Fairfield City
Celebrating diversity

Office of the Mayor
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The Committee Secretary
Senate Select Committee on Mental Health
Department of the Senate
Parliament House
CANBERRA ACT 2600

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on Mental Health

To the Committee Members

This submission has been developed in consultation with the community of the Fairfield Local Government Area. It is not an exhaustive submission and does not address all of the Terms of Reference for the Senate Select Committee.

With a population of 181,900 residents in 2001, Fairfield City was the third most populated Local Government Area (LGA) in the Sydney Statistical Division. More than half (52.2%) of Fairfield's residents were born overseas and nearly all of these (95%) are from a Non English Speaking Country. Fairfield (and Auburn) LGA had the highest proportion of overseas born residents of any LGA in Australia. Fairfield is the LGA with the highest number and proportion (66%) of language-other-than-English speakers, and has the highest number and proportion of residents who do not speak English well or at all.

Fairfield City Council's Management Plan 2004-2007 incorporates the health and wellbeing philosophy in its vision statement and in each of the key focus areas for Council's work. This document will guide Councils work for the three years and indicates there is a commitment to developing initiatives that focus on the health of our residents.

Our initiatives have focussed on resident wellbeing, with a specific focus on mental health. Council convene the Fairfield Mental Health Network, and are actively involved in various partnership initiatives that promote the message of good mental health for local residents. As a result, we are in a position to seek feedback from local residents and services, about their experiences of Mental Health Services.

Given our limited time frame, Fairfield City Council held a public forum, and utilised local radio station 2GLF and local press to inform the community that the Senate Select Committee was calling for submissions. We also assisted several residents to

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write their own submissions. This submission is a culmination of that process and the information given by our local community.

This submission is presented in six key areas, focussing on issues and some recommendations for change:

1. Issues related to Case Management
2. Role of the Case Manager
3. Role of Families and Carers
4. Health and Hospital Services
5. Support Services
6. Other Issues

The information has been presented in point form, to allow for ease of reading. The information presented is by no means exhaustive, as our consultation process did not allow for that. However, the information represents the issues deemed pertinent by those who could participate at that point in time.

1. Issues related to Case Management:

Generally, the comments received from our community indicate that the current model for case management services is poor. Inadequate resource levels appear to be a critical factor in this regard. The following point form summary indicates all the issues identified in Fairfield City Councils consultation process:

- Service is poor because too many clients are allocated to a case manager, hence the case manager does not have the capacity to provide quality care.
- Cases are often documented, but there is no real follow up, support is not provided once client is released from hospital.
- Sick clients are making decisions when they don't have the capacity to make decisions about anything, particularly in times of crisis.
- When clients fail to attend an appointment, or refuse to open the door when worker visits them, the case is then closed.
- At present, many case managers are not aware of available services and thus cannot make appropriate referrals. This is particularly relevant to CALD communities.
- At present, families have no role at all in the treatment process, particularly in relation to medical requirements.
- There appears to be support agencies in existence but they usually refer clients elsewhere, and inevitably clients don't get a service of any sort. People do not meet the strict eligibility criteria
- There is a critical gap in service once a client leave hospital. Lots of cases get lost and are not actioned, due to lack of resources for staff. Clients then have to fend for themselves, relapse, and inevitably find themselves readmitted into hospital. This "revolving door" approach creates undue hardship for the client, their families/carers, (and others such as neighbours, and other service providers) and is an ongoing cost burden to the health system.
- Issue with the number of available hospital beds, simply aren't enough. People need to be readily admitted when they need the service, not have stringent "tick

a box" criteria that forces health professionals to release people into the community without adequate treatment.
- Clients are often unaware of available services, or the importance of taking medication. Many deny they have a problem and will deceive to avoid taking medication. Post release support is critical in this area. It also raises ethical issues when health professionals are relying on the statements given by unwell clients to determine their health status.
- Discharge plans need to be more holistic and appropriate to each individual case and family
- It takes too long to see doctors and access services. Doctors assessments re poor, they adopt practices of viewing a client, perceiving them to look OK and then sending clients away.
- Clients need access to doctors quickly; they shouldn't be waiting in Emergency Units for eight hours.
- People need to understand there is no quick fix, and the limited role of the doctor
- CTO's don't necessarily work, there isn't enough monitoring being undertaken.

