

# Submission to Senate Select Committee on Mental Health

May 2005

Committee Secretary  
Senate Select Committee on Mental Health  
Parliament House  
Canberra ACT 2600

13 May 2005

Dear Committee,

**UnitingCare NSW.ACT welcomes the opportunity to respond to the Senate Inquiry into Mental Health issues.**

The views in this submission are based on the practical experience and reflections of our ministers, managers, workers, and volunteers, in Uniting Church agencies. We asked each of our services that directly or indirectly deal with mental health issues to highlight the key issues facing them in their daily work, successful models they felt could be shared, and case studies that could give the Committee a sense of the human scale, beyond the statistical analysis we are sure you will be provided.

UnitingCare NSW.ACT supports the principles and aims of the National Mental Health Strategy. In particular, we support the process of de-institutionalisation which is the cornerstone of the Strategy because we affirm that all people should have the fullest opportunity to realize their potential as human beings and participate as citizens in wider society, with care provided on a least-restrictive basis.

However, UnitingCare agencies involved directly or indirectly with people who have mental health issues are very frustrated with the capacity and role of the current mental health 'system' to attend to the diverse needs of people with mental health issues.

This frustration is borne of the daily experience of working in a field that is publicly neglected, chronically under funded, badly coordinated and lacking in political leadership. There is a strong perception among our agency staff of a system in crisis. There is some anger that both state and federal governments appear to have little appreciation for the tragic consequences of unmet needs, which include homelessness, drug addiction, imprisonment and suicide.

It is further fuelled by the awareness that things are not getting significantly better. While the government points to funding increases of 65% in real terms over the last decade, our services are all pointing to being more stretched than ever before due to more people with mental illness being unable to access appropriate mental health services and care.

Our response to mental illness in Australia represents a challenge to our notions of fairness and compassion. We hope the Senate Inquiry will have the opportunity to reflect on these values questions while it considers the submissions put before it.

We are available to attend public hearings in Canberra should the Committee find it useful.

Yours sincerely,



Rev. Harry J. Herbert  
Executive Director

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## About UnitingCare NSW.ACT

UnitingCare NSW.ACT is the peak body for all community services, chaplaincy, and social justice and advocacy activities of the Uniting Church in the New South Wales Synod. UnitingCare NSW.ACT is one of the Boards within the New South Wales Synod and is part of the national network of UnitingCare Australia.

Our view of social justice is guided by the Christian scriptures, theological reflection, insights of social, political and economic analysis, the statements of the Synod and Assembly, and our encounters with people and their life experiences in our work. UnitingCare NSW.ACT operates under a Social Justice Charter which guides our internal operations, relationships with service users and advocacy work.

The Uniting Church is one of the largest non-government providers of community services in New South Wales. The church *directly* operates a number of community-based mental health services, including:

- provision of chaplains to mental health services in 4 regions (Central and Southeastern Sydney; Northern Sydney; Western Sydney; and Hunter); these chaplains provide pastoral care to people having treatment or who are being rehabilitated in hospital-based and community-based care services, improving their chances for recovery and management of their illness or disability;
- Annesley House, a low-care facility for older people with mental illness, with 86 beds in Leichhardt;
- Lilian Wells, a psychogeriatric nursing home at Parramatta, which provides shared accommodation for 71 people;
- a leisure club for adults with a major mental illness (a collaboration between Western Sydney Area Health Service, the Schizophrenia Fellowship and Parramatta Mission) with 3581 client visits,
- supported accommodation for people with mental illness in the Parramatta district, with 29 beds
- a youth suicide management project facilitating better linkages between youth NGOs and the Western Sydney Area Health Service
- Two private mental health hospitals operated by Wesley Health

We also come across the needs of people with mental health issues across a range of our other services, including:

- chaplains in general hospitals, prisons, and the police force;
- residential care for older people;
- care for people with intellectual disabilities;
- care for young people;
- refuges, crisis and medium-term accommodation, and drop-in centres for homeless people;
- supported accommodation services;
- telephone counselling services;
- family counselling service; and
- in the daily work of our parishes.

For example, Lifeline Australia (10 of the 16 Lifeline services in New South Wales are agencies of UnitingCare) receives 456,222 telephone calls annually and research in a number of regions has shown a high percentage may suffer from a mental disorder. The most recent study found that people “likely to have a severe mental disorder” made up 72% of callers to Lifeline South Coast over two months in 2003, 78% had experienced symptoms associated with depression over the previous four weeks, and 29% reported having thoughts of self-harm (UNSW 2005).

Our services to homeless people are also dominated by mental health issues. A study last year found that 73% of homeless men and 81% of homeless women met criteria for at least one mental disorder in the past twelve months (Cripps 2005). This poses significant strains on services which are not financially able to provide qualified mental health services.

