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## ACT Branch Report on the 2005 Sax Oration

Professor John Kaldor presented the 2005 Sax oration; The global expansion of HIV prevention and treatment: Synergies and challenges for public health programming, in the Bob Douglas Lecture Theatre at The National Centre for Epidemiology and Population Health (ANU) in May.

John Kaldor is the Deputy Director of the National Centre in HIV Epidemiology and Clinical Research at the University of New South Wales. In this capacity he has been responsible for coordinating national surveillance for HIV/AIDS since 1989, as well as conducting research programs into HIV transmission and disease progression, with a particular focus in the Asia-Pacific region. He is therefore ideally placed to provide an historical overview of HIV/AIDS prevention and treatment.

He argued that during the first decade and a half of the global AIDS pandemic, prevention, largely defined in terms of reducing the behavioural risks of HIV transmission, was understood to be the priority in poorer or developing countries as treatment was extremely expensive and of limited efficacy. Thus, the promotion of condom use and safe sex messages occurred in some countries in Asia, the Pacific and Africa but met with resistance or limited success where they challenged existing cultural norms, practices or government ideology.

He argued that this perspective has changed radically over the past five years, for several key reasons. First, treatment options have been transformed through the new, and more potent drug combinations, and their cost in developing country settings has been cut over twenty-fold through a range of public and private initiatives. Second, there has been an increasing recognition that behavioural strategies alone will not have a substantial impact on transmission rates in a number of settings.

Finally, there has been a renewed emphasis on developing prevention strategies that have a biomedical basis, including vaccines, microbicides and chemoprophylaxis, and treatment itself is now seen as having the potential to reduce transmission rates through its potential to reduce the viral levels in people with HIV infection. He concluded that as a result of these developments, the past divide between the prevention and treatment of HIV infection is likely to narrow, with substantial consequences for service delivery, public health strategies and research priorities.

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## ACT Branch Report on the 2005 Sax Oration - continued from previous page

The substantial audience that attended the Sax Oration was drawn from a wide array of academic, Federal and ACT government departments and Non-Government Organizations, such as the Aids Action Council of the ACT. Members of the audience asked an equally wide-ranging series of questions. They included comparisons between HIV management and treatment with that of other diseases such as hepatitis C and malaria, and whether this new emphasis on treatment would lead to a dangerous disregard for non-biomedical interventions or might give the pharmaceutical industry too great a role in setting the agenda for HIV treatment. In response to these questions John described some of his experiences with recent attempts to trial new prevention and treatment approaches and the difficulties that can occur.

The ACT Branch of PHAA thanks John Kaldor for his interesting oration, which stimulated us to reflect on the new partnerships and approaches that public health will draw upon in the 21<sup>st</sup> Century.



John Kaldor

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**PUBLIC HEALTH ASSOCIATION**  
of Australia Inc

ABN 41 062 894 473

## **NOTICE OF ANNUAL GENERAL MEETING 2005**

**Notice is hereby given that the Annual General Meeting of the Public Health Association of Australia Inc. will be held on Wednesday 28 September 2005 commencing at 1.00 pm to 2 pm in the Golden Ball Room at The Sheraton Perth Hotel, 207 Adelaide Terrace, Perth.**

**The AGM will be chaired by Cathy Mead, National President, PHAA.**

**The ordinary business of the Annual General Meeting is:**

- (1) to confirm the minutes of the previous AGM by teleconference, chaired by Peter Sainsbury in Sydney by teleconference on 9 October 2004;**
- (2) to receive and consider reports (including financial statements) from the Board, Special Interest Groups, the Auditor and the Executive Director of the Association on the activities of the Association during the preceding financial year, 2004/2005. Also to receive the report from the Vice-President (Policy) and to consider the adoption of a stipulated group of policies as PHAA policy;**
- (3) to appoint the Auditor for 2005/2006 Financial year.**

**The Annual General Meeting may transact special business provided written notice of that business is given to members at least 14 days before the meeting.**

**Therefore any special business to be added to the agenda must be advised in writing to the Executive Director by 5 pm 15th September 2005.**

**The Agenda for 2005 AGM and minutes from the previous meeting held on 9 October 2004 by teleconference, chaired in Sydney will then be circulated to PHAA members by email and put on the PHAA website.**

*Pieta -Rae Laut*

**Pieta Laut  
Executive Director  
30 August 2004**

## *Aboriginal and Torres Strait Islander Public Health Awards*

The past few months has seen a considerable commitment from the Public Health Association of Australia to helping Aboriginal and Torres Strait Islander health and associated workers attend significant health events.

In July the Peoples' Health Assembly held their second Assembly in Cuenca Ecuador. The Peoples' Health Assembly is an international congress of people concerned about the growing inequities in health globally, nationally, regionally and locally. The PHAA, in conjunction with the Office for Aboriginal and Torres Strait Islander Health, (OATSIH) sponsored four Indigenous health leaders to attend. They were Pat Anderson from the Aboriginal Medical Services Alliance in the Northern Territory and Stephanie Bell, of the Central Australian Aboriginal Congress, Bronwyn Fredricks from the Bidgerdi Aboriginal and Torres Strait Islander Community Health Service, and Peter Waples- Crowe from the Victorian Aboriginal Community Controlled Health Organisation.

The opportunity provided by PHAA and OATSIH's sponsorship is two way. Firstly, recipients were able to provide the Assembly with a voice from Indigenous Australians, articulating the need for better health, justice and equity, and reaffirming the rights of Indigenous people to be involved in the decisions that affect their lives and health. By doing so they were also able to reaffirm that health is a broad crosscutting issue and develop communications with other Indigenous groups from around the world.

Secondly, by participating in such a world assembly, the recipients gained significant knowledge about the efforts of individuals and communities facing similar problems to Australian Indigenous communities. Mutual learning under such circumstances will enlarge the debate and lead to shared knowledge and practices of alternative models for the promotion and provision of community health.

Pat Anderson, Executive Officer of the Aboriginal Medical Services Alliance NT, said "The opportunity to attend the Peoples' Health Assembly and to participate as an Indigenous Australia is very significant. It is rare that Indigenous people from around the world are afforded the opportunity to meet to debate issues that have such a significant effect on them as does health. It is only by participating in such assemblies that we are able to discuss local, national and global systems, through which the determinants of health, especially Indigenous community health, is affected."

Further to these sponsorships, OATSIH and the PHAA have provided sponsorships for 11 Aboriginal and Torres Strait Islander health leaders to attend the PHAA's Annual Conference in Perth in September 2005. The recipients of these awards are; Peter Waples-Crowe from the Victorian Aboriginal Community Controlled Health Organisation, Bronwyn Fredricks from the Bidgerdi Aboriginal and Torres Strait Islander Community Health Service, Jenny Baraga from the Wirraka Maya Health Service, Lynette Hussey from the Townsville Aboriginal & Islanders Health Services, Mavis Egan from the Njernda Aboriginal medical Clinic, Kane Ellis from the Heart Foundation NT, Malcolm Champion from the Royal Flying Doctor Service, Port Augusta, Liesa Clague the Faculty of Nursing University of Sydney, Joan Smith from the CQ Regional Training Centre for Social and Emotional Well-being attached to the Bidgerdii Community Health Centre, Angela Marr from the Population Health Program, Partnership for Aboriginal Care and Vanessa Clements from the Durri Aboriginal Medical Service.