Recommendations for Change:

- *Case managers need to have specific responsibilities, with a realistic workload and adequate resources to carry out the task.*
- *Service needs to be restructured to allow case managers the time to provide a meaningful service to clients*
- *A greater focus on long term support and monitoring*
- *Greater levels of communication and consultation with carers and families.*
- *More funding for the case management model.*
- *Case managers should liaise with medical teams, families, and any other provider working with client (housing, legal etc).*
- *Focus more on support post release from hospital, perhaps this can prevent people from becoming ill and ending up back in hospital.*
- *Review the assessment criteria for admitting people into hospital or general mental health services*
- *Many more available doctors, beds and nurses to treat people upon arrival to hospital.*
- *Discharge plans need to be more holistic and appropriate to each individual case/family.*
- *Specialist post release programs and support for people when they leave hospitals, this could entail help with medications, maintaining tenancies, dealing with government agencies, etc.*
- *Increasing number of programs to raise community awareness, especially in different languages.*
- *Process for monitoring CTO's need to be reviewed, with adequate resources allocated to allow workers to monitor clients in a meaningful way.*

2. Role of Case Manager:

This section identifies the discussion held with our local community, identifying the sort of model of service delivery they feel would be more appropriate and useful to individuals suffering from poor mental health, and their carers and families. The community felt it would be more appropriate to have a model that focussed on holistic care, one that can be tailored to meet the needs of each individual and their family/carers.

A model that could work with the client to address a range of social needs. The primary aim of this model would be to act as a support tool for the client, a preventative tool by allowing the client to live well and minimise the chances of relapse and hospitalisation. This model moves away from the current "revolving door" approach and implements one that focuses on continuity of quality care once the client leaves the hospital.

Recommendations for Change:

- *A more holistic approach*
- *Focus on overall wellbeing of patient and family, not simply rely on medication as the sole response*
- *Case managers need to be aware of discharge plans, along with family members, and work together to minimise the risk of the client relapsing and going back to hospital.*
- *Consider the various social needs of people*
- *Provide links to services, opportunities for employment, training etc.*
- *Dual diagnosis patients need further time and assistance, intensive support structures and services*
- *Service twenty-four hours a day, seven days a week. that is local, with no waiting list time. It is critical to have services available at times of crisis.*
- *The service would need to be well resourced to ensure case managers have the time to work with clients and families.*

3. Role of Families and Carers:

The need for Carers to be actively involved in discussions with health services featured prominently in the consultation process. Local carers felt strongly that the current model of health service delivery does not take into account the crucial role of carers, nor utilise that knowledge and skill for the purpose of delivering appropriate care to the individual who is unwell. The following points identify the key areas of concern for carers and families:

- Families are not recognized or included in the treatment process. Doctors are making decisions whilst relying on information given by the client.
- There needs to be some process in place, for eg an Agreement, signed by the client when they are well, allowing the medical professionals and carers to be equally engaged in decision making processes
- Over reliance on personal freedom and rights of the consumer. We need greater public debate to discuss how to balance the rights of both carers and consumers, and to discuss and determine at what point is intervention granted.
- No recognition of needs of young carers. Existing services are not aimed at them. Further to this, young people often do not have the capacity to seek out services. They are further disadvantaged.

- There are limited training opportunities for carers, specifically on mental health. This would equip them with necessary skills to cope with their caring role. Programs that are currently available are not always accessible, particularly for carers who work, or whose unwell family members are reluctant to stay with strangers.

Recommendations for Change:

- *Service model needs to be adapted to incorporate the knowledge and views of carers/family members.*
- *Carers/families need to be consulted on any proposed treatment plans for clients*
- *Develop a new model for service delivery where an agreement/consent is signed by the client whilst they are well, allowing carers/family to be included in discussions with medical/ health professionals.*
- *A review to be conducted of the rights and responsibilities of clients, particularly when they are unwell, and their capacity to make decisions may be impaired.*
- *Youth specific services for young carers, addressing support, training, raising awareness, assistance to access services etc.*
- *More flexible programs for training of carers. In order to facilitate this, more creative models of respite service to enable carers to attend such training.*