# Background

## Clear policy objectives needed

In assessing the situation of mental health services in Australia, we think our society and government should ask some basic questions:

1. How does the system measure up against stated policy objectives?
2. How does the system measure up against basic human rights criteria?
3. How does the system measure up against what people with mental illness actually want and need?
4. Are things getting better or worse for people with mental illness?

On this last point, we find it rather concerning that the National Mental Health Report 2004 did not contain a single reference to the mental health of Australians. This information is collected and is published elsewhere, but it seems rather incongruous to discuss progress of the Mental Health Strategy purely in terms of money flows without regard to basic questions about whether our society is more healthy than it was twelve years ago.

## Principles

We propose the following principles be used when considering those questions.

### A holistic approach to health outcomes

Health involves all dimensions of human life – physical, emotional, mental, cultural, social and spiritual. It is essential that those who seek to promote health, to prevent illness, to treat illness, or to ease death and dying recognise that health and healing require more than science and technology. Health depends on taking seriously all dimensions of an individual's life, their spirituality and on the way society functions and impacts on the individual.

### A 'population health' approach

Health policies should protect and enhance the health of the whole population including children, older people, people in rural and remote areas, Indigenous people, people with disabilities, and people who are poor.

### An effective health (treatment) system

In addition to public policies that prevent illness and injury, people need access to treatment. Both patients and health professionals need to work within a framework that recognises that health care is not a cure for the vulnerability of human existence or for human mortality. It cannot eliminate disability or death. But it can ensure that the whole population has access to basic levels of treatment for physical, mental, and dental health problems. The principles on which the Commonwealth government's Medicare scheme is based are appropriate for any health care system, namely:

- universality – all people have the same rights and entitlements to good quality health care;
- access equity – access to care is based on health needs, rather than an individual's ability to pay; services should be low- or no-cost to patients at point of use;
- efficiency – administrative costs are kept low;
- simplicity – the consumer should not have to negotiate complicated bureaucracies.

## Human Rights as the basis for mental health services

Much still remains to implement the recommendations of the HREOC Inquiry into the Human Rights of People with Mental Illness (1993), known as the Burdekin Report. Actions required include:

- reducing discrimination against people with mental illness;
- providing better and more appropriate treatment services for individuals with special needs – children and adolescents, older people, the homeless, women, Aboriginal and Torres Strait Islander people, people from non-English speaking backgrounds, those with dual or multiple disabilities, people in rural areas, and prisoners;
- directing savings from deinstitutionalization into community mental health services and ensuring that these services are adequately funded to provide the necessary level of support and treatment;
- providing adequate supported accommodation;
- improving cooperation between government agencies in the delivery of services to people with mental illness (that is, delivery of the range of services people with mental illness might require, including treatment, income support, housing, and job placement);
- better funding for research into mental illness, its prevention and treatment;
- improved support for carers of people with mental illness;
- support for services and disciplines that promote social, emotional and spiritual, not only medical, approaches to interventions and management of mental illness;
- effectively supporting families of people with mental illness; and
- implementing an effective suicide prevention strategy.

These points correlate almost exactly with our own findings as identified below. In fact, what is most disturbing about mental health in Australia is that the Burdekin Report, if written today, would contain almost identical findings and recommendations. We suggest the committee ensures it is thoroughly familiar with the Burdekin Report rather than assume that its age makes it out of date.

For example, the National Mental Health Report (written by a government member of parliament) itself acknowledges feedback from carers and clients that “the Strategy’s vision of accessible, responsive and integrated mental health services has little resemblance to the current reality in many areas of Australia” (NMHR 2004:31). *UnitingCare NSW.ACT* is certainly receiving the same feedback from its various agencies.

## Key Issues Identified

UnitingCare NSW.ACT contacted all agencies of the Uniting Church in NSW that we considered to be directly or indirectly involved in mental health work, and thus able to provide reflections on their experiences, in order to give the committee a sense of “life on the ground”. We are aware a number of peak bodies such as the Mental Health Council of Australia will be providing detailed submissions containing nationwide statistical information. We received comments from a wide range of services and held a meeting that was able to flesh out the key messages arising from the experiences of service staff, and in some cases, service users themselves.

Our services identified a number of key issues facing them in their day-to-day work:

1. Inadequate funding
2. The need for coordinated support services, especially supported accommodation
3. The need to adopt a multi-disciplinary approach to mental health that is client-centred not provider-centred
4. The importance of ongoing education aimed at de-stigmatising mental illness
5. The effect on families and carers of people suffering from mental illness
6. The consequences of inaction, including homelessness and imprisonment

## Inadequate Funding

Total spending on mental health services in 2002 was \$3.1 billion according to the National Mental Health Report 2004, representing a 62% increase in real terms since the start of the Mental Health Strategy in 1993. This increase matches the growth in the health care sector overall. The same report also mentions that all states and territories report increasing demand for services, that workforce shortages are reported by all jurisdictions – especially in nursing, that major disparities exist between jurisdictions in the mix and level of services, and that alternative residential and disability support services are often lacking despite the Strategy noting they are fundamental to a community oriented service system (NMHR 2004: 30-31). These findings certainly match our experience.

