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SUBMISSION TO THE SENATE SELECT COMMITTEE ON MENTAL HEALTH

BACKGROUND

The Nature of Schizophrenia:

The most common mental illness today is Schizophrenia; it strikes one in a hundred in every country in the world, whether rich or poor, whatever the personality. It is NOT CAUSED by stress, inferior housing, poor parenting or latent homosexuality, nor is there any proof that this is so.

The condition strikes when body-biochemistry becomes faulty, causing changes which result in psychological alterations from the normal in PERCEPTION, THOUGHT, MOOD AND ACTIVITY. Symptoms may include hearing, seeing, feeling, what is not there. These faulty sense receptions impair judgment; thought processes become distorted, mood depressed, behaviour bizarre. The person cannot function in society.

These mental symptoms are as a result of the underlying physiological condition. Body and Brain are One. Symptoms are manifestations of a dysfunctioning body affecting brain function. Mental symptoms are NOT the illness itself. They are not the reality of it. As the spots of measles signify an internal viral infection, not a skin ailment, the aim of treatment should be to identify the causes of symptoms, not merely to suppress them with drugs and disregard the ongoing dysfunction.

Symptoms may be caused or exacerbated, as we now know from the medical literature and clinical experience, by many factors such as allergies, sensitivities, toxic chemical overload, undiagnosed or unsuspected medical condition, deficiencies or imbalances in nutritional status.

There may yet be one physiological reason to be found in the future for mental symptoms but there is, as yet, no single definitive laboratory test for the condition which is why it is often reported that diagnosis has taken years to achieve. It is possible, however, greatly to improve the patient's condition with the help of specific pathology to identify many deficiencies or imbalances and rectify them.

> This is the area that SOMA, since 1979, has been anxious to improve and this is the reason for this, yet another, Submission.

Deinstitutionalisation and its Effects:

Twenty five years ago the theory was introduced by American civil libertarian organizations that the psychiatric hospitals themselves were actually causing mental illnesses. They were so dreadful in every way, they argued, they should be shut down. The financial advantages of hospital closures and community care were enthusiastically picked up in the Western world although there was little knowledge as to who exactly would provide community care and pay for it. Very few, if any, psychiatrists spoke against hospital closure, and parliaments, patients and carers fell into line. Thus followed the chaos of the 1980s the results of which are still being felt today.

(1) A crisis in services as well as treatments reported SMH 2&3.10.01:

Since the number of beds was severely cut back twenty years ago as a result of the deinstitutionalisation policy, the number of beds in NSW has been reduced from 12,000 to 2,000 Of these 2,000 only 734 are available for non-acute cases. 'Non-acute' means 'serious chronic cases unable to live in the community'. There has been an 'abdication of responsibility where beds are concerned' says one psychiatrist. When mentally ill persons are not looked after properly they often break the law and land up in jail. 'Jails are bulging with the mentally ill, most not treated' says a judge. Due to lack of facilities they are locked in bare cells for up to 23 hours a day, a danger to themselves and others. Around 800 mentally ill inmates need treatment but there are just 90 places available at the high security hospital at Long Bay Jail. The State Government's Corrections Health Service has found 7% of inmates (550 prisoners) suffer from serious mental disorders in which patients have lost contact with reality, suffer from delusions and exhibit bizarre behaviour. They are isolated to prevent suicides. They lack human contact and psychiatric support.

(2) From an article 'Flawed Social Experiment' – David Copolov – SMH 07.11.05: There are two schools of thought even after all this time:

(i) one which says we DO NOT want or need psychiatric hospitals or asylums and all treatments should be found in the community (John Mendoza of the Mental Health Council of Australia);

(ii) and the other (Professor David Copolov) which says we DO need specialist psychiatric hospitals preferably attached to general hospitals which can deal with overlooked physical needs of patients. Statistics already show that patients with such serious conditions as schizophrenia live 15 years less than the general public.

This article states that since the introduction of 'community care' in 1985, the First National Mental Health Plan 1992 had already seen a reduction in beds of 73% from 80,000 to 30,000, even though there had been an increase in population of 70%. From that time there has been a 50% increase in imprisonments of patients; psychiatric hospitals are run down and have no reserves for dealing with admission surges; premature discharges occur as a result, with disastrous consequences; there are pressures on Admissions in general hospitals as severely ill patients wait for a scarce bed in a psychiatric ward. We now have only half the beds we need.

Copolov also says that the flaw is not in the IMPLEMENTATION of policy but in the POLICY ITSELF. Neuro-biological conditions like schizophrenia are enduring, relapsing, life-threatening and serious. There is a great immediate need for more beds, both acute and long-term, together with high quality specialist psychiatric services.

