



**Submission to the
Legislative Council Inquiry
into
Mental Health Services**

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To

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Summary

UnitingCare supports the historical process of deinstitutionalization of care for people with mental health issues. It affirms that all people should have the fullest opportunity to realize their potential as human beings and participate as citizens in wider society. Where people need care, that care should be provided on a least restrictive basis. Our focus as a society should be on promoting emotional well-being, not on stigmatising illness.

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.

That frustration has two sources. The first is our observation that the 'progressive' model of contemporary approaches, since 1983, is hampered by the lack of fiscal follow-through. Direct mental health services, in hospital and community-based settings, are resource-constrained. Just as importantly, key agencies that assist people with mental health issues (such as nonprofit nongovernment organizations in the disability, youth and family support fields) are not recognized and supported by government funding.

The second is our observation that government mental health services that operate within a 'by the book' reading of what they can or should do within the terms of the Mental Health Act 1990 are not always *there* for people with mental health issues. They too readily assess a person's predicament as not being a mental health issue, and leave other (nongovernment) agencies to help a client with a mental health issue as best they can. People with dual diagnoses, for example, fall through the gaps. People who will not present to a designated mental health service rely on the stalwart efforts of non-Health Department funded agencies like Lifeline and Burnside (and other agencies not connected with the Uniting Church, of course).

We would like to see the mental health system in New South Wales recognized as a 'system', in which the Department of Health has a *lead agency* role. That system has 3 legs: promotion, prevention and early intervention; acute care of people with mental disorders; and post-acute care of people with chronic disabilities in community residential settings. The government's focus has been on acute care. Greater attention is now being given to promotion, prevention, and early intervention. Post-acute care of people with chronic disabilities in community residential settings is a public policy vacuum.

It is clear that many of the most effective interventions follow from a collaborative approach in which nonprofit nongovernment organizations not deemed by the Department of Health to be

psychiatric disability support services, or funded by that Department, play a key role. There is a need for generic welfare services to have expertise in mental health issues – which will require government funding – and to have (more) cooperation and backup from the Department's mental health crisis teams.

Introduction

The Legislative Council of the NSW Parliament has established an inquiry into mental health services, and called for submissions.

This submission addresses 5 of the matters covered by the inquiry's terms of reference:

- consideration (b): the impact of changes in psychiatric hospitalisation and/or asylum;
- consideration (c): levels and methods of funding;
- consideration (d): community participation in, and integration of, mental health services;
- consideration (e): quality issues in mental health services;
- consideration (g): the availability and mix of mental health services.

What we believe

This submission is from UnitingCare NSW.ACT, which is responsible for the social justice, chaplaincy and community services work of the NSW synod of the Uniting Church.

The NSW Synod of the Uniting Church is committed to the precept that people with mental health issues, including those with psychiatric disabilities, be able to fully participate in society. Jesus said, 'I have come that they may have life and have it more abundantly'. This statement is a recognition of the innermost yearnings of individuals to achieve their full potential.

The God revealed in Jesus Christ is a god who created and values all people, a god who work always to sustain life, to nurture human beings so that they flourish, to heal people of their diseases, and to bring them into community. When human beings work for health, they are cooperating with God. It is for this reason that Christian churches have a very long tradition of caring for the sick and providing health care.

These beliefs inform the values on which we base our services, and the criteria that we use to assess the adequacy of public policy. The Uniting Church believes that these values and criteria are not exclusive to the church. Like other major Christian churches, we support the international covenants and conventions on human rights, as setting out not only the rights of human beings, but the responsibilities of government.

At the very heart of human rights obligations is the value and dignity of the human person, and the intrinsic right of each person to the care and provision that they need in order to flourish. At the very heart of the experience of people with mental illness is the experience that current service provision fails to provide their needs, treat them with dignity, or reflect their value as human beings. In the current, fragmented, system they experience violation of

their right to health and to adequate health care services, and often other rights as well – their right to an adequate standard of living, and their right not to be discriminated against. Such experiences are themselves illness-creating and life-denying.

Christians recognise the complexity of human beings. Human beings need to be treated holistically – they have minds, bodies, emotions, and souls. They live in and are shaped by particular cultures. A health care system has to respect and take seriously all these dimensions if it is to encourage health rather than merely to treat particular symptoms. For people with mental illness, a holistic approach is crucial if it is to maximise their health, because some mental illness makes it more difficult for people to cope with other everyday needs.

Many of the issues that are raised in this submission are not new. Similar problems to those we raise here have been identified by previous parliamentary and governmental inquiries. Yet the system continues to be fragmented and leaves many needs unaddressed. The time lag in effecting addressing these problems makes the failures a particularly serious form of injustice. We say this not to be judgemental, but, rather, to argue that mental illness should be a high priority in the health budget, and in developing effective coordination and delivery of services across government departments.

What we do

The views in this submission are based on the practical experience and reflections of our ministers, managers, workers, and volunteers, in Uniting Church agencies.

The Uniting Church NSW Synod's approach to all disability services is to support:

- a focus on people with disabilities as individuals;
- care for the socio-economically disadvantaged;
- enhanced choice for people with disabilities;
- respect for the rights of people with disabilities;
- partnerships between community organizations, government agencies and socially-concerned private firms.

