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RESOURCE CENTRE FOR MENTAL HEALTH CONSUMERS

Contents

The Federal Budget – what's in it for us? – *by Flick Grey*

The Federal budget was deeply disappointing from the perspective of many consumers and consumer leaders. The Federal government is clearly struggling to understand the *crucial* leadership role consumers should play in mental health. Ultimately, there is almost no money in this budget to support our priorities.

There has been significant progress: I first heard Mark Butler speak the day after he was appointed the Federal Minister for Mental Health, back in 2010 and his speech (to the Mental Health Services conference) demonstrated how much he had yet to learn. He failed to mention consumers even once, let alone recognise the crucial role we ***should*** play in shaping national mental health priorities. He does seem to have learnt quickly – realising that such an oversight is completely unacceptable in the contemporary mental health context – and he embarked on a national whirlwind tour of consultations with consumers (although, unfortunately, with lots of other people simultaneously).

While he may have *tried* to listen to us, the 2011 federal budget is deeply disappointing and represents a massive lost opportunity. Fundamentally, this budget relies far too much on the advice of Patrick McGorry, Ian Hickie, John Mendoza and other high profile psychiatrists, while ignoring the expertise and leadership of the mental health consumer community. While there is – of course! – a place for listening to and valuing the advice of those with considerable expertise-by-training, the budget shows a profound lack of appreciation for expertise-by-experience.

So, what are the issues? What's in the budget for us? What would consumers want in a budget? There are so many issues, but here are some that are unlikely to receive significant attention from other parts of the mental health community (see also some of the "Thumbs down" blurts, p.9).

THE MOST EXCITING/PROMISING BUDGET ITEMS ARE:

1. Money for (and so a commitment to) the "new national mental health consumer representative body." This is critically important to us and timely, building on years of work.
2. The establishment of the National Mental Health Commission, which "will provide cross-sectorial leadership in mental health, *including for consumer and carer activities*, and give policy advice to Government." (p.33, emphasis added) However, it is not yet clear how this Commission will be structured, what it will actually do, or how much influence it will have (or even whether consumer leaders will be integrally embedded, which of course they must be). We sincerely hope that consumer leaders will have *real influence* in this body (possibly even following NZ and having a consumer leader as one of the Commissioners), not just tokenistic "inclusion" or requirements that we be"representative" (when no other experts are burdened with such an impossible responsibility).
3. New rules that allow people on the DSP (Disability Support Pension) to work up to 30 hours a week for 2 years without affecting their eligibility for the DSP. This is important recognition of the reality of people's lives.
4. There are also some other measures that are aimed at people with "severe and debilitating mental illness" (whatever that means exactly) that seem like they might be useful, e.g. more Phams workers – Personal Helpers and Mentors – and better co-ordination between services.

OTHER POSSIBLE OPPORTUNITIES INCLUDE:

- **Mental health research has been declared a priority in this budget.** The exact wording is that:

  > *The NHMRC is committed to the development of evidence for better treatment and health services in mental health ... and has been working actively to embed mental health research into its activities and to consult with the sector. (p.34)*

The Federal Budget – what's in it for us? (cont.)

We sincerely hope that "the sector" referred to in this paragraph includes mental health consumer researchers, academics and knowledge holders. All too often consulting with "the sector" fails to acknowledge that we have our own research priorities, sophisticated research methodologies, and talented consumer researchers (and it's our mental health at stake after all!).

Unfortunately, I am not especially optimistic that our research agendas will be acknowledged or resourced – the emphasis on research into "better treatment" tends to render us passive research subjects, "researched upon" rather than active researchers in our own right. The budget seems to point towards "data collection," lots of research by "other experts" and more bureaucratic reports than you can poke a stick at, instead of resourcing sophisticated consumer research – e.g. the models elaborated in the U&I and Lemon Tree projects, participatory action research and the recent MH-ECO (Mental Health Experience Co-Design) project.

- **Employment for people with mental illness is another priority.** This is obviously an enormously complicated area. While we want appropriate supports for consumers to gain and sustain employment, there are complex issues involved in *genuinely* addressing the barriers we face. I'm not convinced that the budget measures have a foundation in *really listening to the experiences of consumers* who have struggled to get (or keep) meaningful work.

