CSF-Canberra **S**upporting **F**amilies in mental illness
Newsletter of
Canberra Schizophrenia Fellowship
A Member of the Mental Illness Fellowship Australia
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President's report

I spoke with a spokesperson from the Chief Minister's office on Wednesday 25 August that allayed my fears about the proposed amendments to the Crimes Amendments Bill. The Chief Minister believed it a "narrow legal issue" and was unaware of the outrage caused by there having been no community consultation to the proposed amendments.

The amendments propose to prevent the "offender" being batted backwards and forwards between the Magistrates Court and the Mental Health Tribunal. The issue is "fit to plead" before the court for a crime committed. The court will be able to assess fitness to plead on the basis of relevant expert evidence, in the presence of all legal and other representatives, and in particular, the office of the Director of Public Prosecutions.

There are tests to assess whether or not someone is fit to plead. Someone may be very unwell from a psychiatric point of view, but this does not mean that they are not fit to plead.

Being psychotic does not *necessarily* preclude someone from being fit to plead.

The basics of being fit to plead are as follows:

- Understand the nature of the charge
- Instruct counsel
- Understand the difference between guilty and not guilty
- Follow court proceedings

ANNUAL GENERAL MEETING
Wednesday
8 September 04
at 5.30pm
Gallipoli Room
RSL Club
13 Moore St
Civic
Speaker
Simon Corbell
ACT Minister for Health
Subject
ACT Mental Health Strategy and Action Plan

ADVANCE NOTICE
Public Meeting
Wednesday
13 October 04
at 5.30 pm
Gallipoli Room
RSL Club
13 Moore St
Civic
Public Forum
'Surviving Mental Illness'

The court will determine diminished responsibility with a referral for treatment, or the case will then proceed on the evidence provided.

The Mental Health Tribunal will keep its jurisdiction to hear and determine applications for orders in respect of the treatment, care, control, rehabilitation and protection of mentally dysfunctional or mentally ill persons.

The proposed amendments to the *Mental Health (Treatment and Care) Act* 1994, Part 3, Mental Health Tribunal, Functions 11 (e) substitutes: *to determine the fitness to plead of persons charged with criminal offences to make orders in respect of the treatment, care, control, rehabilitation and protection of persons found unfit to plead, to review the welfare of those persons and to order (if appropriate) the release of those persons subject to conditions (if any);* with

11. (e*) to make orders for the treatment, care, control, rehabilitation and protection of people found unfit to plead, to review their welfare and to make any appropriate order for their release (subject to conditions or unconditionally).*

A number of you have relatives who have appeared, and no doubt will continue to appear, before the court. Many people with a mental illness can present quite 'normal and rational' for short periods of time, enough time to misrepresent their real state of mind and reality. We want assurance from the Stanhope Government that our relatives will be referred to, and have access to, treatment in appropriate settings. Judges, Magistrates and court officials must be educated in mental illness and its episodic nature if the proposed amendments are to be supported by the community.

Annette Atherton

Mental Health in Australia "a tragic tale of medical neglect and community indifference"

The treatment of mentally ill people in Australia is often a tragic tale of medical neglect and community indifference, the result of failure by State government services to deliver proper care.

"Those with a mental illness are still being blamed for being sick," according to Dr Sev Ozdowski, Australian Human Rights Commissioner and Disability Discrimination Commissioner.

Addressing a National Press Club lunch in Canberra on 25 August, Dr Ozdowski said that the way nations treat their most vulnerable and powerless is the ultimate test of their commitment to human rights – not what they aspire to, not the Conventions they sign and not even the laws that are set in place.

Dr Ozdowski has just spent two months travelling Australia as part of an expert committee, holding public meetings and consultations on mental health issues, to find out what had happened since the 1993 Burdekin Report recommended sweeping changes to improve the treatment of the mentally ill. When he spoke at the Press Club, it was one week after he and other members of the committee, Dr Grace Groom from the Mental Health Council and Professor Ian Hickie of Sydney University's Brain and Mind Research Institute, had held public consultations at Old Parliament House in Canberra. Meetings were yet to take place in Tasmania and Northern Territory.

