

INFORMATION MATTERS

Schizophrenia Society of Nova Scotia

October 2006



The James Britten Senior Leadership Award 2006- presented to Cyril Allan

From left to right John Britten, Christine Wood, Cyril Allan (award winner), David Britten and Jim Britten

Cyril Allan is a soft spoken leader and a quiet but forceful champion of the society's mission, inspiring others with his optimism, determination and strength of character. A team player, "Cy" has helped many people get through that sense-of-isolation and loneliness that this illness often brings to individuals and families. The Britten family is pleased to recognize these important contributions to healing and recovery. Cyril Allan has been directly involved with many new initiatives this year, including: 'Healthy-Minds-

Cooperative' organization; the 'Family-Voice-For-Mental-Health' support group, and has been a passionate champion for new and better 'Mental Health Legislation for Nova Scotia.

John, David and Jim Britten are seen in the picture above surrounding S.S.N.S. Board President Christine Wood, presenting the James Britten Senior Leadership Award. SSNS is privileged to recognize and honour all of these individuals for their dedicated service.

Publication of this newsletter has been generously provided by:



And



Some Support Numbers Nova Scotia

Kids Help Line, 1- 800-668-6868
Friendship Club, Truro, (902) 895-3429
Crossroads Clubhouse, Sydney, (902) 567-7961
New Hope Clubhouse, New Glasgow--- (902) 755-1838
M. H. Services, Yarmouth, (902) 742-3542
CMHA, Bridgetown (902)-665-4801
CMHA Kentville (902)-679-2422
CMHA Bridgewater (902)-527- 1893
Shelburne Mental Health Centre – (902)-875-4200
Addictions Services: Springhill (902) 597-2156
Truro (902)-893-5900; Pictou (902)-484-4335
Amherst (902)-667-7094

Some Halifax Region Numbers

Mental Health Mobil Crisis Team
(1-888) / 429-8167 (direct or toll free)
Addictions Services, NSH (902)-424-0627
Child Protection Services (DCS/CAS)
(902) 424-2434 / (902) 425-5420
Connections Clubhouse- (902) 473-8692
Self help Connection (902)-466-2011
Family S.O.S. (902)-455-5515

Military Family Resource Centre

Greenwood- (902)-765-1494

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From the Desk of the Editor- Jon David Welland

What follows is an outline for a talk I will give at the annual conference of the Schizophrenia Society of Nova Scotia. More information about the society or the conference can be found at www.ssns.ca

The Connection Between Stigma and Paranoid Delusions/ Feelings of Persecution:

Make no mistake, stigma is real, it affects how people treat us, and it is based on false beliefs about our intelligence and our character. Stigma can make schizophrenia much worse, as one very common symptom is paranoid delusions, where the person believes he/she is being spied on, talked to, followed and plotted against. It is very hard, even for patients with insight about the illness and the prejudice that stigma creates, to discern the difference between them.

The thing we must remember is that people do not see the “real us”, they see a stereotype. Their behaviour towards us is based on false beliefs and assumptions about mental illness, it isn’t personal, and they don’t know us. It is hard for the recipient of such casual cruelty from complete strangers not to feel that there’s something terrible going on. Continued on next page

Hateful Terms and Freedom of Speech

Racist language in the mass media has come to be seen as, at the very best, in bad taste, and at its worst, criminal. We feel the media should use the same sort of conscientious self-censure when reporting on issues and event concerning the mentally ill. Words like “crazy” and “maniac” should be avoided; they are hateful terms that can have a terrible impact on innocent people’s lives. They also shouldn’t use psychiatric terms like “psychotic” “schizophrenic” or “manic” unless they know what those terms actually mean. These are the same standards of reporting they are required to follow when writing about any other subject, but they can’t be bothered to learn the facts about mental illness. They have a duty to the public to be well informed and responsible. They have a duty not to spread fear and ignorance.