The budget makes reference to "an enhanced focus on mental illness and *the benefits of employing people with disability*." (p.32, emphasis added) We hope this will include recognising the value of lived experience – ie. employing us not just because it's "good for us to work" but valuing what we can bring to workplaces as a result of our experiences and recovery. This is especially true in mental health services: for example PRA (Psychiatric Rehabilitation Australia) have an affirmative action policy, actively seeking out people with lived experience (and not just for designated consumer roles), recognising that these experiences add value to the organisation. We hope this will be an approach that will spread to other organisations.

TROUBLING ELEMENTS:

As well as the over-emphasis on "severe and debilitating mental illness" (which is an unnecessarily divisive approach – making us compete to be considered legitimately "serious" to access the scarce resources), there are three particularly worrying elements:

- **The tone of the approach to employment seems to be paternalistic and punitive**, with an underlying sense that it's "good for us" to be in employment and "not fair" for us to rely on welfare benefits. This combination of therapizing and "tough love" might make for a palatable political approach, but it fails to understand, appreciate or address the significant and complex barriers that many of us face in terms of employment. [We are planning to address some of these issues in an upcoming publication about consumers at work].
- **Reductions in ATAPS (Medicare-funded counselling) are disappointing**, including this claim:
  individuals requiring more than 10 allied mental health services may be experiencing more severe symptoms and may not necessarily be ideally suited to treatment through a universal Medicare scheme like Better Access, but rather could benefit more through referral to a more appropriate mental health services such as Medicare-subsidised psychiatrist consultations or state services for people with severe and debilitating mental illness. (p.22)

We believe this to be deeply simplistic (implying that "if you can't "sort out your issues" in 10 sessions, then you need medication"), and will be counter-productive (will lead to distress escalation).

The Federal Budget – what's in it for us? (cont.)

- **Over-labelling of young people.** Statements like the following are concerning to us:

"Internationally renowned experts are telling us there is a growing body of evidence showing that you can identify kids with (or at risk of) conduct disorders or poor development very early – from three years old." This is then associated with the establishment of a "mental health and wellbeing check" for three and four year old children. We don't believe that labelling people – especially at such a young age – could possibly be the most desirable approach to fostering a mentally thriving community. Similarly, we sincerely doubt the claim that "25 percent of people with a mental disorder experience their first episode before the age of twelve" (p.1).

Ultimately, this budget demonstrates the political cleverness of providing certainty – I'm frustrated by quietly impressed by the number of times I have heard McGorry, Hickie and Mendoza declare "we know exactly what we need to do in Mental Health, we just need more money to do it." This is patently untrue, and has been part of silencing consumers. What we desperately need is to listen far more to the experts-by-experience, with resources to match!

NEWS IN THE CONSUMER WORLD: (+ check our regular updates on our website for more information about these events, more consumer jobs, events, research, etc!)

THINKING ABOUT SUICIDE: David Webb in conversation

Eltham resident and suicide attempt survivor David Webb's book calls for a broad community conversation on suicide to bring it out of the closet as a public health issue, and to hear from people who know suicidal feelings "from the inside." David argues that suicide is best understood as a crisis of the self rather than the prevailing view that it is caused by some notional mental illness.

Details: The Barn, Montsalvat, Hillcrest Avenue, Eltham; Sunday June 19th, 3.00pm to 5.00pm

Entry: $10.00/$5.00 conc, incl refreshments. Prepaid and early bookings essential: 9439 8700.

TRANSFORMING LIVED EXPERIENCE INTO EXPERTISE July 19th & August 23

Facilitated by Indigo Daya, Voices Vic, the course aims to prepare peer workers for facilitating group work. While Voices Vic training is usually tailored to working with people who hear voices, this course is applicable for working with any mental health diagnosis. Participants will learn a range of concepts and practical to facilitate peer support groups while also taking care of themselves. Course registrations can be made via Voices Vic website www.voicesvic.org.au.

OUR CONSUMER PLACE UPDATE: WHAT HAVE WE BEEN UP TO?

Finally, Merinda is back! Welcome back Merinda!! She's come back with a swathe of new cartoons, energy and ideas (and enough pain killers to keep her going most days). And in the only other news that could possibly be as exciting as having Merinda back – Our Consumer Place has had our funding secured!! Our initial funding was due to run out at the end of June 2011, and we were not entirely certain that we would be refunded (although we were quietly optimistic and crossing all our fingers, toes, limbs and pets' paws).