In the experience of our agencies, the effects of inadequate funding are felt throughout the community services sector as increasing numbers of people with significant mental health issues are accessing generalist community services. Generalist services are stretched and generalist workers have limitations in understanding and expertise in working with people with a serious mental illness.

Secondly, acute bed shortages mean patients are being turned away without assistance and released early without follow-up plans – even in the case of suicide ideation. Lifeline reported to us that they often receive calls from distressed people in this situation. Lifeline then needs to call local crisis teams and the cycle starts again. In many cases, these shortages mean it takes a violent incident before someone can be admitted to hospital – or, in far too many cases, prison. This issue was also raised by a number of homeless person services whose clients reported being turned away despite being in a state of crisis.

Thirdly, Lifeline found in a recent study (UNSW 2005) that two-thirds of callers with high levels of psychological distress did not receive any other mental health service. Of these, the main reasons identified (in order) were cost, not knowing where to get help and waiting lists being too long.

These barriers to access also affect homeless people who, as mentioned, are highly likely to suffer from a mental disorder. Homelessness is such a serious problem in Australia that every day, over 700 people are turned away from homeless assistance services due to a lack of resources (NCOSS 2005) and an estimated 20,000 people ‘sleep rough’ every night (Mission Australia 2002).

UnitingCare Burnside identified a number of significant problems facing young people with mental illness caused by insufficient funding. They reported that demand for existing counselling and support programs for young people always exceeds supply. Many generalist and SAAP funded youth services are already stretched and staff members have limited expertise in providing services to young people with serious mental illness. SAAP funded services that accept young people are expected to do this without additional funding and with limited support from mental health services (it should be noted in this context that real SAAP funding has not increased in 8 years). Furthermore, young people commonly experience difficulties obtaining after-hours assistance from mental health crisis teams due to inadequate staffing. In the Campbelltown area, for example, the coordinator of a youth drop-in centre reported that she understood there was no after-hours crisis team personnel in her area.

Annesley House staff report having little trouble filling their beds. As one of the only low-care facilities in NSW dedicated to mentally ill older people, this hostel in Leichhardt fields referrals from as far away as northern New South Wales. Despite the fact that Annesley's residents require roughly double the personal care hours of other low-care facilities, there is no additional federal funding for offering aged care beds to the mentally ill.

One Lifeline Centre Manager wrote to us with a rather stark message:

*"In short, the [NSW] mid north coast Mental Health department has not enough people on the ground to cope with the numbers of sufferers of mental health in our area. We have no programs, and no case workers (well 2 for the estimated 5,000 critical sufferers of mental health). We do not have any gazetted beds between Taree and Coffs Harbour, and only visiting psychiatrists. We can't even say there are huge gaps in our mental health programs because we do not have any programs."*

### **Absence of mental health services means people turn to Lifeline**

Lifeline services report that people who have apparent mental disorders, with or without diagnosis, and who are asking for help are often unable to access mental health services and assessment because of distance, unavailability of mental health staff, or a telephone decision by mental health services that there is not the need. People with psychotic disorders and who are assessed by mental health services are often not admitted to on-going mental health care (either as inpatient or outpatient). People who do have a mental health consultation often are advised to seek services elsewhere (e.g. physician, counsellor, Lifeline).

Both the health and general communities consider Lifeline as a major ancillary service provider to people with mental disorders/illness. *For many such people at many times, Lifeline is in reality the only service provider available.*

However, many people with mental disorders tend not to approach carers, including Lifeline, for support until the point where they cannot bear not to approach someone, that is, call out for help. These seem to be people who have sought treatment/support previously, but became frustrated at the void of available services. For many callers experiencing mental health issues, Lifeline is their only point of contact with a counselling service.

The importance of Lifeline services to people with mental health services is highlighted by the case of 'Tony', a client of Macarthur Lifeline, whose story is recounted in Box 1

### **Box 1: Case of person with schizophrenia**

Tony (not the person's real name) was diagnosed with schizophrenia at the age of 18 years. He had a heredity mental health disorder. He was devastated at this prognosis. Tony went from doctor to doctor, test to test. His schizophrenia was intense, rarely with remission.

Tony suffered major depression. He studied his illness from all available literature and other resources. Even though extremely intelligent with a high IQ, he could not accept his affliction. Tony made many attempts to take his life. His family and partner were well aware of his condition and supported him.