The Church *directly* operates a number of community-based mental health services in New South Wales. These include:

- provision of chaplains to mental health services in 4 regions (Central Sydney and Southeastern Sydney; Northern Sydney; Western Sydney and Blacktown; and Hunter); in other areas local visitation teams may cover local psychiatric units; the hospital chaplain at the Prince of Wales Hospital, Randwick, covers the acute ward there; 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;

- Lillian 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), and medium- and long-term accommodation for people with mental illness, in the Parramatta district.

We have also undertaken specific research projects, such as a survey of housing and support needs of people with psychiatric disabilities in inner Sydney (Milne, De Mellow and Collis 1995).

We also come across the needs of people with mental health issues across a range of our other services – chaplains in general hospitals, prisons, and the police force; residential care for older people; care for people with intellectual disabilities; care for young people; shelters, refuges and crisis accommodation for homeless people; telephone counselling services; family counselling service; and in the work of our parishes.

For example, people with mental health issues make up to 60% of the 154,000 annual telephone calls to Lifeline services, depending on the day and time. The volume of mental health related calls has increased over the last five years. (Fourteen of the 17 Lifeline services in New South Wales are agencies of UnitingCare.)

Another example. Supported Living is a UnitingCare service that provides support to adults with intellectual disabilities who live in regular, community accommodation, often on their own, and who require regular support to maintain their independent lifestyle. The service provides support to 26 individuals, some of whom also have an attendant psychiatric disability.

Supported Living also runs an Active Linking Project in inner-western Sydney, as part of the NSW government's Boarding House Reform Process. The project aims to provide activity-based support for individuals who live in licensed boarding houses. Many of the recipients of this service are people with psychiatric disabilities, who have lived for many years in the boarding house system, some because of leaving long-term institutions after the release of the Richmond Report.

Background

An ongoing, and incomplete, reform process

Reforms to the way in which people with psychiatric disabilities have been treated and supported began in the early 1980s in Australia, with New South Wales leading the way. These developments were not unique to Australia: governments, health practitioners and consumer advocates have been pursuing broadly similar paths in comparable overseas jurisdictions.

The two major aspects of the reforms have been a shift in the treatment and accommodation of people with a mental health disorder from institutional to community-based settings, and the integration of specialized mental health care into mainstream health services (Australian Institute of Health and Welfare 2001, p.123).

Mental health care is provided by both hospital-based and community-based services.

Hospital-based care can be in stand-alone psychiatric hospitals or specialized psychiatric units and ward in public acute care hospitals. There has been a shift in psychiatric care from stand-alone psychiatric hospitals to specialized units in acute care hospitals. This has been described as desegregation or 'mainstreaming' (Australian Institute of Health and Welfare 2001, p.125). It is a significant component of deinstitutionalization and has allowed for downsizing or closure of stand-alone psychiatric hospitals.

Community-based mental health care services provide a range of residential and non-residential services. The residential services include special units for older people, including psychogeriatric units – units for the confused and disturbed elderly (CADE). Community-based residential care services are a growing segment of the overall service delivery in specialized mental health services. They provided 9% of the available beds in 1992-1993 in all admitted or residential care settings (that is, psychiatric and acute hospitals, and community-based residential units with 24-hour staffing), Australia-wide. This proportion increased to 19% in 1997-1998 (Australian Institute of Health and Welfare 2001, p.125).

The community-based non-residential services ('psychiatric disability support services') are typically run by nonprofit nongovernment organizations.

Clear policy objectives needed

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

- How does the system measure up against stated policy objectives?
- How does the system measure up against basic human rights criteria?
- How does the system measure up against what people with mental illness actually want and need?

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.

Priorities for mental health and disability services

Much still remains to implement the recommendations of the federal-sphere Inquiry into the Human Rights of People with Mental Illness (1993). 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;
- 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.

A person with an impairment can enjoy a high level of health. Often lower levels of health are a product of the stress and trauma of discrimination and uncoordinated services, rather than of the impairment itself. Health depends on:

- access equity, such as non-discrimination in public spaces and public and social life society, and non-discrimination in the work place;
- a health care system that ensures everyone has access to the aids and prostheses they need;
- appropriate treatment and services, such as coordinated health care, especially for people with several impairments or chronic conditions;
- coordinated provision of services (across jurisdictions and within jurisdictions), such as health, housing, income support, and home care.

Inquiry reference B:

Impact of changes in psychiatric hospitalisation and/or asylum

The Richmond Report of 1983 is widely attributed with initiating the process of providing residential care in the community to people with a mental illness, and facilitating the movement of those people from long-stay institutions and into ordinary housing options. In addition, it impacted on services for people with intellectual disabilities, as those were previously mainly delivered in similar institutions under a predominantly medical system. Soon after the Richmond Report, the NSW government transferred responsibility for disability services from the Department of Health to the Department of Community Services. However, the considerable changes in the delivery of disability services across Australia are mainly attributable to the regulatory frameworks established because of the passing of disability services legislation, firstly at the Commonwealth level, and then across the states and territories.