Over the past month, we've been spread a bit thin. In addition to our regular work, supporting various consumer groups, projects and initiatives, we have been updating our website, hopefully making it a more useful resource – check it out! We have participated in consultations with the Mental Health Legal Centre about changes to Guardianship laws (which are far more interesting than they sound – they are

about who makes decisions on our behalf if we are deemed unable to do so ourselves), as well as consultations about the upcoming Certificate IV in Mental Health Peer Work.

Our next booklet about consumers Telling Our Stories is in production, and our next booklet on Consumers in the Workforce is well under way! We've both also been writing consumer perspective for various mental health textbooks as well as lecturing from a consumer perspective.

Intentional Peer Support (IPS) training – at last!!

Our Consumer Place is running an ***Introduction to Intentional Peer Support training*** over two days: Friday 24th and Saturday 25th June. Further details TBC - information will be uploaded onto our website as it's confirmed (very soon!). Participants who complete this 2-day introduction will then be able to attend a further 3 days of training later in the year. We have divided the original 5-day course in this way to enable more people to trial IPS and see if they are interested in completing the entire course. We also believe that there is benefit in dividing the course so that participants have a chance to put into practice the understanding and skills they have learnt in the introductory course to bring deeper thinking to the second half of training.

At this stage, training is restricted to people in Victoria. As there is high demand for IPS training, and we want to get a good mix of people, there is an application process. Please go to our website (www.ourconsumerplace.com.au) to download an application form, or give us a call (9320 6802) and we can post one to you.

Please note: there will be many more opportunities to attend this training in the upcoming months

A new cartoon by Merinda, for our book on consumers using our stories

Singing the B-B-B-Bipolar Blues by Ann Tullgren

Ann Tullgren is a consumer from Hobart. She is co-author of the text book 'Social Work Practice in Mental Health', by Robert Bland, Noel Renouf and Ann Tullgren, Allen and Unwin, 2009. She is an Honourary Associate of the School of Sociology and Social Work at the University of Tasmania and is passionate about developing the role of consumers as educators.

I know that medication isn't for everyone, but for me it works. Some people think popping a pill is an easy option (all considerations of fat being a pharmaceutical issues, the sheer cost involved in maintaining compliance, making sure your scripts are up to date and that the pharmacy has some in stock and doesn't need to order it in….). However, it doesn't cease to amaze me how many skills are involved with taking medication.

Issue number one: because the dose may go up and down, I have to be prepared to break medication in two in order to titrate the dose. An easy matter?

Think again…

I should have known that I was in for trouble when I noted that the box was larger, a more interesting shape.

Tablets come in all sorts of shapes and sizes from round with a clear score line down the centre, to 'sexy' shapes with curved score lines. Tablets may be round, oval or triangular. Breaking tablets into two even pieces, with minimal crumbling, sometimes requires a PhD in engineering. I've tried scissors, pen knives and I'm on my third 'pill cutter'. I think I've finally found the Rolls Royce of pill cutters, with a rubber coated holding area for the pill and a sharp metal cutter. The problem is that many pills, especially the sexy curved ones, can't be anchored fast into the holding area, causing some uneven cutting, and loss of dosage, but it's the best I've come across.

Feeling rather proud of my research abilities (visiting various pharmacies in pursuit of the AAA Pill Cutter Extraordinaire, demonstrating resourcefulness, dogged determination and having contributed significantly to the household swear jar in the process) I recently had to battle an unexpected problem.

Issues number two: the change of packaging. I should have known that I was in for trouble when I noted that the box was larger, a more interesting shape. Then I pulled out a foil strip and proceeded to pop out the pill. Simplicity is definitely not sexy enough for this Big Pharma company which had replaced the foil bubble for the pill with something far more complex and of course there were no instructions to get the bloody pill out. This is what I discovered: first isolate the pill by breaking along the dotted lines; then seize a corner and bend it backwards and forwards until the first foil covering is exposed; then grab hold of this corner with your front teeth (my pliers were in the shed) and peel it back, exposing the second layer of covering which you can pop, thus exposing the pill. Cut the pill in two and try to find somewhere to keep the severed half until tomorrow morning – loose in the box seems to work.

This is child safety gone mad. So I emailed Big Pharma, which had had so many complaints from consumers, pharmacies (via the reps) and doctors that they are going back to the original packaging.