Tony phoned Lifeline regularly over a two-year period, particularly when he became very distressed and psychotic, just wanting to speak to someone and let them know how he was feeling and how cheated he felt about life. Although he had significant carers, there were times when Tony felt alone and scared. It was on some of these occasions when he phoned Lifeline. Indeed, sometimes he would tell the telephone counsellor that he had his medication all set out in front of him on a table, ready to overdose on them, and that he had written a suicide note. It was on such occasions that Tony was crying out for help.

There were times when Tony ceased taking his medication, this being his attempt to just be normal. Conversely, there were several times Lifeline called an ambulance because Tony had overdosed on his medication, wishing that his life would end.

Tony was immensely grateful to his carers who did give him time and understanding. However, he became tired of his compounding problems of family relationships, a feeling of being different to other people, constant attempts to be healed, a sense of rejection by some carers, high doses of medication, etc. Tony took his life, at aged 25.

One of the greatest burdens experienced by Tony over the years, and which he spoke about to telephone counsellors, was going to hospital or to another medical service for help but where he would be told to go home and take his medication.

Uniting Church agencies strive to provide an excellent service but in general this does not include professional psychiatric treatment and related support services which are what people actually need. Some staff expressed the view that church programs for homeless people were keeping people from dying, but in the process papering over the very large cracks in the mental health system.

### **Coordinated Community Support Services**

The de-institutionalisation of people with mental illness is a welcome development. Long-stay accommodation in such places on the basis of a diagnosed mental illness was tantamount to incarceration for many people. It resulted in situations where abuse by staff at the institutions was frequent and chronic, both in terms of sanctioned over-medication of patients, and in terms of unsanctioned events of physical, sexual and emotional abuse by staff.

However, there are a number of instances where the movement of people with a mental illness out of long-stay accommodation into the community has resulted in a worse environment for those people. These include where the person has been discharged to the community and:

- inadequate or no support has been provided to enable them to successfully live and operate in the community;
- they have inadequate health care, which leads to a cycle of admissions; or
- the person is not entitled to support because, on discharge, they were found to be inappropriately institutionalized in the first place.

One of the key messages sent by a number of our services to us was that the mental health sector is far too focussed on acute medical care. As a result, beds for rehabilitation and supported accommodation are severely lacking.

UnitingCare supports the public policy objective of supporting people with mental health issues, including those with psychotic illnesses, to live in a 'normal community environment'. We note that for people without psychotic illnesses, living in the community is not just about a house of their own (a building) – it is about relationships with other people: at work, at leisure, etc. There is no one 'community' of New South Wales: rather, we have a series of 'micro-communities' defined by geography, social class, wealth and income, housing tenure, age, ethnicity, recreational interests, health status, (dis)ability, etc. Integration of people with psychotic illnesses in the 'community' involves a careful consideration of appropriate housing situation (for example, cluster housing rather than isolated, individual units) and broader social supports that counter stigmatization.

Accommodation for mental health patients should be as near to "normal" as possible. This rarely means incarceration and very few either acute or long-stay patients require the total care that psychiatric hospitalisation provides. Patients, consumer groups and relatives seem agreed that hospitalisation should be for the minimum time necessary. However, a small percentage of people with mental illness require longer stay hospitalisation and it is both futile and counter-productive to ignore their need. They need longer hospitalisation in "rehabilitation" units where they are assisted to develop the skills required to move out of hospital, but are not treated as incapacitated. Elderly residents especially need assistance in finding suitable aged care facilities.

A significantly greater number of people do not require such high levels of care but do require supported accommodation. The main philosophy underlying supported accommodation is to ensure services optimise long-term quality of life for people with severe and persistent mental illness. The common goal of these services is to support people to achieve and maintain a permanent home that meets their needs. It is generally agreed that stable, secure and safe housing is the most important component of rehabilitation for people with a mental illness.

High levels of unmet need for supported accommodation among people of all disability types are reflected in large 'waiting lists' and waiting times for supported accommodation and unacceptably high levels of long-term burden on unpaid (usually family) carers, plus of course homelessness. While in some areas people with mental illness are given priority access to public housing, the enormous waiting list and lack of appropriate housing means that accommodation is not readily available.

Furthermore, caseloads of mental health case managers are now so high they can only attend to medical needs, so other support is virtually nonexistent. These other needs could be met by NGOs if provided with funding to do so.

The Schizophrenia Fellowship has argued that "under-funded, incomplete, fragmented and poorly monitored community-based services make community services inaccessible to most people. The homeless mentally ill arguably have suffered most as a result of these shortcomings, having multiple needs for intensive and ongoing support." (see [www.sfnewsw.org.au](http://www.sfnewsw.org.au)).

UnitingCare's Supported Living is directly involved with those people with mental illness who were discharged and ended up living in licensed boarding houses in the community, in inner-western Sydney. Arguably, the conditions in these boarding houses are as bad as or worse than those inside the institutions.