TREATMENTS:

Treatments in mental illness are the least discussed aspect of these conditions. It is easier to obtain funding for 'mopping-up operations' than it is in finding it to investigate more effective concentration on causes. Medication should not be regarded as the first and only treatment in schizophrenia. Drugs may be necessary and useful but every care should be taken to identify all the factors involved in a dysfunctioning body system. If diagnostic tests are not carried out, if medication-only is used as first-line and only-line treatment, then the strongest possibility is that the patient will never improve sufficiently to live an independent life and will spend the rest of his/her life in and out of hospitals, on the streets, even in jail.

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It is estimated that only about one quarter of all sufferers are medically treated for their true basic condition, many of the rest try to treat themselves with alcohol or street drugs and become addicted and part of another set of statistics.

The protocols for treatment in schizophrenia are laid down by the College of Psychiatrists. These protocols state virtually that 'treatment is medication - and some counselling may be helpful'. The College issues a Position Statement on Orthomolecular Psychiatry (which is what updated diagnostic and treatment methods in psychiatry were called by Linus Pauling) every three years. SOMA HEALTH has been endeavouring to enlarge the scope of treatments in schizophrenia and other mental illnesses since inception in 1979, 27 years ago, but the College is intractable. Every three years the Position Statement rejects updated treatment. This situation is proving detrimental to many patients and doctors.

Many people are now demanding that treatments in any condition affecting brain function be put into the hands of, say, biochemists and medical diagnosticians, as psychiatry is seen to have failed in so many ways in treating the mentally ill.

- Psychiatry, in effect, concentrates largely on the psychological, psychosocial and behavioural aspects of symptoms, rather than on evidence-based medical factors as to causes.
- There is a close-liaison between psychiatry and drug manufacturers. Many say, too close. The latest drugs often cause severe obesity and it may be found in future that side-effects may damage the liver and cause diabetes.
- Drugs used to suppress serious symptoms may also rob the body of essential nutrients and this, in turn, can result in tardive dyskinesia, a most distressing iatrogenic condition.
- Suicides are prevalent, many perceived as accidents. Tragedies hit newspaper headlines several times a week and many must involve unsuspected or neglected mental illness.
- As a result of College intractability, families are increasingly looking overseas for improvements in diagnosis and treatment, especially where children are concerned. This means that our own Australian pool of knowledge and expertise is diminishing and will continue to do so, especially when branches of reputable overseas clinics are established and welcomed here in Australia. The time will come when change will be seen to be immediately necessary and Australian psychiatry will be found wanting.

The College of Psychiatrists evidently works in close liaison with the Medical Board and the Complaints Commission. Out of date treatment protocols assure that up to date medical professionals may be very disadvantaged. As a result of intractability there has arisen the question of whether psychiatry as a serious medical discipline is worth acknowledging. We hear every day of public dissatisfaction with psychiatry's methods and outcomes and see the dismal outcomes from restricted treatments on the streets and in the numbers in jails.

We are exasperated by piecemeal activity masquerading as great leaps forward. If psychiatry is going to flourish, it must bring itself up to date – not only with the latest drugs - but also by using corrective psychiatry, looking for demonstrable biochemical defects.

We now learn that it has just been 'discovered' that persons with low Serotonin levels may become depressed. This is what SOMA's patron, Dr C M Reading, Retired, has been saying for twenty-odd years but no mention is made in the introductory SMH article 01.03.06. that Serotonin levels will be low if the person is lacking in Vit. B6, Zinc, Manganese, Magnesium, amino acids, etc. Talk is about 'adjustments' and 'skilling patients up', i.e. 'counselling a change in mood'. Who is interested in WHY serotonin is important and how it, and its co-factors, become deficient, and what we do about its levels? This is pertinent to our plea that patients should undergo diagnostic testing to obtain a full picture of the person's body biochemistry prior to treatment. Perhaps a bell will now ring with the Committee before the clapper is removed.

In conclusion, SOMA states that we need:-

- an OPEN PUBLIC ENQUIRY into psychiatry, and the medical treatment of persons, young or old, affected by any illness or condition that affects brain function;

- the establishment of a DIAGNOSTIC AND TREATMENT UNIT under the supervision of experienced and keen medical doctors who will update diagnostic and treatment methods in psychiatry.

- to see an end to the brain drain, the loss of skills and up-to-date knowledge that is being lost simply by the out-of-date attitudes of the College of Psychiatrists. These attitudes are detrimental to the medical profession and especially to patients who need all the help they can get and which many of them have been missing out on so far.

This Submission is presented in narrative form rather than according to itemised Terms of Reference Clauses. Special note, however, should be made of clauses nos. (b), (j), (k), (l), (n), (p).

SOMA HEALTH

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