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.

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.

UnitingCare's Supported Living has supported an individual who fits into the last category, who was referred to them 10 years after he was discharged from Gladesville Hospital. He was found not to have, and never to have had, a mental illness; yet he endured the indignity of incarceration within that facility, was given little basic skills training in how to survive in the community when inside that facility, and then was provided with no assistance in moving into a Department of Housing dwelling in the community.

De-institutionalisation has also created an extra dimension and load to Lifeline counselling services. Lifeline counsellors are well equipped to respond to callers and clients in the areas of general counselling, but many are not equipped to serve clients/callers with mental health issues. There is now a high level need for counsellors to gain skills and have support in delivering a relevant variety of counselling approaches, so that the needs of mental health callers can be better addressed by Lifeline counsellors.

The changes in mental health policy following the Richmond Report have been welcome, dramatically beneficial, but belated and, sadly, inadequately funded.

Beside the more fundamentally important 'primary prevention', creating and maintaining a healthy community attitude to mental health (Western Sydney Area Health Service 2002), mental health care should be seen as two separate issues: early diagnosis and effective treatment; and long-term management, rehabilitation and accommodation for people with mental illness.

In relation to early diagnosis and effective treatment, the current NSW situation is a dramatic improvement on what existed in the 1970s. Psychiatric treatment has diversified from the old psychiatric hospitals to include not only psychiatric units attached to general hospitals and private psychiatric hospitals, but more significantly, community mental health centres, private psychiatrists and local GPs. Most people with mental illnesses never go to hospital at all, with by far the greatest percentage of diagnosis and management happening through local doctors, community mental health centres and case managers.

In relation to long-term management, rehabilitation and accommodation for people with mental illnesses, there are positive signs of an improvement in the previously pessimistic prognosis for long-stay residents of psychiatric institutions. Department of Health personnel, both hospital and community based mental health rehabilitation staff, are promoting recovery

and rehabilitation opportunities through living skills centres, work and recreational programs and regular contact with community-based mental health staff.

Church-based support and rehabilitation programs encourage a normalising of psychiatric clients' attitudes to themselves. Mental health chaplains are part of the Health Department's mental health education thrust with significant community groups, schools, general practitioners, clergy and congregations.

Disability packages, accommodation subsidies and Department of Housing arrangements, as well as sheltered accommodation in group homes and hostels, provide a welcome alternative to both psychiatric institutions and boarding houses.

However there are gaps, notably due to the 3-tiered structure of our psychiatric hospital system, whereby people with sufficient funds can get (time limited) treatment in private psychiatric units; people whose behaviour and ability to comply with treatment is socially acceptable can be accommodated in psychiatric units attached to general hospitals; and indigent, less articulate and marginalized people find themselves in the old state psychiatric hospitals.

Ironically, while the living conditions in stand-alone psychiatric hospitals are depersonalising and restrictive, their spacious grounds and grand architecture are often seen as more conducive to asylum and refuge. Currently, only a few of the most severely disturbed psychiatrically ill residents can stay for any length of time in the relaxed environment of the psychiatric hospitals.

Although the 'least restrictive treatment' policy of the Mental Health Act decreases the incidence of abusive and destructive custodial care, there are still some injustices and inappropriate placements when people who could profit by longer low intensity asylum in the old, less stressed atmosphere of the psychiatric hospitals are not allowed in because they are 'not sick enough'; while people who would be better helped in a less forbidding, more 'normal' general hospital psych unit, or a comfortable motel-like private psychiatric hospital, are excluded by financial incapacity or their temporarily inappropriate behaviour.

Inquiry reference C:

Levels and methods of funding of mental health services

Hospital-based care

Increases in requirements for documentation and statistics, without employment of clerical staff, decrease the time that staff have for clinical responsibilities with clients and patients. A nursing unit manager told one of our chaplains that she was not using the skills that she was employed for because she spent most of the time filling in forms. The service needs more clerical staff support. Also, an increase in the level of remuneration for clerical staff would help the service retain these vital support staff.

The acute teams and the acute wards have added pressure when private psychiatrists go on leave. Often patients are referred to the public system if they need continued care. However, no private funding comes into the public system to compensate for the increase in service demand.

Veterans needing treatment can be extra source of income for an acute ward. The fresh stream of money they bring can help a ward keep in 'the black'. This presents a potential for 'cherry picking'.

Community-based care

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 nonprofit 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.

Inquiry reference D:

Community participation in, and integration of, mental health services

Those mental health services that are delivered in the community, as opposed to those delivered within clinical settings, are as much, if not more, oriented to community participation and inclusion than other disability services. Specifically, the provisions of the Mental Health Act do not allow for a person who has experienced a relapse in their mental health, but who has recovered, to be kept within a clinical setting for longer than the course of their treatment, and they are then released into the community. While there is a shortage of adequate support services within the community, the Richmond Report has helped to establish a commitment to the provision of support in the community, and to strategies of support that include the participation and inclusion of people with mental illness within their communities.

