Submission:

To

Senate Select Committee

On

Mental Health

From

Mental Healthcare Chaplaincy

Under the Auspices of

Healthcare Chaplaincy Council of Victoria Inc.

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Mental Healthcare Chaplaincy (MHC) is an ecumenical body auspiced by the member churches of Healthcare Chaplaincy Council of Victoria Incorporated (HCCVI). MHC is committed to provide quality leadership, consultation and education in the strategic development and promotion of spirituality, chaplaincy and pastoral care in Victorian Mental Healthcare services, while also offering direct service delivery to clients with more complex needs. MHC represents differing faith traditions and is committed to working in an interchurch, multi-faith and multi-cultural context. MHC is committed to being pro-active agents of change towards excellence of care for people living with mental illness – through education, research, consultancy, advocacy and direct service delivery.

Our philosophy is grounded in the belief in the intrinsic worth and dignity of the person, respect for their autonomy and sensitivity to their vulnerability and need. MHC seeks to be responsive to the spiritual, religious and pastoral needs of people living with a mental illness, their families, carers, faith communities and mental healthcare workers. MHC recognises the value of community in relationship to the person and seeks to move within the complexity of relationships, responding sensitively to both community (family, friends, carers and professionals) and individual needs.

At the heart of being human is a spiritual experience, which may be challenged or dislocated in the face of mental illness. The value of chaplaincy/pastoral care, therefore, is the recognition of this dimension in order that people can be supported in their search for meaning, purpose, faith and hope, and be enabled to recognize the wholeness of life within mental illness. It is the task of those who work in the area of spiritual care to help people find, interpret and express the meaning of the picture of the life that they see, to find their own meaning, purpose, strength and hope in life.

The National Mental Health Strategy estimates that more than 20% of the adult population will be affected by mental healthy problems/illness in their lifetime. Of that number approximately one third will fully recover while two thirds will live with some degree of mental ill health, varying from mild to severe impact on the quality of the person's life. In recent years significant research literature, especially from Britain and North America, has reported that religious and spiritual support is associated with desirable mental health outcomes. It is clear from this literature and indeed the experience of those working in MHC, that spiritual, religious and other personal issues must be addressed if recovery from illness and its accompanying limitations is to be fully facilitated. There is a clear role for Chaplains and Pastoral Care Workers in a "comprehensive, multi-disciplinary, multi-faceted services." Chaplaincy/pastoral care offers a complimentary modality to other healthcare professions.

This is clearly expressed in the following statements;

The Mental Health Act 1986,as amended in 2002 Objectives of the Department, Section 7 (a) (ii):
"To establish, develop, promote, assist and encourage mental health services which...take into account the age-related, gender-related, religious, cultural and language and other specific needs of people with a mental disorder…"

The Australian Health Ministers' Mental Health Statement of Rights and Responsibilities (1991 as revised 1995) states that;
"In providing services, service providers have a responsibility to...be responsive to the diverse social, cultural, spiritual, emotional and physical experiences and needs of consumers, carers and advocates..." (p.21)

Prior to deinstitutionalization 11 chaplains/pastoral care workers were employed by DHS Victoria to provide pastoral care and support to patients in hospital settings and continuing care in the transition period from hospital to community, and for some providing longer term pastoral support in the community. MHC is the service that has emerged from the deinstitutionalization process, and DHS provides $90,000 per annum in funding for this service. While acknowledging and appreciative of DHS's support in this area it is definitely a service that is under funded.

At present MHC offers limited support to Victorian Hospital in providing a consultancy service for general hospital chaplains/pastoral care workers who may receive referrals from the psych words and also supervising chaplain inters and pastoral counselling students in field placements. Often a period of hospitalization is a crises time for all

concerned. There is little provision for regular religious, spiritual or pastoral care for patients or their relatives and friends at such a crisis time. According to the Mental Health Act and the Ministers' Statement, as cited above, patients have the right to have their religious and spiritual needs address as an integral part of their care and treatment. This is an area that MHC believes the National Mental Health Strategy needs to take into consideration in order to provide a service that ensure the rights of people living with a mental illness and also reduce the impact of mental illness on the person, family and the wider community.

MHC is the only organisation within Australia that is offering a specific education programme in the area of Spirituality and Mental Health. In 2004 we had representatives from every State, except the Northern Territory attend our National Conference. In April this year the 2 people involved in the education programme presented a workshop at the Australian Health and Welfare Chaplains Association Conference in Fremantle, W.A., of the100 people attending the conference 75% attended this workshop. Nation wide there is considerable need, interest and demand for specialised training in this area.

