NATIONAL MENTAL HEALTH FORUM 03NOV11

REPORT BY R.N. KELLOWAY, APPVA RERPESENTATIVE

INTRODUCTION

APPVA has appointed Richard Kelloway to be its representative to the National Mental Health Forum. He first attended a meeting of the Forum on Thursday 3 November 2011.

This report outlines what the APPVA representative saw as being the key issues raised. It should be regarded as reflecting personal interests and observations.

In due course, the Forum Secretariat will release Minutes of the meeting, which will be forwarded to the National President.

OBJECTIVES OF FORUM

The objectives of the Forum are to:

- enable broad consultation on mental health issues;
- promote a network between ex-service organisations, health providers, Department of Defence and Department of Veterans' Affairs (DVA) that support the adoption of recovery and wellbeing orientations to mental health issues, with a focus on prevention, early intervention, diagnosis, assessment, rehabilitation, treatment and relapse management;
- contribute and be responsible for raising awareness of mental health issues although the forum will not develop educative processes directly; and
- provide a sounding board for advice on national mental health programs, services and initiatives, particularly as they affect the veteran community.

AGENDA AND ISSUES

The meeting began at 0900, chaired by Major General Mark Kelly AO, CSC, (Rtd), Repatriation Commissioner, and closed at 1515. The agenda items and key issues discussed follow.

Memory Clinic Program

Presented by Professor Philip Morris, a psychiatrist practicing on the Gold Coast, this was the main agenda item of the day. His presentation outlined a DVA-funded research program involving 25 veterans with dementia or Alzheimer's disease.

Applying the concept of *neuro-plasticity* (see www.normandoidge.com/), the program sought evidence that a degenerating brain can be trained to adapt to the disease so as to maintain brain function and cognitive performance. Delayed loss of alertness and independence would be the outcome.

The Program adopted a *multi-modal approach*. The modes were:

- **Lifestyle:** exercise, strength improvement, weight loss, improved diet, social interaction, intellectual stimulation, and active leisure.
- **Nutrition Supplements:** mega-folate, multivitamins, Omega 3.
- **Memory and Cognition Training:** computer-based and psychologist-guided memory training.
- **Stress Management:** stress reduction, resilience building, and depression and anxiety management.
- **Community Support:** engagement with Alzheimer's Australia.
- **Medical Support:** Low dose aspirin, blood pressure control and anti-cholesterol and anti-tri-glyceride medication.
- **Memory-Enhancing Medication:** as prescribed.
- **Home Care Support:** ACAT assessment.

Of the 25, 16 have completed and 2 have nearly completed the program. The results observed are:

- 2 have shown significant improvement.
- 3 have shown substantial improvement.
- 9 have shown some improvement.
- 2 have shown no change.

Relevantly for Advocates, in response to my question about a case he cited in which the patient scored 27 out of 30 on the Mini-Mental Index test (see: http://en.wikipedia.org/wiki/Mini–mental_state_examination),
and 93 out of 100 on the Addenbrooke's Cognitive Examination (see: http://egret.psychol.cam.ac.uk/medicine/scales/Mioshi_2006_ACE.pdf),
Professor Morris responded that these tests were quite coarse and that he had seen patients with scores 100% or so who nonetheless clearly suffered from a degenerative brain disease. A letter from him to this effect may be useful in supporting degenerative brain cases before the VRB.

Traumatic Brain Injury (Concussion) Update

Dr Graeme Killer, DVA's Principal Medical Adviser, outlined the proceedings of a *Think Tank* convened by DVA and the Centre for Veterans' Mental Health, bringing neurologists, psychiatrists and psychologists from the US, Australia and NZ together with representatives from DVA, Defence and ESOs.

TBI is a current, major concern as a result of IED encounters, and overpressure exposure sustained from *breacher charges* and artillery. The clinical picture can be very complex with the possibility of misdiagnosis. He cited the example of amnesia being caused by either head injury or an acute stress reaction. Reliable neurocognitive tool and baseline data are needed.

Dr Killer advised that there were significant differences between the US and UK approaches to the injury - the US taking it very seriously. DVA is cleaving towards the US position He agreed in response to a question that, there seems to be a correlation between TBI, PTSD and dementia. The epidemiological evidence is, however, not yet available to support the hypothesis.

ADF Mental Health Prevalence and Well-Being Study

This "world-beating" study aimed to:

- establish a baseline of the prevalence of mental health disorders in the ADF;
- identify high risk groups;
- enable targeting mental health services;
- refine the methods for detecting mental health disorders in the ADF;
- explore the impact of occupational stressors on mental health and wellbeing in the ADF.

The survey of all serving ADF members gained a 48.9% response rate. (In my experience, a 10% response rate is typical in surveys of the wider population). The predictive factors sampled included deployment history, trauma exposure, level of social support, bullying, recognition of service, stigma and barriers to care, and dietary supplements, caffeine and tobacco use. The outcomes sampled included the extent of help seeking, resilience, physical health, mild TBI, sleep and anger, family relationships, support networks, and quality of life.

The findings covered mental health (anxiety, depressive, mood and alcohol) disorder and suicidality rates. The survey and associated clinical examinations enabled conclusions about the effect of deployments, the extent of help seeking, impact on the ADF workforce of mental disorders, and issues specific to each service. As the report has yet to be accepted by Council, the results should not be

recorded here. Until the report is released officially, suffice to say that a good understanding of the characteristics of the population has resulted, enabling weighting of factors, facilitating representative estimates.

