jhr
McGill Chapter

Speak!
Mental Health

Volume 7, Issue 2

Social construction of health

Cover photo: http://www.artistsurvivalskills.com/blog/2009/05/12/the-links-between-mental-illness-and-creativity/

jhr McGill Chapter

Journalists for Human Rights at McGill

Journalists for Human Rights (jhr) McGill, a Students' Society of McGill University club since 2003 and the McGill chapter of the national NGO, is a group of students actively engaged in informing their community about local, national, and international human rights issues through media campaigns and other on campus projects.

jhr's goal is to make everyone in the world fully aware of their rights. Creating rights awareness is the first and most necessary step to ending rights abuses. By mobilizing the media to spread human rights awareness, jhr informs people about human rights, empowering marginalized communities to stand up, speak out and protect themselves. By concentrating our programs in post-conflict African countries like the Congo (DRC), Liberia and Sierra Leone, jhr is improving human rights where they are most at risk.

jhr provides unbiased media and capacity building training to African journalists. Typically, a jhr trainer will work alongside an African journalist for 6-8 months, mentoring him or her and helping with field production. jhr stays in each country for only 5 years, in order to promote sustainability without dependency. jhr partners with local media organizations to reach millions of people at risk of abuse with information on how to protect their rights, and the rights of others.

jhr McGill also provides students with national and international human rights journalism opportunities. Through the jhr Chapters Program, we have offered McGill students opportunities for publication in national magazines and academic journals and the chance to participate in media internships in Ghana. jhr's Train the Trainer Conference on Media and Human Rights has been hosted four times at McGill.

jhr McGill is always open to new members, so if you would like to write and edit articles for Speak!, assist with the radio broadcast or TV production, or help organize fundraising or advocacy events, send us an email at jhrmcgill@gmail.com and we will add you to our listserv.

To learn more about jhr's international work, please visit: **http://www.jhr.ca**
For more info about jhr McGill and our upcoming activities, please visit: **http://jhrmcgill.wordpress.com**

JHR McGill Executive

President..... Maggie Knight	VP Television..... Beatrice Paez
VP Internal..... Kartiga Thavaraj	VP Radio..... .....Abby Plener
VP Newspaper..... .....Sarina Isenberg	VP Advocacy.....Kaitlyn Shannon
VP Layout..... Mookie Kideckel	VP Advocacy..... Portia Crowe
VP Communications..... Kallee Lins	VP Events..... Dave Huehn

From the Speak! Editor-in-Chief

This issue of Speak! Magazine focuses on the nexus between mental health and human rights. With issues of mental health becoming more prevalent in the media, as well as in our daily lives, I decided it was time for JHR to explore this fascinating theme. This issue covers a range of topics from the growing use of Ritalin as a study drug, to mental health in the Montreal homeless community, to the changing DSM and its implications for societal perceptions of mental health, to the rise of eating disorders in Canada, to the Chilean miners' cases of PTSD, and the list goes on. If you want to get involved with the next issue of Speak!, please contact Sarina Isenberg at jhrmcgill@gmail.com.

Sarina Isenberg

UNDER PRESSURE: THE USE OF 'STUDY

By: Sarah Feldman

For many McGill students, November is the worst month of first semester. October memories of pumpkin pie and fall leaves are overshadowed by November's freezing temperatures, short days, and deadlines, deadlines, deadlines. Worse, the festivities and fruitcake of December lie far out of reach, past nightlong study sessions at McLennan and the frustration of final examinations. According to Laura Chapnick, a U1 English Literature student, "The stress is overwhelming. I need it to end." In this, Laura is not alone. According to the findings of a survey conducted by the Centre for Addiction and Mental Heath, 30% of Canadian students reported experiencing psychological stress in school. While this figure is perhaps not surprising, the coping mechanism of many students may be. For a growing number of anxiety-ridden students, stress relief no longer lies at the bottom of ice cream tubs, but rather in the consumption of prescription pills.

Ritalin and Adderall, along with other psychostimulant medications, are frequently prescribed to sufferers of Attention Deficit Hyperactivity Disorder (ADHD). Over the past few years, these drugs, which increase one's ability to focus and stay awake, have made their way into the medicine cabinets of students who have not been diagnosed with ADHD. According to one McGill student, who wished to remain anonymous, the use of "study drugs" resulted, unexpectedly, in "overwhelming interest in what I was studying, even though it was totally dry." She continued to talk about paper writing, which she said "went way better after taking study drugs. I was able to write paragraph after paragraph without checking Facebook once." For another student, the "inability to focus, an intense double essay all nighter, and the appeal of using drugs to be productive" led to his decision to try Ritalin to aid studying.

While there are no sure-fire statistics on the illegal use of psychostimulant medications at McGill, an article published in the Montreal Gazette over a decade ago proves that on-campus consumption of Ritalin is not a new phenomenon. In the article, "Students Popping Ritalin to Stay Alert," Dr. Norman Hoffman, the director of McGill's Mental Health Services, estimated that between 5% and 10% of McGill's students used Ritalin to aid studying in 1998. Given the increasing recognition of Ritalin as a "study drug", and the relative simplicity of acquiring it through friends or online, it is likely that this number has risen considerably in the past 12 years.

