CSF-Canberra Supporting Families in mental illness
Newsletter of the
Canberra Schizophrenia Fellowship
A Member of the Mental Illness Fellowship Australia
PO Box 6216, O'Connor ACT 2602. PH: 6205 1349
This newsletter is sponsored by the Canberra Southern Cross Club

Volume 10 Number 6 *July 2005*

President's Report

Like the farmers who are busily sowing grain crops after recent rains our national body, the Mental Illness Fellowship of Australia [MIFA], has this month been spreading the key message of Awareness Week - that a severe mental illness need not exclude people from competitive employment, **IF THEY ARE BACKED BY APPROPRIATE SUPPORTS**.

That was the theme of a breakfast presentation by MIFA on 15 June, to the **Parliamentary Friends of Schizophrenia**. Geoffrey Waghorn, of the Queensland Centre for Mental Health Research, showed them that traditional rehabilitation programs do not prepare clients for competitive employment, but with more attention to supportive connections they would be able to do so.

Relevant principles for successful rehabilitation were described in the June Newsletter. Ariel, a trainee at Café Pazzini, told the parliamentarians how his time there had helped him regain skills and confidence, and that he would soon be working in a real job for three days a week.

* * *

This issue of the Newsletter carries a SANE article that draws attention to an all-too-common outcome of the rehabilitation process, which is an inability to solve that most painful but rarely-discussed consequence of mental illness - social isolation and loneliness.

Another event on 15 June was the signing of a Memorandum of Understanding [MOU] by Ron Cahill for the Richmond Fellowship, and myself for the Schizophrenia Fellowship. After a long informal association, this MOU provides a basis for future cooperation between the two Fellowships on behalf of people affected by mental illness. The MOU also sets out arrangements for the two Fellowships to operate from.adjacent buildings at 41B David St

An immediate opportunity for such cooperation arose with the preparation of complementary submissions to the Legislative Assembly Standing Committee on Health and Disability, concerning appropriate housing for people living with mental illness. I wish to thank our members who contributed their particular concerns for inclusion in the CSF submission.

* * *

A matter of special interest to CSF members [and perhaps others] is our name. In recent years several of our Australian sister organisations have replaced the word "schizophrenia" in their name with "mental illness". The Governing Board considers that members should now have the opportunity to debate the question **"should we change our name?"** I am therefore sending all members a letter that sets out points for and against changing it to "Mental Illness Fellowship of the ACT". All financial members are entitled to vote on this proposition, when it is put to CSF's Annual General Meeting in September.

Note: membership subscriptions for 2005-6 fall due on 1 July. One of the inserts in this issue of the newsletter is a membership renewal form.

Ian Morison

PUBLIC MEETING
Wednesday
13 July 2005
at 5.30pm
Gallipoli Room
RSL Club
13 Moore St
Civic
Speaker
Representative from Carers ACT
Topic
Special Mental Health Projects

ADVANCE NOTICE
PUBLIC MEETING
Wednesday
10 August 2005
at 5.30pm
Gallipoli Room
RSL Club
13 Moore St
Civic
Speaker
Representative from NISAD (Schizophrenia Research)
Topic
The tissue donor program

Christmas in July
When : 6.30 pm Friday 15
Where: Harmonie German Club, 49 Jerrabomberra Ave Narrabundah ***Costs:$40, $30 concession***
****3 course traditional dinner***
****Entertainment – Linda Hansen & Band***
Talent Quest – (call Andrea 6251 6099)
Phone Carol 6295 9853 11am to 6.30pm by 7 July

PEOPLE NEED PEOPLE

Social isolation and loneliness are among the most painful consequences of having a mental illness for many, yet these issues are rarely discussed…

No man is an island…wrote poet John Donne almost 400 years ago, and we all understand immediately what he means.

Social isolation - being cut off from contact with others - is recognised as a painful, highly undesirable state. It is routinely used as a punishment in prisons and detention centres.

Yet it is also a common experience for many people affected by mental illness. This important but neglected issue is the subject of the first in a series of SANE Research Reports, to be published mid-2005, providing authentic and compelling evidence of the need for improved community support services.

There are many reasons for this cruel consequence of mental illness. Symptoms can affect functioning, making it difficult even to hold a simple conversation appropriately at times. People with depressive or psychotic disorders often experience anxiety and sometimes paranoia too. If a first episode of psychosis occurs during the teen years, before mature social skills have developed, for example, these can be difficult to learn as the years go by.

Stigma also has a subtle but corrosive effect, so that people may come to regard themselves as unwanted outcasts, feared and reviled by society at large. For all these reasons, many people affected by mental illness have difficulty relating to others, and lead lives in 'solitary' for much of the time.