Mental health services, similar to many services provided to other people with disabilities, might be under-resourced to the extent that they are able to focus only on the maintenance of people with mental illness in their communities, and not to adopt more proactive strategies to achieve integration and participation at a more intensive level. Strategies such as active network building, and intensively working with people as they take on roles of responsibility and prominence within the community, are the exception rather than the rule in all disability services. To better adapt the community to meet the everyday needs of people with mental illness, new community support services need to be established: those would work closely with service users to be actively included in their community, and at the same time build the capacity of that community to support and sustain its members with mental illness.

Burnside's Minto Family Centre ran a project in 2001 year looking at the issues faced by families where one member is living with a mental illness. The most common message throughout the whole projects was that people living with a mental illness want to be able to access general services as well as specialist ones. One of the biggest barriers they felt were the stereotypes and discrimination.

There seems to be very poor integration of services required by people with mental health disorders. Those services include GPs, medical specialists, mental health services, community health services, counselling services, case managers, and local hospitals including casualty departments.

In some parts of the state agencies associated with UnitingCare have sought to improve their relation with Health Department mental health services on a formal basis.

For example, in the Hastings, Manning and associated districts there is a formal protocol between mental health services and Lifeline Mid Coast, through which each refers to the other and the mental health team provide some in-service and occasional supervision. Over the months November 2001 to February 2002, mental health services referred 13 of their clients to Lifeline for face-to-face counselling.

Another example is on the south coast. In June 2001, Lifeline South Coast became part of the Illawarra Area Health Service Mental Health Integrated Project. It receives funding from that project and works with other local mental health service providers. The association will continue until July 2003.

Lifeline South Coast's association with the project has led to:

- a more structured supervision and management approach (using best-practice guidelines) to work with callers with mental health problems;
- an improved telephone counselling protocol, thanks to a group of telephone counsellors meeting monthly with a consultant psychiatrist;
- the development of interagency service agreement protocols, which improve the relationship between Illawarra Area Health Service mental health services, Lifeline South Coast, private psychiatrists, GPs and other relevant service providers;
- better assistance for GPs working with clients experiencing depression, by providing structured problem solving through the 24-hour telephone counselling service provided by Lifeline;
- increased competence in working with callers who do not access formal mental health services due to geographic, financial or attitude barriers;
- increased social capital through training, supervising and supporting volunteers to play a role in the mental health of the region through telephone counselling.

The percentage of productive calls to Lifeline South Coast has increased steadily since the introduction of the structured supervision and management approach. The extent to which telephone counsellors found calls satisfying has also increased. This is an important component in reducing the resignation rate of telephone counsellors and thus increasing the ongoing viability of Lifeline services.

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 stigmatisation and inferiorization.

Inquiry reference E:

Quality issues

A psychiatrist working in front-line hospital admission wards commented to one of our chaplains that for the service to really work, it must first pass the question: *Do we want to be a service that cares or a service that simply treats?* A service that cares will ensure that adequate medical intervention is coupled with a variety of services that attend to the many aspects of a person's life when they are afflicted with mental illness. However, a service that just treats, can easily overlook other vital areas in a person's life that need attention and support during the mental illness. It seems that the service is currently only interested in treatment.

Another psychologist commented to one of our chaplains on the lack of time he has available to offer psychotherapeutic services to those clients who have clear psychological and social influences that affect or typify their illness. He feels that psychotherapeutic services are not offered and that these skills are being lost to the system.

Several staff who work as part of community teams commented to our chaplains that their workload for the supported accommodation teams is so heavy (100 to 150 clients) that they can do nothing more than attend to the medical and/or pharmaceutical aspects of mental health. The focus seems to be on quantity rather than quality. Staff are burning out and are dissatisfied. There needs to be an appropriate limited client load allocated, so that quality care and sustained service can be provided.

It is increasingly difficult for workers to offer patients the time and the support that they need to come to terms with the mental illness, or to understand many of the underlying issues that are associated with their illness. Indeed, there seems to be guilt hanging over many health practitioners because they are unable to offer a service that truly does care and offer clients viable options to learn to live with and to understand their mental illness. The problem of care is not as much a problem of the staff who work with the mentally ill, but of a system that continues to reduce its resources to such an extent that staff simply cannot offer the fullness of their skills and the care that they have to give.

Some acute wards have to deal with highly aggressive young people who present with psychotic symptoms after drug taking. The management of these patients is difficult and at times dangerous for staff. The shortage of experienced qualified staff and legal requirements to have qualified staff to administer medications has led some acute admission wards to call on security guards to help 'contain' the ward. The guards are at times inexperienced and not specifically trained in the procedures required to secure violent mental health patients.

Inquiry reference G:

Availability and mix of mental health services

Availability of beds in hospitals

A limited number of beds in the acute wards of hospitals leaves many patients, who need hospitalisation, in the community supported by a crisis team. The community becomes aware of these mentally ill people because their symptoms are more visible and for increasingly longer periods, since there is not enough beds. This adds further pressure to the crisis team, who then have to respond to alarmed neighbours who phone for help and wonder why these people are not being treated. The community-based service is becoming increasingly reactive rather than proactive in the community.