To date, the media has resisted all attempts to educate them and the public about the facts. There have been many initiatives to do this, and they have always resulted in an angry backlash from the media, who consider our concerns to be “politically correct” and any criticism of their methods as “censorship.” We are not infringing on their freedom of speech; we are exercising our own. If they can say anything they want, regardless of the consequences, then so can we.

An example of the media’s flagrant (and illegal?) abuse of their freedom of speech is the case of a radio station in Quebec who announced one morning that a mentally ill person was a burden to society and should be gassed. If the DJ in question had been referring to Jews, he would be in prison right now, as well he should. But the press and the public were quick to cry “censorship” when the CRTC pulled the plug.

The stations attempts to reverse this decision were finally halted when a woman whom it had slandered sued the station and was awarded damages. The media then called this an example of how the courts can resolve such issues without any involvement with the government; of how people who have been slandered have a legal recourse they can use to stop such behaviours. Unfortunately such recourse is only available who can afford a lawyer, and most people with a mental illness do not have such a luxury.

This isn’t an issue of the freedom of the press; this is a case of the media becoming a bully that will only attack people who can’t fight

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A MESSAGE FROM THE EXECUTIVE DIRECTOR ~Hugh Bennett

SSNS will continue to develop and change to meet the needs of Nova Scotia. In 2006 our organization’s By-Laws were updated and a new Board of Directors was elected by the members. It is our belief that these will strengthen our capacity to support and develop chapters across the province and maintain SSNS as a voice for all those who share the goal of overcoming, in every aspect, Schizophrenia. I would like to acknowledge all of those living with schizophrenia, caregivers, friends and neighbors, volunteers, chapters, donors and the many other quiet supporters-- you are the real champions. Thank you all. We are continuing to develop our alliance with the Schizophrenia Society of Canada through the new ‘Federation’ of Schizophrenia Canadian provincial societies; and, we will continue to work with and cooperate with the many public and private organizations in Nova Scotia that share our interests, missions and activities. We remain committed to early diagnosis, treatment and the principles of recovery. We will work to end discrimination, to support those living with schizophrenia and end the cycle of poverty.

MARIJUANA AND SCHIZOPHRENIA-PUBLIC POLICY IMPLICATIONS

Two new research journal articles came out in the August 2006 issue of the “Canadian Journal of Psychiatry” on the issue of how cannabis (marijuana) use is linked to an increased risk of schizophrenia- and what public policy should be, given that what they describe as this is now a generally accepted fact of psychiatry today.

In their research study they state “Evidence from 6 longitudinal in 5 countries show that regular cannabis use predicts an increased risk of a schizophrenic diagnosis or of reported symptoms of psychosis. These relations persisted after controlling for confounding variables such as personal characteristics and other drug use. The relation did not seem to be the result of the drug being used to self-medicate symptoms of psychosis. A contributory causal relation is biologically plausible because psychotic disorders involve disturbances in the dopamine transmitter system with which the drug reacts, as demonstrated in animal studies. It is most plausible that cannabis use precipitates schizophrenia in individuals who are vulnerable because of a personal or family history of schizophrenia.”

In a newspaper article in the Ottawa Citizen the researchers stated: “Cannabis use can trigger schizophrenia in people already vulnerable to mental illness, and this fact should shape drug policy.” The link between marijuana use and schizophrenia is generally accepted in the psychiatric community. The problem is that the vulnerable population –mostly teenagers- generally isn’t eager to absorb the message.

In a related article, the authors discussed the public policy implications of the drugs link to schizophrenia saying: The observational evidence and biological plausibility of the hypothesis that cannabis is a contributory cause of psychosis is at least as strong as evidence for causal relations between heavy alcohol and amphetamines use and psychosis. On public health grounds, there is a good case for discouraging cannabis use among adolescents and young adults. It remains uncertain how best to discourage use and at whom campaigns to reduce cannabis use should be targeted.

We should discourage young adults seeking treatment in mental health services from using cannabis and inform them of the probable mental health risks of its use, especially early and frequent use. We must exercise caution in liberalizing cannabis laws in ways that may increase young individuals’ access to cannabis, or increase their frequency of use. We should consider the feasibility of reducing the availability of high potency cannabis products.