It is important to note that while Ritalin results in high levels of concentration and the essential elimination of the desire to sleep, it comes at a cost. As one student explained, "It kills your appetite. I remember I would go days without eating, which was totally unhealthy. As well, at the end of the day, I would notice that I felt slightly depressed." Another user experienced "funny stomach feelings and post-productivity jitters," and added that Ritalin was "definitely a stronger drug than I had anticipated."

(Ritalinpurchase.com)

DRUGS' AT MCGILL

While both students agreed that these side effects are unpleasant, they were split on whether or not they would consider using Ritalin again. For one student, watching her friends develop harmful habits as a result of Ritalin dependency discouraged her to continue using the drug. In her experience, "If you use [Ritalin] a lot, you become dependent on it and can't study as well without it." She explained that this was a problem because her "memory is already bad as it is."

For another student, Ritalin's benefits outweigh its drawbacks. When asked if he would use Ritalin again, he answered with a resounding "yes." When writing papers at the last minute, he found that Ritalin enabled him to write at a high degree of efficiency and effectiveness. These papers, written overnight under the influence of psychostimulant drugs, have all received commendable grades between a B and an A-. While the use of Ritalin has proved beneficial for some, it is crucial to bear in mind that it is a powerful drug intended for medical purposes. Like any drug, it affects each of its users differently and can adversely affect some more than others.

Anxiety during examination periods can be managed in healthy ways, without the need to resort to prescription drugs. For tips on stress relief, visit the McGill Mental Health Service, which, according to its website, "offers a range of psychological and psychiatric services for all McGill students who have paid their Student Services fees," including counselling and emergency psychiatric appointments. The service, located in the Brown Student Services building, is open between 8:00 a.m. and 5 p.m., Monday to Friday.

For those who prefer the anonymity of a telephone call, McGill Nightline is a free and confidential phone-in service for students in all kinds of stressful situations, whether it is the need to locate the nearest café for a late night study latte, or the open ear of a non-judgemental student for the venting of exam-related frustrations. McGill Nightline can be reached at 514-398-6246 between the hours of 6 p.m. and 3 a.m.

jhr
McGill Chapter

Editor-in-Chief:
Sarina Isenberg

General Editors:
Antonia Burchard-Levine
Jessica Xiao

Graphics and Layout:
Mookie Kideckel
Sarina Isenberg

Contributors:
Narissa Allibhai
Laura Benshoff
Sarah Feldman
Emily Lennon
Kelly Leung
Liza Ponomarenko
Tanushree Rao
Ian Sandler
Natasha Sartore
Amir Ben Shabat
Kaitlyn Shannon
Claire Wilmot

~~~~~~~
jhrmcgill@gmail.com
Visit us online:
www.jhr.ca, or
http://jhrmcgill.wordpress.com
~~~~~~~

ETYMOLOGY OF MENTAL ~~ILLNESS~~ HEALTH

By: Liza Ponomarenko

The terminology of mental health has evolved since the study of psychosis as an illness began in the twentieth century. The evolution of the etymology of mental health diagnoses has changed both culturally and scientifically, with the two not being mutually exclusive.

Fifty McGill students were surveyed at random about which term they used more frequently, "mental health" or "mental illness." An overwhelming majority, 42 students, use "mental health." Six students said "mental illness," while two said they were unsure.

The psychiatric community, spearheaded by the American Psychiatric Association (APA), is now examining the benefits, repercussions, and effectiveness of using one term versus another in regards to treatment. Recently, changes have been proposed to the bible of psychiatric diagnosis, the Diagnostic and Statistical Manual of Mental Health Disorders (DSM). Likewise, colloquial language is adjusting to be more positive and inclusive in its description of psychiatric survivors, people diagnosed with a mental disorder, people with a mental history, the neurodiverse, mental health clients, people with psychosocial disability, and the psychiatrically-diagnosed. Previously, these people were labelled with antiquated title "mentally ill." In Western society, discussions are now of "mental health" and not "mental illness" because of the associated stigma. These non-medical changes have come about through government policy and civil society policy advocacy.

Some examples of these transformations include the Mental Health Commission of Canada, chaired by Senator Michael Kirby and established in March 2007; its goal is to promote the development of a national strategy and create a Knowledge Exchange for mental health professionals, advocates, and the Canadian public. In terms of nonprofit organizations, Mental Health America in the United States has been highly influential in both American and global social perception, even going so far as to establish May as a mental health awareness month. There are also independent organizations, such as the Health Policy Monitor, initiated in 2002, which evaluates governmental and social movements in mental health such as the Mental Health Commission of Canada and Mental Health America and their influence on terminology (which they report to be effective).

Terminology not only effects social stigma, but also the diagnostic medicine. The DSM is currently in the testing processes of several changes, which will be incorporated into the fifth edition, scheduled for release in May 2013. In February 2010, a draft of those changes was released, which is a result of the work of almost 400 international researchers as well as DSM-5 Task Force and Work Groups, which are made up of 160 world-renowned clinicians and researchers. According to the APA, a relatively controversial change proposed is the recommendation of new categories for learning disorders and a single diagnostic category, "autism spectrum disorders" that will incorporate the current diagnoses of autistic disorders, Asperger's Syndrome, childhood disintegrative disorder, and pervasive developmental disorder. This has already ignited a number of protests among professionals, particularly in Canada and the United States, because of the strong differentiation between autism and a condition like Asperger's Syndrome.