Dr Ozdowski described the reports from the committee's current consultations as "horrifying", with many stories of preventable suicide. In Canberra, the committee was told about a young man with a history of depression, and openly suicidal, who jumped from a sixth floor balcony only two days after being refused admission to the psychiatric unit following a second suicide attempt.

He said there was widespread concern about a lack of services to deal with combined drug addiction and mental illness, such as schizophrenia and depression. He had heard many first-hand accounts about violent behaviour, suicide attempts and "endless bouts of hospitalisation or imprisonment" yet medical policy dictates that drug addiction be treated first, before the mental illness is tackled. He added:

"There is increasing evidence that widespread use of common drugs such as cannabis, amphetamines, alcohol and ecstasy is contributing to an increased rate of mental illness among young people. In addition, they are making those young people even more disturbed when they finally present for care."

He went on to say that the most frequently mentioned gap in mental health services was the absence of early intervention services for young people, and the fact that emergency services were overburdened and often inaccessible.

"We are also seeing a pattern of underspending and a lack of investment in mental health," he said. "There are some brave words by some State governments, but little real action.

"With one exception: Western Australia took action. Within six weeks of signing up to a National Mental Health Plan, the Western Australian Government withdrew $4 million from mental health services. The reason? Different priorities."

Similarly, according to anecdotal evidence, the situation in NSW and South Australia "has not been encouraging", and has suggested a lack of appropriate accountability for money earmarked for mental health. He had even heard of mental health money from the Federal Government being diverted into the general hospital system.

Although consultations were not yet complete, his considered conclusion is that there needs to be real accountability about where the mental health money is going.

He also said there must be priority given to the coordination of mental and psychological care, in other words, drug and non-drug therapies. And there must be a real commitment to new and innovative return-to-work schemes for people recovering from mental illness. Australia's success rate in this is the lowest among the OECD countries.

"Above all," he said, "there must be more money put on the table - for research, innovation and better services. For example, more money* is needed for research on links between drugs and mental illness in young people."

Dr Ozdowski's final words to his audience were these:

"The statistics on sanity are that one out of every five Australians this year will experience some form of mental illness. Think of your four best friends. If they're okay, then it's you."

The Mental Health Council of Australia is inviting people to send in written submissions about their experiences with the mental health system so that they can take these to the government. If you would like to have your concerns put on the record, please send these to the Council at PO Box 174,

Deakin West, ACT 2600 or by email www.mhca.com.au
Closing date is 30 September 2004
*Australia currently spends about seven per cent of its health budget on mental health in comparison with other first world economies, which are spending between 10 and 14 per cent. New Zealand now spends twice as much per capita as Australia.

Therapy with Psychologists

The Fellowship's public meeting in August heard from psychologist Harold Bilboe about a scheme that allows people with a mental disorder to have up to six free private therapy sessions with a clinical psychologist. This was good news for those who would like to talk to a health professional about how to manage their condition.

Apparently the scheme has existed for years, via the ACT Division of General Practitioners, but seems to have been a well-kept secret. Many GPs may still not be aware of it, and few of us had heard of it, so getting access to the service is not easy.

The scheme is available on a voluntary basis to people who can:

- Find an ACT or Queanbeyan GP who is registered with the scheme. (With luck your regular GP will be on it, or will register after finding out about the scheme from you. If not you will have to ask around.)
- Satisfy a GP with whom you have 'an ongoing relationship' that you suffer from a condition that can be treated by one of the scheme's clinical psychologists.

While a family member or friend can find the GP, it is the person with the disorder who has to get through the second gateway and make an appointment with the psychologist to whom they have been referred. Harold Bilboe emphasised this point, as voluntary agreement was crucial to the success of any course of therapy. The support and encouragement of others may nevertheless be of great help to a person in deciding to take that step.

Harold Bilboe also made it clear that today's therapy is about finding the tools that are needed, in parallel with prescribed medication, to manage a mental disorder so as to function better at home, school, work and in society in general. Therapy today tends not to ask us to dwell on the traumas of our early lives.

This seems to make a lot of sense, for two reasons. Firstly, everyone can recall bad early memories, and talking about them rarely helps us to decide how to make changes in our lives. Secondly, with the 'shrink' tag out of date it's socially OK to see a psychologist.

Let's ask our own GPs about the scheme. That will encourage more of them to register with the ACT Division, and make it easier for those in dire need to undertake a course of therapy.