Feeling delighted at the power of consumer feedback, I resolved to purchase the generic brand until Big Pharma reverted to the non-sexy packaging. But, guess what I discovered? The cost of the brand name tablets is $37.65 on the PBS, which includes a $5 surcharge for this particular brand. But, the cost of the generic pills is $17.95. Guess who won't be buying Big Pharma's brand anymore?!

And who said compliance was just doing as you're told?

INTRODUCING ... Consumer Consultant Update From Mind

-By Michael Stylianou and Nadine Cocks, Mind Consumer Consultants

Mind is one of the largest community managed support organisations in the mental health sector offering service to consumers in many different ways, from residential programs and outreach services to partnerships with clinical services in Prevention and Recovery Care services. Some people might know Mind by its former name – the Richmond Fellowship of Victoria that began over 30 years ago in 1977.

There have been many changes over the years besides the name. The organization has grown and in the last few years that growth has been dramatic. Some of the significant milestones for consumer participation have occurred within the last six years. Consumer consultants were employed at Mind from 2005 and in 2006 a Consumer Reference group was set up and is still in operation. About that time also a consumer newsletter -The Vine commenced going out to consumers who were receiving a service from Mind. Along the way there have been many challenges in ensuring that the voice of consumers is heard within a large and growing organization. In 2010 the Mind strategic plan made consumer, care and family involvement strategies a key developmental priority and the Consumer, Carer & Family and Peer Engagement team was commenced. This saw the Consumer Consultants and Carer Consultant working in the same team with additional management and project worker support.

One of the early decisions of this team was to re develop the consumer newsletter. Up until this point the work of producing the newsletter had fallen to the consumer consultants. This included the formatting, printing and distribution! Happily the new vision for the newsletter sees the consumer consultants in a consultative role on the newly formed newsletter steering committee.

It is pleasing to see on the position description that a lived experience of mental ill health and recovery is the first requirement listed.

Another key decision has been to appoint a newsletter editor that is external to the organization who will lead the production of the newsletter. The Editor will become the face of the newsletter to Mind consumers. Their role will be to bring a contemporary look to the newsletter that will engage consumers with interesting and helpful articles. It requires someone with the skills to grow the interest of consumers in both expressing their views and in learning new information. It is pleasing to see on the position description that a lived experience of mental ill health and recovery is the first requirement listed.

Consumer input and decision making as to content and direction will also be sought through two client editorial groups, one in Victoria and one in South Australia. Yes Mind has grown considerably and has operated in SA since 2005. It is planned to distribute the newsletter to all Mind clients across both states four times a year and to ensure that there are plenty of spare copies in every Mind service for people to pick up and most of all to read! Plans are also underway to make each edition available on line.

The position of Editor of the Mind Newsletter will be advertised in May and appear on the Mind website*. [See also the advertisement on page 2. of this newsletter]*

THUMBS UP/THUMBS DOWN

1. **THUMBS UP** to all the consumers who attended the whirlwind round of consultations with Mark Butler, the Federal Minister for Mental Health. Our voices can all too easily be marginalised, so we need to keep speaking up at every opportunity!!
2. **THUMBS UP** to the funding in the budget for the new national mental health consumer representative body.
3. **THUMBS DOWN** to the absence of any other recognition of the crucial role of consumers in the budget. Almost no money has been allocated for consumer initiatives (except for the national body). What about all the peer support projects, including Intentional Peer Support, the desperate need for more consumer advocates, consumer educators and academics, consumer research and consumer researchers, consumer authors, writers and creative projects, consumer run organisations, etc ... What a sad, wasted opportunity!
4. **THUMBS DOWN** to screening 3 year olds for "conduct disorders" and other "behavioural disorders" ... this seems like an ominous move towards medicating (or at least labelling) very young children!
5. **THUMBS DOWN** to the structuring of the budget around the category of "**S**evere **A**nd **D**ebilitating" (SAD!!) mental illness with so little available for anyone else. Exactly who this group is has not been defined, although historical examples of this kind of concept (like "serious mental illness" or SMIs in the First National Mental Health Strategy in 1993) has tended to be somewhat exclusive (and mainly to people with psychotic diagnoses). We fear it will be yet another way that other consumers (without diagnoses deemed to be "severe") will have their distress minimized, with services limited to "those most in need." This logic already leads people to self-harm or otherwise escalate their distress just to get support. This is awful, and counter-therapeutic!
6. **THUMBS DOWN** to the Budget's badly disguised, punitive attack on people who depend on Disability Pensions. The spectre of the "undeserving malingerer" hangs over this budget.
7. **THUMBS DOWN** to the cuts to the Medicare-subsidised access to psychologists and other allied health professionals (ATAPS), reducing the number of appointments to 10 (from 12).
8. **THUMBS UP** to all the consumers who labour month after month on committees often in contexts where our expertise is undermined and who are expected to "represent" other consumers when everyone else around the table is respected for their *expertise*.
9. **THUMBS UP** to consumers who no longer want to spend (waste?) their time sitting on "other peoples' committees" (as Flick calls them). They would rather put their time and expertise into strengthening those things that really honour our priorities and aspirations.
10. **THUMBS UP** to Dr Roy Krawitz, a psychiatrist from New Zealand who team-teaches with a wonderful consumer, Wendy Jackson, to educate the New Zealand mental health workforce about Borderline Personality Disorder. We invited them both as guest speakers for Our Consumer Place's forum on 'Consumers as Clinical Educators' (to be held in Nov. 2011) but because Wendy was unavailable, Roy declined to present without his team-teacher. We don't know many psychiatrists in Australia who team-teach with consumers, let alone so deeply and respectfully appreciate the value of such a partnership.

