

## **MindLine No 17**

**ARAFMI Hobart: Spring 2005**  
97 Campbell St Hobart 7000 Ph 62 369 251 HelpLine

Published first week of Feb, May, Aug & Nov. **MindLine copy:** Please deliver any items for the Editor of *MindLine* by the first day of the last week of April July & Oct. Packing first week of months Feb, May, Aug, Nov.

**A BIG Thank You to everyone for their donations of stamp booklets for MindLine!!!**

*Our thanks also to our supporters:*

The Mental Health Services, Australian Ethical Investments, National Australia Bank, Astra-Zeneca, Pfizer, The Hobart Clinic, Mr K Kerr, Tasmanian Community Fund.

### Support Meeting Venue

### Date / Topic

<p><b>All meetings start at 7.30pm</b> <b>97 Campbell St Hobart</b> Some parking at rear of bldg.</p> <p>Everyone is welcome!! Supper available – would you like to bring a plate?</p> <p><b>PLEASE return your Library Overdues this week.</b></p> <p><u>Trade table:</u> craft items available.</p>	<p><b>11<sup>th</sup> August 7.30pm</b> <b>Info on new statewide services:</b></p> <p><b>Patrick Carlisle from Richmond Fellowship,</b> <b>Chris Skinner from Anglicare and</b> <b>Phil Hose from Aspire will explain non-government services.</b></p> <p><b>8<sup>th</sup> Sept Violence at Home new laws (Family Violence &amp; mental illness)</b></p> <p><b>13<sup>th</sup> Oct catch up meeting of our own</b></p>
---	---

## **Southern Community Mental Health Forum**

**Thursday 25 August 2005**  
**10.00am – 1.00pm**  
**Glenorchy Civic Centre**

### **“An Overview of Forensic Mental Health Services”**

#### **AGENDA**

10.00am	Welcome and introductions
10.00am – 10.30am	Bridging the Gap Update – Fatima Ali
10.30am - 11.00am	Forensic Mental Health & Correctional Health Renewal Project Overview – <i>John Alderdice, Project Manager Correctional Health Services Renewal Project</i>
11.00am - 11.30am	Morning Tea
11.30am - 12.00pm	Wilfred Lopes Centre for Forensic Mental Health – Update on the Secure Mental Health Unit – <i>John Crawshaw, Statewide Clinical Director</i>
	Service Model for Secure Mental Health Unit – <i>Alice Godfrey, Occupational Therapist</i>
12.00pm - 12.30pm	Community Forensic Mental Health Overview – <i>Scott Beswick, Team Leader</i>
12.30pm – 1.00pm	Open Panel Discussion – <i>John Alderdice, John Crawshaw, Alice Godfrey, Scott Beswick &amp; Narelle Butt</i>

**RSVP by Friday 19 August 2005 to:**

Susan Applebee

6273 0022

[gavitt.house@dhhs.tas.gov.au](mailto:gavitt.house@dhhs.tas.gov.au)

**How family work and psychosocial treatments help people with schizophrenia or bipolar.  
3rd International Conference on Early Psychosis 2002**

**Psychoeducational multifamily groups in first episode and prodromal psychosis**

W. McFarlane<sup>1</sup>, A. Fjell<sup>2</sup> <sup>1</sup>Main Medical Center, Department of Psychiatry, Portland, ME, USA, <sup>2</sup>Ullevaal University Hospital, Department of Research and Education, Oslo, Norway

In nearly every case of first episode (or prodromal) psychosis, family members are intensely involved. For that reason alone, family intervention at this early stage if illness is essential. However, 20 years of research has demonstrated conclusively that family intervention has powerful effects on the short and intermediate term course of schizophrenia and other psychotic disorders, while more recent research has documented remarkable effects on functioning, negative symptoms and even reductions of medical illness in relatives who participate as partners in treatment and rehabilitation. Psychoeducational multifamily group treatment is an elaboration of the models developed by Carol Anderson, Ian Falloon, and Michael Goldstein. We have developed specific ways of working with families in a long-term treatment model to help them develop increasingly sophisticated coping skills for handling the many difficult problems posed by mental illness in a family member. These problems include such common issues as participation in aftercare programs, medication compliance, the use of illicit drugs, alcohol abuse, violence, and the range of positive and negative symptoms presented by the patient.