4. Health and Hospital Services:

Discussions with our community indicate that there is a degree of discontent about the way services are delivered to mentally ill people, and also the reliance on waiting lists. There is concern about a model that focuses purely on the rights of the consumer, a person who often is not in a position to be making decisions because of their illness. The community also identified the need to develop and deliver services to Culturally and Linguistically Diverse Communities, in a timely and appropriate manner. This issue is particularly crucial to residents of Fairfield City, as the majority of our population are Non English Speakers. Access to health services for Non English Speakers is a critical and ongoing concern for Fairfield City Council. Our community is concerned at the lack of transparency of budgeting for mental health services, and feel strongly that all government agencies and funding bodies should incorporate mental health into their programs. Mental health is not the sole responsibility of health services. All key public agencies should prioritise mental health highly as an issue and incorporate strategies to address community needs within their programs, this includes direct service delivery and funding programs.

The following points are a summary of the issues raised by our community:

- Concerned about the process of scheduling patients. The current model restricts patient access to hospital, the criteria are very defined, and doctors rely on a brief meeting with the patient to determine if they need treatment. This is totally inappropriate, and often leads to people being released and harming themselves, or others.
- The criteria for accepting patients into hospital needs to broadened, allowing individuals access to appropriate, and safe health care.

- Having a client wait 8 hours in Emergency is unacceptable. Problems with staff shortage and lack of available beds.
- Clients with family/carers are often refused entry to hospital, because the beds are kept for people with few support structures. This is not an equitable model of health care. It creates an unfair burden on carers and means their loved ones essentially are being disadvantaged. Our community feels this is a form of discrimination.
- There are serious issues when a client refuses to acknowledge they have a problem, and are unwilling to accept health care. In this scenario, doctors rely on information given by a resistant client, and inevitably they are released from hospital.
- The system needs to be remodelled, to ensure that clients have advocates, and carers are consulted to ensure all available information is collated by health staff before any decisions on treatment are made.
- The current system places too much focus and rights on the consumer, and nothing on the carer.
- Mental Health Act restricts what health services can do, it needs to be reviewed.
- Expenditure of funds on health services needs to be publicly transparent. It's difficult to see where the money is going. New buildings are wonderful, but the community wants to know how will they be staffed and resourced?
- Our community wants more resources allocated to mental health promotion initiatives, and these should occur on an ongoing basis.
- Need to ensure the systems are in place to attract suitably qualified staff to work with mental health patients, but also to ensure retention of good staff.
- Individuals need timely access to services and information. Waiting lists are highly inappropriate and allow people to go without services in times of need. This inevitably leads to further social and health problems, creating angst for carers, families and the community in general.
- Mental Health services are based on Western models, and need to broaden to provide appropriate and accessible services for people of CALD, who are simply not accustomed to the counsellor model. Training is required to develop new models of service.
- Mainstream mental health services need more culturally specific workers.
- For the few services targeting CALD communities, such as STARTTS, there are lengthy waiting lists. There seems to be a perception amongst mainstream health services that they don't need to be culturally appropriate, as CALD clients can go to STARTTS or Transcultural Mental Health.
- CALD clients and families need access to interpreters. Health services should be willing and able to work with interpreters. CALD communities should not be disadvantaged, or placed in a position to make serious decisions without fully understanding the implications of the information being presented.
- The Federal Government has a limited and narrow view on settlement periods for CALD residents. People are entitled to some services on arrival into the country, however their health needs are usually ignored until other more pressing needs are addressed. We need to review what period of time constitutes a settlement period.
- Young people have difficulty accessing mental health services. They are often dismissed as having behavioural problems, and parents have commented that

health staff blame them for the childs problems. Parents are concerned that they cannot get services for their children.

- Health service should work more closely with schools and school counsellors. Education, prevention and treatment needs to occur at an earlier age.
- Need more community awareness about mental health services.
- Health sector needs to focus much more on prevention.
- All government agencies should target mental health within their existing programs, particularly if their fund other community based services. Mental health is a community problem, not the sole responsibility of NSW Health. Our local services should have funding agreements and organisational plans that allow workers to engage in activities that promote good mental health, to assist clients to seek mental health services, to assist clients to express grievances or complaints with services etc.