UnitingCare's Supported Living staff report that supports and services in the community are inadequate for the maintenance of people with mental illness in good mental health, and that

the pattern of admission, discharge and further admission is the rule rather than the exception for a good many people who experience mental illness. The problem lies in the inadequacy of support services that can address everyday needs of people with mental illness, and provide a useful corollary to the acute mental health 'crisis team' services that in general work quite effectively.

Compared with other disability services, there is a lack of support services available to people with mental illness, outside of the clinical and medical supports that extend now beyond the hospitals and into the community.

There needs to be much greater investment in services that operate along similar lines to other disability services, and which have as their focus the development and maintenance of living skills, linkages into the community, and the building of community supports for people with mental illness. These would stand alongside the current range of medical and other services provided by the Department of Health, and might best be provided by non-profit nongovernment agencies. There might also need to be increased funding made available, and the separation of medical and non-medical supports made, perhaps through administration of new funds through a department other than the Department of Health, such as the Department of Ageing, Disability and Home Care.

The current focus on mental health services within the tight scope of the Mental Health Act does not recognize the role of generic welfare services in promoting good health outcomes for people with mental health issues.

Lifeline services are a case in point. The incidence of mental health callers to Lifeline Mid Coast's telephone counselling service has increased to the extent that both telephone and face to face counsellors, although being trained and competent for their roles, are experiencing undue stress. Counsellors are increasingly requesting more in-service and coaching support in respect to mental health callers and clients. There is a high level need for professional support for counsellors, both telephone and face-to-face, in mental health issues, to ensure their service is of the standard desired, and to eliminate the risk of Lifeline losing the services of counsellors who find mental health calls and clients require a service the counsellor is unable to provide.

## **Access to mental health services by people who also have an intellectual disability**

UnitingCare's Supported Living has been directly involved in attempting to acquire services and supports for its service users who have an attendant psychiatric disability alongside their intellectual disability, with some difficulty. This experience of Supported Living is common across many services that provide support to people who have a 'dual diagnosis' – a disability plus a mental illness. Despite the existence of a specific diagnosis (usually schizophrenia, in the experience of Supported Living), there is frequently no success in calling on community-based mental health services, such as Crisis Teams, if there is some fear that the service user is experiencing mental health problems. At this point of contact workers at Supported Living are informed that the person has a 'primary intellectual disability' (implying a 'secondary mental illness'), and that they, as a disability service, are the most appropriate agency to deal with the problem. This response is more about funding and resources than it is about the best mode of support for the individual. It is only when hospitalisation is required for an individual that the mental health services are forced to become involved. Supported Living has worked successfully after this point to obtain and maintain levels of ongoing support and crisis intervention services from the mental health system for people in the community after they have come out of hospital.

Members of the community who experience mental illness for the first time, or at infrequent times, do not and should not expect to be hospitalised before their condition is taken

seriously. The range of clinical supports available in the community is designed to intervene before admission to hospital is necessary, and to prevent admission wherever possible. People who do not have a label of disability can expect this response as part of the range of health care available to the public. To deny this sort of support to people with intellectual disability, because of their disability, is unacceptable discrimination.

Many of the problems with availability of services stem from a lack of resources. Once this is addressed, it will be important for mental health services to examine closely their intake and support protocols, and ensure that they work closely with other agencies to provide adequate support to people who have other disabilities attendant to their psychiatric disabilities.

### **Issues for people with dual diagnoses**

The number of patients with dual diagnoses (drug and psychosis) who come back for second or third admissions to hospitals is high. These patients are often back logged in the acute wards well after their psychosis is under control enough for them to be move to a general psychiatric ward. They cannot always be discharged into the community because of the drug-related nature of their illness, or because they have no appropriate accommodation to go to. This is a priority in the health area, with new beds being built at Macquarie Hospital and the development a specific dual diagnosis program. However, the new beds come at the same time as closure of other rehab beds at Macquarie Hospital. Long-term patients are expected to be rehabilitated into supported accommodation 'in the community', but again, without such facilities actually being available.

People with dual diagnoses are the victims of 'buck-passing' between health services, even health services funded by the Department of Health. For example, Burnside youth services in the Macarthur region report that if a young person has a dual diagnosis, for example alcohol or other drug abuse and a mental health issue, the mental health services say that it is a matter for alcohol and other drug services, while alcohol and other drug services say it is a mental health service problem. It is of deep concern to us that these people have great difficulty in gaining access to much-needed services.

### **Lack of real multidisciplinary approach to mental health**

While the mental system is supposed to be multidisciplinary, with each discipline contributing to the management plan of a patient, we still have a very medically-based model. The psychiatrists rule, and many staff feel the insights from their disciplines go unheard.