The resulting 2011 ADF Mental Health and Wellbeing Strategy, "Capability through Mental Health" and included "2012-15 Action Plan" aim to promote good mental health and wellbeing by good leadership at all levels, developing a supportive culture, better preparing ADF members for their unique occupational risks, developing treatments, recovery and transition programs.

DCO Service Delivery

Mick Callan, Director-General, Defence Community Organisation, outlined key outcomes of the family support program.

He noted that the DCO byword was: "Strong Community. Strong Family. Strong Member." His organisation is rolling out "Family Smart" as an essential adjunct to "Battle Smart". The focus is on families (a fundamental change from the preceding "support for command"), enhancing self-resilience, and encouraging a culture of "whole of community responsibility".

Clarification of the roles of and hand-over points between Defence, Veterans' Affairs and the community was apparent. DCO is responsible for the funeral, family transition, housing, and estate arrangements - but, importantly, is taking a DVA representative with it from the first contact with the surviving family ("DVA is primed immediately"). DVA take over post-funeral, providing a case-worker to coordinate DVA's functions.

From responses to queries, the involvement of ESOs is, in my view, not yet resolved by DCO or DVA. I can see a role for appropriately trained ESO Welfare and Pension Officers - their being invited to engage with the families more early and in a formal way than currently happens. Gaining the confidence of Defence, DVA and the families that there might be a useful role for ESOs in facilitating the settling of the family in the post-transition period, will be essential to any earlier and more formal role, however. As one representative said: "DVA is responsible for the family for life".

Development of a more formal role for ESOs appears to be an initiative that would need a combined-ESO approach.

"Now. After."

An excellent U-Tube clip was played, which had appeared to have been made by an American ex-soldier from Iraq. It portrayed an ex-soldier who was studying under the "GI Bill" (a Government-funded, post-discharge, university study program), but suffering from PTSD and down to the end of his resources – his grades were not meeting the requirements of the GI Bill and his allowance had

been reduced significantly. At wits end, he finally goes down to the Veterans' Affairs office, where his arrival is noted by older veterans from earlier conflicts, who gather round him to provide support. A little "twee" for Australian tastes, perhaps, but quite powerful none-the-less.

The viewing prompted De Killer to observe that an Australianised version of the clip would be very useful. I supported Dr Killer, adding my impression that the "At Ease" material, while excellent, required a "calm mind". It was not accessible by a disturbed person. A clip like that proposed could be the link between a disturbed mind and the mental health materials available through the DVA website.

Dunt-Action Update

The key issues raised were:

- The "Well-Being Toolbox" is now online through a link on DVA's "At Ease" website.

- A "Family Help-Line" pilot has been conducted in Brisbane and Ipswich to determine what information families need, with a focus on the families of younger ex-servicemen.

- "Operation Life", DVA's suicide prevention and mental health and resilience strategy, is now accessible through the "At Ease" website.

- The "At Ease" website is about to be revamped.

- The "Mind the Gap" program is being canvassed through the Divisions of General Practice to facilitate General Practitioners' awareness of veterans' mental health needs.

- The "VetAware" program is underway, directed at Community Nurses, to facilitate their awareness of veterans' mental health needs.

- The evaluation report of the "Secondary Mental Health Care Provider Training" initiative, a four-year program that was budgeted in 2007, is about to go to the Repatriation Commission.

Other Business

A number of questions were asked of the DVA representatives, including:

- I asked whether it would be possible to provide Welfare and Pension Officers with access to the "Managing Challenging Behaviour" module that is provided to DVA staff. A DVA representative responded that it was a

TIP module. Believing myself to be fully trained, subsequently, I rang Reg Tulip, RSL, to inquire. He advised that it is not part of the National TIP core curriculum, but agreed that it is needed and said he would carry it forward as an additional training module.

- As briefed by the National President, I inquired about the status of the program, which, we recall, was funded in 2006 to provide respite centres for younger veterans but had, to the bet of our knowledge, been rolled out only in Canberra. The DVA representatives undertook to investigate and to report back at the next meeting of the Forum. IN the interim, they referred us to the Fact Sheets ,which allow for 196 hours pa of respite and up to five days in motel accommodation in an emergency.

- David McCann, VVAA representative, followed with a companion question, having noted that both in the wider and the veteran communities, young people with a disability were being placed in aged care facilities because of the lack of suitable alternatives. The DVA representatives advised that they had researched the problem and had found that there were only eight or so veterans in that situation and the solution was compounded by the wide dispersal of the veterans. They added that the Federal Government had responsibility for people over 65 years of age, and State Governments for those under 65. They recognised that drug and alcohol addicted veterans were a specific problem, as were veterans with PTSD who had to be severely affected before residential care was needed. Terry Meehan, RSL representative, advised that he knew of two centres in Queensland – Youngcare Inc. with 16 beds in Brisbane (see: www.youngcare.com.au/), and the Keith Payne Hostel on the "north coast".

- Returning to the DVA briefings, Gail Macdonell, PVA representative, asked for data on the number of veterans, or proportion of the veteran community, with dementia. DAV representatives responded that the best data available was from pharmaceutical dispensing data and from ADF mental health data, and acknowledged that research was needed as was follow-up with veterans three years after separation – either voluntarily or through mental health.

Observations

1. Representation is very worthwhile. It provides APPVA with a crucial voice directly to the Commissioner and senior levels of DVA and Defence.

2. Once the Minister has approved my appointment, I would be very grateful for having APPVA business cards in my name printed.

Richard N. Kelloway
APPVA Representative