It is anticipated that these sponsorships recipients will add a distinct voice to the Annual Conference and will also gain much from the experience of attending a conference that covers such a diverse array of health issues.

## *Prisoner Health Special Interest Group*

Thanks to the efforts of Michael Levy and Janine Turnbull we now have a Prisoner Health Special Interest Group (PHSIG). The PHSIG aims to:

- advocate for a national prisoner health policy;
- advance prisoner health policy, programs and practice; and
- provide opportunities for putting research findings in the intersecting areas of health and the criminal justice systems into practice.

In order to achieve these aims the PHSIG has developed the following objectives:

- Facilitate periodic seminars and workshops and discussion/issue papers for members;
- Contribute to the development of prison healthcare policy in Australia;
- Gather evidence to inform and improve prisoner health in Australia;
- Develop PHAA policies to support prisoner health in Australia;
- Collaborate with other stakeholders to advance our aims; and
- Work toward a third national prisoner health conference.

The PHSIG has an interim Committee comprised of Michael Levy, Doreen Rae, Steve Liebke, Jonathon Carne and Richard Thode. Twenty members expressed endorsement of the SIG and we are now calling on those 20 and any other members who would like to support the SIG to join by making their ten dollar payment to the SIG's funds.

The *Australian and New Zealand Journal of Public Health* has already published a number of articles in this area, including on the health of prisoners, post-incarceration mortality, and the impacts of incarceration on children of prisoners.

The Public Health Association of Australia has held two prisoner health conferences – in Sydney (1999) and Brisbane (2003). We are hoping that the SIG will generate sufficient interest that we will be able to hold a third Prisoners Health Conference in 2007.

A web page and bulletin board for the PHSIG will be developed on the PHAA website as soon as possible.

### **Sponsors for the 2005 Public Health Association Annual Conference**

The Public Health Association of Australia wishes to thank the National Health and Medical Research Council, the Government of Western Australia Department of Health & the Commonwealth Department of Health & Ageing for their generous conference support.



**Australian Government**

**National Health and Medical Research Council**



**Department of Health**



**Australian Government**

**Department of Health and Ageing**

## *PHAA's Presentation to the Senate Select Committee on Mental Health, Canberra, Wednesday, 27 July 2005*

PHAA Executive Director Pieta Laut, the MH SIG's previous Convenor Valerie Gerrand, and interim Convenor Sue Humphries presented PHAA's evidence to the Inquiry, based on our written submission (see PHAA website).

Senator Lyn Allison is chairing the inquiry, whose terms of reference and transcripts are on the parliamentary website ([www.aph.gov.au/senate/committee/mentalhealth\\_ctte](http://www.aph.gov.au/senate/committee/mentalhealth_ctte)).



Our introduction highlighted PHAA's population health focus and multi-factorial approach to understanding and treating mental ill health. We also referred to our interest in promoting mental health and wellbeing, and concern that Australians with mental ill health receive the right treatment at the right time, irrespective of age, location and income.

Referring firstly to positive developments, we noted that anti-stigma campaigns are working, with more people seeking assistance, although services are yet to match the increased demand. More evidence-based treatments are also available, including drugs with fewer side-effects and new psychological interventions. Service innovations abound, such as 'step-up/step-down' services, which provide a transition after discharge and an alternative to in-patient admission.

The National Mental Health Strategy has given real impetus and direction for reform and we now know how to transform institution-based service systems into community-oriented care, and how the Commonwealth can assist.

However, problems continue. There is significant on-going stigmatisation, with mental health professionals perceived by consumers as those most stigmatising in their attitudes. Some diagnostic labels can be real barriers to treatment.

Access to treatment still largely depends on geography and income. An over-reliance on drug treatment also limits access to the full range of evidence-based interventions, and the publicly-funded mental health workforce is used ineffectively and inefficiently. For instance, location, long waiting lists and unavailability limit access to private psychiatrists after hours.

Further, clinical psychologists in private practice are not reimbursed under Medicare, so they are only available to those who can afford around \$120 to \$180 per session. GPs lack training and have limited support from specialist psychiatrists, with consequent over-reliance on drug treatment. University-based GP psychiatry training costs around \$18,000. Cuts to Commonwealth funding for the Better Outcomes in Mental Health Care program of \$18 million over the next four years is the exact opposite of what is required.

Clinicians need to include the invisible workforce of families and friends in treatment or discharge planning. There is now considerable evidence to show that engaging families can prevent relapse. Dr Grainne Fadden's British-based Meriden program, which trains staff to work with families, was highly recommended.

In states which still have separate psychiatric institutions, a large proportion of the state mental health budget goes to running these facilities, severely limiting provision of other services. People with psychiatric disability still have poor access to basic community resources such as housing, HACC services, day rehabilitation and vocational programs. The difference between what is in place, what is planned and what is needed is large.

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## *PHAA's Presentation to the Senate Select Committee on Mental Health, Canberra, Wednesday, 27 July 2005 - continued from previous page*

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Solutions proposed were firstly to revitalise the leadership role of the Commonwealth in mental health reform, and its provision of upfront funding to support transition. Ongoing measures could include the following: targeting a proportion of the Commonwealth-State Disability Agreement funding to services for people with psychiatric disability; providing Medicare rebates for clinical psychologists; and incentives for private psychiatrists to be more accessible and for GPs to undertake specialist training. Measures to encourage more applicants for mental health nursing are crucial. Adequate funding is needed for family support organisations, and staff require training in working with families.

The Committee's questions were informed and thoughtful. In responding to a query about confidentiality, PHAA noted the UK Royal College of Psychiatrists' 2004 guideline:

'Even when the patient continues to withhold consent, carers are given sufficient knowledge to enable them to provide effective care. The provision of general information about mental illness, emotional and practical support for carers does not breach confidentiality.'

PHAA also refuted the popular image of deinstitutionalisation resulting in patients being 'thrown onto the streets'. Under the national strategy, savings from institutional closures were to be reinvested in new mental health services. In Victoria, this enabled establishing new types of inpatient and community residential services, and other community-based services.

PHAA noted increased participation by consumers in service planning and development, and also spoke of the importance of services having carer as well as consumer consultants. Lastly, PHAA referred to inadequate mental health care for people in the prison system, particularly those whose offences result from their mental illness.

## *Political Economy of Health Update*

*Doug Welch, PEH SIG Convenor*

### **Perth Workshop "Health In a Globalised World"**

The PEH Workshop and AGM will be held from 10 am 12 pm on Sunday 25 September in the Murchison Room at the Perth Sheraton.

Presentations from David Legge and the Scholarship winners on the Peoples' Health Assembly 2 (PHA2) and issues from globalisation plus lively discussion should make this another in the tradition of PEH interesting, fun and provocative workshops.

### **Election of National and State Convenors at AGM**

I would urge all members to give serious thought to nominating for a position in the PEH SIG. The commitment required is modest, consisting of a couple of teleconferences each year and occasional comment on requests, policy and assessment of abstracts.

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## **Health Inequalities**

The recent ABS figures on income distribution in Australia show increasing concentrations of wealth and increasing wealth inequalities between the top and bottom SES groups. Predicting from one of the 'truths' of public health that identifies the relationship between inequalities in wealth and inequalities in health, we must look forward to the depressing prospect of an increase in health inequalities in Australia.