The Ottawa Citizen summarized the study as follows: “In a companion article they argue that young people should be warned of the risks, since most cases of schizophrenia are diagnosed in the late teens, about the time they are experimenting with cannabis. “There are a lot of other reasons to discourage young people from using cannabis.” They believe that young people should know about the link and also be on the lookout for symptoms that show up among their friends who use cannabis.

They say people who want to smoke cannabis should wait until they are at least 25. The human brain has developed fully by that time, and if schizophrenia is present, it has usually already become apparent. The research paper suggests the following, in terms of clinical implications of the research: Screening all patients with psychosis and advising those who use cannabis to stop should discourage cannabis use among the clients of mental health services and reduce the number of cannabis-related psychoses.

TREATMENT DISRUPTION HAS SERIOUS CONSEQUENCES FOR FAMILIES LIVING WITH SERIOUS MENTAL ILLNESS

First International Caregiver Survey: Caregivers ask doctors to focus on Maintaining long-term wellness

The disruption of a family member's treatment for mental illness and subsequent worsening of psychiatric symptoms can have harsh physical, emotional and financial consequences for families. Keeping Care Complete, an international survey of 982 family caregivers of individuals with schizophrenia, bipolar disorder and schizoaffective disorder, reveals the devastating consequences of relapse, defined as the worsening of symptoms after apparent recovery, and sheds light on a desire among caregivers for doctors to focus on long-term care rather than managing crisis situations.

"More than 50 million people suffer from serious mental illnesses worldwide. When you consider all of the parents, siblings, spouses and children connected to these individuals you see how far the shadow of serious mental illness is cast," said Preston J. Garrison, Secretary General and Chief Executive Officer, World Federation for Mental Health. "This survey shows that many caregivers have experienced both the chaos of relapse and the relief that comes with stabilization."

Approximately 200 Canadian families participated in the survey, which was developed by the World Federation for Mental Health (WFMH) and Eli Lilly and Company. Independent market research company Ipsos-Insight in cooperation with All Global Ltd. conducted the survey of caregivers in Australia, Canada, France, Germany, Italy, Spain, the United Kingdom and the United States. Complete survey data and fact sheets on schizophrenia, schizoaffective and bipolar disorder and the caregiver perspective are available at the WFMH website, www.wfmh.com.

Mental illnesses, such as depression, bipolar disorder and schizophrenia, are caused by a complex interplay of genetic, biological, personality and environmental factors. Mental illness is indiscriminate and affects people of any age, race, sex or economic status. Although mental illness can be treated effectively, stigma and/or discrimination present a serious barrier, not only to diagnosis and treatment, but also to acceptance in the community. Over 20 per cent of Canadians will personally experience a mental illness during their lifetime. In fact, directly or indirectly, mental illness will affect almost everyone in Canada through a personal experience or an experience with a family member, friend or colleague. Some studies estimate that the annual economic impact of mental health problems in Canada is \$14.4 billion.

Relapse Consequences and Triggers

Caregivers whose family members experienced relapse reported that as a result, their loved ones were unable to work, were hospitalized, tried to commit suicide and/or were incarcerated. Many of these caregivers also said that their own mental and physical health and financial situation deteriorated following the relapse. Among the 134 Canadian caregivers whose family members stopped taking their medication, 92 per cent reported their family member relapsed after discontinuation. In addition, 65 per cent of the 134 caregivers who said their family member's medication was changed said their loved one experienced relapse after the switch.

"Patients who have found a medication that works for them should remain on therapy," said Dr. Roger S. McIntyre, Associate Professor of Psychiatry and Pharmacology, University of Toronto and Head,

Mood Disorders Psychopharmacology Unit, University Health Network. “It is important that medications are not switched unless it is in the best interest of the patient. Switching can result in treatment discontinuation and even trigger relapses, and also increase costs through hospitalization and other rehabilitative services. Prior to making a switch, physicians need to evaluate the risks and benefits of each treatment while considering the patient’s overall response to a new medication.”

