"MENTAL HEALTH AND HUMAN RIGHTS"

ADDRESS TO THE ANGLICARE CANBERRA GOLBURN

LITMUS PROGRAM LAUNCH

HELD AT

THE SENATE ROSE GARDENS, CANBERRA

AT 11.00 AM ON THURSDAY 9th OCTOBER 2008

BY DR SEV OZDOWSKI OAM

DIRECTOR, EQUITY AND DIVERSITY, UNIVERSITY OF WESTERN SYDNEY

1.0 Acknowledgements

Allow me to start in the customary way. I would like to acknowledge the traditional custodians of this land. Allow me also to acknowledge young carers and their families; Anglicare leaders and workers and many other distinguished guests.

Thank you for inviting me to address Anglicare Canberra Goulburn Litmus Program Launch today – when we are celebrating Mental Health Week.

It is good not only to be able to showcase the services provided by Litmus Program, but also to be able to focus on young carers and on the impact of mental illness on the family team.

The timing of your conference is certainly impeccable.

It is the time when the Rudd Government works towards operationalisation and implementation of its promising Social Inclusion Agenda.

2.0 Introduction

Allow me to start by declaring my interest. I am not totally unbiased when it's coming to mental illness and in particular impact of mental illness on families.

My youngest brother was born with mental illness – I was then 14 years old. I remember it vividly; and the impact it has had on me and on the rest of our family.

Being the oldest child – I unexpectedly acquired a range of carers duties which lasted till the day I departed Poland and beyond.

I also had to deal with stigma and discrimination associated with mental illness at my school and elsewhere. I learned fast that stigma is a kind of disease one acquires also by association with a mentally ill person...

However, reflecting now back with wisdom of hindsight, I must conclude that the birth of Marcin had totally changed our family. It almost destroyed it, to be perfectly honest.

All efforts of our parents and all of our however modest financial resources went to help Marcin. My younger brother and sister continue till today to be upset that parents no longer had all the time they had for them before. Family holidays we used to enjoy together became less frequent. And family dinner conversations changed – now the key topic of them was Martin and how to help him.

But let us now focus on Australia.

3.0 Prevalence of mental illness

Let us start with a brief look at the *Australian Bureau of Statistics* (ABS) mental health statistics and at the results of the *National Surveys of Mental Health and Wellbeing of Adults* (SMHWB).

The first conclusion that needs to be drawn is that mental health problems are impacting on a great number of Australians. In 1998 ABS estimated that 2,383,000 adults, out of some 20 million Australians, had a mental disorder.

National Survey of Mental Health of 1997, which is based on diagnostic criteria rather than self report, reported that almost one in five adults (18%) had a mental disorder at some time during the twelve months prior to the survey. Three out of every hundred (about 3 %) will be seriously affected.

Depression and anxiety are the most prevalent mental disorders experienced by Australians.

Some researchers had reported even higher proportion of those with mental illness in Australian population. For example, a study by Robyn Vines asserts that *"About 25% of Australians report at least one mental disorder in any 12-month period, and between 19% and 40% presenting to general practitioners have mental health difficulties*."

To sum up, mental health problems impact on at least one in five adult Australians each year.

In addition, for many Australians mental health or behavioural problems are a long term condition and the proportion reporting a long-term mental is on the increase. In 1995 the proportion was 5.9%, in 2001 it was 9.6% and in 2004-05 it was 11.0%.

Further, it is important to note that mental illness affects in particular young people. At least one third of young people have had an episode of mental illness by the age of 25 years.

The rate of mental disorders is highest in the 18 to 24 year old age group with a staggering rate of 27%. Suicide in this age group accounts for about one-quarter of all male suicide deaths.

In fact, the majority of mental illnesses begin between the ages of 15-25 years. This poses a significant threat to our nation's future workforce capacity and economic prosperity.

4.0 Causes of mental illness

There is a whole range of factors associated with mental illness.

Some mental illnesses could be inherited. For example, according to the Black Dog Institute, the genetic risk of developing clinical depression is about 40%.

Other factors relate to an individual's own environment. For example, the prevalence of mental health disorders is highest among people who are separated or divorced and people who live alone.

About 20% of women experience symptoms of depression during pregnancy or in the postnatal period.

Particular risks face people who use drugs and consume alcohol daily.

In fact drugs and alcohol are known triggers of schizophrenia and depression in young people.

Mental health problems may also result from a hyper competitive work environment with long working hours and unbearable work stress. In fact there is a growing number of common law claims in Australia for psychiatric harm suffered as a result of employment conditions.

