions for people presenting with their first 'capacity exemption' for anxiety or depression. The trial will provide the MHCA with some important insight into the experience of mental health consumers who are job seekers on Newstart Allowance.

Service Delivery Reform

Through the Service Delivery Reform initiative, DHS is changing the way Centrelink, Medicare, Child Support Agency, Hearing Australia and CRS services are delivered. Service Delivery Reform received a major boost in the 2011-12 Federal Budget. Features of the budget that will impact on Centrelink service delivery include:

Local Connections to Work

There will be an extension of this successful initiative, which has already been trialed in nine Centrelink Program sites. Under Local Connections to Work, Centrelink targets the needs of highly disadvantaged job seekers and their families with employment, education and community support services through the provision of Australian Government, state government and non-government service providers 'under one roof' on a rostered basis. An additional fifteen sites will be funded by 2014-15.

Case Coordination
Forty four Centrelink Program sites will be involved in a targeted case coordination trial. Each site will provide integrated and intensive support for people who need it most by connecting them to services.

Centrelink Community Engagement Officers
These officers will work in collaboration with customers and community agencies to deliver DHS services, on an outreach basis, to people who are homeless, or at risk of homelessness and who do not access mainstream Centrelink. At this stage it is not clear where these officers will be located.

The Local Solutions Fund
Funding of $25 million over four years has been identified for grants to community programs and organisations. Funding will be allocated through an Expression of Interest (EOI) selection process, with eligible providers then invited to submit a more detailed application. This process is intended to acquire a high level of community input in the selection of funded services.

Community Innovation through Collaboration
Government Action Leaders and Community Action leaders will be identified.

- Government Action Leaders (GALs) are DHS employees based in each of the ten locations identified in the Better Futures Local Solutions package.
- Community Action Leaders (CALs) will be engaged by a community organisation and have experience in delivering local level community initiatives.

These initiatives are beginning to look like the sort of 'wrap around' services favoured by the mental health sector.

Better support for employment participation
Full employment participation is a key goal of the Australian Government. The Department of Education, Employment and Workplace Relations (DEEWR) develops and delivers the strategic policy on employment participation and is crucial in achieving this goal.

The mental health sector has some good ideas about how to increase the employment participation of mental health consumers and carers in a fair and equitable way and ensure that they are able to retain employment. Unfortunately DEEWR does not seem have any appropriate mechanisms to work with the mental health sector, including consumers and carers, to inform planning and implementation of employment and income support services for people with mental illness. Some MHCA members, who are employment support service providers, have expressed frustration with this situation, noting that they have raised significant concerns around how best to meet the needs of their clients who are mental health consumers but feel that their feedback to DEEWR on these issues falls on deaf ears.

While the MHCA has had some contact with DEEWR in the past, particularly around the launch of the MHCA publication *Let's Get to Work: A National Employment Strategy for Australia*, there has been little opportunity for dialogue about the more recent implementation of the Australian Government *National Mental Health and Disability Employment Strategy* and its implications for employment participation for mental health consumers or the services that support them. The MHCA recently had the opportunity to meet a DEEWR representative at a Centrelink Mental Health Issues Working Group meeting and provided them with the following concerns raised by MHCA members about employment participation policy:

1. Mental health consumers and carers advise that they are not always well serviced by generic disability employment services, who often do not:
    a. Know enough about mental illness to place them in appropriate employment. Inappropriate placements result in exacerbation of illness (and the cascading social exclusion effects of social and health problems that result from this), termination of employment etc.
    b. Have the resources to sustain them in supported employment in the long term – similar results.

2. There is no communication mechanism for consumers and carers or the MHCA to provide this information to DEEWR and it is unclear how well current contract monitoring arrangements are able to reveal this information to DEEWR;

3. Specialist mental health disability employment services who are MHCA members advise that their funding agreements are not well designed to assist them to support people with complex needs.