You may have missed ...

There is a growing body of brilliant thinking coming from the community who are often labelled as autistic or aspergers, and self-identify in a range of different ways – including "being on the spectrum," neuro-atypical or neurodiverse. They sometimes label "normal" people "NTs" (neurotypicals).

Whether you understand mental health consumers as allies to this community, another part of human diversity, or as coming together under an umbrella of "mental disability," many of us can no doubt relate to the brilliance of labelling those chronically normal people! Here's just one example of this brilliant parodying (from http://isnt.autistics.org/dsn-npd.html).

Institute
For the Study of the
Neurologically Typical

"The common belief that (persons) with pervasive developmental disorders are humorless is frequently mistaken." - Stephen Bauer, M.D., M.P.H.

DSN-IV (The Diagnostic and Statistical Manual of 'Normal' Disorders)

Personality Disorders

301.666 Normal Personality Disorder

Meets qualification for at least two of the following criteria:

A. Egocentrism (at least one of the following):

(1) Egocentric perspective (e.g. fails to realize that others may have a different perspective, needs, nature, or experiences from his or her self)
(2) Egomania (e.g. acts or talks as though better or more important than peers or others)
(3) Selfishness (either of both of the following)
(a) Marked greed or covetousness
(b) Domineering or "bossy" attitude

B. Lack of originality (at least one of the following):

(1) Rigidly follows traditions or social rituals

(2) Is often "faddish," follow the latest fads, fashions, or "crazes" invented or set by others

(3) Often demonstrates a "herd mentality" (e.g. thoughtlessly follows a social reference group or a local group of friends, often gives into "peer pressure")

C. Lack of Sympathy (one or both of the following):

(1) Cruel or callous towards the feeling of others (e.g. engages in teasing or ridiculing other, plays potentially harmful "practical jokes" on unsuspecting victims who are unlikely to be amused)

(2) Often Manipulative (e.g. uses others as tools to towards own goals, treats others as objects which may be acquired for own satisfaction, uses dishonesty as convenient way to achieve social goals)

Description

An incredibly prevalent disorder, Normal Personality is dangerous and often chronic. Normal Personalities are primarily marked by conformity (either to tradition or to "fads"), self-centered attitudes and behavior, and a general lack of genuine caring for others.

Normal Personality often appears to begin early in life. As children, they are often excessively aggressive and cruel. They commonly believe they must have the latest toy from a commercial, or wear the latest fashion. Often Normal children have trouble with possessive pronouns, and will call all objects "mine." Starring at cathode ray tubes (such as TVs) for long periods of time is also a common behavior.

As Normal Personalities are both extremely common, and potentially dangerous, the importance of them cannot be understated. The prognosis is often poor; however, Normal Personality can sometimes be successfully cured. When dealing with Normal Personalities, it is generally best to watch your back, and to be as understanding as possible. In many cases it may be necessary to avoid contradicting the normal behavior, as normal people are likely to show aggression to those who refuse to follow their "norms."