Preliminary findings from the SANE Research Report study on social isolation reinforce the Low Prevalence Study results. Seventy-two percent report feeling lonely 'all' or 'most' of the time, and over 90% believe friendships are an important part of staying well. People who have a wider social network because they attend a rehabilitation program report being better able to manage their illness, but less than 20% attend these programs.

These findings strongly indicate that treatment in the community has a long way to go in providing effective and accessible services to people affected by mental illness.

For a range of reasons, then, helping people to get on more easily with others and develop relationships should be an important goal of rehabilitation. It can be a means of rehabilitation too, with every successful social contact making the next one easier.

At the same time, it needs to be recognised - as the SANE study reports - that rehabilitation programs need to help people with mental illness make social contact in the wider community, not become 'mini-institutions' in which people only mix with others who are similarly affected.

What can be done to help?
The SANE Charter calls for improved community services and an important aspect of this is provision of psychosocial rehabilitation to help people re-integrate with society at large.

A number of steps are needed for this to happen successfully:

A network of rehabilitation programs
Availability of programs across the country is ad hoc, with huge variation between States and a severe lack of services in country areas. Systematic provision of programs across the country is required as part of the National Mental Health Strategy.

Evaluation and training
There is an urgent need for research and training on the most effective forms of rehabilitation to help people re-learn social skills and integrate with their communities.

Employment support
Having a job, even for a few hours a week, is one of the best ways to make contact with other people. Closer coordination of (State-provided) rehabilitation and (Commonwealth-provided) employment services is needed, along with a commitment to ongoing support.

An end to stigma
If people affected by mental illness are to feel they are genuinely a part of the community, then continuing strong action is needed to combat stigma: to ensure they feel included in society, and not regularly ridiculed and reviled, especially by the media.

This article is from SANE News, Winter 2005.

COGNITIVE BEHAVIOUR THERAPY (CBT) AS EARLY TREATMENT OF SCHIZOPHRENIA

When schizophrenia is detected and treated early, through the evidence-based use of drug treatments, family interventions and cognitive-behaviour therapy, the prospect of an improved outcome is increased.

This is especially the case when treatment is delivered in a setting designed specifically to be accessible and non-stigmatising for young people.

In an article published in *Current Opinion in Psychiatry** earlier this year, it was shown that recovery rates from the first episode are high, with 85

per cent of patients achieving remission over an average time of three months.

During a first episode, people are sensitive to both the therapeutic effects, as well as the adverse effects, of antipsychotic drugs. This means they are more likely to respond to lower doses than in later episodes, but are also more susceptible to motor side effects.

Most expert opinion advocates second generation antipsychotics as the first line treatment (e.g. initially 0.5-2 mg risperidone, or 2.5-7.5 mg olanzapine per day, with benzodiazepines often used as well to control agitation or catatonic symptoms.

However, poor adherence to treatment is often more problematic than at later stages in the illness with up to half of patients being non-adherent in the first year.

This is where cognitive behaviour therapy (CBT) is useful.

A large randomised controlled trial in the UK showed that a five-week package of CBT in the acute first episode had advantages over routine care alone in speeding up remission in positive symptoms. There was also a modest - but significant - reduction in 'blindly rated' symptoms at 18 months. The authors of the study comment that these relatively small gains are likely to be enhanced by longer packages of CBT.

A complicating factor which worsens every type of outcome is the large proportion of people suffering first episode psychosis who abuse alcohol and illicit drugs. In such cases, a critical pillar of management is to try and persuade patients to abstain. In many cases, interventions by specialist services may be needed, including motivational interviewing and other medications. Because family support is critical – carers often find the negative symptoms of psychosis most difficult to cope with – structured support can take the form of psycho-educ-tion and behavioural problem solving, where possible with the involvement of a family support worker.

* *Curr.Opin Psychiatry*. 2005; 18(2): 147-150

NEW DRUG MAY REDUCE ALCOHOL INTAKE

A clinical study in the United States suggests that a new drug treatment which rapidly reduces alcohol intake could have potential in treating people suffering from the dual diagnosis of schizophrenia and alcohol dependence.

The results of the study*, published in the Journal of the American Medical Association (JAMA) in April this year, showed that a once-monthly dose of Vivitrex®, a long-acting injectable form of naltrexone, together with low-intensity counselling, was an effective and well-tolerated treatment for alcohol dependence.