Ian Morison

Cannabis use linked with earlier onset of schizophrenia

The age at which the first episode of schizophrenia occurs in is strongly linked with cannabis use, according to a study published in March this year in the *American Journal of Psychiatry**.

Although the study sample was relatively small (133 patients in total, including 70 cannabis users and 97 males), its aim was to examine the independent associations between gender and cannabis use and age of onset of schizophrenia.

The research team, from the University Medical Centre at Utrecht, Holland, defined milestones of early onset as: first social and/or occupational dysfunction, first psychotic episode, and, first negative symptoms.

It found that male patients were significantly younger than female patients on all three criteria. As well, cannabis users were significantly younger on all counts when compared with non-users.

Male cannabis users had their first psychotic episode a mean of 6.9 years earlier than those who did not use the drug.

"Multivariate analyses showed that cannabis use - but not gender - made an independent contribution to the prediction of age at first psychotic episode," according to the team leader, Dr Natalie D. Veen.

"Since early onset is associated with a poorer prognosis of the disorder, the relationship between cannabis use and the risk of developing an early-onset type of schizophrenia is an important focus for future research."
**Am J Psychiatry 2004, 161:501-506*

Out of the Asylum, into the Cell

A new report by Human Rights Watch has found that US prisons contain three times more mentally ill people than psychiatric hospitals.

The study confirmed what mental health and corrections experts have long known: incarceration has become the nation's default mental health treatment.

While the report offers good suggestions on how to help

those who are incarcerated, a bigger question is what we can do to keep them from ending up behind bars at all.

The Los Angeles Country jail, with 3400 mentally ill prisoners, functions as the largest psychiatric in-patient institution in the United States. New York's Rikers Island, with 3000 mentally ill inmates, is second. According to the Justice Department, roughly 16 per cent of American inmates have serious psychiatric illnesses like schizophrenia, a bipolar disorder and disabling depression.

Life on the inside is a special nightmare for these inmates. They are targets of cruel manipulation and of physical and sexual abuse. Bizarre behaviour, like responding to imaginary voices, or self-mutilation, can get them punished. The usual penalty, solitary confinement, only worsens hallucinations and delusions.

How did it happen? Actually with the best of intentions.

Forty years ago, President John F Kennedy signed the Community Mental health Centres Act, under which large state hospitals for the mentally ill would give way to small community clinics. He said of the law that the 'reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability'.

Kennedy was acting in response to a genuine shift in attitudes towards the mentally ill during the post-war years. The public and lawmakers had become aware of the dreadful conditions in the state mental hospitals.

Between Kennedy's signing of the mental health law in 1963 and its expiration in 1980, the number of patients in state

mental hospitals dropped by about 70 per cent. But asylum reform had a series of unintended consequences. The nation's 700 or so community mental health centres could not handle the huge numbers of fragile patients who had been released after spending months or years in the large institutions.

Those discharged from state hospitals were often caught in a revolving door, quickly failing in the community and going back into the institution. And those were the lucky ones – many others ended up living in flop-houses, on the streets, or as Human Rights Watch has reminded us, in prison.

Reforms, like segregating mentally ill prisoners in treatment units would help. Of course, the ultimate aim is keeping psychotic people whose criminal infractions are a product of their sickness out of jails in the first place. The first reform entails repairing a terribly fragmented mental health care system.

For many thousands of mentally ill people, America has failed to make good on John F. Kennedy's promise of 40 years ago. Releasing them from the large state institutions was only a first step. Now we must do what we can to free them from the 'cold mercy' that comes with criminalising mental illness.

Reprinted from June 04 newsletter of the Schizophrenia Fellowship of South Queensland.

In Australia, the prisoner support group, Justice Action, is concerned about the continuing number of people with a mental illness who end up in jail because there are no other options. Many aspects of the above story would be familiar in Australia.

NORTHSOUTH CONTRACTORS

<u>GARAGE SALE</u>

DATE: 4 September 04
PLACE: 41B David St O'Connor
TIME: 7am to 12 Noon

<u>All proceeds to go to Canberra Schizophrenia Fellowship.</u>

If you have any unwanted items that you would like to donate, you can drop them off at the O'Connor office Monday to Thursday from 8.30am to 4pm.