It is impossible to know the true effects of the terminology changes. However, it seems as if both civil societies and medical professionals are now much more of aware of the impacts of terminology. Being aware of new mental health terms can better equip society to combat with social stigmas, and medical psychiatric experts to classify and treat their patients. Whether these shifts in etymology can actually accomplish that goal will become evident in the coming years.

Increasing demand for mental health care at university:

IS MCGILL READY?

By: Emily Lennon

In August 2009, an article in the Globe and Mail stated that nearly half of the undergraduate student body will consider seeking mental health support over a four-year degree and 15% of these students will be diagnosed with a mental illness. In August 2010, CBC reported a significant increase in mental illness on university campuses in both the U.S. and Canada over the past decade. The same study showed that 51-60% of students report feeling hopeless and consider seeking professional help. As clinic visits increase, university health services need to reassess their current structures. It is difficult to measure the accessibility of McGill's Mental Health Services, as it contains inconsistencies between theoretical functionality and the reality of student experience.

Funded entirely by students, McGill Mental Health Service works alongside various other student services such as McGill Health and Counselling, the Office for Students with Disabilities (OSD), Chaplaincy, and Career and Planning Service (CAPS). Dr. Robert Franck is the Clinical Director of McGill's Mental Health Service; he acts as a liaison between student representatives and university administration. He describes the process students undergo as a triage of sorts because the first stage addresses immediate concerns then redirects them to the appropriate service. He admits this method "is not necessarily efficient but [it is] effective in helping the student." By "effective" he means that students receive suitable care once they arrive at the correct office. Sam*, a U0 student recalls his frustration with the McGill Mental Health Service's inability to connect with OSD on his behalf. The operating bodies of health services cooperate with one another; however, it seems that students do the legwork.

Dr. Franck suggests increasing accessibility through "demystifying" the service. He commends programs such as Nightline (a confidential and anonymous listening, information and referral service): "this is the best form of outreach because it is student led and student-run," which allows it to "resonate better among the student body." He hopes to see further collaboration between students and faculty. Sam and Mark (U2) admit that they knew little of the service's existence prior to being directed there by floor fellows. This begets a reliance on intermediary bodies to disseminate the service's existence via word of mouth. Dr. Franck suggests efforts be made towards emitting a greater presence at frosh activities to raise awareness early on and battle mental illness stigma on campus. Sam says that this type of publicity is essential to making the service more accessible. "Knowing your options allows you have back up plans, and back up plans reduce stress, even if you don't use them."

While many uncertainties lie in navigating the service, there is no questioning the quality of care available. Both Mark and Sam agree that they received excellent treatment and felt very comfortable throughout the process. "I think McGill is one the best places for students to access quality care," says Franck, but he adds: "that being said, we cannot rest on our laurels." Indeed, like McGill administration's notorious record of bouncing students around from office to office, mental health services too needs to pull up their socks; however, Dr. Franck is extremely cognisant of problems the service faces. He reiterates the need for student participation in the service's functioning; "if we are spending students' money, we need to make informed choices", referring to his tri-annual meetings with SSMU and PPGS. "We need to be efficient, transparent and accountable for our students."

Against a backdrop of university life's numerous pressures, the quality of care available remains meaningless if the service itself is inaccessible. Perhaps this calls for a more prominent role of student participation in the service's functioning to continue 'de-mystification,' or further investigation into streamlining the bodies' interactions. Students, administrators, and physicians alike must continue to seek explanations for the increasing rates of students who need professional help and to investigate the ways in which these services can become more accessible and navigable.

THE VIRAGE AMBULATOIRE

Deinstitutionalization and homelessness

By: Claire Wilmot

In 1995, the Quebec Ministry of Health and Social Services instigated a shift in mental health care services across the province in the form of the "Virage Ambulatoire," an action plan that reallocated mental health care resources from hospitals and institutions to community-based care programs.

The Virage Ambulatoire came at a time when mental health care was pressed for deinstitutionalization, maintaining that long term success in combating severe and persistent mental illness would be better achieved through community care and social reintegration.

Of the $816 million budget for mental health care in Quebec between 1994 and 1995, 64 percent was directed towards hospitals and institutions, while only 34 percent of funds were going to community-based care programs. The Virage Ambulatoire aimed to reverse these percentages between 1995 and 2001, as well as substantially cut the number of beds reserved for long-term psychiatric care.

Despite government assurance that all funds excised from hospitals would be reallocated towards community-based care facilities, a report by the Canadian Psychiatric Association found that funding for mental health care decreased by about 25.5 percent after the instigation of the Virage Ambulatoire. The Regional Health Board of Metropolitan Montreal financial reports indicate that between 1995 and 1998, mental health care spending fell 18 percent, from $30.6 million to $25 million.

Although most community organizations dealing with mental health care agreed that a shift in focus and funding was necessary, after the Virage Ambulatoire, many organizations found themselves experiencing an unprecedented increase in numbers and complexity of clients, without proportional funding and training support. In many cases, those turned away from hospitals ended up at the doors of homeless shelters.

Matthew Pearce, General Director for the Old Brewery Mission homeless shelter in downtown Montreal spoke to Speak! about the effects of deinstitutionalization on his organization. "It wasn't deinstitutionalization," he said, "It was re-institutionalization." Mr. Pearce emphasized the demographic shift that the Old Brewery Mission has experienced in response to the Virage Ambulatoire.

"We estimate for homeless men, about 40 percent of the clients we serve have an evident issue with mental health. For homeless women, it is around 80 percent. Before deinstitutionalization, that was not the case."