The mental health system is committed to using best statistical practice in measuring outcomes from practitioners' work with patients. While this has developed a sense of accountability, it often fails to recognize that many aspects of patient care are not directly measurable. Church chaplains report that some staff fear that these statistical requirements to record and measure are used to justify closures or to take away support services. While we can easily measure the number of days a patient spends in rehabilitation, we cannot easily measure things like the patient's acceptance of their illness or the quality of life experienced by the patient. Mentally ill people are often unable respond to a cognitive questionnaire and are intimidated by the battery of testing they must endure. Chronic patients simply refuse to cooperate and will often say anything to satisfy those seeking data from them. Also, it is impossible to provide large enough samples to be statistically significant. Some day program areas in rehabilitation worry that the caring aspects of their programs are undervalued and are at risk of being removed, because they do not have a measurable outcome to patients' mental health.

In addition, many government mental health services seem to have a 'silo' approach that leads them to refuse to assist people whom they deem not to be at sufficient risk or who have comorbidity issues. In the course of taking a silo approach they can ignore the impact

on other people and on welfare services. At times Burnside has called for assistance from a mental health team when they thought that there were significant issues for a person, but the mental health team assessment resulted in no action. Burnside considers this is problematic, especially when young dependent children are involved. UnitingCare services also have problems getting information from mental health services – information which would be important for how the welfare service can assist the client. In one case, a woman who has psychotic episodes was referred to Burnside from the Department of Community Services. Burnside was concerned about being able to support the woman properly, but mental health services would give it no information about the woman's condition.

State and Federal Governments have moved to program delivery approaches that emphasize collaboration and partnerships between agencies (government, community sector, and private firms) in a number of social policy areas. In NSW they include the Premier's Department *Regional Coordination Program*, the *Rural Social Justice Statement of 1999*, the *Families First* program, *Community Drug Action Teams*, and the *Schools as Community Centres* program. The same broad and partnership-based approaches need to be developed and applied in mental health services. In a 1995 report prepared for our Balmain Mission (Milne, De Mellow and Collis), the authors said that, "Ideological splits and financial splits riddle the mental health safety net." We are hoping that this Inquiry presents an opportunity to move beyond problems, to pathways for solutions.

It is clear that many of the most effective interventions follow from a collaborative approach in which non-profit nongovernment organizations not deemed by the Department of Health to be psychiatric disability support services, or funded by that Department, play a key role. For example, Burnside's Reconnect (a Resource Adolescent Program) on the NSW central coast have a formal relation with Lifeline and the Department's mental health crisis team. Burnside finds that young people will not necessarily present to an identifiable mental health service, but will attend youth services. So there is a need for generic welfare services to have expertise in mental health issues and to have (more) cooperation and backup from the Department's mental health crisis teams.

One initiative that did receive positive comments from our staff was the Housing and Accommodation Support Initiative (HASI) of the NSW Government.

HASI, which began in 2002, provides co-ordinated disability support, accommodation and health services to 118 people requiring high level support to live in the community. This includes 42 people in regional and rural NSW. Preliminary outcomes in the South Eastern Sydney trial over a twelve month period show that inpatient beds days for enrolled patients decreased from 197 days to 32 days (NSW Health 2005)

According to the Mental Health Coordinating Council,

*"Many positive reports are being received on the value of the Mental Health Housing and Accommodation Support Initiative (HASI), just two years since the first round of funding was rolled out to the NGO sector ... The project's aim of strengthening partnerships between Area Health Services, NGOs, the Department of Housing and consumers and carers is also showing up to be successful with fruitful relationships being developed. Providers report partnerships been very effective in creating a coordinated approach to delivering services ... HASI is showing that people with a mental illness can live in the community when they are provided with the support they need to get back on their feet."* (MHCC, 1 Nov 2004)

HASI is currently being formally evaluated by the Social Policy Research Centre at the University of NSW.

In summary, the provision of mental health services currently fails to meet the many and often complex needs of people suffering from mental illness, even aside from questions of funding. Lack of coordination and a 'silo mentality' hinder access to services which are

theoretically available. We urge the committee to give serious attention to ways in which the mental health 'system' can integrate a client-centric approach rather than a 'provider-centric' one.

## **Destigmatising Mental Illness**

While public education about mental illness, and in particular depression, is improving, our feedback suggests there is still a long way to go and destigmatisation remains a key priority for federal and state government action.

Stigma is an attempt to label a group of people as less worthy of respect than others. Stigma against people with a mental illness often involves inaccurate and offensive representations in the media, portraying them as violent, comical or incompetent.

Research by SANE shows stigma is a major cause of distress to those affected, their families and friends. It can discourage people from seeking help because they don't want to be perceived as 'crazy'. It also leads to prejudice and discrimination. Stigma, like racism, has no place in a civilised society. Some people affected by mental illness say that the effects of stigma can be as distressing as their symptoms (SANE 2004).