Efficacy is top treatment priority for caregivers

Ninety per cent of the Canadian caregivers who participated agree that efficacy is their primary concern when weighing treatment options for their family member and that an effective medication is needed to control symptoms before overall well-being and health can be properly tackled. Results further show that caregivers believe that effective treatment has enabled their family members to perform daily tasks more independently, stay out of the hospital and hold a steady job or volunteer position. In addition to medication, caregivers cited family support and social support, talk therapy, exercise, having responsibilities and a stable schedule among key factors that help keep their family member well.

Desire to raise expectations and focus on long-term wellness: Most caregivers say physicians should focus on long-term management of their loved one’s mental illness rather than managing crisis situations: 63 per cent of caregivers who participated from Canada said that they are frustrated by a doctor’s approach to set very low goals for long-term improvement of the relative’s illness.

“When you first realize that your child is living with a mental illness, there is no other experience like it,” said Diane Froggatt, caregiver and Executive Director, World Fellowship for Schizophrenia and Allied Disorders, when retelling the story of how her son was diagnosed and the years that followed. “You feel uncertain of what to do; even helpless and ill-equipped until you understand what you’re dealing with. However, my son’s condition improved after we worked with a doctor to develop a long-term treatment plan.” Diane’s son is now able to work one afternoon a week in a cafe supported by a government grant as part of the local mental health system. Diane works to strengthen families through empowerment. Her goal is to help them learn about these illnesses and become skilled enough to work with their relative towards stabilization and improved functioning.

About Bipolar Disorder, Schizophrenia and Schizoaffective Disorder

Bipolar disorder, formerly known as manic-depression, is characterized by debilitating mood swings with symptoms categorized by mania and depression. Schizophrenia is characterized by acute psychotic episodes including delusions (false beliefs that cannot be corrected by reason), hallucinations (usually in the form of non-existent voices or visions) and long-term impairments such as diminished emotion, lack of interest and depressive symptoms, such as hopelessness and suicidal thoughts. Schizoaffective disorder is characterized by a combination of symptoms of schizophrenia and an affective (mood) disorder.

Twenty-seven million people suffer from bipolar disorder and 24 million people suffer from schizophrenia worldwide. Although the exact prevalence of schizoaffective disorder is not clear, it is estimated to range from two to five in a thousand people. Schizoaffective disorder may also account for one-fourth or even one-third of all persons with schizophrenia. In Canada, approximately one per cent of the population will experience bipolar disorder in their lifetime and another one per cent of Canadians will experience schizophrenia in their lifetime. For support and more information on mental illness, visit the Mood Disorders Association of Canada website at www.mooddorderscanada.ca, the Schizophrenia Society of Canada website at www.schizophrenia.ca or the World Fellowship for Schizophrenia and Allied Disorders website at www.world-schizophrenia.org.

Letters to the Editor

In addition to my editorial work for the Schizophrenia Society, I also moderate a weekly writing group at Connections clubhouse. One of the writers who attend this group offered this profound essay (below) about her experience -for publication in Information Matters. We thank Laura Burke for this contribution.

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The worst thing about psychosis is the barren wasteland it creates in the mind, sweeping the corridors clean of all traces of source and self in order to create a clear passageway for the irrefutable nightmare it threatens to bestow upon the lost and hungry, ultimately impressionable and unstable matter, which can only within itself be defined as loss or lack.

It's like someone is switching off all of the lights, and I'm running around trying to turn them on again. But, creativity, our savoir, can flow from anywhere, any source. I have to go back to the unconscious... What good is the conscious mind at a time of urgency, when editing and reshaping often only serves to blunt and slow down the process of revelation? Before I knew who I was, words would bring me to the fore. I was grateful for mysterious process now, more than I ever could have imagined.