The focus of MHC's is to provide consultation and education to ministers, lay, professed or ordained, theological and university students, staff, carers, consumers and family, volunteers and those wanting to know more about the religious and spiritual issues within mental illness, while also offering direct service delivery to people living with a mental illness in the community.

Education programme we offer

- Intensive week programme
- Invited by Mental Illness fellowship to run another intensive programme in a rural area.
- Annual National Conference on Spirituality and Mental Health
- Mental Health and Spirituality as a subject in Pastoral Studies Certificate Course
- Network group for chaplains/pastoral care workers employed by their church community to provide pastoral care and support in community settings
- Consultation to faith communities, community organizations, family members and carers around the spiritual, religious and pastoral needs of people living with a mental illness.
- Responding to requests from community based agencies, government and non-government, for seminars and workshops
- Supervision of Clinical Pastoral Education students, tertiary students on field placement and workers in the field.
- Promotion of mental health issues by bringing the needs of those living with mental illness to the awareness of faith communities and other community organizations.

  Consistent with the current psychiatric services providing care within the community, it is important that spiritual and religious resources also be established in the community. These resources, which are currently very limited, need to be developed further through education and liaison with community groups.

<u>Areas to be considered for increased focus and funding</u>:

- Expansion of training programmes focussed on education and promotion of mental health issues.
- Training in Spiritual risk assessment related to mental health issues
- Further research into the relationship between the provision of spiritual and pastoral care and the reduction in relapse and readmission amongst people with a mental illness; and an exploration of the possible relationship between psychosis and unattended spiritual needs.
- Strengthening of networks to improve quality of care and continuity of care between inpatient and community services.
- Implementation and evaluation of a new initiative to provide a mental health chaplaincy consultant covering all metropolitan hospitals.

- Funding for new initiatives in the provision of spiritual and pastoral care, which promote the principles identified in the National Mental Health Strategy (2003-2008) and strengthen collaborations between metropolitan and rural service providers.
- Delivery of training programs and consultancy to rural mental health services.
- Development of infrastructure to ensure good governance

Senate Select Committee on Mental Health

In response to The Senate Select Committee's (SSC) invitation and on behalf off MHC I will reflect on several of areas of your inquiry. In reflecting on them I will endeavour to do so in light of the aims of the National Mental Health Policy (NMHP).

- Promote the mental health of the Australian community;
- To, where possible, prevent the development of mental disorder;
- Reduce the impact of mental disorders on individuals, families and the community; and
- Assure the rights of people with mental illness

a. *The extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress*;

b. The adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;

- Prevention, early intervention and acute care are totally interrelated areas of care. From my experience early intervention is extremely limited due to lack of funding and resources as well as family members having little awareness of signs of mental health struggles or problems in their family member. Surely early intervention is critical to the life potential of the person living with mental illness. There is a huge need in this area of increased education and support for individuals and family members. Education needs to be more than about facts and medical statistics, it need to offer the possibility of change and hold the person in the fullness of who they are. This form of education holds the potential to reduce the impact of mental disorders on individuals, families and the community.

  In the State of Victoria there is a constant shortage of beds in acute inpatients facilities and as the length of stay is extremely short symptoms only are treated with medication. There is no systematic attempted to work with individuals in a therapeutic manner that enables the person to live well in the presence or absence of mental illness. While fully endorsing the benefits of community care there is a chronic shortage of appropriate community care in an environment that enables the person to have a sense of belonging, meaning and purpose in their life.

  The CATT and the police are the only services that attend after hour's crisis situations. The philosophy behind the establishment of CATT is good whereas the reality is fair at best. There have been times when CATT have take considerable periods of time to respond to a crisis, this may be partially due to lack of personnel, however in the interim the crisis situation escalates. CATT clinicians' face difficult tasks and need to be trained in the area of crisis management. The policy and practice of CATT in attending people living with mental illness needs to be reviewed and new policies established that outline the scope and function of the teams.

c. Opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;

d. The appropriate role of the private and non-government sectors;

e. The extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;

The environment and our living conditions, supportive relationships and meaning and purpose in life are all factors that contributed to better mental health for all peoples. Sadly for many people living with mental illness many of these basics of life are denied them proving to be a significant barrier to better mental health outcomes.