Naltrexone is widely used to counter addiction to opioids but has been shown also to be effective for treating alcohol dependence. However, adherence to daily oral doses can be problematic and clinical acceptance and usefulness of oral naltrexone have been limited because of this.

The 6-month, randomised, double-blind, placebo-controlled trial (conducted at 24 US public hospitals, private and Veterans Administration clinics and tertiary care medical centres), involved 627 individuals, diagnosed as being alcohol-dependent.

Treatment in the experimental group significantly reduced the average number of heavy-drinking days in alcohol-dependent patients from 19 days a month to three days a month.

(There was no indication that any of the subjects in the trial had schizophrenia.)

The majority of the patients in the trial were actively and heavily drinking at the beginning of the study. The results of the study in the experimental group showed that the higher the dose of naltrexone, the greater the decrease in alcohol intake.

This was one of the largest and most comprehensive clinical trials evaluating the use of medication for the treatment of alcohol dependence.

At the time the study was published in April this year, the new drug had not received FDA approval.

**JAMA 2005; 293:1617-1625*

CSF publishes articles in its newsletter in good faith and does not accept responsibility for any inaccuracies or views expressed in contributed articles.

DON'T KEEP COMPLAINTS TO YOURSELF!

Sheelah Egan, a past president of the CSF, has reminded us recently that the only way we can improve services for mentally ill people in the ACT is to complain to the right authorities when things go wrong.

As a Carer representative at the meetings of Mental Health ACT (MHACT) Planning and Strategic Executive and Risk Management Committee, Sheelah says that as a result of carers regularly raising issues of concern with Brian Jacobs, CEO of MHACT, the Carers' Committee has received a letter from him in which he states:

"I note and share your concern about staff sensitivity and attitude to some consumer and carer groups. All Mental Health ACT staff are required to attend training in working with diverse groups. I have an expectation that staff treat all our consumers and carers with dignity and respect. If members of the committee, or in fact any other members of the community, are unhappy with this, or any other aspect of our service, they are entitled to lodge a complaint, and the complaints handling process will link to organisational Improvement mechanisms within the service delivery area."

Sheelah says she knows lodging complaints is not easy, and she is willing to help anyone who would welcome assistance on this.

Topics discussed at recent meetings of the two committees of which Sheelah is a member included

- Organisation of Forensic Services within MHACT
- Definition, roles and levels of Health professional officers
- Triage Access Line
- Consent for exchange of information

If any of our members would like to make Sheelah aware of any views they may have on the above topics, she says she would be happy to hear from them, as most topics tend to be on-going.

Sheelah's e-mail address is: lipsinc@bigpond.com

Don't forget to visit our Website!

For information about the CSF, schizophrenia, support services in Canberra and much more go to www.csf.org.au

HELPING SOMEONE WITH MENTAL ILLNESS

A new brochure from ACT Health provides tips and advice on helping a colleague or friend cope with mental illness.

The brochure, launched in May by ACT Health Minister, Simon Corbell, has sections on dealing with your own feelings about your friend e.g. informing yourself about the illness, its cause, course and possible outcomes, as well as providing emotional and practical help to the person who is ill. There is also a section for managers on how to deal with a mentally ill person in the workplace – things to do and things not to do – as well as where to find out more information.

A carers' contacts flip-chart (with magnet for a refrigerator door) was launched at the same time. It contains telephone numbers and/or websites for crisis contacts, alcohol and drug services, information and education services, respite and time out facilities, legal services and places to provide feedback on any aspect of mental health and where to find advocacy services.

For copies of the brochure and/or flip-chart, contact Mental Health ACT on 1800 629 354.

Letters to the Editor

Letters to the Editor are welcome. Please keep your letters to no more than 200 words. Either post to CSF Newsletter, Box 6216 O'Connor ACT 2602 or email csfell@webone.com.au

CSF MEMBERSHIP SUBSCRIPTION FOR THE YEAR 05/06 ARE DUE FROM 1 JULY 05

A separate membership form has been enclosed with this newsletter for current members.

Concession	*$10.00*
Individual	*$15.00*
Family	*$25.00*

Canberra Schizophrenia Fellowship

Membership Form

Please send your payment to:

Canberra Schizophrenia Fellowship
PO Box 6216
O'Connor ACT 2602

NAME (Mr/Mrs/Ms/Miss)

……………………………………….

ADDRESS

……………………………………….

……………………………………….

PHONE

(H)…………………….….

(W)…………………….….

EMAIL ……………………

CATEGORY
(Please circle)
INDIVIDUAL $15

CONCESSION $10

FAMILY $25

DONATION: …………

(Donations of $2.00 and over are tax deductible)