5.0 Mental illness results in disadvantage and poverty

But regardless of the causes, in all countries I surveyed, including Australia, mental disability is associated with disadvantage and poverty.

People with mental illness and their families have much smaller incomes, participate less often in the workforce and are more often unemployed. They face difficulties with accessing education, housing, transport, communication, health and social services and so on. For example, reports indicate that up to 85% of homeless people have a mental illness.

Many people with mental or psychiatric disability suffer daily violence, intimidation and denial of their basic civil rights in addition to economic disadvantage.

Further more many of them suffer stigma and stereotyping. In fact they are one of the most marginalised groups in our society.

6.0 Mental health is a human rights issue

Now let us focus on mental health as a human rights issue. And it is very appropriate for this Litmus Program Launch to emphasise the human rights dimensions of mental health.

As you would know the Australian system of human rights protection is not the best in the developed world. Australia does not have the US style constitutional Bill of Rights; it also does not have a statutory document similar to the *British Human Rights Act* (1998); neither is it a party to the *European Convention for the Prevention of Human Rights and Fundamental Freedoms* (1950). In particular our civil liberties are not well protected.

However, there are a number of mechanisms in Australia that could be effectively used to protect rights of people with mental illness, namely:

- relevant standards set up in international conventions acceded to by Australia;
- a range of domestic laws, both state and federal, including common law as well as independent courts, free media and the broader civil society including mental health advocacy NGOs; and
- a range of official watchdogs, including the Human Rights Commission (HRC).

6.1 International human rights law

As early as in 1948 Australia signed and then ratified the *Universal Declaration on Human Rights*. Article 25 of that *Declaration* refers to *'the right to medical care and other necessary social services as part of a right to an adequate standard of living*.'

The Universal Declaration is not a binding treaty. But it is accepted around the world as a common standard for governments to strive towards and, in the case at least of more prosperous countries like Australia, a standard that people should feel entitled to expect.

Then, Australia signed and ratified a range of important human rights treaties, which explicitly recognise the right of everyone to the highest possible mental health care. For example:

- the *International Covenant on Economic Social and Cultural Rights*, Article 12, states: *'The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.'*
- *The Convention on the Rights of the Child*, Article 24, states: '*States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.*'

Australia also adopted *the 1991 Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, which reinforce the rights enshrined in the International Covenants and provide valuable guidance as to how those rights ought to apply to people with mental illness, namely:

- Principle 8 (1) makes clear that people with mental illness have the right to the same standard of health care as other ill persons.
- Principle 14 states that mental health facilities should have the same level of resources as any other health facility.
- Additionally, Principle 7 emphasises the right to be treated and cared for as far as possible in the community.

Recently Australia has signed and ratified the new UN *Convention on the Rights of Persons with Disabilities* and its *Optional Protocol*. The *Convention* will provide a further protection of rights of people with mental disability. It includes mental health into disability definition, aims at empowerment and inclusion (Art. 9) and specifically refers to the right to work and employment (Art. 27).

Although the Australian Government was closely involved in the negotiation of the human rights treaties and then ratified them, the fact is that the treaties and international declarations of principles do not implement themselves as they are not self-executing in Australia.

Supporters and opponents alike of the role of the United Nations in human rights often speak as if the main point of international human rights law is as a commitment to the international community. But really the point of the Australian government subscribing to human rights treaties is as a commitment to the people of Australia. Delivering on that commitment and keeping faith with the people requires accountability.

6.2 Domestic implementation of international HR treaties

To implement international human rights treaties, Australian Parliament needs to create domestic laws.

In fact, in Australia there is a whole range of laws, both state and federal, budgetary and other measures and programs for people with mental illness.

One way in which Australia has tried to promote accountability on human rights issues is by establishing domestic anti-discrimination legislation and human rights commissions.

In 1992 Australia enacted the *Disability Discrimination Act (DDA)*, which contains a broad definition of disability which includes mental disability. DDA prohibits discrimination on the basis of "*physical, intellectual, psychiatric, sensory, neurological and learning disabilities*".

Australia also has quite a complex welfare system with medical and social services for people with mental illness.

Despite all of the above I and many others would argue that the rights of people with mental illness are as yet not adequately protected in Australia. To put it bluntly, the current laws, institutions and budgets are simply not sufficient to provide adequate protection.

To illustrate this point, allow me now to report briefly to you on three inquiries I conducted as a Human Rights Commissioner that dealt directly with mental illness.