Often the shortage of acute beds means that patients are prioritised so that those with the greatest need get vacant beds first: the other patients must wait. Some workers try and bypass the queue and succeed in getting their patient admitted into an acute ward ahead of others. However, this means that another patient who might have been assessed as in greater need will have to wait even longer, until a bed is available. This also demoralises acute team staff.

The pressure on beds places medical staff under great pressure to discharge patients as soon as possible.

Geographic spread

The spread of mental health services is variable across the state.

There is no in-patient facility for the entire Central Coast.

There is no after-hours mental health crisis team in the Macarthur region. When UnitingCare Burnside tries to get assistance for someone after hours who is at risk of harming themselves or others, mental health services tell them to get the person to voluntarily present themselves. This is not a viable option in most cases. This has also been said in business hours.

Often the mental health crisis team refuses to respond ('they need the client to contact them'; 'there isn't enough staff') and the police have to be called. The police often make the situation more difficult simply because of what they represent. Burnside staff have been involved in two instances where a person feeling suicidal was hauled into a hospital emergency department in the back of a paddy wagon.

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. This might be because they are geographically isolated, reluctant to use formal mental health services, or they wish to retain their anonymity.

Lifeline Mid Coast receives 5,500 telephone counselling calls and provides 1,000 face to face counselling sessions each year. Of these, approximately thirty per cent (30%) are mental health callers or clients. The number does not vary between telephone and face-to-face counselling.

The high incidence of mental health callers/clients reflects the reality that the lower mid-north coast region has the second highest population ratio of mental health needs in New South Wales, second only to the Liverpool area. Lifeline Mid Coast covers the region from Nambucca Heads south to Bulahdelah and west to a line running north from Gloucester. Telephone counselling rooms operate in Port Macquarie, Taree, and Kempsey. Face-to-face counselling is provided in Port Macquarie and Taree. These services are all offered at no cost to the caller or client. The providers are trained volunteers, with Lifeline providing the necessary infrastructure, supervision, and support.

Twyford Consulting conducted qualitative telephone interviews with 15 Lifeline telephone counsellors during March 2002. All telephone counsellors had more than 5 year's experience. All were based in regional NSW locations. The feedback from these telephone interviews is summarised here.

- Callers with mental health conditions can make up between 10% and 60% of the calls in a shift, depending on the day and time.
- More callers with mental health conditions are experienced on weekend and overnight shifts. These are times when other support services are not available. Between a third and a half of all calls on these shifts are typically from callers with mental health conditions.
- Callers' mental health conditions often include schizophrenia, bi-polar, anxiety and depression. Most callers are acute sufferers of mental illness; that is, they have experienced hospitalisation or are under a medication or treatment program.
- Most callers with mental health conditions will disclose, during a call to Lifeline, that they are experiencing a particular mental illness or undergoing treatment. Callers know their condition – they will readily adopt the label of 'bi polar', schizophrenic, etc.
- Most telephone counsellors believe that the volume of mental health calls has increased. In some circumstances, this appears to be related to the withdrawal of or changes made to mental health services, especially the availability of mental health crisis teams.
- Callers with acute mental health conditions often phone Lifeline repeatedly. Some callers can phone several times during a 4-hour shift – one telephone counsellor experienced the same caller phoning 8 times during a shift.
- Many callers with mental health conditions feel alienated from the community and very lonely. They therefore have high support needs, regardless of the nature of their mental illness. There is still an issue of stigmatisation of people with mental illness.
- Telephone counsellors find it very difficult to 'move things forward' with acute mental health callers. Often, counsellors feel frustrated at not being able to make a helpful impact on the caller's situation.
- Traditional counselling techniques are not effective for callers where mental health conditions are applicable. Telephone counsellors believe that they need training and guidance in alternative techniques.
- Telephone counsellors would like means through which they can debrief after difficult calls where mental health conditions have been a factor.
- Some telephone counsellors are becoming so frustrated about the volume of callers with mental health conditions that they are resigning, or considering resigning. An important motivation for being a Lifeline telephone counsellor is the ability to help others, that is, to make a difference for people in need of help. Unless alternative strategies and techniques are adopted for callers with mental health condition, the morale of telephone counsellors will be adversely affected.

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 hereditary 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.

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.

Use of mental health services for people with alcohol abuse issues

NSW magistrates have been using the Inebriates Act 1912 to commit chronic alcoholics to psychiatric institutions for up to twelve months. For example, a UnitingCare chaplain reports three patients who have been committed to a hospital within Northern Sydney Area Health within the last two years.

This legal practice is inappropriate.

Firstly, mental health facilities are meant to treat and rehabilitate people who are suffering from mental illness. It is necessary and appropriate to constrain some patients within secure wards to ensure their own safety and the safety of the community for the duration of their mental illness. As soon as a person begins recovery, they are given freedoms. The imprisonment of a person under the Inebriates Act, with no reference to a discernable mental illness, means that the mental health facilities are being used for imprisonment rather than rehabilitation. People with no presenting signs of mental illness are forced to live in hospital wards until their committal is complete.