From a political economy perspective a greater commitment to the reduction of health inequalities in Australia should form an important plank in national health policy. The PEHSIG has been involved with the Victorian Branch in the rewriting of the PHAA Policy on inequalities.

A recent report in the UK reviewed the evaluation of progress towards goals for the reduction of health inequality. No significant progress was reported for the health outcomes and whole of government initiative goals. However, they did identify a reduction in child poverty.

## **Global Arms Trade**

Global military expenditure and arms trade form the largest spending in the world at over \$950 billion in annual expenditure. Over two years to 2003, world military spending increased by 18 per cent in real terms.

The main reason for the increase is the massive increase in the United States, which accounts for almost half of the world total. The U.S. military budget request for Fiscal Year 2006 is \$441.6 billion. This includes the Defence Department budget and funding for nuclear weapons activity of the Department of Energy Budget. It does not include other items such as money for the Afghan and Iraq wars (\$49.1 billion for Fiscal Year 2006), or Homeland Security funding (\$41.1 billion for Fiscal Year 2006).

While US military expenditure is set to continue to grow and will continue to propel world military spending, the pace is likely to fall back somewhat in the next few years. In the longer term it is doubtful whether current levels will be economically and politically sustainable.

High-income countries account for about 75 per cent of world military spending but only 16 per cent of world population. This spending is slightly higher than the aggregate foreign debt of all low-income countries and 10 times higher than their combined levels of official development assistance in 2001- Stockholm International Peace Research Institute, June 9, 2004.

## **Scholarships to Peoples Health Assembly 2**

The PEH SIG provided scholarships to support the attendance of two young committed health activists at the PHA2 in Cuenca Ecuador. These were awarded to Bronwyn Fredericks and Peter Waples-Crowe.

## **Congratulations to Fran Baum**

On a brighter note our own Fran Baum achieved well-deserved recognition with her appointment as one of the Commissioners of the WHO Commission on Health Inequalities. Chaired by the iconic Sir Michael Marmot, the commission hopefully shows a reorienting of the WHO towards the Health For All goals. These values have been somewhat lost during the last decade as the neoliberal globalisation and trade agenda infused the world bodies culture.

## *PHAA Advocacy - July and August 2005*

*Pieta Laut*

*Executive Director, PHAA*

Over the past two months, the Secretariat has maintained a significant concentration on the policy development process and on the development of the up and coming Annual Conference in Perth. Consequently the level of advocacy action has been somewhat slower than in previous months.

That said, we have remained active in advocacy with submissions to significant Inquiries and meetings with some key federal politicians.

Laurie Ferguson MP has recently taken over the shadow ministerial role for public health and health regulation. Cathy Mead and I met with him and his staffer for about an hour and discussed PHAA's views on the most significant public health issues facing Australia at the moment. Our conversation concentrated on equity in access to health care services and Aboriginal and Torres Strait Islander Health although other issues were raised by both parties. I have followed up with his staffer by providing a number of pieces of background information that she requested during the meeting.

Through joint effort with the Gynaecological Awareness and Information Network, (GAIN), we were able to talk privately with Senator Lynne Allison about the possibilities of holding a Sexual Health Promotion Conference in Parliament House next year. This may prove to be a very positive way to advance our prevention messages around sexual health.

A submission to the Productivity Commission's inquiry into the health workforce has been completed and submitted. The submission will be placed on the PHAA website as soon as possible. The submission concentrated on the public health workforce and sought for the Productivity Commission to look at the widest possible meaning of the term 'health workforce' rather than taking a narrow "doctors and nurses only" viewpoint.

A short submission on safety-net thresholds was developed and sent to the Community Affairs Committee Inquiry on the effects of changes proposed to the Medicare Safety-Net Act. The proposed changes would increase the threshold levels. The submission noted that the proposed increases in the thresholds would hurt those least able to help themselves in a health crisis – that is, the poor and ill. This submission will be placed on the PHAA website as soon as possible.

Having provided a detailed submission to the Senate Select Committee on Mental Health in July, the co-convenors for the Mental Health SIG and I presented additional information to the PHAA submission, with Valerie Gerrand and Sue Humphries from the SIG as the main witnesses. Senator Allison had an informal discussion with us after the formal session was completed.

The Reproductive Health Alliance and the Secretariat have had a first discussion about our joint objectives (in the widest context) and the possibilities of a sexual health conference. Advocacy in this area will firm up over the coming six months.

# *South Australia Set to Develop and Implement Psychosocial Rehabilitation Support Service Standards*

As a component of achieving mental health reform in South Australia (SA), the Mental Health Unit (MHU) of the SA Department of Health (DoH) has commissioned Quality Management Services (QMS) to develop, promote and pilot quality standards for psychosocial rehabilitation support services.

The project aims to enhance the quality of services delivered to SA mental health consumers by moving toward community-based support.

## **Who is QMS?**

QMS is a not-for-profit organisation specialising in standards development, quality improvement, review and accreditation services to human service organisations.

Our experience in standards development includes recently producing: the NSW Department of Community Services (DoCS) Quality Service Standards and the NSW Health funded Human Service Organisations Generic Quality Framework.

## **Mental health reform in SA**

The mental health system in SA is currently undergoing significant reform, with a move to the development and enhancement of community rehabilitation and recovery services. These are provided by a range of non-Government organisations (NGOs).

In 2002, SA spending on mental health was five per cent above the national average; however, expenditure was concentrated in clinical psychiatric facilities, followed by co-located hospital beds.

Overall, SA's inpatient capacity was 39 per cent above the national average. The State had a spending mix with the lowest share (37 per cent) directed towards community services and the highest share (45 per cent) allocated to stand-alone psychiatric hospitals.

Spending on community services provided by the NGO sector was 2.6 per cent compared to 5.4 per cent nationally. Victoria's expenditure in the NGO sector was 9.1 per cent.<sup>1</sup>

These reforms aim to ensure that people with a mental illness in SA achieve the best possible recovery. The system will be aligned to the national mental health strategy and focus on restoring full citizenship rights and strengthening the central role of consumers and carers in decision-making. This system will be based on the proven principles of continuous quality improvement.<sup>1</sup>

## **How will the standards for psychosocial rehabilitation support services be developed?**

QMS will work with service providers delivering psychosocial rehabilitation services as well as broader stakeholders to review existing standards, including the *Victorian Health Psychiatric Disability Rehabilitation Support Service Standards* and the *National Standards for Mental Health Services*.

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## *South Australia Set to Develop and Implement Psychosocial Rehabilitation Support Service Standards - continued from previous page*

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Standards will be developed in consultation with the sector. These standards will then be piloted across several organisations providing these services. External review against the standards will be the mechanism for assessment. Integration with existing standards and quality systems will be a priority.

The standards will be developed between July 2005 and July 2006.

### **Who will be involved?**

An important part of the project will be to establish a Project Advisory Group consisting of stakeholders from the NGO sector, specialist mental health sector, consumers and the SA DoH, with the aim of ensuring sector relevance in a sustainable and comprehensive process.

In keeping with this inclusive approach, the pilot review process will include the training and use of Peer Reviewers as part of the review team. This will bring sector knowledge and experience as well as facilitating sector and professional development. The practice of using Peer Reviewers is well-established and proven within existing QMS systems.