7.0 Children in Immigration Detention Report

First, I would like to share with you my work on the Children in Detention Report, called: "A Last Resort?". I have decided to mention this Inquiry because it had demonstrated a very unusual case of government policy that had resulted in mental illness of many detainees and contributed to mental health problems of many others.

In December 2000, when I was appointed as the Human Rights Commissioner, the Australian mandatory immigration system had become one of the most important human rights concerns. In November 2001 I announced that the Commission would hold a National Inquiry into Children in Immigration Detention (CIDI).

The conduct of CIDI inquiry by HREOC was only possible because Australia ratified the Convention on the Rights of the Child (CROC) in 1989 and because CROC has been incorporated into the HREOC mandate.

Although CROC covers almost everything from education to health, both physical and mental, to the right to play and the right to family unity, Article 24(1) of CROC requires ensuring that all children in Australia enjoy: "the highest attainable standard" of physical and mental health that Australia can offer.

The report was the result of two years of detailed research and writing.

I visited all detention centers in Australia - some of them a number of times - and spoke to staff and detainees. We also conducted many focus groups with former detainees.

The Inquiry compelled the then Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) and the Australasian Correctional Management (ACM) to provide us with key documents - some 50 to 60 large boxes of them.

We carefully analyzed all those documents.

We also took oral and written evidence from DIMIA and ACM, child detainees and their parents, and a vast range of individuals and organizations.

The inquiry was extensive. It was exhaustive. It was comprehensive.

What is particularly important is that the Inquiry put the issue of children in immigration detention on a national agenda and helped the emergence of informed discussion. In my opinion, without the

emergence of civil rights movement against mandatory detention, some children would be still prisoners in Immigration Gulag Archipelago.

So what did the report show?

It showed that children's rights had been breached by making immigration detention the only resort rather than the last resort.

Rights had been breached by ignoring the children's best interests.

Rights had been breached by the very length of immigration detention - the longest being a child who was behind the wire for five years, five months and twenty-one days. This child was eventually recognized to be a refugee and now lives in Australia.

What is of particular relevance to this Launch today is that rights had been breached with regard to the mental health of children and to children with disability.

During the CIDI inquiry it became painfully obvious that long-term detention was associated with the emergence of a wide range of mental health problems among children and adults. In particular, adult males who have lost their traditional roles as family provider and protector were vulnerable.

However, the most serious finding of the detention inquiry was the failure of DIMIA to implement the recommendations from mental health professionals that certain children and families with mental health problems cannot be treated in detention and that they should be released for appropriate treatment.

The findings read as follows: the Government's ‘failure to implement repeated recommendations by mental health professionals to remove children with their parents from detention amounted to "cruel, inhumane and degrading treatment."’

The report revealed that all this had occurred despite the efforts of several watchdogs who were supposed to oversee the welfare of these children.

The report provided many graphic examples of the impact of long term detention on mental health of detainees.

Here is one such image:

A 13 year old child who has been seriously mentally ill since May 2002. The boy regularly self-harmed. In February 2003, a psychiatrist wrote: "*When I asked if there was anything I could do to help him, he told me that I could bring a knife so that he could cut himself more effectively. He said it was more effective than the plastic knives that were available*"

The most disturbing fact is that there had been approximately 20 recommendations from mental health professionals saying that he should be released from detention with his family. Some said that removal from detention was a matter of urgency.

When finally released, (after 3 years detention, and 2 years after mental illness diagnosis) as refugees, following a Refugee Review Tribunal finding, into the Adelaide community, all members of the family were severely mentally traumatized; prescribed heavy, daily medication, too ill to work and requiring extensive community support and assistance.

As Professor Procter has said: "*What the system has done, is to add mental anguish to the trauma of flight and dislocation from their homeland*". In other words, we locked them up, we traumatized them and now as they join the Australian family, we are going to have to pay a price for that treatment.

Some time later I visited the family of the 13 year old boy in Adelaide and I found that the boy and his father still suffer from mental health problems and in addition I found that they experience major problems in accessing mainstream mental health services.

I started looking at what sorts of treatment are available to refugees released from the detention centres and to other people in the community. A whole new picture of human rights concerns emerged from the shadows.

It was time to take another look at the performance of mental health services in Australia.

8.0 Human Rights and Mental Health "Not for service" Report

In 2004, following my work on immigration detention and representations from NGO's about problems with mental health services I had joined forces with the Mental Health Council of Australia (MHCA) and the Brain and Mind Research Institute to conduct a national review of human rights and mental health.