Secondly, mental health facilities are staffed and programmed to treat people with mental illness. There are no specific programs or specialized staff to deal with the issues surrounding alcoholism in those facilities.

Thirdly, the Mental Health Act protects people from being wrongfully committed to mental institution through a detailed process of admission and a legislated limit on the time a person may be treated without consent. The Inebriates Act gives no such protection, and third parties (like relatives) may arrange for a relative to be incarcerated into a mental health facility with no reference to the Mental Health Act. The maximum committal under the Inebriates Act is 12 months, with no provision for review. A UnitingCare chaplain reports of a current (March 2002) patient within the Northern Sydney Area Health who has been given a committal of 6-12 months. However, he has not been given a mechanism to have his committal reviewed after 6 months. His family has threatened to sue the hospital if he is released before the end of his 12-month committal. Clearly, the Inebriates Act is open to abuse of human rights that is purposely denied by the Mental Health Act.

Fourthly, alcoholics suffering withdrawal can be violent, demanding and difficult to manage. Staff struggle to contain such people on wards where management is specifically designed for aggressive mentally ill people, whose impulses are often the results of their illness, not from withdrawal. Ward rules are often inappropriate for the management of an alcoholic person. An alcoholic person in a mental health ward can unduly stress staff and other patients.

One of our chaplains reports the case of an alcoholic man without criminal record or history of violence recovered from a blackout experience after an alcoholic binge. He had been admitted into an intensive care ward of a general hospital and many thought that he would die because of the poisonous substances he had taken while in an alcoholic blackout. While still recovering, his brother and sister accompanied by an officer of the police brought him before a magistrate who then committed him to '6 to 12 months' at a psychiatric institution. The patient was admitted to a Mental Health Rehabilitation Hospital.

He was a model patient. As the ward staff began to trust him, he was given permission to have leave within the grounds of the hospital and into the community. On one of these excursions into the community, the patient found that one of his friends had died a couple of weeks earlier. He consumed alcohol and, when discovered, was brought back to Macquarie Hospital. This time, however the patient was placed in the secure ward reserved for people with drug-induced psychosis and associated violence, and for mentally ill people who could be harmful to others or themselves.

The patient's siblings, his brother and sister, threatened to sue the hospital if they released him into the community again. Yet, the patient showed no signs of mental illness whatsoever. Indeed, after this incident he sought support from chaplaincy and began to speak about spiritual matters, and work towards reorganising his life so that he could begin anew on his

release into the community. Again, he was a model patient, very cooperative with staff and eager to get on with his life.

Because of the legal threat and the ambiguity between the Inebriates Act and the Mental Health Act highlighted by threat of being sued, staff refused to give this patient any more leave. Consequently, the patient could not go to Alcoholics Anonymous, or embark on retraining or even visit an alcohol and drug counsellor in the community. The patient could only sit and wait for the legal situation to be clarified. He could complete his committal before the legal ambiguities are resolved. It was at this point that the patient began to feel frustration.

This case study exemplifies the problems that exist in the system when magistrates apply the Inebriates Act to place patients into the mental health system.

- While the concept of containment, forcibly preventing a person from accessing alcohol, can be beneficial, it also can be detrimental because it prevents the patient from accessing the services that they might need in order to put in place realistic support structures.
- A mental health hospital usually does not have the staff that specialise in drug and alcohol issues. The patient is not formally offered ways to deal with underlying issues that might contribute to their alcohol abuse.
- The model that is necessary to work with such clients is often at odds with the methods and principles used in rehabilitating mentally ill patients.
- The systems that operate within the mental health system are paralysed as they seek to work through the enormous problems in when two Acts intersect with each other. In this case, the fear of being sued over-rides the patient services and patient care.

Clearly, the Inebriates Act needs to be amended to reflect the principles of the Mental Health Act. It should not be used to place alcoholics into mental institutions. It needs to be amended to avoid the potential of a client's family or indeed business partner using it in an inappropriate and or illegal way. Secondly, the expectations of the Act need to reflect the expectations of the Mental Health Act and have built-in protections for those people committed under the Act. Without this, the Acts are at odds with each other, rather than complimenting each other and providing a way to deal with the difficult problem of alcoholism and the real but different issues surrounding mental illness.

Issues for people with personality disorders

People with personality disorders are not treated systemically. Since they continually return to acute wards, staff resent them and they become more difficult to manage as their needs are not met. There is a need for a specialty personality disorder unit with the resources to deal with underlying issues in these people's lives. In other comparable countries, these people are treated outside the acute mental health system in specialized programs. Church chaplains

report seeing patients who are labelled as 'PD' who present as victims of sexual abuse, but are only treated for their presenting symptoms. They report that one woman presented with disclosures of sexual abuse as a child and young woman. Health care workers stabilized her suicidal ideation and then discharged her. She kept returning. She was referred to the Sexual Assault Unit, which is so stretched that it can only deal with current cases of sexual abuse. The system creates a 'PD' whose behaviour continues to deteriorate, as she learns new ways to get negative attention.