**Using our model of family psychoeducation, we have been able to reduce the rate of relapse of these patients to under 50%** of what would have been expected had they received more traditional forms of treatment. (Initiatives) include joining with families, conducting an educational and coping skills workshop, multiple family group leadership, problem solving and communication skills training, and specialized methodology for addressing the social and vocational rehabilitation needs of the patient). Emphasis is placed on dealing with common impasses in the management of this illness.

-----

**Early recognition and intervention for bipolar disorders** – an investigation into cognitive, emotional and psychosocial factors influencing vulnerability and recovery in early onset bipolar disorders

M. Schwannauer\*, C. Brodie, M. Power Bipolar Disorder Service, Department of Psychiatry, University of Edinburgh, UK

The current study investigates the efficacy and effectiveness of a psychosocial intervention for people with a first episode diagnosis of bipolar disorder. This particular psychosocial intervention has been developed for the purpose of this trial and includes elements of cognitive therapy and interpersonal therapy in both a group and individual format. This study further aimed to develop a multifactorial model of aetiology and treatment of bipolar disorders that takes account of mood specific changes in the perception and function of various psychological factors and the clinical processes that can be employed to change the effect of these vulnerabilities.

In targeting a first episode population in comparison with a group experiencing multiple relapses we are able to investigate the connection of these processes with the development and course of the illness. In this study we applied a partially randomized design in which patients were randomized into waiting list control or treatment group. Results of a first episode sample reveal significantly lower relapse rates and inter-episode residual symptoms, as well as better psychosocial functioning, **these findings have strong theoretical implications for the early intervention paradigm for bipolar disorders.**

You are invited to attend  
**The Twenty-First Annual General Meeting of A.R.A.F.M.I. Tas Inc.**  
 to be held at  
**The Emmanuel Centre - 123 Abbott Street, East Launceston.**  
**Monday 22nd August 2005 at 7.30 p.m. (please be early)**  
**Guest Speaker: Wendy Nash - Art Therapist**  
**Topic:**  
**"Open your mind to the healing benefits of Art Therapy**  
**for people living with a mental illness"**

**Come and hear this colourful, joyful guest speaker and join us for free supper**

**The changed provisions for Community Treatment Orders (hereafter CTOs).**

Last month the Mental Health Act 1996 was changed in relation to CTOs. The Act is changed such that if a person has been put onto a CTO and the person has failed to comply with the order, and all reasonable steps have been taken to obtain the person's cooperation and their health has worsened or there is a significant risk that their health will deteriorate (because of not getting their ordered treatment), an approved medical practitioner (together with another authorised officer or doctor or person responsible) may authorise for them a temporary admission to hospital as an involuntary patient.

A copy of this authorisation is to be given to the patient and to the person responsible.

The person may be taken into protective custody (& use such force as is reasonably necessary) and transported to the hospital. The authorisation allows detention for not more than 14 days.

The temporary admission ceases when the first of the following things happens:

1. The approved medical practitioner cancels it, or
2. More than 28 days have passed since making the order unless they have been admitted by that authorisation, or
3. The patient is discharged by the doctor in charge of their treatment or
4. a Continuing Care Order is made for the patient or
5. 14 days from the admission date have elapsed or
6. the CTO ceases or is discharged by the approved medical practitioner, or the M H Tribunal or it was not renewed at the end of its term. or
7. after its review, the Mental Health Tribunal discharges the authorisation.

Please note that there is no obligation for a Person Responsible (usually the closest relative) to sign the authorisation and in most cases it would be preferable for an authorised officer or medical practitioner to sign. This is because of the potential harm the signing of the authorisation could cause to the ongoing relationship between the Person Responsible and the patient."

See:

**Mental Health Amendment Act 2005 (No. 32 of 2005) <http://www.thelaw.tas.gov.au>**

After section 44 of the Principal Act, the following Division is inserted in Part 7:

*Division 3 - 44A. Authorisation for temporary admission as involuntary patient under community treatment order.*

-----

***"To those in Desperation"***

I never thought the storm would cease. The Mania. Psychosis. Violent outbursts.

The anxiety that gnawed at me each morning persisted for months. Years. I would spend my days full of foreboding and dread. Sitting alone. Hiding in my garden shed. I lost all hope.

At times I would take a knife and cut my face. Silent screams at the unrecognizable image in the mirror. Eyes haunted and black.

I thought there was no way back, I stopped washing. Dressed in shabby clothes. Stopped eating. Lost half my body weight.

My nights were full of terror. I would wake, wet with sweat.