My doctor talked to me about a client who found she was lonely when the medication stopped all the voices she was used to hearing. No one thought to give her back HER voice. How does one do that? A difficult task, but hasn't psychotherapy been proven to retrieve, unbury and strengthen one's sense of self and purpose? Does this process awaken the parts of us housed in dormant, encrypted synaptic codes long forgotten? Does not this process strengthen the connections between fragmented pieces of the self? What parts of any neurological process cannot be modified by external input, or internal output?

Sometimes, I will feel a visceral flash of something missed and I feel, deep down, the impulse to cry.

So I write it down, because in the world of the imagination- the world of truth- I see myself weeping softly somewhere. My presence is condensed among towering evergreens, which have grown into an insular canopy of protection and isolation. The sun now belongs to them.-though at times the weeping girl misses the sun. She knows her presence is felt, and even those greedy deciduous trees bend over and grow around the rhythms of her small but lively form.

I know she is in there, like I know the taste of fresh raspberries, like I know I was once five years old, like I know that I will feel this impulse to cry once more.

It's important to crack apart the notion of illness as concrete, linear, insidious and all consuming. What parts of us, as humans, are consumed by illness, and what parts of us simply go into hiding because of the sheer force of the shifts they must make? If there is no clear and understood role for these pieces of us to inhabit, can they do anything but to remain dormant and to protect themselves from the stress of displacement, the stress of the unknown?

Isn't reintegration of what we only believe to be destroyed the real quest to pursue in the rehabilitation of those we perceive to be mentally ill? I am on my way to wellness. This is a healing process that must be allowed patience, gentle perseverance and strength. I must try to ground myself in meaning every day, to work with my fear compassionately, and grow into my new self. Desires to heal and connect to creative healing in a profound manner can be used as direction and as fuel for recovery.

I have to remember to keep the ground under my feet and to listen to the voice that comes from deep in my soul, to be quiet and patient when it seems to elude me, to keep goals in my mind in regards to healing and understanding the communication of my soul's deepest knowledge.

I must respect my imagination and my emotions, and regard them as gifts. I must stay open to the realignment and the reintegration of myself, and try not to grasp for past feelings and experiences. I must have hope, faith and knowledge that will heal and reform me into a full human being with important gifts to offer. Thank you to all who have helped me on this journey so far, and to those who continue to struggle. Your courage is an inspiration and I would be lucky if I was given the opportunity to help you along the way.

By Laura Burke

DID YOU KNOW...?

You can access SSNS conference materials, newsletters and lot of valuable information from our website:

www.ssns.ca

Our website is continuously being updated so check back often!

Many individuals and organizations support SSNS in so-many ways, such as the Royal Bank, WBLI accountants and Marriot Hotel to name just three. You can even send your Sobeys grocery receipts to the Schizophrenia Society. In return, SSNS receives a donation from Sobeys for the receipts. So, ask your business or organization how they are supporting this cause.

Donations play a vital part in the survival of the Schizophrenia Society of Nova Scotia. One way that you can help is through our Monthly Giving Plan. It is as simple as calling the provincial office and setting up a plan that suits your budget. We are currently offering this service with VISA only.

Help SSNS to *'alleviate the suffering caused by schizophrenia'*.
Please contact 1-800-465-2601 for more information or to sign up.



SCHIZOPHRENIA SOCIETY OF NOVA SCOTIA
A REASON TO HOPE. THE MEANS TO COPE.

WHAT IS SCHIZOPHRENIA?

Symptoms of schizophrenia most often first appear in people in their late teens and early 20's. Schizophrenia is a physical disorder of the brain in the same way that diabetes is a disorder. It does not discriminate and 1 in 100 people will develop the illness.

Yes, it is treatable with medication a comprehensive psychosocial therapy and support. It is important that people with schizophrenia be diagnosed and begin treatment as soon as possible. With the improved medications and treatments and a strong support system people with schizophrenia lead very productive lives- far better than even a few years ago.

Researchers are learning more about this illness, leading to early intervention, treatments, and new ways to identify the disorder in early stages. Contact SSNS for more information.