Recommendations for Change:

- *Review the process of scheduling clients into hospital*
- *Review the criteria for accepting people into hospital*
- *Increased funding for staff and hospital beds*
- *Doctors to consult with carers/families before making treatment plans or decisions on release from hospital*
- *All clients to be treated equitably, regardless if they have carers or not.*
- *Funding of mental health services needs to be publicly available. The community should be able to see what money is allocated and where it is spent.*
- *Services should be funded adequately to provide appropriate levels of quality care.*
- *More funding allocated to mental health promotion and preventative initiatives. This should apply to a broad range of service providers in the community, not simply mental health services.*
- *Increased recruitment and training of mental health staff*
- *Consult with mental health staff to identify barriers to staff retention and then develop strategies to address those concerns.*
- *Develop a model where clients without carers have advocated to work with them.*
- *Develop a model where clients and their carers can have access to advocates*
- *Review the Mental Health Act and restrictive roles of health staff*
- *Further public discussion about the role and input of carers*
- *Review mental health service model to consider cultural differences of CALD communities*
- *Training/cultural competency of health staff to work appropriately with CALD communities*
- *Further discussion and negotiation with government agencies (State and Federal) to review funding and services available for settlement purposes of newly arrived communities.*
- *Further discussion and negotiation with government agencies (State and Federal) to incorporate mental health into their services and funding programs.*
- *Mechanism to consolidate the work of existing services/programs, to ensure we are not duplicating services, and that limited resources are being used to maximum effect. This mechanism could also look at encouraging other*

agencies in the community to be actively engaged in local initiatives. Need to look at how we can work collaboratively with each other, rather than competing (due to funding structures).
- *Specific services need to be developed for young people as carers.*
- *Review of how young people access mental health services and their experiences of those services, in order to identify who is using the service, in what way, and who is not using the service and what areas could be improved. This process may also identify other pertinent issues such as resource levels, cultural issues, community perceptions of services etc.*

5. Support Services:

Our community noted the need for supported accommodation programs. This appears to be an area of great need, with very few options available at present. It was felt that supported accommodation could be pivotal in reducing the burden of care and stress on families/carers, it would provide a mechanism to work closely with the mentally ill to allow them to live independently, and it would alleviate the trend of dealing with the mentally ill as criminals. Our community were concerned that when there is a crisis, health services cannot intervene, but rather Police are called. Mental Health is a health problem, and if people were given ongoing, professional support structures, they would be less inclined to forget/refuse to take their medications, become unwell and inevitably become a nuisance or threat to themselves or those around them. Our consultation process identified the following issues of concern:

- Need more support services in general, as the current level of services is totally inadequate
- Need services available at times of crisis, waiting list model simply doesn't work
- Need services to assist individuals to live with dignity and independence. This would include assisting with maintaining successful tenancies, budgeting, living skills, etc. At present, people are being left to their own devices, failing to survive and then relapsing, and going back into hospital. We need an advocate model to work with the whole family.
- Need more services specifically offering social/living/prevocational skills for young people with a mental illness. Current services focus on adults.
- Small organizations like NEAMI work successfully as a model, but they can assist only a very minute number of individuals. Funding small services for limited clients is a band-aid approach. These sort of programs need a large injection of funds to provide staff and resources.
- Need greater amount of resources to provide support to individuals once released from hospital. This is a critical time, and without adequate support, individuals often find themselves back in hospital as they become unwell.
- Need greater focus on developing accessible and flexible respite services. Clients do not like the current model, it's not working well. Clients often comment that the person needing care is reluctant to accept respite services. There is a need for flexible respite services. One proposed model is to give the family a few days away together, with a worker. The person in need of care does not feel abandoned/threatened, family are nearby and getting a break as the carer takes on the caring role. This model does not currently exist, but would allow time out for carers in a way that benefits the entire family.

- Further development and expansion of the Pioneer House Model that exists around the world. We have one property in Manly. It affords carers the opportunity to develop skills, receive intensive assistance. It is a safe place that provides social activities linked with employment and training initiatives.
- There is an overwhelming need for supported accommodation programs. People often find themselves homeless as a result of their mental illness.
- Of the limited opportunities for supported accommodation, most will not accept tenants with dual diagnosis. This is often listed as exclusion to the eligibility criteria.
- People with mental illness struggle to maintain successful tenancies, (this applies to both public and private housing providers) and often find themselves evicted or walking away from their tenancies because they do not have the skills/support to help them live independently.
- Clients often find themselves before the CTTT, facing punitive consequences as a result of failing to maintain tenancies successfully. Further to this, with a mental illness, often they do not understand the process and/or rights to appeal, and end up going through a system that fails them because they do not have advocates working with them.