A homeless man and his dog on the streets of Montreal. (http://www.flickr.com/photos/jp1958/with/2373097790/)

Mr. Pearce explained that despite the need for a more community-based, integration centred approach to mental health care, the implementation of the Virage

Ambulatoire left much to be desired. "What they didn't do was all of the work necessary to make the program a success. That means preparing organizations, and providing support for those who were likely to find themselves dealing with people with mental illnesses."


(Uncluttered White Spaces))

Many of those coping with serious mental health problems in hospitals at the time of the Virage Ambulatoire did not have homes. Therefore, when they were turned away from the institutions that could no longer provide for them, they ended up at shelters like the Old Brewery Mission. "We were not prepared, not involved in the decision, and we were not trained." Mr. Pearce added, "There was no foresight given as to where these people would end up, so they ended up at our doors, and we coped the best we could."

Mr. Pearce described how in many cases, those told to leave hospitals were sent to homeless shelters like the Old Brewery Mission.

"A woman arrived at our women's pavilion wearing a housecoat, holding a teddy bear, with a plastic bag of medication, and some belongings. On a piece of paper was written 'Patricia Mackenzie Pavilion' and the address. They put her in a taxi, and she arrived here." Mr. Pearce explained, "there was no diagnosis, and no contact from the hospital saying to please take care of her. She was just sent. We contacted the hospital, and made quite a case of it at the time, because that's the kind of thing we were experiencing. So when you think of deinstitutionalization, it was not just people haphazardly showing up. There was some of that, but it was also people being sent to the homeless shelter, when what they really needed was some kind of specific care for their particular mental illness."

The new challenges faced by the Old Brewery Mission as a result of deinstitutionalization were met with new solutions; a dialogue emerged between the Old Brewery Mission and the Douglas Hospital. Today, the two institutions are partners in combating the mental health problems experienced by Montreal's homeless population.

The Virage Ambulatoire's inadequate shift of resources from hospital services to community mental health services resulted in homelessness for many Montrealers coping with serious and persistent mental health illnesses. This placed an increased strain not only on community health services, but also homeless shelters, as they attempted to diversify their services to deal with a more complex clientele requiring specialized treatment.


(Epoch Times)

A brief history of semantics in the DSM

Recent editions of the DSM. (namingandtreating.com)

By: Laura Benshoff

Homosexuality, multiple-personality disorder, and alcohol dependence all have something in common: they are all officially recognised mental disorders which have been redefined. The Diagnostic and Statistical Manual of Mental Disorders (DSM), now in its fourth iteration over fifty years, has defined mental illness in North America since World War II. It marks a definite shift towards a biological conception of the mind and continues a long tradition of circumscribing behaviour deemed abnormal. This text serves as a reference in courts to evaluate a defendant's mental status, dictates which treatments insurance companies decide to cover, and feeds into a rapidly burgeoning mental health industrial complex. The manual's historical course reveals patterns of redefinition and inclusion that reflect dominant social and political institutions' shifting anxieties about unacceptable behaviour and how these influence human rights.

The American Psychiatric Association attempted to standardize the vocabulary and diagnostic tools related to mental illness by publishing the DSM-I in 1952. This publication created an official list of illnesses, each qualified with a corresponding set of symptoms or behaviours. By nailing down the vocabulary of mental disease, the DSM turned behav-

iours into illnesses by forcing scientific methodology onto metaphoric language. Questions of efficacy also arose, as studies initially showed large gaps between the written parameters for diagnosing mental illnesses in the DSM and the symptoms reported which garnered treatment for them. At the time, however, the DSM-I haled a new era of accessibility for psychiatry in society by making public the tools of diagnosis. According to The Selling of the DSM, by Stuart Kirk and Herb Kutchins, the publishing of DSM-III in 1980, marked a radical departure from previous conceptions and treatment of mental illness, as seen in the first two manuals, because it moved away from the fifty year tradition of diagnoses rooted in psychoanalysis. Kirk and Kutchins argue that this version of the DSM failed to provide new explanations for mental illness or any new treatments and furthermore "did not discover a single new disorder." Widespread public and academic awareness of the DSM created a critical audience for the third edition. Ten years after the DSM-III's publication, more than 2300 scientific articles referenced the manual. According to Kirk and Kutchins, this widespread attention brought with it an unprecedented amount of criticism regarding the text's reliability and mystification of illnesses. This tarnished the text and ushered in a new understanding of the DSM as a provisional tool - one inextricable from medical, economic, and political influences.

(http://www.soyouwanna.com/kinds-mental-disorder-1395.html)

The most recent proposed changes to DSM diagnoses and language are visibly influenced by pressure from the different communities affected by its pronouncements. For example, according to the American Association for the Advancement of Science, rather than using terms such as 'dependence' or 'abuse' to categorize addiction disorders, "varying degrees of 'use disorder,' as in 'alcohol use disorder,' are proposed," changing the language to accommodate a broader variety of addictive behaviours. These changes reflect a move from discrete labels and vocabulary, which carry stigmatized or moralizing connotations, toward more neutral and arguably more objectively descriptive terms. Not all diagnoses can be scrubbed of problematic associations, however. Transsexual advocates are already displeased with the proposed retention of "gender identity disorder" and Asperger syndrome groups protest lumping together Asperger, a "milder" form of autism, with all others under the more inclusive "autism spectrum disorder." Furthermore, other diagnostic texts like The International Statistical Classification of Diseases and Related Health Problems (ICD), a guide which figures more prominently outside of North America, now share the spotlight and introduce competing definitions which may complicate clear-cut diagnoses and treatments.