QMS is a licensed provider of the Quality Improvement Council (QIC) Standards and Accreditation Program, which offers a core module of standards for all health and community services and a series of service delivery modules, including the *QIC Mental Health Services Standards*. The Commonwealth Department of Health and Ageing has approved the combined use of QIC's core and mental health services modules in lieu of the *National Standards for Mental Health Services*.

QMS is also an approved provider of external assessments using the South Australian Service Excellence Framework (SEF) and experienced in conducting appraisals against the Home and Community Care (HACC) National Service Standards.

### Further information

For further information about the Psychosocial Rehabilitation Support Service Standards project, please contact Alison Sinclair, Executive Manager, Review Services [alison.s@qms.org.au](mailto:alison.s@qms.org.au) or Belinda Loveless, Project Officer [belinda.l@qms.org.au](mailto:belinda.l@qms.org.au) at QMS South Australia (08) 8210 8208.

### References

1. 2003, SA Mental Health Rehabilitation and Recovery Workshop, Mental Health Unit, Department of Health, South Australia, accessed on-line 16/08/05 URL: <http://www.dh.sa.gov.au/mental-health-unit/documents>

# Safe smoking cessation and mental illness: Quitline guidelines

Suzanne Stillman, Deputy Director, Quit Victoria

Ian Ferretter, Quitline Manager, Quit Victoria

The impact of tobacco use for people with mental illness is a serious health issue. Quit Victoria has developed research-based Quitline guidelines, that incorporate a caller seeking their doctor's advice about quitting; in order to provide safe smoking cessation support. Approximately 25% of Victorian Quitline callers indicate a history of, or current, mental illness.

Tobacco-smoking rates in people with schizophrenia, bipolar disorder, personality disorder, anxiety and depression continue to remain extremely high.<sup>1,2</sup> Consumption has been estimated between two and three times that of the average Australian smoker,<sup>3,4</sup> smoking more, and more often brands with higher tar and nicotine levels.<sup>5</sup>

Smoking has severe health implications for people with mental illness. Deaths from respiratory and heart disorders are 60% and 30% respectively more likely among people with mental illness compared to the general population.<sup>6</sup> Smoking has financial and social implications, especially when there are increasing restrictions on where people can smoke.

Quitting provides the possibility of a healthier and longer life, and can free finances for food, accommodation, recreation, and better self-care and presentation.<sup>7</sup>

However, there is a complex interaction between smoking, symptoms and some medications. This may result in smokers with mental health conditions developing a more complicated dependence than others in the general community. The complex interaction between nicotine and other components of tobacco can affect the course of psychiatric disorders, the modification of psychotic<sup>8</sup> and other psychiatric symptoms,<sup>9</sup> and increase some and reduce other side-effects of particular medications.<sup>10,11</sup>

In addition, nicotine temporarily increases the activity of brain chemistry, providing some short-term beneficial effects. Therefore, some smokers may also use cigarettes to self-medicate symptoms,<sup>12</sup> alleviate the side effects of their prescribed medications,<sup>13</sup> or for an anti-depressant effect.<sup>14</sup>

People with a history of depression are more likely to smoke and to find quitting difficult. They are also at increased risk of suffering significant mood disturbance or depression following cessation.<sup>15,16</sup> Not every smoker with a history of major depression who successfully quits relapses to depression. However, the increased risk remains high for at least 6 months following cessation.<sup>17,18</sup>

Guidelines regarding cessation in smokers with mental illness advise monitoring by their treating doctor. They monitor for effects on psychiatric illness; consideration of pharmacotherapies and other treatments to assist withdrawal; and the management of medications, during and following smoking cessation.<sup>19,20,21,22</sup>

## (Endnotes)

<sup>1</sup> *Mental illness and smoking cessation: an urgent public issue*. Forum proceedings, 19 November 1996, compiled by Quit Victoria.

<sup>2</sup> Reichler H, Baker A, Lewin T, Carr V. Smoking among in-patients with drug-related problems in an Australian psychiatric hospital. *Drug and Alcohol Review* 2001;20:231-237.

<sup>3</sup> Wilhelm K. The relevance of smoking and nicotine to clinical psychiatry. *Australian Psychiatry* 1998; 6(3):130-132.

<sup>4</sup> Meadows G, Strasser K, Moeller-Saxone K, Hocking B, Stanton J, Kee P. Smoking and schizophrenia: the development of collaborative management guidelines. *Australian Psychiatry* 2001; 9(4):340-344.

*continued on next page*

- <sup>5</sup> Strasser KM. 2001. Smoking reduction and cessation for people with schizophrenia: Guidelines for general practitioners. Available online at [www.health.vic.gov.au/mentalhealth/publications/smoke/smoke.pdf](http://www.health.vic.gov.au/mentalhealth/publications/smoke/smoke.pdf) (see also .../smoke2.pdf)
- <sup>6</sup> Baxter DN. The mortality experience of individuals on the Salford psychiatric register. *British Journal of Psychiatry* 1998; 168, 772-229; The *SANE Australia Smokefree Kit*, 1998, p3.
- <sup>7</sup> Polgar S, McGartland M, Borlongan CV, Shytle RD, Sanberg PR. Smoking cessation programmes are neglecting the needs of persons with neuropsychiatric disorders. *Aust NZ Journal of Medicine* 1996;26, 572.
- <sup>8</sup> Strasser K, Moeller-Saxone K, Meadows G, Hocking B, Stanton J, Kee P. Smoking cessation in schizophrenia: General practice guidelines. *Australian Family Physician* 2002; 31(1), 21-24.
- <sup>9</sup> Glassman AH. Cigarette smoking: implications for psychiatric illness. *American Journal of Psychiatry* 1993; 150:546-553.
- <sup>10</sup> Goff DC, Henderson DC, Amico E. Cigarette smoking in schizophrenia: relationship to psychopathology and medication side effects. *American Journal of Psychiatry* 1992; 149: 1189-1194.
- <sup>11</sup> Lyon ER. A review of the effects of nicotine on schizophrenia and antipsychotic medications. *Psychiatric Serv* 1999;50(10):1346-50.
- <sup>12</sup> Dalack GW, Healy MD, Meador-Woodruff JH. Nicotine dependence in schizophrenia: Clinical phenomena and laboratory findings. *American Journal of Psychiatry* 1998; 155:1490-1501.
- <sup>13</sup> Adler LE, Hoffer LD, Wiser A, Freedman R. Normalisation of auditory physiology by cigarette smoking in schizophrenic patients. *American Journal of Psychiatry* 1993; 150(12), 1856-1861.
- <sup>14</sup> Foulds J. The relationship between tobacco use and mental disorders. *Substance misuse: Current Opinion in Psychiatry* 1999; 12:303-306.
- <sup>15</sup> Glassman AH. Cigarette smoking: Implications for psychiatric illness *American Journal of Psychiatry* 1993; 150:5446-553
- <sup>16</sup> Covey LS. Tobacco cessation among patients with depression. *Primary Care* 1999;26(3):691-706.
- <sup>17</sup> Miller M, Wood L. *National Tobacco Strategy 1999 to 2002-03: Occasional Paper. Smoking cessation interventions: Review of evidence and implications for best practice in health care settings.* August 2001. Commonwealth of Australia, 2002.
- <sup>18</sup> Glassman AH, Covey LS. Smoking and affective disorder. *American Journal of Health Behavior* 1996; 20(5): 279-285.
- <sup>19</sup> Fiore M C et al. *Clinical Guideline: Treating tobacco use and dependence.* U.S. Department of Health and Human Services. June 2000.
- <sup>20</sup> American Psychiatric Association. Practice guidelines for the treatment of patients with nicotine dependence. *American Journal of Psychiatry* 1996; 153:10, October 1996 Supplement. Available online at [www.psych.org](http://www.psych.org)
- <sup>21</sup> Miller M, Wood L. *National Tobacco Strategy 1999 to 2002-03 Occasional Paper. Smoking cessation interventions: Review of evidence and implications for best practice in health care settings.* August 2001. Commonwealth of Australia, 2002  
Available online at [http://www.health.gov.au/pubhlth/publicat/document/smoking\\_ces.pdf](http://www.health.gov.au/pubhlth/publicat/document/smoking_ces.pdf)
- <sup>22</sup> NSWHealth. Guide for the Management of Nicotine Dependent Inpatients. Available on line at [www.health.nsw.gov.au/public-health/health-promotion/pdf/Tobacco/patsmoke.htm](http://www.health.nsw.gov.au/public-health/health-promotion/pdf/Tobacco/patsmoke.htm)