Lifeline reported to us that their own research has demonstrated to them the importance of their non-pathologising approach. Noting that up to 60% of callers with a mental disorder do not access any other mental health services, the manager of one Lifeline Centre commented on the effectiveness of soft entry points such as Lifeline for people afraid of stigma or unwilling to accept their illness due to significant negative and/or inaccurate stereotypes in the community.

Police education equally remains a priority. The NSW Police Association themselves have often expressed concern about their increasing de-facto role on the frontline of mental health. From our perspective, in a recent interagency meeting staff talked about police and mental illness. Many workers who work in homeless and similar services felt strongly that many police they see deal with their clients have a very elementary understanding of mental illness and its effects. Some workers find this frustrating because they feel the police respond poorly when dealing with their clients.

Another element of stigma is the public portrayal of people on disability support pensions by members of the federal government, 25% of whom have psychological conditions (MHCC Newsletter 2005). The proposed changes to eligibility criteria in the 2005 Budget reflect an assumption that large numbers of people receiving the DSP are undeserving (ie. lazy welfare bludgers). The work requirements further misunderstand the issue in assuming the problem is one of supply rather than demand – the simple fact is that in a competitive marketplace, people suffering from mental illness will struggle to gain employment regardless of their desire and capacity to do the work.

## **Effect on families and carers**

One of the strongest messages we received from our services was that the effect of mental illness on families and carers is completely ignored by the government.

Mental illness has a highly traumatic effect on the families of the people who suffer from it. Relationships are disrupted, financial pressures increase and in a small number of cases there is violence or the fear of violence. But more than this, families inevitably suffer with their loved one and experience their own trauma and stress as they go about caring for the person with the illness. Because of the difficulties with admission to acute care, there needs to be a concern for physical safety before action is taken, and at this point it is the police, not ambulance personnel, who must be called. The experience of calling the police on one's own

family member causes significant emotional trauma for all families, no matter how much they might know it is in the best interests of their loved one.

Privacy laws restrict access to basic information. One of our staff told the story of a parent who was not able to determine if his own son was being treated at a particular hospital – even to establish that he was still alive.

Another talked about counselling parents who have just heard their son or daughter tell them over the phone that they felt suicidal for the 100<sup>th</sup> time and then hang up the phone.

Another concern is the increasing number of children and young people caring for their parents. This is not only an unfair burden that the state seems to find acceptable but it also entrenches these children and young people in a poverty trap because they struggle to attend school regularly and achieve academic qualifications to ensure a secure future. According to Carers NSW, it is estimated that more than 50,000 children in NSW alone care for a family member who has a long-term illness or disability – many of them psychological (see Carers NSW website, <http://www.carersnsw.asn.au>)

These traumatic experiences cannot be completely overcome, but they can be alleviated. Access to free or subsidised counselling for families and carers would be hugely beneficial. Awareness of the complex needs and difficulties facing carers on the part of social security agencies (as opposed to the often hostile and suspicious environment many report facing, which appears to be encouraged by many elected politicians) would also go a long way. Greater financial assistance in the form of increased carers pensions and disability support pensions seems like a pipedream despite widely advertised budget surpluses and generous tax breaks for the wealthy.

## **Mental Health and Prisons**

Service staff painted a grim picture of the consequences of the failure of the mental health system to adequately meet people's needs. These include homelessness, violence, drug abuse and imprisonment. As the Hon Brian Pezzutti, Chair of the 2002 NSW Legislative Council Inquiry into Mental Health said, "Deinstitutionalisation, without adequate community care, has resulted in a new form of institutionalisation: homelessness and imprisonment" (Pezzutti 2002: xv)

The prison system in NSW has been described by many as becoming a "surrogate mental hospital" (Beyond Bars: Alternatives to Custody, Fact Sheet 9). Since the closure of large psychiatric institutions there has been a "steady drift" of people with mental illness into NSW prisons. Without lack of support in the community the increasing risk of homelessness puts people at risk of offending behaviour or coming under more intensive police surveillance. 30 per cent of people are in prison because of their mental illness (Moore 2003).

Mental Health statistics in prisons are quite startling:

- Women in Prison – 30% have attempted suicide, 25% are on psychiatric medication and 25% have been admitted to a psychiatric unit or hospital.
- Men in Prison – 20% have attempted suicide, 13% are on psychiatric medication and 34% have been admitted to a psychiatric unit or hospital (Beyond Bars Fact Sheet 9).

Prisons can be a frightening place for those with mental illness. The above figures may be underreported as many prisoners are reluctant to report their mental illness for fear of violence, abuse and/or exploitation by other prisoners. They may also not want to end up in "dry cells" that are used for suicide watch, under 24 hour surveillance by prison officers and more likely to exacerbate mental illness.

The Cornelia Rau case highlighted the large number of women in prison in Australia with mental illness. "In 2003 the NSW Corrections Health Service found that 86% of women entering prison were suffering some form of mental illness and that 12% had psychotic disorders. Considering the numbers of women who are screaming for help in Australian prisons, it's no wonder Rau wasn't heard". (Kilroy 2005).