Associated Features & Differential Diagnosis

The exact relationship between normal personality and other forms of personality is disorder uncertain. It has been suggested that Normal PD may be a milder variant of Antisocial Personality Disorder. Also, many normal people are overly emotional, possibly showing evidencing a connection to Histrionic Personality, or even (considering the excessive need for even shallow companionship and selfish behavior) Borderline Personality. It may often be difficult to differentiate the more common Normal Personality from these other, more publicized disorders. As these diagnostic categories are not generally considered normal, they are not covered here, however, information on them may be found in the widely distributed DSM-IV, make their inclusion here unneeded.

It has also been noted that most cases of Normal Personality also have Neurotypical Disorder, and that converse is also true. However, Neurotypical individuals without normal personality are known, as is Normal Personality in rare non-Neurotypical people. Thus there is no reason to assume the presence of Neurotypicality automatically implies a Normal Personality; therefore, a dual diagnosis of both Normal Personality and Neurotypical Disorder is perfectly acceptable. However, a possible causal relationship may exist, with Neurotypicality contributing to the development of Normal Personality. Therefore, the presence of Normal PD should be reason to check for possible Neurotypicality.

Prevalence

The exact prevalence and incidence are not known. However, normal personality appears to be frighteningly common, and it incidence may be increasing.

Prognosis

Normal personality is most often a lifelong condition. Rarely is there any significant improvement of symptoms. It has been suggested that the presence of Neurotypicality makes the prognosis worse, though this has not been substantiated. Despite the severe social dependencies and possible cognitive impairments associated with Normal Personality, such people are often relatively high functioning. Many of them even become successful professionals, with politicians being an especially common in this population. However, the egocentrism, poor insight, and narrow standards of acceptability may make the person with Normal Personality dangerous to other in the community, being particularly threatening to those who are not themselves Normal.

See also: Staff personality disorder, and Psychiatry Disorder. Both VERY funny!

Some very exciting research: Coming off antipsychotic medications.

Carmela Saloman at the University of Melbourne is researching consumers' experiences of coming off antipsychotic medications. We believe this is important research because far too little is known about our various experiences of coming off medications (especially antipsychotics).

Anyone associated with OCP who has experienced coming off antipsychotic medications (*whatever* the experience was like) is invited to participate in the survey. Please be aware that only those who live near Melbourne can be interviewed in the 2nd stage. See the advertisement below – the survey is on our website (www.ourconsumerplace.com.au).

MELBOURNE HEALTH

SURVEY: consumer past experiences of stopping antipsychotics medication

THE UNIVERSITY OF MELBOURNE

Many people are treated effectively with antipsychotics in Australia each year. Some people, however, are required or decide to stop taking them for a number of reasons. Currently we do not know much about their experiences during this time.

As part of a University of Melbourne research project we are distributing a confidential survey asking people about past experiences of stopping antipsychotic medication. This survey does not encourage people to stop taking their medication, it simply asks about any past experiences they may have had. Stopping medication suddenly can cause adverse effects. You should speak to your doctor before making any medication changes.

Maybe you tried to stop antipsychotics but restarted again? Maybe you stopped and never took antipsychotics again? Maybe you had an experience that is somewhere in-between?

By filling in a confidential survey about your past experiences you could help to raise awareness about support needs and challenges during the coming off process.

You can download a copy of the survey on the OCP website. Or to request a survey please phone the researchers on 03 90354224 and leave a message. Alternatively e-mail: c.salomon@pgrad.unimelb.edu.au

We hope that this research will help to increase both consumer and clinician awareness of ways to minimise harms and to increase supportive strategies during the coming off period.

The survey takes about half an hour to complete and consists of 24 multiple choice and short answer questions. You do not need to provide your name to fill out the survey.

People must be over 18 years of age, living in the community and able to communicate in English in order to complete the survey.

The student researcher Carmela Salomon is conducting this survey as part of the requirements for her Masters of Philosophy degree. It is supervised by Dr Bridget Hamilton and Prof Judith Parker. The University of Melbourne has provided funding for the project. If you have any questions about the survey please contact the research team on 0435362701 OR email: c.salomon@pgrad.unimelb.edu.au. The ethical aspects of this research have been approved by the Melbourne Health Mental Health Human Research Ethics Committee (HREC). Should you have any concerns about the conduct of the research please contact the HREC's manager DR Sarah Rickard on (03) 83428530.

Experiences of stopping antipsychotic medication: newsletter/email advertisement (02/01/11, version 2, HREC # 2010.271)