Our common purpose for this national review of human rights and mental health issues was not to produce another report, but to put the issue of the lack of mental services on the national agenda.

To achieve this, the involvement of the Australian civil society was needed. In particular the review needed public opinion makers, media, church leaders and many others to publicise the issues associated with mental health services shortages to be effective. The review needed cooperation of the whole civil society working together with HREOC for a change.

8.1 Methodology

The primary mechanisms used to collect data for this review included:

- written submissions 360 submissions received;
- consultations - conducted all over Australia: Perth, Brisbane, Sydney, Canberra, Bunbury in WA, Rockhampton and Broken Hill
- open community forums - 20 forums with some 1,200 participating, and
- two community surveys.

In addition, the Human Rights Commissioner wrote to all state and territory governments seeking information about the levels of community need and the effectiveness of mental health services. A draft report was provided to all governments for their comment.

The volume of input we received to the review from all these sources was overwhelming, as shown by the fact that the "*Not for service"* report is nearly as large as the original Burdekin report.

8.2 The findings - key points

The story that unfolded is not a pretty one. It is true to say that there is a long way to go before Australia's mentally ill can truly enjoy "*the highest attainable standard of mental health"* as the human rights treaties require.

The state government services were failing in the delivery of proper care to mentally ill and their families. Not only was there a general lack of services, but there was also a huge shortage of services that cater specifically to young people who need help.

It was often a tragic tale of medical neglect and community indifference. Those with a mental illness were still being blamed for being sick. And this kind of thinking was affecting service delivery in every State and Territory.

Below there is a list of specific findings made by the review:

Inadequate resources

Resources provided were simply inadequate to match the level of needs and ensure access to treatment and services when they were needed. Australia currently spends only about 7% of its health budget on mental health. By comparison, other first world economies are spending between 10-14% of their health budgets on mental health. New Zealand now spends twice as much per capita compared with this country.

The review was also told of a pattern of underspending and lack of investment in mental health.

Furthermore, accountability for money allocated to mental health services was seriously lacking. And even when resources were provided in name, there was no serious accountability for how that money was spent. For example, the West Australian Government withdrew $4 million provided under the National Mental Health Plan from mental health services and reallocated the money into general health. The reason? Different priorities.

Absence of early intervention

The most frequently mentioned gap in mental health services was the absence of early intervention and other specialist services for young people. We know that approximately 75 percent of mental illness first occurs in people aged between 15 and 24 years old. One in four people in that age group will suffer a mental illness in any 12 month period. Yet when the illness emerges many of these young people are denied basic treatment and care – they are simply told to go home and sort themselves out and only to come back when they are really ill.

This is despite the fact that Australia leads the way in development of early intervention programs for the mentally ill. A group of Australian clinicians led by Professor Pat McGorry in Melbourne has developed world-leading programs for young people in the early phases of psychotic and other severe mental illnesses. These programs are now being rolled out nationally in the United Kingdom and underpin major initiatives in Scandinavia, Europe and the USA. However, these same programs are still not being delivered routinely in Australia.

Lack of prevention and early intervention will mean the high cost of the treatment, in the future. As somebody said to us during one of the Melbourne consultations: "*It is better to put a fence at the top of a cliff, instead of an ambulance at the bottom."*

Lack of services for dual diagnosis

Many people with mental health problems have a range of other health and care needs.

As I have mentioned earlier, in Australia, there is increasing evidence that widespread use of common drugs such as cannabis, amphetamines, alcohol and ecstasy is contributing both to an increased rate of mental illness among young people as well as making those young people more severely disturbed when they finally do present for care. This also increases the likelihood that police or corrective services will become involved as well as increases the likelihood that involuntary hospitalization will eventually be required. In such cases, the chances of medical

neglect or other obvious human rights abuses increase. International evidence now clearly shows the link between cannabis abuse and onset of psychotic illnesses such as schizophrenia. It appears that the earlier the adolescent is exposed to such drugs the higher the chance of developing a mental illness.

Furthermore current research suggests that up to half of the cases of alcohol and drug abuse that we now see in our young people are secondary to earlier mental health problems that have gone undetected or untreated.

Despite the increasing evidence of links between drug use and mental illness Australia still lacks adequate mental health facilities to cope where a person has both drug addiction and mental illness at the same time – or other forms of dual diagnosis. This is especially the case for those youth who are dependent on alcohol or drugs. Medical policy dictates that drug addiction be treated first, before the mental illness is tackled. But the reality is that they are often interconnected. So they are left in limbo, with the likely result being anything from preventable suicide, permanent brain disease, destroyed families to huge economic and social costs for society as a whole. And the failure to treat a dual diagnosis may lead to at least 20 years of life expectancy being lost.