## Awards

The Mental Health Special Interest Group is pleased to announce that Mr Tint San has been awarded the Mental Health SIG travel scholarship to attend the PHAA's Annual Conference in Perth this year. Mr San is a student from Burma, who is currently studying issues about asylum seekers via La Trobe University.

The Health Promotion SIG has awarded its annual Health Promotion Evaluation Award, which this year was won by Ms Anne Stephenson. The Health Promotion Evaluation Award is an early career award given to provide promising new contributors to the field with an opportunity to present their work at the PHAA Annual Conference. The spirit of this award is to encourage new researchers and practitioners to improve the practice of health promotion through evaluation.

Congratulations to both of our winners. We hope that you have an interesting and invigorating time at the Perth Conference.

## *“Avoid the Cure” - A national campaign to spread the word on cancer prevention*

*Melissa Ledger, The Cancer Council WA*

In Australia, one in three men and one in four women will be directly affected by cancer before the age of 75. More than 88,000 new cases of cancer are diagnosed each year.

There is accumulating evidence that body weight and physical activity influence the risk of some types of cancers.

These factors are also associated with other common chronic diseases, including type 2 diabetes and cardiovascular disease. Fortunately, there tends to be convergence on the public health recommendations that can be made based on epidemiological evidence about various chronic diseases.

Why did we make an advertisement on bowel cancer prevention?

More than 25% of bowel cancer could be prevented if people are more active, eat well and have a healthy body weight. We also know that following this advice can go a long way to prevent other cancers too, including cancer of the breast, endometrium, mouth, throat, liver, and possibly even prostate and lung.

So, The Cancer Council Australia decided it was time to make some noise... There is a lot we can do to help people be more active and eat well.

We know the public have a poor understanding about bowel cancer, including risk factors such as physical activity, diet, body weight and family history, or its natural history and development sequence. There is also a low level of understanding of bowel cancer when compared to breast cancer, thus highlighting the importance of public education in this common cancer.

Through the Centre for Behavioural Research in Cancer Control, Curtin University, WA, The Cancer Council conducted formative research to explore lifestyle and cancer risk message concepts. In early 2004, professional interviewers randomly recruited participants in the Perth city centre to participate in a study assessing reactions to different message concepts about physical activity and chronic disease prevention. Only physically inactive persons (i.e. those whom, in the past two weeks, did not do any regular vigorous physical activity) were included in the study. The study assessed whether audience reactions differed as a function of the disease mentioned in the communication (bowel cancer or heart disease) and the spokesperson delivering the message (Government Health Department spokesperson or a known credible nutritionist).

The research illustrated:

- Perceived believability of the message was high in both conditions, but believability was substantially lower in the bowel cancer than the heart disease condition. This may be due to two factors: (1) the bowel cancer prevention message is a new message; and (2) the link between physical inactivity and bowel cancer is harder to comprehend.
- Perceived personal relevance of the message was substantially lower in the bowel cancer than the heart disease condition. This highlights the need to increase the salience of the risk of bowel cancer in the community.
- There were no significant differences between a prominent nutritionist/expert and a government Health Department spokesperson in terms of achieving behavioural intentions to increase physical activity among respondents.

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## *“Avoid the Cure” - A national campaign to spread the word on cancer prevention*

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The results highlighted the need for The Cancer Council Australia to increase public awareness of the prevention message of maintaining physical activity to reduce the risk of developing cancer. The production of a community service announcement was one of several proposed strategies to facilitate this.

In June 2005, The Cancer Council Australia launched the first national lifestyle and bowel cancer prevention television and radio campaign called “Avoid the Cure”, targeting Australian males and females aged 30-60. Rosemary Stanton, Australia’s most well-known nutritionist, and Dallas English, a prominent cancer epidemiologist, launched the advertisement after leading a 15-minute walk along Perth’s Swan River foreshore.

The “Avoid the Cure” advertisement is the first step in promoting our lifestyle messages to Australians. The advertisement was aired during June nationally as a free-to-air Community Service Announcement. If you haven’t seen the advertisement yet, you can have a look on-line at [www.cancerwa.asn.au/prevention](http://www.cancerwa.asn.au/prevention). Additional strategies to support the campaign included:

### Web based information

Each state and territory Cancer Council and The Cancer Council Australia worked to develop lifestyle information for their websites ready for June 2005.

### Moving and Eating to Prevent Cancer Speaker’s Kit

The release of a national Speaker’s Kit coincided with the launch of the CSA. The kit is a comprehensive resource for Cancer Council staff and health professionals to conduct presentations in their communities. The kit includes speaker’s notes and PowerPoint slides.

### Print resources

State and territory Cancer Councils have developed a range of quality resources in the areas of nutrition and physical activity. These resources include brochures and fact sheets on vegetables and fruit, physical activity, meat and cancer, wholegrains and cereals. Posters include Cancer - Reduce Your Risk (vegetable and fruit) and Move Smart – Reduce your risk (physical activity).

If you would like more information on lifestyle and cancer prevention, please contact the Cancer Council Helpline on 13 11 20 or if you would like information on the advertisement please contact your State or Territory Cancer Council.

### **Cancer Incidence Projections Australia 2002 to 2111**

This report presents detailed projections of cancer incidence for major cancers. It provides projections of both incidence rates and expected numbers of new cases by age and sex for 60 cancers and groups of cancers. The projections in this report are based on trends in national cancer incidence data from 1982 to 2001 held by the AIHW in the National Cancer Statistics Clearing House.

The projections in this report were commissioned by the National Cancer Strategies Group to support planning of cancer services and this report is an important reference for all those interested in the prevention, detection, treatment and management of cancer in Australia.

AIHW Catalogue No. CAN-25; Available from CanPrint (ph: 1800 889 873); \$25.00

## *Rural Areas in WA to Benefit from Mental Health Promotion Campaign*



Act-Belong-Commit is the theme of a new campaign to promote positive mental health that is being implemented in WA. Mental health and wellbeing is particularly important in rural areas of WA that tend to be under-serviced and have problems with transitory populations.