I became an outcast in my community. The local joke. The stigma of mental illness was too much for my family. There was no support or encouragement. I was full of guilt.

Admitted to hospital involuntarily, I was so ashamed. Drugged to the eyeballs. Sitting in padded cells. My lowest ebb. Incoherent. Spirit broken.

My personal relationship became chaotic and eventually my partner left me, taking with her my two year old son.

For years I simply couldn't function. Totally exhausted and burnt out. I would simply sit and chain smoke. Thoughts of suicide my only solace. Everything was too far gone. I thought I would never live a 'normal' life again. It was simply too far back, too hard.

To think before all this happened, I was working for the Police, a commendation under my belt and a promising career beginning to unfold. My fall from grace was dramatic and complete. I was shunned by workmates.

More visits to hospital, different doctors with various medications failed to lift the gloom and despair.

I grew more despondent. Introverted. I simply couldn't speak. The pain was too intense. I would despair at the thought of another day. Life seemed worthless; I was a shell of my former self.

Looking back I don't know how I made it through.

The message I wish to convey is that eventually I did and you can too. Don't ever give up. The experience may seem unbearable at times, existence pointless, but these are illusions generated by the illness.

I lost seven years of my life but for the first time, I am beginning to live again.

To put the past behind me. To look ahead with a little hope. All I want to say is never give up. Sure, take time out, but always remember there is a way even if at times the path is obscured.

Sincerely, Kelvin Hall

(Diagnosed Bi-Polar Disorder 1998)

### *A Patient's Personal Perspective:*

I have a number of options and set elements in a personal stress management plan: This includes the following:

1. A set morning routine which includes some planning time (written and mental);
2. Daily prayer (usually silent);
3. Yoga and meditation as a mild forum of physical and mental exercise (cultural considerations are relevant);
4. A healthy and well balanced diet;
5. Healthy exercise relative to age and lifestyle requirements – this includes occasional planned walks with friends in parks and reserves and on beaches, swimming and some gardening and involvement in agriculture and sailing etc;
6. Ensuring creative energy is used effectively e.g. drawing, painting, design, writing and so on;
7. Maintaining contact with at least one friend who believes in my mental strength and stability (some level of rotation is acceptable);
8. Some methodical pastimes e.g. stitching, playing music....;
9. Improving family communications and understandings through discussions and meetings to reduce potential conflict;
10. Assisting those around me (as possible) who may appear to be stressed so their tension is not magnified and does not add to mine;

11. Talking – preferably to professionals about problems to resolve and attempting to minimize discussion of problems with friends. (Friends should be capable of letting me know if they wish to change the topic of conversation);
12. Requesting positivity from significant others and for them to consider my perspective so that their positivity has a sound basis (e.g. How about some regular religious observance for a time to remind you of some good principles and good company);
13. Finding an agreeable friend or friends or professional (or both) who can act as a ‘sounding board’ for feedback on ideas prior to implementation;
14. Writing, or speaking, in privacy, of negative elements and thoughts to off load them, and then doing the same to present positive elements and thoughts for purposes of encouragement and self esteem building and recovery (I suggest disposals of bad ideas);
15. In stress related crises, attempting to slow down and diffuse the situation e.g. by temporary relocation, letter writing and redrafting, restricting information flow and movement for short time periods;
16. Seeking assistance with financial planning and management (appropriate to age and situation of peers in general) to improve stability;
17. Redefining career goals (e.g. avoiding a career as a politician) and looking for a relatively smooth pathway and direction which allows time off to alleviate stress;
18. Identifying obvious hindrances and attempting to avoid these and express territory so that any person hindering recovery and good health is made aware of his or her obtuseness and given opportunities to avoid collision.

I now find that my caring family and friends are beginning to see the light. They can take some convincing, however, nice people will always be happy to see patients and former patients progressing and no longer being drug dependent. A good first step is in being non-judgmental and considering sustainable changes.

Continuing mental health awareness raising is of utmost importance and I like to contribute to ARAFMI through drawing and writing, so that this occurs. If you believe that this article has caused you to think, you may wish to discuss relevant matters with the professionals who treat you. I certainly advise this in all cases. I now consider myself to be healthy.