Children in adult facilities

In all states I received reports of children and young people being admitted to inappropriate adult facilities.

Poor emergency services

Emergency services are overburdened and often inaccessible. To illustrate I will give you two examples:

First, in Western Australia I was told about a twenty year old man who reported to hospital suffering from an episode. The hospital's clinical response was to chemically induce sleep for 20 hours, because there was no psychiatrist available.

Second, a Sydney hospital clearly took the "lock 'em up and throw away the key" mentality a step too far recently. It locked a mental patient and his two accompanying young police officers together in a room, and refused to let them go until a doctor arrived several hours later. The constables remained 'locked up' with the patient, even after their police sergeant made a direct request to hospital officials for their immediate release.

Poor acute care services

Acute care services are too often simply missing, especially in regional Australia. To put it simply, these acute beds simply disappeared after the deinstitutionalisation reform. While this was never the intention of deinstitutionalisation, evidence exists that in a number of cases the lack of acute care services resulted in preventable death.

In fact, suicide rates in teenagers and young adults remain historically high. We were told a great many stories of preventable suicides of young people. Let me tell you two of them:

A Central Coast teenager was admitted to a psychiatric unit because of attempted suicide. He was prescribed Valium and released the next day with no follow up. He died hours later after throwing himself in front of a moving train. The coroner found that he was inadequately assessed and discharged too early, because an on-going shortage of beds in the unit.

In Canberra we were 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.

Inadequate accommodation

Going back to the original objectives of the National Mental Health Strategy in 1992, all governments committed to:

- Reducing the size or closing existing psychiatric hospitals and at the same time providing sufficient alternative acute hospital, accommodation and community-based services; and
- Increasing the number and range of community-based supported accommodation services and ensuring a range that provides a level of support appropriate to the needs of the consumer.

It is obvious that governments really got on with the closure of the psychiatric institutions. However, one of the biggest problems, it seems, is that they have not followed through with their commitment to build a strong system of community based care. One which includes adequate supported accommodation as the lack of appropriate supported accommodation for people with a mental illness was a very strong theme coming through our community forums. The problem of course becomes much more acute in rural areas.

We also received submissions from family carers which report being advised by hospital staff that they should try and organize accommodation for their sick son in a backpacker's hostel or if that failed then living in his car should be considered as an option. In the absence of appropriate supported accommodation, many people end up sleeping on the street or worse, in gaol cells.

The experts in the field advised the review that safe and stable accommodation is a vital element in someone's recovery. Without it, people have little hope of getting well or staying out of hospital.

Use of prisons to provide mental health care

Not only are Australia's mentally ill being turned away from the health services that they need, they often end up in gaols instead. When in prisons they may face particular difficulties getting access to help. The earlier mentioned case of wrongfully detained Cornelia Rau provides a good illustration – her acute mental illness went undiagnosed during her imprisonment.

One can further claim that on the basis of the data collected through community forums and submissions there did appear to be a broader trend towards a "law and order" type response toward mental illness. We received many reports of the high percentage of people in our prisons with a mental illness. We were told that even in the community, it is the police who are often left to respond when someone is in the midst of a mental health crisis. This approach is so different to the approach taken to people suffering from physical illness. People having a heart attack, for example, are not left to be dealt with by the police.

Physical health care

The review staff were told on numerous occasions that the physical health of people with mental illness is considerably worse than the average. This was explained by the fact that a GP would tend to focus on mental health issues and neglect undertaking physical health check-ups. Communication problems were also blamed for the situation.

Community services unable to cope

The evidence suggested that community supports were seriously overburdened and unable to cope with the existing demand. Further, the carers of people with mental health problems were frequently ignored by services.

The issue of community resources, or lack of them, also had particular application for young people still within the family environment. And I refer here to the issue of the young person's "carer or carers' being removed from the home due to their own mental illness. In these cases, that young

person, and typically in these scenarios we are talking about more than one child, may be left in the home with insufficient community support mechanisms to ensure they are properly attended to, while their carer is receiving treatment for their mental illness.

Family carers taking the brunt

Major gaps in government services often resulted in families being forced to take the brunt.