Due out in May 2013, the DSM-V will offer renewed legal, financial, political, and therapeutic possibilities to the populations it effects. Its ever expanding coverage, from 106 classified disorders in the DSM-I to almost 300 in the most recent published version, speaks to the steadily growing trend of studying and understanding people by diagnosing them. As long as DSM diagnoses circumscribe treatment options, influence court rulings, and colour personal choices regarding bodies and minds, this text will continue to structure the nature of the illnesses it aims to represent.

ANOREXIA AND BULIMIA

Interview with Dr. Steiger

By: Narissa Allibhai

Professor Howard Steiger is based at the Douglas Hospital. His research focuses on Anorexia Nervosa, Bulimia Nervosa, and related Eating Disorders.

How common are anorexia and bulimia amongst university students compared to other age groups?

They are the highest risk age group. One of the myths about anorexia is that it happens in young adolescents. It does start in early adolescence but the peak age for anorexia is actually 28. The twenties and early thirties are where you see the most anorexia and bulimia. In that group, somewhere around 1% of women will have full blown anorexia, and around 2% will have full blown bulimia [purging a few times every week to every day]. With regard to subclinical forms [those that don't meet all of the criteria, such as people constantly occupied with body image, weight, eating], you're talking easily up to 10% of that same female age group.

How common are anorexia and bulimia in males?

Both disorders probably happen in about 1 male for every 10-15 females.

Is it true that these disorders are increasing, taking into consideration the "thin is in" culture?

Another myth about anorexia is that it has significantly increased in prevalence over the last few decades. The truth is that the prevalence and incidence of anorexia are quite stable. Anorexia occurs worldwide and throughout history. This leads to the conclusion that anorexia has a more biological basis.

Bulimia is what seems to be increasing, and is more associated to the culture of thinness, which is a little less known. Bulimia is what happens when you subject the population to too much pressure to diet.

(http://www.douglas.qc.ca/researcher/howard-steiger?locale=en)

What are the causes of anorexia and bulimia?

Both are biopsychosocially determined. Both, of course, respond to the cultural pressure towards thinness but there is evidence to suggest that anorexia in its purest form is very strongly associated with personality traits of perfectionism and a preference for order. It goes along with anxiety. We used to think of anorexia as a cultural creation, but really it's not, it's quite hereditary. Bulimia also has a hereditary component but it seems to go along with tendencies toward mood instability, impulsivity, and the like. With bulimia, you see a much stronger impact of culture. Societies that really encourage the population to diet have larger occurrences of bulimia.

(continued on next page)

What does the treatment entail?

Since these disorders have multiple causes, the treatment has to be multimodal too. The old style was to force people to eat to combat malnutrition. Treatments now have evolved away from any kind of coercive model. The usual mode of treatment is "cognitive therapy" which looks at the way people think about eating, weight, body image. It starts with helping people evaluate their beliefs such as those about the importance of thinness and then more generally looking at how people define themselves and how they maintain their self-esteem, seeing if they have stable moods and seeing if they are coping inappropriately with social experiences, and so on.

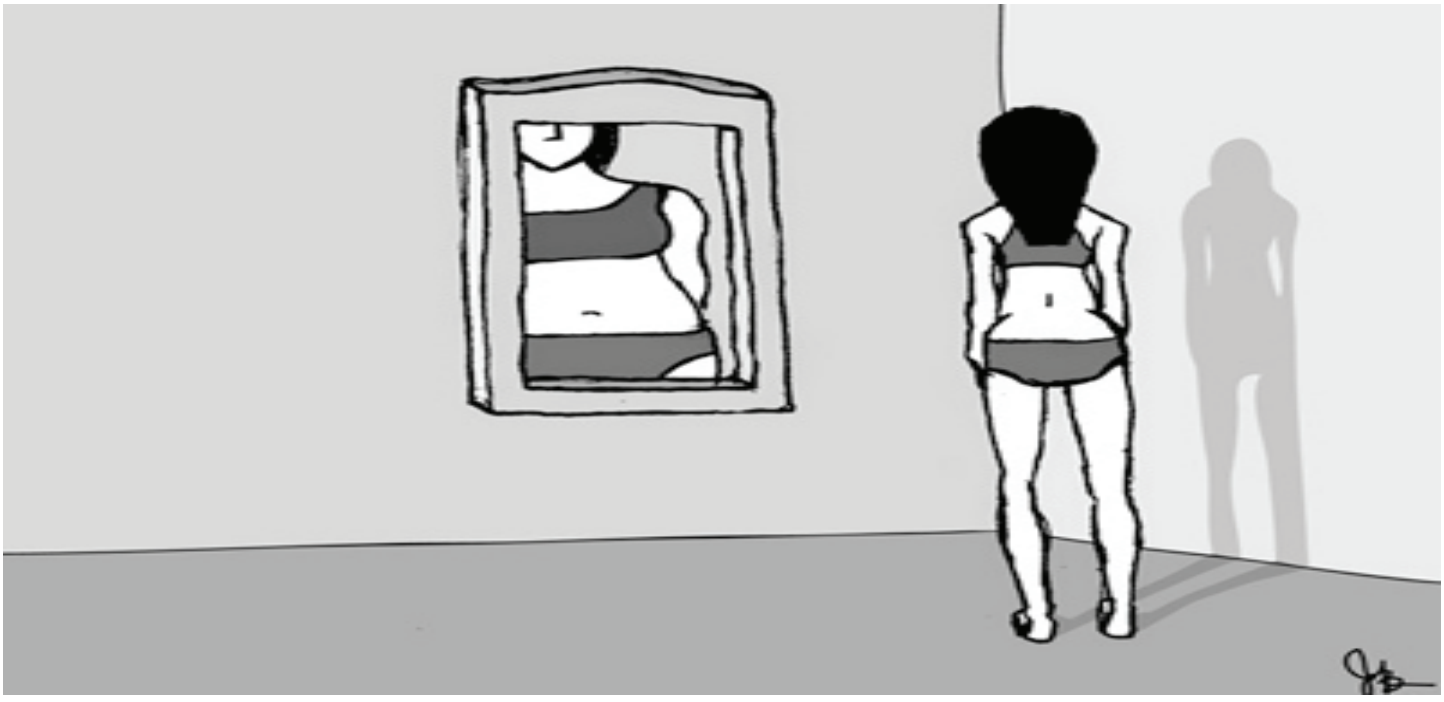
There are also some useful pharmacological agents. Bulimia has to do with 'dysregulation' of the serotonin system [associated with mood regulation, anxiety, and satiety]. There is evidence that bulimia typically happens in people who have a serotonin vulnerabilities, which can also be triggered by dieting. So there is some use for medicines that increase serotonin activity.