Mental health services will often say an issue for a client is behavioural, not a mental health concern. In March 2002 a young woman who was 19 showing suicidal high risk and self-harming behaviour presented to Burnside in the Macarthur region. Yet the criteria for gaining any mental health service in that area was so difficult to meet that it was difficult for Burnside to refer any of its clients.

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. For example, there was a backlog of about 20 patients waiting for a bed in rehabilitation at Macquarie Hospital (as at March 2002). 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'.

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. Alcohol and other drug usage (particularly prolonged usage) can be the catalyst for serious psychosis and suicide ideation, even with marihuana smoking. It is ludicrous that there is a difficulty in gaining access to services. This is an ongoing concern for all services in Macarthur, which, given the region has no after-hours mental health crisis team, is exacerbated considerably.

Accommodating people with psychiatric disorders in residential aged care facilities

There is a lack of mental health services available to older people in residential care in some parts of the state.

In one of our aged care residential facilities in western Sydney, nursing staff have been trying to move a resident out of the facility for 18 months(to date) without success. The resident is aggressive and has assaulted staff. Trials of various antidepressants, sedatives, and anticonvulsants have not been successful in controlling her behavior. It was not until March 2002, that a specialist geriatrician documented his clinical opinion that the resident was in need of a placement permanently in a psychogeriatric unit: this opinion has assisted the facility to arrange a transfer, but it is still waiting for a vacancy. During its attempts to deal with this resident the facility found the Area Health Service less than fully cooperative.

Homelessness

Another common issue is homelessness. It is difficult for people who are regularly institutionalised and/or living with a mental illness to maintain housing. UnitingCare Burnside services have worked with people who come out of the local psychiatric unit (such as Waratah House in the Macarthur region) to inappropriate housing or no housing at all.

The Hope Hostel operated by Parramatta Mission is a generic facility for homeless men under the Supported Accommodation Assistance Program (SAAP). At any one time 20% of its 36 residents could have mental health issues. The hostel deploys one worker on duty and one worker on sleepover, each night. The Mission describes the situation as 'an occupational health and safety time bomb'. Generic homeless men's facilities are the wrong place for people with psychiatric disabilities who are chronically homeless. There needs to be a number (say 3) of special facilities with no more than 6 beds each for those people.

People with mental illness living boarding houses

UnitingCare's Supported Living Active Linking Project offers support to people with mental illness living in government-licensed boarding houses in inner-western Sydney. The goals of the project to link people with the community are limited by a number of factors, however.

Those are:

- a replication of institutionalized life;
- replacement of 'government' control by 'private' control;
- inadequate health promotion;
- lack of community education.

While the residents of those boarding houses are not living in mental hospitals, they still largely have an institutionalized life. They lack privacy, because they might share rooms with from 1 to 6 other people. They might have to move rooms when/if a reshuffle occurs after any resident changes, either through exit or intake of new residents. The development of a range of subsidized housing models (Sach and Associates 1991; Milne, De Mellow and Collis 1995) would benefit the individual from a point of view of privacy, development of living skills and taking responsibility, through to the availability of flow-through models of residential support with varying degrees of support. Support ratios are poor in those government-licensed boarding houses in inner-western Sydney. With different housing models, with appropriate support, service users would be better supported to develop skills, self-management, and self-esteem.

The New South Wales government does not have a program similar to the South Australian Special Needs Housing Unit or the Victorian Rooming Housing Program. In South Australia the Housing Trust, through a Special Needs Housing Unit, manages 9 boarding houses for people who are homeless, transient or who have a housing disadvantage. Services provided to the tenants range from room only to furnishings with full board. Nonprofit nongovernment landlords or individuals lease houses from the Trust under a headleasing arrangement. Lessees must operate and manage the boarding house in accordance with guidelines and conditions specified by the Trust. Trust boarding houses are subject to state residential tenancy law. In Victoria, the government has a Rooming Housing Program that provides long-term, unsupported accommodation for singles and childless couples, generally in a shared environment. Nonprofit nongovernment landlords manage these rooming houses. The aims of the program include provision of low-rent, secure, and appropriately-designed accommodation that is suitable and responsive to the needs of a diverse range of consumers, including those with disabilities. There are 88 rooming houses providing 1,323 housing situations, managed by 27 nongovernment landlords.

'State' control has been replaced by 'private' control. Private landlords who own and manage the government-licensed boarding houses have control over access to the kitchen; meals are rigid and there is limited consumer choice over diet. In many cases money is still directed from the Protective Commissioner's office to the boarding house managers for 'comfort needs'. Many residents do not understand how to access their money, and the individual has not been given an opportunity to develop skills in handling money, for example, opening a bank account and budgeting and making choices about what they want to do with what little money is available.

There is no effective case work model to coordinate health care or interventions and follow up. Residents in boarding houses can fall through gaps and might not get referred or might not get treatment which would be expected generally in society. The boarding house manager

might not have a medical background. Alternatively, some residents with a long-term psychiatric disability are living in boarding houses and have not had any episodes, and their mental illness is contained. These people are well capable of learning new skills and would benefit from being supported in a better-funded housing model to renew links with community.