The Mentally Healthy WA campaign, funded by Healthway, Lotterywest and WA Country Health Services, aims to change perceptions of 'mental health', encourage behaviours that increase individual resilience, and increase participation in community organisations and clubs. The campaign will encourage people to be more active mentally, physically and socially; to join and participate in clubs and community organisations; and to make personal commitment to a group, event or activity: to improve their own mental health.

The campaign recognizes the diversity of people living in rural communities and will target women and men of all ages. It will work closely with mainstream and women's organisations to ensure that benefits flow to women as well as men.

The six participating regions are Karratha, Kalgoorlie, Esperance, Albany, Geraldton, and Northam/Toodyay/York. Project officers have been recruited and will be organising community forums and launches in each town over the next 3 months. In September a survey of community members will be conducted in each of the participating regions, and people from non-participating towns will also be interviewed by telephone.

Country people of all ages are encouraged to take part in forums and activities in their regions. For more information on the Mentally Healthy Campaign or to subscribe to the newsletter please contact: Colby Sidebottom by tel 9266 3788 or email [C.Sidebottom@curtin.edu.au](mailto:C.Sidebottom@curtin.edu.au).

### **Populations and Health: An Introduction to Health Disparities in the U.S.**

A very positive review of the new textbook *Minority Populations and Health: An Introduction to Health Disparities in the U.S.* by Thomas LaVeist (ISBN: 0-7879-6413-1, Hardcover, 368 pages, April 2005, Jossey-Bass), has just been posted at [http://www.doody.com/rev550/books/MainFrameSet\\_ProfiledBooks.asp?ShoppingCartID=1DSLUAP1208840-081905-125459-819528&NewFlag=ON](http://www.doody.com/rev550/books/MainFrameSet_ProfiledBooks.asp?ShoppingCartID=1DSLUAP1208840-081905-125459-819528&NewFlag=ON).

This book explains the core issues and theoretical frameworks needed to address race disparities in health-related outcomes.

Faculty who would like to obtain a review copy can write to [jegbert@jbp.com](mailto:jegbert@jbp.com).

The author has prepared instructors materials, which can be viewed at <http://www.MinorityHealth.com>.

## *The relationship between overweight/obesity, cardiovascular risk factors and diabetes is shown consistently in the literature.*

*Deborah Joy Hilton*

Many epidemiological studies have examined risk factors for diabetes and, as such, provide evidence for the contribution of increased weight to the development of this serious condition. Several of these are summarised below. Research in the USA that included over 68,500 adults showed that obesity is strongly and independently associated with diabetes, independent of the association with physical activity (which was also a risk factor as levels of activity decreased independent of body mass index (BMI)).<sup>1</sup> A prospective cohort study of 37,878 women, followed for approximately seven years, produced similar findings except that the risk of the development of diabetes associated with increasing BMI was greater.<sup>2</sup>

The AusDiab study, which included 11,247 Australians aged  $\geq 25$  years, assessed the relationship between three measures of overweight (BMI, waist circumference and waist-hip ratio (WHR)) with the presence of cardiovascular disease. The findings were that all measures of increased weight were associated with cardiovascular disease (CVD) risk factors (type 2 diabetes, hypertension and dyslipidaemia). However, it was concluded that WHR was the most useful measure of obesity for the identification of individuals with CVD risk factors.<sup>3</sup> Further analysis of this dataset verified that a larger waist circumference was associated with undiagnosed diabetes and, as such, is an important predictor for the metabolic syndrome.<sup>4</sup>

The AusDiab survey results were compared with an analysis of 592 Torres Strait Islander people, with the results showing that the latter group had rates of obesity three times higher and diabetes rates six times higher than that of other Australians.<sup>5</sup> Australian research published in 2002 which included an analysis of 5,911 subjects from the Australian Diabetes Screening Study examined risk factors associated with undiagnosed diabetes, with the diagnosis of diabetes made using either the World Health Organisation definition, the American Diabetes Association criteria, or the Australian stepwise screening strategy, with risk factors for consideration being age, hypertension, family history or being overweight in addition to having a cumulative number of risk factors (two or more)<sup>6</sup>. When these were analysed along with symptoms for diabetes, the main risk factors for diabetes by either criteria included: increasing age, overweight (particular for the age group 50-70 years) and the presence of several risk factors for diabetes.

These studies all show and emphasise the importance and contribution of increased weight (measured in various ways) with predictors of metabolic dysfunction and undiagnosed diabetes. Risk reduction programs need to specifically target these high-risk groups for optimal effectiveness, as the literature shows that being overweight is one of the main risk factors for the development of type 2 diabetes.

### *References*

1. Sullivan PW, Morrato EH, Ghushchyan V, Wyatt HR, Hill JO. Obesity, inactivity, and the prevalence of diabetes and diabetes-related cardiovascular comorbidities in the US, 2000-2002. *Diabetes Care* 2005;28(7):1599-603.
2. Weinstein AR, Sesso HD, Lee IM, Cook NR, Manson JE, Buring JE, Gaziano JM. Relationship of physical activity vs body mass index with type 2 diabetes in women. *JAMA* 2004; 292(10):1188-94.
3. Dalton M, Cameron AJ, Zimmet PZ, Shaw JE, Jolley D, Dunstan DW, Welborn TA; AusDiab Steering Committee. Waist circumference, waist-hip ratio and body mass index and their correlation with cardiovascular disease risk factors in Australian adults. *J Intern Med* 2003; Dec;254(6):555-63.
4. Snijder MB, Zimmet PZ, Visser M, Dekker JM, Seidell JC, Shaw JE. Independent and opposite associations of waist and hip circumferences with diabetes, hypertension and dyslipidemia: the AusDiab Study. *Int J Obes Relat Metab Disord* 2004; Mar; 28(3):402-9.
5. Leonard D, McDermott R, Odea K, Rowley KG, Pensio P, Sambo E, Twist A, Toolis R, Lowson S, Best JD. Obesity, diabetes and associated cardiovascular risk factors among Torres Strait Islander people. *Aust N Z J Public Health* 2002; Apr;26(2):144-9.
6. Hilton DJ, O'Rourke PK, Welborn TA and Reid CM. Diabetes detection in Australian general practice: a comparison of diagnostic criteria. *Medical Journal of Australia* 2002; 176(3):104-107.

# *The Black Dog Institute: Raising clinical standards in the diagnosis and management of the depressive disorders*

*Lea Andric, Professional Education and Training, Black Dog Institute*

## **Depression**

Today, few would be surprised to learn that cardiovascular disease is one of the leading causes of death in world. Nor is it a surprise to learn that of the 20 million people who survive heart attacks and strokes each year, a significant proportion will require ongoing costly clinical care. What might take us by surprise, however, is that today depression is an even more disabling disorder, currently affecting some 121 million people around the world (World Health Organisation (WHO), 2005). 'Depression' can present itself in numerous ways: a depressed mood, feelings of low self-worth, loss of pleasure, low energy, and poor concentration, just to name a few of its specific symptoms. Less specific, but common, are sleep and appetite disturbance, a lack of pleasure in activities and a need to keep to oneself. Depression can also vary in severity, duration and 'type', affecting daily functioning, and thereby hindering a person's ability to live, work and communicate with others. Depression doesn't discriminate, affecting both men and women, young and old, from all types of backgrounds. Tragically, depression can also be fatal, with some 850,000 suicides occurring annually as a result of this condition; a condition that, if accurately diagnosed, can in fact be treated effectively in primary care (WHO, 2005). Depression can also be associated with mood 'highs' (Bipolar Disorder), and with Bipolar Disorder also established in the Top 10 of the World's most disabling conditions.