## **Mental Health and Mandatory Detention of Asylum Seekers**

Detention of asylum seekers poses specific mental health risks. These risks have received wide media attention in the last few years, most notably in the recent revelations surrounding the detention of Cornelia Rau at Baxter. We have mixed feelings about the extra attention her case has generated: on one hand, we are glad the spotlight is finally being shone on the appalling (non-)treatment of detainees with mental health problems, but on the other it says something rather disturbing about our country that it takes a white woman to get our attention.

The mental health affects of long-term and/or indefinite detention are now well documented. In some cases mental health problems pre-date arrival to Australia, particularly symptoms related to post-traumatic stress disorder and depression. It also appears true that the policy of mandatory detention itself, however, is a contributing factor. According to Steele & Silove (2001), "Factors regarded as increasing the risk of mental distress included prior experiences of torture or other forms of persecution in the country of origin, the stresses created by the length and conditions of detention, and the feelings of anxiety and desperation in those whose refugee claims are rejected." Similarly, a study of long-term detainees at Villawood commented that "It is ... difficult to avoid the conclusion that the policy of mandatory detention of asylum seekers is leading to serious psychological harm." (Sultan & O'Sullivan 2001)

The HREOC National Inquiry into Children in Immigration Detention "received a wide range of evidence which indicated that detention has a significantly detrimental impact on the mental health of some children ... many experts told the Inquiry that the detention environment made it virtually impossible to meet the mental health needs of children and their families. This was because the source of many of the problems was the detention environment itself. (HREOC 2004: 30-31)

The Inquiry's findings relating to mental health concerns are damning:

*"The Commonwealth failed to take all appropriate measures to protect and promote the mental health and development of children in detention over the period of the Inquiry and therefore breached the Convention on the Rights of the Child.*

*"With respect to some children, the Department failed to implement the clear – and in some cases repeated – recommendations of State agencies and mental health experts that they be urgently transferred out of detention centres with their parents. This amounted to cruel, inhuman and degrading treatment."*

Finally, we draw the committee's attention to the recent Federal Court case in which Justice Finn condemned the federal Government for its mental health services at the Baxter detention centre, describing the treatment of one Iranian detainee as "culpable neglect". He said the Government failed to provide adequate mental health services in Baxter, failed to implement recommended treatment plans, and ignored medical reports on the deteriorating health of detainees known as "M" and "S". The judge agreed with three independent psychiatrists that the Baxter environment was the primary cause of the men's mental illness and keeping them there condemned them to ongoing injury (a full transcript of the judgement is available at [http://www.austlii.edu.au/au/cases/cth/federal\\_ct/2005/549.html](http://www.austlii.edu.au/au/cases/cth/federal_ct/2005/549.html)).

Asylum seekers – even those whose applications have been refused – are entitled under Australian law to protection of their human rights, including the right to mental health. Current federal policy of potentially indefinite mandatory detention constitutes the most egregious abuse of mental health by the Federal Government.

## Conclusions and Recommendations

Hearing the stories and reading the comments offered by our service staff, combined with the overall picture painted by the Mental Health Coordinating Council and the National Mental Health Report, is depressing business. Our mental health system is in a state of crisis in which people who desperately need help are unable to get it.

The key priorities for the federal government should be:

- Lift funding for mental health from 6.4% to 12% of the overall health budget
- Direct the majority of these new funds towards supported accommodation and other forms of community-based care
- Expand on existing initiatives and education campaigns aimed at destigmatising people with mental illness
- Expand multi-disciplinary projects such as HASI
- Find ways to prevent people with mental illness ending up in the criminal justice system
- Find alternatives to long-term detention of asylum seekers, especially children, in light of both our international human rights commitments and the substantial evidence pointing to such detention as a cause of, as well as an aggravation to, mental illness.

We also support the implementation of specific targets such as those proposed by Hickie et al (2005) which provide both direction and accountability for federal government. We noted earlier that the National Mental Health Report 2004 did not discuss any data relating the mental health of the nation. Precisely how we are expected to evaluate the effectiveness of the increase in funding over the last twelve years is not clear without it.

Ultimately, questions about mental health services are questions of values. Australia is a wealthy nation benefiting from more than a decade of economic growth, stable governments, and a public commitment to caring for those who need it. It is thus a source of great shame that mentally ill people are subject to such appalling treatment. What does it say about our “values” when people are left to sleep in street gutters, suicidal men and women are turned away from A&E wards of public hospitals, when prisons are full of people with mental illness?

The Uniting Church believes the reality of mental ill-health in Australia is a disgrace in the light of Christian social thought, and also in the light of liberal democratic values and our professed commitment to human rights. We call upon the Committee to hear the cries of the neglected and work furiously to ensure the federal government acts with compassion.

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