Can one completely overcome anorexia or bulimia?

Absolutely. A majority of people recover quite fully. There is a subgroup in whom it has become very entrenched and this can be a stickier problem. Unfortunately it is true that anorexia nervosa has the highest mortality rate of any mental health problem. Somewhere around 5 or 10% of people who maintain chronic anorexia eventually die of either medical complications or of suicide. But, with effective treatment, a vast majority of people improve and a majority recover.

Any final comments?

People don't develop eating disorders because of a lack of strength of character, it happens in people who really have susceptibility, and it's important to understand that.



(http://jbooy.wordpress.com/2009/12/03/anorexia-nervosa/)

Crisis Line lends an ear

By: Kaitlyn Shannon

"The crisis line is like an aspirin for an emotional headache."

This is how one caller described the Fraser Health Crisis Line, a 24-hour telephone support service located in the Lower Mainland of British Columbia. This crisis line, which has been running for 40 years, provides immediate, free, and confidential telephone support, crisis intervention, and resource information to callers.

Although this service is not solely for people with mental illness, about 30% of callers self-disclosed that they live with a mental illness, and another 20% are suspected of having a mental health issue, based on what they are doing or saying in the call. As such, the crisis line's number is routinely given out by mental health professionals, and people with chronic and persistent mental illness are often encouraged to use the crisis line as part of their ongoing safety net.

The crisis line is almost entirely run by trained volunteers, with six paid workers to ensure that all shifts are covered and the lines are always operating.

Debi Shannon, a casual crisis line support worker, stresses the importance of empathy when speaking with the caller. "By listening to the caller and letting them know we hear what they are saying, we validate them as a person, their feelings, and what they're going through, and that's one of the biggest ways we serve." Loneliness and isolation are two major reasons why people call the crisis line, and volunteer call-takers engage in non-directed problem solving. The crisis line never tells a caller what they should do, but instead helps the caller explore the problem, and possible options to help them come up with a plan of action. Jackie Yurick, manager of the crisis line, states "the hoped-for outcome is that the caller has an increased ability to cope."

The crisis line also offers referrals to other community and mental health services in the area. From April to September 2010, 2302 referrals were made.

Previously, the crisis line was one of three operating in the Lower Mainland, and served a population of 750 000 people. However, in order to offer a more efficient and higher quality service, the three crisis lines were merged into one in April 2010, and now serve a population of 1.5 million people.

Yurick believes centralization has been positive for the crisis line. She says, "by putting most of the dollars into one program, it has enabled us to hire more staff, thereby increasing phone room monitoring and supervision." Indeed, as a result of this centralization, the crisis line now receives 2800 calls a month, or about 80 a day. Whereas in the past, the crisis line answered about 20 000 calls annually, it is projected that this first year of the new service will answer about 30 000 calls.

Yurick says, "the service is fabulous, it's just that we need more call-takers to meet demand." Although a current training program will raise the number of volunteers from 80 to 110, more volunteers are needed to run at full capacity (5 phone lines 24/7).

The centralization and hiring of new staff is a first step in increasing the capacity of the crisis line. Yurick suggests this new system of both volunteer and paid call-takers "allows the crisis line to better meet demand as well as continue to increase the quality of service." However, she adds that even more resources could result in having "paid staff in the phone room all the time, enabling volunteers to be coached on an ongoing basis." Thus, with more resources to hire more staff, the crisis line has the potential to do even more.

Yurick suggests that the crisis line is especially important for people living with mental illness, as this particular demographic is often marginalized in Canada, and it is more difficult for these people to advocate for themselves. The crisis line is just one of the services in the Lower Mainland that helps address the needs of this part of the population.