Recommendations for Change:

- *Develop and fund a model for services that can work proactively and closely with a family. This would focus on a range of social issues, incorporating the individuals mental health needs, and would allow people to live independently, in a dignified and socially responsible manner.*
- *Services that focus specifically on linking individuals to employment and training opportunities*
- *Education campaign and incentive program for employers to take on people with a mental illness, but that allows them flexible working conditions to take account of when their health is poor and they cannot work.*
- *Target support services to help people maintain successful tenancies, to prevent nuisance issues, promote and develop living skills and assist prevent them from becoming homeless.*
- *Ensure there is an advocacy system in place to work with the mentally ill, particularly in relation to matters that have dire consequences, such as legal and housing.*
- *Specific programs and services targeting young people with a mental illness.*
- *Far greater amounts of supported accommodation opportunities for people with a mental illness. Accessing Department of Housing property has proven to be unsuccessful because tenants are not offered ongoing support to help them maintain those tenancies.*
- *Target support programs upon release from hospital.*
- *Develop and trial different models of respite care, enabling the participants to comment on what aspects of the models worked well and why.*

6. Other Issues:

An important issue raised by our community related to the availability and use of interpreters for people from CALD backgrounds. It was felt families may be missing out on the service, and struggling to understand information, hence making poor decisions about health care, due to the unavailability of interpreters.

Our community also felt strongly that there is a need for greater and ongoing publicity within the community to raise awareness about mental health. In many CALD communities, mental health is perceived with extreme negative stigma, and in some cultures, there is no official translation for mental health. Our community has raised the following issues:

- Our community expressed concerns about Federal Governments policies requiring people receiving the Disability Support Pension having to seek employment. This policy has a punitive focus on compliance, not assisting individuals to gain genuine opportunities to training and jobs that provide a degree of flexibility to accommodate their changing health needs.
- What is being done to educate employers about the needs of employees with mental illness, and developing and implementing workplace practices that allow people with mental illness and their carers, to have greater flexibility to accommodate absences from work in times of crisis. When people have a relapse, are unwell, they are deemed to be poor employees, unreliable. Workplace structures do not allow people the flexibility to be away from work for periods of time to recover from their period of illness.
- Health professionals should not be asking clients if they need an interpreter. Our community has grave concerns that clients often do not get access to an interpreter, because one isn't available at the time, and it would mean waiting weeks for another appointment. People are desperate and not willing to wait even longer for essential services. Further to this, our community believes that as a matter of procedural fairness, all CALD clients should be afforded the opportunity to use interpreter services, to ensure that they understand the information being conveyed, that they are in a position to make informed decisions, and that they understand the consequences of those decisions.
- We are concerned about the lack of available data that is specific to the Fairfield community. NSW Health should release information to the community, in order to identify if usage rates of services reflect community need, and results of any evaluation and/or reviews. As a community, we need this information to support an argument for specific services, proposals for partnership projects, funding applications etc.

Recommendations for Change:

- *Employment and training programs specifically designed to assist people with a mental illness and their unique needs/circumstances.*
- *An ongoing education campaign for employers, to encourage them to employ people with a mental illness.*
- *The government may consider an incentive scheme to encourage employers to take on people with a mental illness*

- *Further work to restructure Australian workplaces, to provide more flexible work arrangements.*
- *Support services to assist people with a mental illness who've been discriminated against or lost positions as a result of their illness.*
- *Interpreter services should be offered to clients as standard practice. If onsite interpreters are not available, services should utilise telephone interpreter services.*
- *Ongoing training for services on how to work effectively with interpreters and CALD communities*
- *Private mental health practitioners should be able to access free interpreter services for their clients.*
- *NSW Health should collate data that has relevance at an LGA level*
- *The Chief Health Officers Report should provide information based on LGA.*
- *Data collected from NSW Health should be made publicly available.*

We thank the Senate Select Committee for this opportunity to submit the concerns of our local community, and look forward to hearing your findings and recommendations.

Yours faithfully

NICK LALICH
MAYOR OF FAIRFIELD CITY

5 May 2005