## **About the Institute**

In answer to the growing need to address the problems associated with the mood disorders, the Black Dog Institute is committed to raising clinical standards in the diagnosis and treatment of the condition. Officially launched in 2002, the Institute facilitates a range of activities, including research, professional education and training, clinical services, and population health approaches; all of which focus on the depressive disorders. As a not-for-profit organisation, the Institute builds on its predecessor, the Mood Disorders Unit, which has been conducting clinical research on the depressive disorders since 1985. The Institute is supported by the New South Wales Department of Health via the NSW Centre for Mental Health and by the University of New South Wales.

Over the past two decades, research undertaken by the Mood Disorders Unit and the Institute has established that there are distinctive depressive disorders, some categorical and strongly biologically underpinned, while others are more a reflection of personality and life event stress. Hence, for each disorder, we argue that there are preferential first-rank and second-rank treatments, and that the capacity of any single strategy (be it antidepressant medication or other approach) to treat 'depressions' across their many manifestations is limited. Regrettably, much current management is dictated more by the practitioner's discipline or therapeutic paradigm, rather than by characteristics of the particular episode or with sufficient respect paid to aetiology or causes. For example, by consulting a general practitioner, a person who presents with depressive symptoms is most likely to receive antidepressant medication; whereas if going to a psychologist, they will most likely receive cognitive behaviour therapy (CBT); or, if going to a counsellor, they would expect to receive counselling, irrespective of the type of depression. Thus, currently there is a fallacious model – that all depression is essentially equal, and all treatments are comparable – that we challenge and rework.

## **Education – to advance, we must understand**

Today, the Institute continues to challenge the current model, which views the condition as a single entity – an 'it' – which essentially leads to a 'one size fits all' treatment model, which in turn can lead to the condition being misdiagnosed and consequently mismanaged. To achieve its mission, the Institute aims to support and advance

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research into the mood disorders, provide a resource for consumers, the general public and health professionals, and crucially, to raise clinical standards of diagnosing and managing mood disorders. The Institute's accredited education and training programs on the mood disorders are leading the way to improving diagnosis, treatment and management of Depressive Disorders and Bipolar Disorder in the general population. These programs have been developed from material which is based on some 20 years of clinical and research experience at the Mood Disorders Unit / Black Dog Institute. The Institute's Education Project Team works with various external entities, including the Alliance of General Practice Divisions, the College of Psychological Medicine, the NSW Department of Health and the Commonwealth Government in developing its general practice programs.

### **Consumer & Community Resource Centre**

The Institute also offers a Consumer & Community Resource Centre that provides quality information for the general public on mood disorders. The Resource Centre is open to the public every weekday from 9.30am to 5pm. Please contact us first to make an appointment (on Ph: 9382 4523). We have many resources, including books, videos, CDs, research papers and access to the Internet. Friendly staff are also on hand to help you find information and help you track down relevant mental health services.

### **Website**

Our website ([www.blackdoginstitute.org.au](http://www.blackdoginstitute.org.au)) is one of the most highly ranked sites in Australia, assisting diagnosis and providing information on management and how individual sufferers can get help.

Black Dog Institute, Hospital Road, Prince of Wales Hospital, Randwick NSW 2031.  
Tel: (02) 9382 4530. email: [blackdog@unsw.edu.au](mailto:blackdog@unsw.edu.au). Website: [www.blackdoginstitute.org.au](http://www.blackdoginstitute.org.au)

## Scoping Study of Depression among Australia's Indigenous peoples

*Glenda Trevaskis, Senior Project Officer, Australian Indigenous HealthInfoNet  
Kurongkurl Katitjin, School of Indigenous Australian Studies*

It is well known that there is little precise information about the levels of social and emotional wellbeing (including depression) among Indigenous peoples. In response to this concern, beyondblue, the national depression initiative, recently convened a meeting of key stakeholders, including NAACHO and the Australian Indigenous Doctors Association (AIDA) to consider options for identifying and collating information about depression. The Australian Indigenous HealthInfoNet has since been commissioned by beyondblue to undertake a scoping study to find out of what we know about depression among Indigenous peoples, especially programs and projects that address this important health issue. We would value any information that you would be able to provide, in relation to services and/or programs that are offered through your organisation, or any relevant statistics of which you are aware. We are particularly interested in information around prevention and early intervention, as well as learning about innovative treatments or programs that you may have initiated in your area. Provision of information from your organisation is voluntary, and will be added to a final report which will include a bibliography of the literature and a database of relevant programs and projects that target depression in Indigenous communities. This information will be made freely available as a means of sharing information and resources for anyone working in this area. If you are interested in contributing to this study, the following weblink, <http://www.healthinfonet.ecu.edu.au/depression/> allows you direct access to a short questionnaire that can then be forwarded to us. If you have any queries regarding this request, please do not hesitate to contact me on the number as listed below.

# The Plight of the Mentally Ill in Boarding Houses

Dr. Sue Webster, Angela Thorpe (Boarding House Team) and Paul Clenaghan

The history and growth of boarding houses accommodating people with a disability can be clearly linked to the de-institutionalisation programs, which began in the 1960's. These programs accelerated after the release of the Richmond Report in 1983, which saw people with disabilities released from institutions into the community. As a consequence of the limited range of accommodation options for people with disabilities in the community, private boarding houses sprang up to fill the gaps.

However, despite the rhetoric of 'normalisation', boarding houses themselves often had the characteristics of institutions, where residents were often isolated, having little or no contact with the wider community, accommodating large numbers of people in one house, dormitory style bedrooms and/or no individual planning outcomes.

A series of reports into boarding houses consistently highlighted serious concerns with regard to people with disabilities residing in this sector. These include:

- Poverty and Mental Illness, Australian Government Commission of Inquiry Into Poverty. 'Henderson Report' (1975)
- The Health Care Complaints Commission Report (1996)
- The Report of the Task Force on 'Private for Profit Hostels' (1993)
- The Report of the National Inquiry into the Human Rights of People with Mental Illness – 'The Burdekin Report' (1993)

Generalised themes of concerns in some or all of these reports and other articles included:

- **Poor to terrible physical and structural environment of many houses**

The poor condition of some older accommodation necessitates significant upgrading to meet fire and other regulations.

- **Inadequate staffing, in respect to both numbers and qualifications**

The boarding houses that focus more on 'economic priorities' rather than the needs of the persons who reside in such facilities, with staffing one area that proprietors cut back on in order to maintain a profitable operation. There have also been reported instances of overuse of medication.

- **Financial Exploitation**

Residents often contributed their entire pensions and allowances to the cost of their care and the health, welfare, and rights of people with disabilities were largely neglected in order for the boarding house to make maximum profit.

- **Reduction of some services**

There has been a decline in the number of boarding houses, with little likelihood of industry growth. With rising property values in the major boarding house areas of Central Sydney, many operators/proprietors are choosing to realise the appreciation on their capital asset.

- **Lack of external or generic support services or advocacy**

In some cases, outright hostility on the part of proprietors to such services.

- **Inadequate protection** of residents from other forms of neglect or abuse.