"While there are a lot of very good services for people living with mental health situations, we do hear from callers that sometimes it's difficult for them to get the help they're looking for." Yurick stresses that with more volunteers and more funding to increase the number of available phone lines, this already valuable service could serve even more people.

*The Fraser Health Crisis Line is one of fourteen crisis lines currently operating in British Columbia. Similar crisis lines exist throughout Canada.

(http://www.indiciumtechnology.co.uk/telsys.html)

MIND IN THE MINES

Mental health and the Copiapó mining accident

By: Tanushree Rao

Edison Peña's completion of the New York City marathon this month was a mark of strong will, determination, and endurance. Rescued from the Copiapó mine less than one month earlier, Peña completed the 26-mile run with a brace on his left knee, a strong sense of pride and the Chilean flag to represent his country and the 33 miners who were trapped underground for 69 days.

Peña was one of the few Chilean miners to combat challenges to both his physical and mental health by maintaining a routine of running up to 10 kilometres each day through the mine's underground tunnels. In doing so, the triathlete chose to treat the disaster as a minor disruption to his life and not something that would control his mental state and lifestyle. Rather, Peña used running as a means to defeat the level of stress and the psychological trauma that he and his fellow miners faced.

Edison Peña runs on Bedford Avenue, Brooklyn. (New York Post)

Freeing the miners before their mental health deteriorated into a state of trauma, stress, and depression made the rescue an urgent matter. The most concerning issues at this point were anxiety and panic attacks, exacerbated by spending extended periods of time in a small, dark, enclosed space segregated from the outside world. Following their release, as a result of the traumatic nature of their experience, several miners showed signs of post-traumatic stress disorder (PSTD) and similar stress-related psychological challenges.

Peña, for whom such mental challenges were minimal, embraced the newfound status as somewhat of an international celebrity. He welcomed the Americans, who chanted his name during the marathon, with a smile and used this as motivation to complete his run. When he appeared on the Letterman show in October, Peña was full of laughter, joy, and even gave a rendition of Elvis Presley's "Suspicious Minds." However, not all the miners were able to deal with their new lives in such a successful way. The miners' mental health paid the price not only of 69 days and 700 metres below their homes in Copiapó, but also under the constant shadow of cameras and media representatives tracing their every move from the rescue to the hospital to the return home.

Once released from the mines, the media frenzy took over their daily lives. At the campsite above the miners, one thousand journalists awaited their release in the hope of attaining the first statement. In preparation for the new role thrust upon them, the miners underwent media training with journalist Alejandro Pino, in order to limit the overwhelming madness that would soon occur. Yet no amount of media training could account for the total change in lifestyle that would follow. This new celebrity status affected their reintegration into daily lives, as seen with miner Johnny Barrio, who the paparazzi followed from the rescue to his return home. Similar situations occurred with several other miners, forcing them to eventually insist that the media distance themselves, allowing for an easier return to the life they lived prior to the mining disaster. The stress piled not only onto the shoulders of the mentally recovering miners but onto their families, who bore the brunt of the media frenzy following their loved ones.

The need for sensitivity when reporting on issues of emotional trauma is critical. The high risks of PTSD and psychological trauma immediately after the Copiapó mine rescue made it critical to manage the media attention appropriately. In spite of this, the madness of the media attention surrounding their entrapment, release, and return to society above the ground played a strongly negative role in aiding their transition back into their daily lives.

Pro

By: Kelly Leung

All too often, the mentally disabled are shunned, ridiculed, and marginalized by society as second-class citizens. Given society's reservations about how mental disorders should be handled, and their relative complexity, it is not uncommon for people to generalize and stigmatize the people who suffer from mental illness.

In court, what is commonly known as the "insanity defence" is yet another example of a concept relating to mental illness that is highly simplified in the minds of the general public. As with most issues involving the legal system, it is extremely complicated and often misunderstood. People commonly perceive the insanity plea as an excuse that enables criminals to be pardoned.

Until 1992, Canada's Criminal Code included an "insanity defence," which allowed an accused individual to be found not guilty by reason of insanity. However, despite being found not guilty, the defendant would immediately and indefinitely be kept in strict custody in a mental health facility. The Supreme Court of Canada correctly realized that this arbitrary and indefinite detention violated the Canadian Charter of Rights and Freedoms on behalf of the individuals in question, and amended the Criminal Code.

The amendments made do not disregard the dangers involved in dealing with offenders diagnosed with mental disorders. The court and review boards recognize the need to protect the general public from dangerous persons, but also the need to protect the rights of the individuals accused.

Currently, the Criminal Code calls for a defence of "not criminally responsible on account of mental disorder" that renders the accused "incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong." The defendant is thus no longer immediately and indefinitely held in custody, unless they are recognized as posing a threat to the safety of the public, in which case they are detained for an amount of time relating to the seriousness of the offence.

Point-Cou

INSANIT

http://marketingimplementer.wordpres
discovered-from-being-on-jury-duty/

The amendments to the "insanity defence" were positive steps towards recognizing the rights of those with mental disorders in our society. However, these amendments are not perfect, as demonstrated by the fact that the number of people with mental-health problems in prisons is currently on the rise in Canada.

In September, the Commissioner of the Correctional Service of Canada noted that Canada's penitentiaries have become "the default mental health system," with at least 11% of prisoners suffering from mental-health problems, up seven percent from a decade ago, as reported by the Montreal Gazette.