Interestingly, while this article was being written, DEEWR invited the MHCA to provide some input on the development of training modules on mental illness for Centrelink, Job Services Australia and Disability Employment Service frontline staff. The modules aim to increase the capacity of these staff to better identify and assist mental health consumers gain employment, and better connect them with the appropriate services, including community mental health services and Medicare Locals. We only had a week to provide feedback but we hope it is the beginning of a long a fruitful dialogue between DEEWR and the mental health sector, particularly consumers and carers.

With Minister Mark Butler now holding the key portfolios of mental health and social inclusion, the MHCA also looks forward to collaboration between these areas and those of Minister Brendan O'Connor, who has the ministerial portfolios of human services and employment participation. Ideally these relationships would assist in ensuring that these portfolios are fully informed by each other's activities and in breaking down some of the policy barriers that do little to assist fair and equitable employment participation of people with mental illness.

MHCA NEWS and UPDATES

Update on Committees

Following the MHCA's AGM on 15 November 2011, there were a number of changes made to MHCA Committees:

Board
The MHCA is very pleased to welcome Mr Geoff Harris (MHCSA) and Dr Caroline Johnson (RACGP) to the Board, along with re-elected members Dr Valerie Gerrand (AASW), Mr Arthur Papakotsias (NEAMI) and Professor Lyn Littlefield (APS). Continuing Board members include The Hon Rob Knowles as Chair of the Board (MIFA), Mr Tony Fowke (ARAFMI) as the carer representative, Ms Clare Guilfoyle (GROW) as the consumer representative, and The Hon Craig Knowles as an Independent member.

The Board is also pleased to announce Professor Lyn Littlefield as the new Deputy Chair of the Board.

Audit and Compliance Committee
The Board is pleased to announce Mr Arthur Papakotsias as the new Chair of the Audit and Compliance Committee. Members also include Ms Clare Guilfoyle, Mr Tony Fowke, Mr Geoff Harris and Mr Frank Quinlan.

Governance Committee
The Board is pleased to announce Dr Valerie Gerrand as the new Chair of the Governance Committee. Members also include: The Hon Rob Knowles, Professor Lyn Littlefield, Mr Tony Fowke, Dr Caroline Johnson and Mr Geoff Harris.

Members of the MHCA Board with MHCA CEO Frank Quinlan at the November 2011 AGM.

Annual General Meeting
As well as electing the new Board (see above), members also approved amendments to the MHCA Constitution. The updated Constitution can be found at http://www.mhca.org.au/index.php/about-us/about-the-mhca

Member's Policy Forum
The Member's Policy Forum was also held on the 15 November 2011 in Canberra. Members discussed MHCA reporting and feedback, member engagement, a proposed Annual Planning and Advocacy Cycle, current challenges and opportunities for members, key priorities and issues, and MHCA funding. Further details can be found in the MPF report which will be distributed to members in the coming weeks.

MHCA Staff

Prior to the holiday break, MHCA's generous staff made a contribution to Barnardos ACT Giving Tree to help spread some joy for children and families over the festive season. If your organisation would like to become involved next year, please contact Barnardos ACT on 6228 9500.

OUR CONSUMER PLACE

Our Consumer Place is a groundbreaking mental health resource centre run by consumers. They are funded by the Victorian Department of Health and auspiced by Our Community.

They have just released the second booklet in a series for mental health consumers in Victoria.

Speaking Our Minds: a guide to how we use our stories is all about mental health consumers' stories and has been written entirely by consumers for consumers.

It's written from the perspective of those who have been there and have the stories to tell about many things, including service quality, what student clinicians need to know and consumers doing things for themselves. It also includes some fabulous new cartoons from Merinda Epstein.

All Our Consumer Place booklets are available in hardback in small quantities or at cost price for larger orders and can be downloaded for free from the Our Consumer Place website.

Please visit the website -http://www.ourconsumerplace.com.au/article?id=4681 – for more information and to order or download booklets.