The Boarding House Reform Program (BHP) started in October 1998, with a budget of \$30.71 million, and ended in 2001. It sought to address some of these elements by relocating about 300 residents referred to as having "high/high" needs into accommodation that is more appropriate. The remaining boarding house residents were provided with new support services, which were seen as an improvement in the standard of accommodation. One of the BHP functions was also to monitor compliance with licensing conditions and report breaches to the Department of Aging, Disability and Home Care (DADHC). Many of the boarding houses were closed, but many of the issues remain unresolved. The monitoring function of the BHP has now been transferred back to DADHC.

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## The Plight of the Mentally Ill in Boarding Houses - continued from previous page

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The profile of residents in licensed boarding houses in Sydney's Inner West:  
(data from 2001 survey)

- 40% have a psychiatric diagnosis
- 31% have an intellectual disability
- 15% have alcohol-related brain damage
- 5% have an age-specific problem
- 3% have an organic brain syndrome (e.g. dementia)
- 43% have two or more diagnoses
- 29% are aged over 65 years

The Independent Alt Beatty Evaluation Report (August 2001, which has not been publicly released) also speculates on an interesting issue – namely, that a different profile of potential new residents is emerging who may not be attracted to the Boarding House Model.

The usual boarding fee of 85% to 95% of a resident's pension deters some potential clients who can get much cheaper accommodation in an unlicensed 'rooming house'. Furthermore, younger clients have grown up without a history of institutionalisation that characterises the older, traditional boarding house residents. Many have different expectations, especially clients and guardians of those with intellectual disabilities whose expectations have been formed by the Disability Services Act. This has been apparent in the observations of the present Boarding House Team and the reform period does not appear to have addressed these issues.

Sydney South West Area Health Service (SSWAHS) has a team of 3.2 FTE Registered Nurses supporting 360 residents who reside within the licensed boarding houses in the region formerly covered by Central Sydney Area Health Service (CSAHS).

The major role of the team is to provide:

- Goal oriented service coordination for specific residents;
- Enhancement of access to mainstream Primary Care (e.g. GPs), and access to appropriate health & allied health services such as dental and podiatry services (which are funded by DADHC);
- Linkage with NGOs and promotion of psycho-social functioning.

The primary care issues for residents of boarding houses are the most difficult for the team to manage.

Boarding House clients with mental health problems and the Mental Health Boarding House Team experience challenges which are different from mainstream mental health services.

- Some residents may not have access to a regular GP. Even though most boarding houses have GPs visiting on a regular basis, there are often difficulties in arranging a routine scheduled physical assessment. Many residents only see a GP when there are already obvious signs of a physical problem or if they are in need of a psychiatric review by the team.
- One GP visits multiple houses and one private psychiatrist treats and reviews residents in three of the houses. This can lead to a lack of choice of community- based practitioners for the residents.
- Conditions related to cleanliness and the physical environment creates difficulty in treating communicable diseases, such as scabies.
- There are poor recreation spaces provided; hence, many stay in the small suburban yards during the day, unprotected and at risk of sun-related skin problems.

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## The Plight of the Mentally Ill in Boarding Houses - continued from previous page

- Poor nutrition leads to many clients being increasingly at risk of more serious conditions such as diabetes and poor dental hygiene.
- Aged residents (over 65 years) need access to more appropriate health care. They have to be assessed for clearance by Aged Care Assessment Team (ACAT). At times, ACAT acts as a gatekeeper, maintaining the status quo. Hence, we still have many frail residents continuing to reside in boarding houses. Although acknowledging some clients are eligible for nursing home placement, they often do not share the same sense of urgency in facilitating the re-location process.

Despite a significant injection of funding from the Government and elevated awareness of mental health issues in the community, the goal of providing facilities for adequate accommodation and health care services, protection, dignity and reasonable life-style continues to prove challenging, if not elusive.

Private enterprise ethics often clash with professional perceptions as to the best interest of the clients. Many of these clients are isolated, in that they have neither family support nor relationships, are vulnerable and frightened of change. The only direct contact with anyone prepared to take up advocacy on their behalf is with mental health staff and NGOs. NGO staffing levels and other resources are stretched, and while NGOs have a high degree of empathy towards the plight of the clients, there is an evident limitation in their skill base in mental health care. There is a high degree of frustration and a feeling of powerlessness amongst staff who frequently encounter obstacles to achieving the best possible outcomes for the Boarding House residents. Many of these obstacles are inherent in the tensions between private for-profit business ethos and mental health clinicians.

The future of Boarding Houses needs further review. A Boarding House could offer a level of social support, meals and medication supervision. There are people with mental illness who can live in community settings but require this level of support. The desired model for mental health cannot be implemented by private business, but a partnership between an NGO, health and housing could implement such a model. This paper recommends Health and Housing consider developing a “not-for-profit” model of Boarding Houses.

### Chronic Respiratory Diseases in Australia

Chronic respiratory diseases, such as asthma and emphysema, are very prevalent in Australia. They disrupt the daily life and productivity of many individuals and lead to thousands of deaths each year.

Many of these diseases are largely preventable and manageable.

This report brings together data from a variety of sources to highlight the prevalence and impact of chronic respiratory diseases in Australia. The information included in this report will be relevant to policy makers, the broader community and anyone with an interest in the respiratory diseases.

AIHW Catalogue No. PHE-63; Available from CanPrint (ph: 1300 889 873); \$28.00

## *Items of Interest*

### **Disability Support Services 2003-04**

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This report presents data on services provided or funded by governments under the CSTDA, and the people accessing these services between 1 July 2003 and 30 June 2004. It presents a range of data relating to service users, their characteristics, their informal carers, and patterns of service usage. In addition, there is information on the service outlets providing disability support services nationwide during 2003-2004.

AIHW Catalogue No. DIS-40; Available from CanPrint (1300 889 873); \$25.00

### **Alcohol and other drug treatment services in Australia 2003-04: Report on the National Minimum Data Set**

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This report presents national, state and territory data on publicly funded alcohol and other drug treatment services and their clients, including information about the types of drug problems for which treatment is sought and the types of treatment provided. This is the fourth report in the series of annual publications on the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS). This report, along with others in the Drug Treatment Series, is useful for policy-makers, planners, researchers and the broader community.

AIHW Catalogue No. HSE-100; Available from CanPrint (ph: 1800 889 873); \$24.00

### **Medical Labour Force 2003**

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This report presents demographic and labour force statistics on the medical profession in Australia. It is based on the main findings of the 2003 national survey of registered medical practitioners. Information presented in the report includes the number of registered practitioners in each geographic region and in each state and territory, their age and sex profiles, areas of practice, medical specialties and hours worked. The report also includes comparisons over time using data from the 2000, 2001 and 2002 national surveys of registered medical practitioners.

AIHW Catalogue No. HWL-32; Available from CanPrint (ph: 1800 889 873); \$22.00

### **Asthma in Australia 2005**

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Asthma is an important health problem in Australia. This report brings together data from a wide range of sources to describe the current status of Asthma in Australia. It includes information on the number of people who have asthma, who receive various treatments for asthma, who have written asthma action plans, and who visit their GP, are hospitalised or die due to asthma. Health care expenditure for asthma is also discussed. In addition, a chapter has been included in this report that focuses on asthma in Australian children.

AIHW Catalogue No. ACM-6; Available from CanPrint (ph: 1300 889 873); \$35.00



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(03) 9288 3580

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1 Dec 2005. Course 3 'Working with  
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