People told me many stories of unnecessary suffering, heroism and sometimes of tragic outcomes. Allow me to quote from a statement made by NGO Service provider who said in Public Forum in West Perth the following:

"We already have long waiting lists and taking away funding makes them even longer.
One of the young consumers who was on one of our waiting lists for four months was also caring for her mum – she killed herself because she felt she could not cope looking after her mum anymore without some support."

During the Inquiry I have also learned of many cases where

- Young carers had no resources to purchase even the most basic necessities; many young carers had no access to government pension of any kind;
    - And let us not forget that young carers are making an enormous economic contribution when looking after their mentally ill relative;
- Children who cared for their mentally ill parents were missing on schooling and in fact, some of young people of mandatory school age were hiding from authorities being afraid that they will be separated from their parents after being required to attend their schools;;
    - This means that for all practical purposes young carers are disadvantaging their future well-being'
- We were often told about inability to pay for appropriate accommodation, sometime resulting in homelessness;
- There was a general lack of support services;
- Lack of respite
- And the list goes on …

Stigma and discrimination

There is still fear and intolerance of people with mental health problems. Those with a mental illness were still being blamed for being sick. Also carers of people with mental illness can experience much of the same stigma as the people they support.

This stigma is reflected in discrimination against people with mental illness in their daily life. People with mental illness are denied job opportunities, access to accommodation and health services and so on.

Rural and remote areas – double disadvantage

While people living in capital cities had many difficulties in accessing the mental health care and support that they needed, those problems were exacerbated in rural and remote areas. Let me give two examples of the additional problems facing people in rural areas.

First, distances between available services and the people who need them have meant there is an over-reliance on treatment by phone - which is completely inadequate for many people with a mental illness.

Second, we heard that there were sometimes extremely long journeys for people needing acute care under conditions which were entirely inappropriate. For example GP's may be required to over-

sedate someone so that they can be transported by air. Or people who need medical assistance, not punishment, may be required to travel long distances under police escort – which is demeaning for the patient, distressing for families, and an unwelcome diversion of police from the jobs they are trained to do.

Double disadvantage because of minority status
An example of such disadvantage was given in opening remarks of my address.

In case of Indigenous Australians living in isolated areas this phenomenon could be easily described as triple disadvantage.

8.4 Conclusion of "Not for service" Report

The report documented beyond any doubt that people with mental illness and their young carers are still denied their rights. In fact the review has documented a mass of suffering and a mass lack of services and treatments which takes opportunities away from people with mental illness and imposes a severe burden on the economy.

As one submission to the '*Not for Service'* review put it in simple terms*: 'The dream of closing psychiatric institutions and moving towards community-based care has turned into a nightmare. Community care is under-resourced and integrated services are lacking. Too many people are denied treatment and slip through the gaps.'*

Furthermore, when one adds the stigma and stereotypes that surround the mentally ill to this already explosive cocktail the extent of this bleak picture can be seen. Truly, all this gives flesh to the pattern of neglect which has been described by the phrase: "*Out of hospital, out of mind*."

9.0 Conclusion

In conclusion, let me re-state the fact that mental illness in varying degrees affects the daily lives of thousands upon thousands of people in our country.

Let us also remember that:

- people do not choose to be mentally ill;
- Mental illnesses can take many forms just as physical illnesses do.
- Mental illness is not something shameful.

With treatment and support, the majority of people with mental illness can and do recover well.

Despite this mental illnesses are still feared and misunderstood by many people

Despite this people with mental illness are still denied their rights and services

This needs to be changed.

I opened my talk with a story of success. With a story of a civil rights movement that led to the release of some children from behind the barbed wire.

I look forward to similar community action on mental health.

I look to all of you to encourage our governments to clean up the mental health mess. We need to ensure that this issue stays on the national agenda until Australia fully meets its international human rights obligations.

The ultimate test of our commitment to human rights as a nation is not what we aspire to, not the conventions we sign, and not even the laws that are set in place.

Rather it is how we treat our most vulnerable and powerless.

And at the moment we are not focusing on how to assist mentally ill, because it is about the rights of the less visible and often stigmatized people in our community.

I congratulate the Anglicare Canberra and Goulbourn for establishing the Litmus Program. I wish that the program will start the people's movement to ensure that:

- The young carers of mentally ill do have appropriate support systems in place, so they can maintain their life as a young person in addition to their caring responsibilities;
- The well being of families with a parent with mental illness is given much higher priority by service providers; and
- Your program inspires a change in governments programs and funding to deliver services that are much more integrated and balanced and recognize the well-being of family as a whole.

In closing, let me paraphrase a quotation: "*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*."

Thank you.