ARAFMI Member Katherine (Kate) Greenhill

### **OPTIMISING TREATMENT OUTCOMES IN SCHIZOPHRENIA**

(Presented by Prof. David Castle, Mental Health Research Institute) TheMHS conference 2004

Prof. Castle acknowledges that the psycho-social needs of people with psychotic disorders are not being adequately addressed. To address this deficit, his team (in Victoria) has been working on developing a new “framework” (or “approach”) to service delivery and therapeutic intervention in the management and treatment of schizophrenia. This framework is “collaborative” in that it incorporates a partnership between, not only the G.P, psychiatrist, case managers and non-government organizations, but most importantly- **FAMILY MEMBERS**. It is hoped that the incorporation of a “psycho-social” dimension to treatment will become part of **ROUTINE** clinical practice in the not too distant future.

Three pilot studies are currently underway, where organizations and mental health professionals adopt this approach to service delivery and therapeutic intervention for consumers. After completion of these pilot studies all trials will be evaluated and the approach disseminated across Victoria.

What the framework seeks to do is to assess the psycho-social “needs” of the consumer so that a more comprehensive rehabilitation regime can be undertaken, one which goes beyond *just* medication. Currently, the treatment regime for schizophrenia consists primarily of medication (91%) and only a very small amount of time and focus is given to also incorporating a “socially- oriented” dimension into therapeutic treatment (9%).

Particular types of activities and self-help strategies are chosen by the consumer in collaboration with particular members of his or her “team”. Although all members in this partnership work together, the onus for improving the consumer’s outcome remains *with the consumer*. The strategies assist in the consumer’s ability to maintain a level of social functionality so that they are able to contribute to, participate in, and not feel

isolated from, the wider community. These strategies and activities may include for example, strategies on how to cope in certain social situations; on developing new skills; educating him or her on how to recognize particular symptoms of say, social anxiety. This is a common social barrier among consumers living with schizophrenia.

For some consumers, Schizophrenia is not the only illness they have to manage. About a third of people living with schizophrenia have a form of social anxiety which is *not part of the symptoms* of schizophrenia. This new collaborative approach to therapeutic treatment allows the consumer to address this barrier (and any others which may arise) through either group therapy or one-on-one therapy with a counsellor. For other consumers, the effects of substance misuse may be a barrier in their lives.

All these strategies and therapy modalities are devised by the consumer in collaboration with members of his/her “team”, and outlined in the form of a “My Health Plan” as well as a “Relapse Prevention Strategy”. The latter focuses on showing how the consumer can watch out for any “early warning signals” which indicate possible deterioration in their progress and how he/she can deploy strategies to prevent signals from spiralling out of control. These “plans” allow all parties in the partnership, in particular the consumer, to keep track of the whole recovery process, and to monitor progress. At times, particular symptoms may arise, or other factors may hinder an individual’s progress which requires alternative therapeutic approaches or the development of new coping strategies.

Thanks to Aemelia

### **New Library Additions:**

‘The F word’ video about families.  
 ‘Broken Open’ by Craig Hamilton: broadcaster  
 ‘MP the life of Michael Peterson’, surfer by Sean Doherty  
 ‘Bipolar Disorders Abstracts’ from International Conference 2004.  
 ‘Carer Mapping Project Report’ NSW ARAFMI

Book Reviews: from one extreme to the other ie a balance...

### **Electroshock by Max Fink MD OUP 1999 & Peaceful Mind by John Macquaid Ph.D. P Carmona New Harbinger Pub Inc. 2004.**

Fink’s book is quite technical and concise and thorough. It explores myths surrounding ECT. Details of what ECT is, how it is given, its risks and how it works are outlined. Dr Fink is quite persistent in his viewpoint that ECT is better than medication and other therapies such as CBT. Whether you agree with this perspective is really a matter of experience and what has worked for you. It is a thought-provoking book and it is good to understand the procedure. It does take away the controversial media images that tend to stick in our minds about ECT. Where it shatters myths is in the clear exploration of the procedure and the reason why it is administered. The book takes away misinformed images.

Macquaid & Carmona’s book details the methods of Cognitive Behaviour Therapy and mindfulness. It incorporates exercises which are valid and workable. It is well written and the language used is of a positive resourceful nature. There are many chapters of this book which I really liked, for example, tackling core beliefs, understanding and changing depressed thinking, mood and people skills and mindfulness.

The book covers a wide selection of issues that surface during depression and treats the reader with a sense of dignity and compassion. It doesn’t proclaim a simple fix for depression though, it sets the reader a challenge to accept the depression and overcome it by using our thoughts to observe and still our judgements. It offers light to a dark subject.

Reviewer Sandra Direen.

97 Campbell St  
HOBART  
TAS 7000