The Boarding House Team of Central Sydney Area Health Service is primarily a project team initiating specific projects, for example, dental and podiatry or physiotherapy projects, and can support people with accessing medical needs. The Boarding House Team has recently been downsized. This raises a question of whether more funding will be directed to community mental health to take up some of the role, either as outreach or to support residents to access services already existing in the community.

Currently it appears that service users and boarding house managers use community mental health crisis teams in crisis intervention situations and in follow up post-hospitalisation. Development of a mental health promotion unit to include education and strategies for relapse prevention would empower residents to participate in maintaining mental health.

People with mental illness living in boarding houses are victims of social exclusion. To a large degree they live outside of society and its potential opportunities, even though their housing is 'in the community'. Community perception of people with mental illness, poverty, and the social implications of difference are huge barriers to linking people with mental illness with the wider community. Community education to dispel myths and fears would enhance the possibility for opportunities for people with mental illness to have a voice, to join groups in civil society, and to develop meaningful friendships, and have a valid social role.

Services to families of people with mental health issues

There is a lack of back-up services/support for women with mental illness. An intensive family support service provided by UnitingCare Burnside in western Sydney has a female client who blacks out. She is occasionally hospitalized and Burnside attempts to arrange support for her children. But there is a huge shortage in terms of short-term foster care and other back-up services. The local mental health service will not help with these sorts of issues.

Services like Lifeline often have to fill the gap where mainstream mental health services will not respond. Box 2 gives an example of a client of Macarthur Lifeline.

Box 2: Case of person with depression, suicide ideation and self-mutilation

Louise (not the person's real name) was 16. She was self-mutilating, communicated very little with anyone, suffered depression and developed suicidal ideation. She cut her knees and arms and inscribed onto them the words 'death Louise'. She isolated herself in her room at home, hours on end, lying on her bed, looking at the ceiling and listening to music. She had been seeing her own doctor and was referred to a private psychiatrist, whom she saw once, but refused further consultations.

Louise's school counsellor phoned Lifeline to seek assistance with Louise. The school counsellor had been working with Louise for 18 months. Lifeline subsequently contacted Louise's mother for discussion. The mother felt powerless, confused and concerned. It became obvious to Lifeline counsellors that Louise's parents did not know how to cope with their daughter's predicament and were either now denying it or considered they had done enough and could not help her further.

The school counsellor and Louise's mother agreed for Louise to be offered a Lifeline 'Buddy', an experienced telephone counsellor with advanced training in suicide prevention and who supports the client through a period of suicidal ideation. The Buddy is available by phone to the client any time, 24 hours. Lifeline spoke with Louise who said she would consider the Buddy offer. Some days later, Louise contacted Lifeline very distressed. She received immediate telephone counselling and was appointed a Buddy, a young (23 years) experienced female Lifeline worker.

Notwithstanding the support that Louise was receiving from different carers, she continued with bouts of depression, suicide ideation and self-mutilation. She was suspended from school because of her continual self-mutilation, which was emotionally affecting her school peers.

A meeting was held between Lifeline, Louise, her parents and her two siblings. The purpose of the meeting was to try to encourage dialogue between the family members.

On one occasion Louise attended the local mental health service for assessment. That service advised that Louise was perhaps suffering a borderline personality disorder and should seek private specialist consultation. The mental health service was not interested in seeing Louise again, despite approaches by Lifeline to the service and discussion with the service's psychiatrist. One comment made by that psychiatrist to Lifeline's General Manager of Counselling was that the service was too busy to have to deal with Louise.

Louise had been taken to hospital by ambulance on two occasions, once for an overdose and the other for self-mutilation. On the latter occasion, although both parents were in the house at the time of the event, they did not offer to assist Louise. Louise phoned for her Buddy. When it became known what had happened, Lifeline phoned for an ambulance. No family member accompanied Louise to the hospital. Two Lifeline counsellors met Louise on her arrival at the hospital (at about 10.00 pm) and stayed with her until the following day when they returned Louise to her home. Louise received stitches to her arm that she had badly cut with a razor blade.

This night appeared to be a turning point for Louise. She became more accepting of help and began to communicate with her carers and with her mother. She completed her schooling over the next year and a half and in that same period did not have occasions of self-mutilation.

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 proactively assist people whom they deem not to be at risk. 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.

The NSW Government has 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. They include the Premier's Department Regional Coordination Program, the *Rural Social Justice Statement* of 1999, the *Staying in Town* policy of 2000, the Families First program, Community Drug Action Teams, and the *Better Futures* Action Framework for Vulnerable Young People. The same broad and partnership-based approaches need to be developed and applied in mental health services.

Reynolds, Inglis and O'Brien (2001) point to the success of 'generic models that cater to multiple needs groups'. This requires the development of strategies to enhance the ability of generic services to effectively support people with a mental illness.

It is clear that many of the most effective interventions follow from a collaborative approach in which nonprofit 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 north 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.

In a 1995 report prepared for our Balmain Mission (Milne, De Mellow and Collis), the authors said that, 'Ideological splits and financial slits riddle the mental health safety net.' We are hoping that this Inquiry presents an opportunity to move beyond problems, to pathways for solutions.

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