Though there is still much to learn about mental disorders and how they can be definitively diagnosed, society has come too far in its knowledge to dismiss them. Those with mental disorders must be recognized and acknowledged as sufferers of an illness, and given the help they need. It is indeed possible that sane offenders who committed crimes with intent may use the insanity plea as their defence. However, having this provision in the Criminal Code is better than not offering the defence to those who truly need it.
Rather than delegitimizing it, it is vital that we not only implement more stringent practices for the diagnosis of mental disorders to avoid manipulation of this defence, but that we encouraging understanding and acceptance of the general public towards those with mental illness.

unterpoint

Y PLEAS

Con

By: Ian Sandler

ss.com/2008/11/12/the-4-secrets-i-

No matter the situation, a crime always involves two parties. The offender, subject to the full force of the law, resigns his rights to the rules established by society. The victim seeks revenge. Whether through monetary compensation or an admittance of guilt, the victim needs the offender to know the act was wrong, to understand the pain it caused, and to make sure it will never happen again. But what if no one takes responsibility, and a crime is left unanswered?

The insanity plea skirts responsibility and degrades the seriousness of a crime. In reality, the sole purpose of a trial is to designate guilt, to put the victim's heart at ease, and make the offender pay for the crimes committed. Often used as an excuse to evade jail time, the insanity defence leaves no one to blame. Although righteously applicable in certain situations, the question of defining insanity and its purpose in the justice system remains unsolved.

As stated in Section 16 of Canada's Criminal Code, the insanity defence is "where the jury, or the judge or provincial court judge where there is no jury, finds that an accused committed the act or made the omission that formed the basis of the offence charged, but was at the time suffering from mental disorder so as to be exempt from criminal responsibility."

Accepting that the offender had a mental disorder is not a problem. Instead, the problem lies in the exemption of criminal responsibility. Regardless of the motives and personal history of the accused, a crime was executed. A victim cannot truly put the past behind them when the assailant is just as capable of doing it again, free of guilt and blame.

A question of rights is secondary to a question of responsibility. Prior to 1992, all those accused and found not guilty by reason of insanity were placed, indefinitely, in mental health facilities. Through recent amendments, the "cured" past offenders are no longer confined to any hospitals, and are once again subject to society's laws. Should the rights of the offenders be protected if it puts our lives, property, or well being in jeopardy? The victim must live knowing the person who has caused them pain is once again roaming the streets.

Adding further insult to injury, the same section of Canada's Criminal Code states that,
"No application for federal employment shall contain any question that requires the applicant to disclose any charge or finding that the applicant committed an offence that resulted in a finding or a verdict of not criminally responsible on account of mental disorder." Again, in protecting the rights of the mentally ill, we put ourselves at risk. Legally obligated not to inquire about a past offence, an employer could be hiring a rapist, a murderer, or a thief; however, these actions prove irrelevant if carried out by an individual with a mental disorder.

Agreeably, the best action would be to learn more about mental illness in general. Hopefully, by finding cures or treatments for some disorders, many crimes would not happen at all. Unfortunately, mental disorders do exist and consequently crimes are committed. Rather than abolishing the insanity defense all together, steps must be taken to ensure that such atrocities never happen again.

THE AFTERSHOCKS OF WAR

By: Amir Ben Shabat

(News Blaze)

Upon returning home from Iraq and Afghanistan, many soldiers are diagnosed with post-traumatic stress disorder (PTSD). Considering the horrors of warfare, this is perhaps unsurprising. According to the National Institute of Mental Health of the United States, PTDS is defined as "an anxiety disorder that can develop after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened." Some of the events that could trigger this mental illness include, "violent personal assaults, natural or human-caused disasters, accidents, or military combat." According to James W. Cartwright, a social worker for the US Army, a soldier must experience the following symptoms to be diagnosed with PTSD: "The traumatic event is re-experienced; things that remind the soldier of the event are avoided and reactions are numbed; and the soldier is keyed up much of the time."

As American troops return home from Iraq and Afghanistan, the U.S. government and army is having difficulty reintegrating the soldiers back into society. The government had the same problem during Vietnam and the first Persian Gulf War.

According to Stéphane Grenier, the Canadian Army's special adviser on operational stress injuries, many of the soldiers that return home never receive the help they need. As stated by Grenier, "The first problem is an over-stretched and under-informed civilian system that cannot handle soldiers and veterans." Thus, some soldiers resort to self-medicating with drugs and alcohol. As soldiers, the government had asked them to fight in a war; however, upon returning home, soldiers have to deal with the reality of death, despair, and destruction entirely on their own.

Many soldiers who suffer with PTSD are not being treated for it. According to USA Today, soldiers today more frequently experience "depression, detachment or estrangement, guilt, intense anxiety and panic, and other negative emotions. They often feel they have little in common with civilian peers; issues that concern friends and family seem trivial after combat." Most of the soldiers just want to repress their memories of combat and hope that the visions, flashbacks and nightmares will go away. Unfortunately, for many soldiers, the symptoms of PTSD only get worse over time. Consequently, many of the soldiers will have difficulty finding and keeping jobs, which is but another setback on their long road to recovery.

jhr McGill Chapter

CHECK OUT THE JHR MCGILL CHAPTER'S UPCOMING EVENTS...

Rights in Black and White - date TBA

JHR DocFest - date TBA

Keep checking out the website for updates! jhrmcgill.wordpress.com