Affordable accommodation in general is a huge area of unmet need for people living with mental illness. Many live in a single room in a run down boarding house in inner city areas where the majority of residents are living with mental health problems. I regularly visit one accommodation and I feel as though I have stepped back into a ward in the hospital that has long since been closed. In many cases I believe that deinstitutionalisation has done little more than move the ward from a hospital setting to a boarding house, where management and staff have no understanding of mental illness. Community Care Units (CCU) that have been established in Victoria are an excellent example of supported accommodation. However this accommodation is not permanent, individuals have to move on and the length of stay is becoming increasingly shorter - then they often move into a boarding house.

Recently an elderly couple related to me their distress at having to place their child, who is under 50, in a nursing home. In the past 6 years since the closure of the hospital their child had lived in 3 residential units and had done well. However after a period of time had to move on. Surely this constant movement from one residential unit to another must be counter productive for better mental health outcomes. People living with a mental illness have the right to better living conditions than this. The government needs to take seriously the need for permanent affordable supportive accommodation for people living with long-term mental illness.

f. The special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;

Children, adolescents and the aged are venerable groups within our society, who often do not have an audible voice and as such their basic human rights are often neglected. Carers in these areas need specific training to be able to hear and understand the specific needs of these diverse populations.

Many people living with mental illness have complex needs whether there is a dual diagnosis or not. Drug and alcohol dependency is an issue in our society generally, not confined to people living with mental illness. The issue here is how the person living with a mental illness is viewed once it is known that they are also dependant on drugs/alcohol. From a clinical perspective often the person is split into the person living with a mental illness and the person who is drug dependant and both issues are dealt with separately and at times by different services, and at times the needs of the person fall somewhere between both services. A greater integrated approach within services is needed that first sees the person as a person and then who treats the person as a whole.

g. The role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness;

In many cases the primary carer is a family member who has had this role thrust upon then, with very little understanding or support from the community or indeed mental health clinicians.

There needs to be better structures in place for carers to be referred to support groups, agencies etc. as well as training.

h. The role of primary health care in promotion, prevention, early detection and chronic care management;

i. Opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated;

Promoting recovery focused care is vital and must include consumer involvement as experts who know what they need for the process of recovery. Recovery is about reclaiming a positive life and interestingly consumers have a growing interest in the role of spirituality in their own recovery process. There is a need to gain increase understanding and awareness of the intersection between the spiritual path and the recovery journey.

That government take seriously the need for education in this area of mental health workers.

j. The overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people;

This area is a major concern for all. At times I believe that the justice system has become a defacto institution for people with mental illness, and as such does not serve the human rights of the individual nor the system. This environment is not conducive to good mental health. The Victorian Institute of Forensic Mental Health provides inpatient and community services to mentally ill offenders in Victoria. Thomas Embling is an excellent facility for mentally ill offenders.

That policy and procedure be established to protect the human rights of people with a mental illness to ensure that they receive appropriate treatment and care.

k. The practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion;

l. The adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers;

Recently, a mature aged student did a field placement with us in pastoral counselling. This also involved supervision and taking part in our education process. Her greatest area of learning during this period was an increase in her self-knowledge and change in attitude. She commented on the huge change in herself and when asked to say what that was, she replied:
"Well when I first came her I saw people with a diagnosis, no to be honest I saw I diagnosis who happened to have a person along with it, whereas now I see the person who has perhaps a wounded/ broken heart."

This is a tremendous sift in her perception of mental illness. Much of the education provided in the community is very clinical and addresses facts or introduces slogans, this approach does little to de-stigmatise mental illness in our society.

m. The proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness;

n. The current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated;

At present the current mental health research and funding is directed towards a very medical model understanding of mental illness. I affirm this as a positive movement while also believing that this area of research is only one part of the picture of the whole person, as body, mind and spirit. There is a growing body of evidence that suggests that spirituality plays a significant role in the lives of people experiencing psychiatric problems. (Appendix 3) Given the types of empirical evidence available one might assume that spirituality and the development of effective strategies for spiritual and religious care would be a priority in the care of people living with a mental illness. However, it is apparent that in our present system this is no longer the case, and one could say that spiritual and religious care is the neglected area in wholistic mental health care.

Spiritual, religious and other personal issues must be addressed if recovery from illness and its accompanying limitations is to be fully facilitated and in the provision of a "comprehensive, multi-disciplinary, multi-faceted services."

It is evident that there is a need for further research into the relationship between the provision of spiritual and pastoral care and the reduction in relapse and readmission amongst people with a mental illness and an exploration of the possible relationship between psychosis and unattended spiritual needs.

o. The adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health opportunities to link funding with compliance with national standards; and services at all levels of government and

p. The potential for new modes of delivery of mental health care, including e-technology