Catholic Welfare Australia
A COMMISSION OF THE AUSTRALIAN CATHOLIC BISHOPS

29 September 2005

Dr Ian Holland
Committee Secretary
Senate Select Committee on Mental Health
Department of the Senate
Parliament House
CANBERRA ACT 2600

Dear Dr Holland,

Re: Senate Select Committee on Mental Health

Please find attached Catholic Welfare Australia's answers to the two Questions on Notice we took during the public hearing of the Senate Select Committee on Mental Health on Monday, 4 July 2005 in Canberra.

The two Questions were asked by Senator Scullion. The first was in reference to statistics we had referred to regarding the rates of unemployment for those with mental illness. In our response to this question, we have provided further background to the original statistics we provided, as well as some additional research findings on this topic.

The second question was in reference to the onset of different mental illnesses and the timing of their diagnosis. In our response we have raised some of the concerns discussed within our Member Organisation Network on this issue. We have also provided a case study from within our Network, which focuses on a service that is providing assistance to people with mental illness that 'fall through the gaps' because their illnesses are not severe enough to link them into State government mental health services.

Mental health servicing in Australia is an issue of great importance to the Catholic Welfare Australia Member Organisations. Please contact my office if you require any further follow-up to the answers provided to these questions or other issues relating to the Inquiry.

Yours sincerely

Frank Quinlan
Executive Director

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Senate Select Committee on Mental Health

PUBLIC HEARING

MONDAY, 4 JULY 2005

Answers to Questions on Notice

Question 1 (Senator Scullion to Richmond Fellowship Australia and Catholic Welfare Australia) (page 12, *Proof Hansard*)

Senator SCULLION — I have a couple of questions to put on notice…One issue is about how I can compare the statistics that you have given me a little better. You tell me that there is something like a tenfold differential associated with mental illness between those people who have access to employment and those who do not.

Catholic Welfare Australia –

Australian researchers, Waghorn, Chant and Whiteford, from the University of Queensland, looked at National Survey of Mental Health and Wellbeing data[1], and specifically targeted a sample of 980 people having been screened as having psychosis. They reported:

> *The overall unemployment rate for people with psychotic disorders in this sample is 77.8%, a rate 9.8 times that for all Australians in 1997. Females aged 17-65 years with psychoses had an unemployment rate of 76.1%, whereas 78.7% of males with psychoses aged 17-65 years, were unemployed. Young people aged 17-24 years with psychoses had an unemployment rate of 80.4%, 5.7 times the rate for all Australian youth in 1997 (Australian Bureau of Statistics, 1997, 1998a, 1998b).*[2]

To put into context the broader impact of psychosis in Australia, SANE Australia reports that 20 per cent of adults are affected by some form of mental disorder every year. Anxiety disorders and depression are the most common mental illnesses. The remainder are affected by psychotic conditions such as schizophrenia and bipolar disorder, by eating disorders and other diagnoses.[3] They also report that 3 per cent of adults are affected by a severe mental disorder every year. The 'severe mental disorders' include schizophrenia, bipolar disorder and other forms of psychosis, some forms of depression, and anxiety disorders such as panic disorder and obsessive compulsive disorder. Schizophrenia is a persistent form of mental illness that affects approximately 1% of Australians at some stage in their lives. Bipolar disorder affects up to 2% of Australians at some time in their lives. Depression affects around 20%, and anxiety disorders around 10% at some time in life.[4]

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[1] Jablensky, A., McGrath, J., Herrman, H., Castle, D., Gureje, O., Morgan, V., & Korten, A., 1999, *National Survey of Mental Health and Wellbeing*. Report 4. People Living with Psychotic Illness: An Australian Study 1997-98, Commonwealth Department of Health and Aged Care, Canberra

[2] Waghorn, G., Chant, D., & Whiteford, H., 2002, *Clinical and non-clinical predictors of vocational recovery for Australians with psychotic disorders*. The Journal of Rehabilitation, 68(4), 40-51

[3] SANE Australia, 2005, Facts and figures about mental illness, Sane factsheet, available online at http://www.sane.org/index.php?option=displaypage&Itemid=315&op=page

[4] SANE Australia, 2005, Facts and figures about mental illness, Sane factsheet, available online at http://www.sane.org/index.php?option=displaypage&Itemid=315&op=page

Waghorn et al have commented that the overall burden of disease associated with psychotic disorders is high even though there is relatively low prevalence of these disorders in the community.[5] They were specifically concerned that the burden of disease associated with two of the psychotic disorders, schizophrenia and bipolar affective disorder, is particularly high among young Australians. They quote from the 1999 Australian Institute of Health and Welfare paper, *The Burden of Disease and Injury in Australia*, which notes that in 1996, these two disorders accounted for 10.8 per cent of the total disease burden in Australian males aged 15-24 years. This was the third leading cause of disease behind road traffic accidents and alcohol dependence and abuse. At the same time, these two psychotic disorders were the second leading cause of disease burden for Australian females aged 15-24 years (11.7 per cent) behind depression.[6]

Waghorn et al go on to state that:

> *The high disease burden associated with psychotic disorders may be further compounded by the absence of sufficient assistance and opportunity for vocational recovery.*

Considering a broader classification of those with mental illness, Peter Butterworth from the Centre for Mental Health Research at the Australian National University found that:

> *The results of the current analysis are similar [to findings of the National Survey of Mental Health and Wellbeing conducted by the Australian Bureau of Statistics conducted in 1997], showing that 18.6 per cent of Australians of workforce age who were not receiving income support payments had a clinical mental disorder. In contrast, 30.4 per cent of those receiving income support payments were identified with symptoms indicative of a clinically diagnosable mental disorder. The association between receipt of income support and mental illness was significant ($c^2 = 113.1$, $df = 1$, $p < .001$).*[7]

Butterworth goes on to discuss that:

> *The prevalence of any mental disorder in each of the individual client segments is illustrated in figure 3. It is apparent that mental disorders are more common in all groups receiving income support payments, with the exception of the partnered women with children. This was confirmed by a logistic regression of client segment on presence of any mental disorder. The Wald statistics showed that each of the client segments except the partnered women differed significantly from the no income support group. The odds ratios (which demonstrate the increased odds or chances of experiencing a mental disorder in comparison to those not receiving income support payments) show the increased prevalence of mental disorders amongst the remaining*

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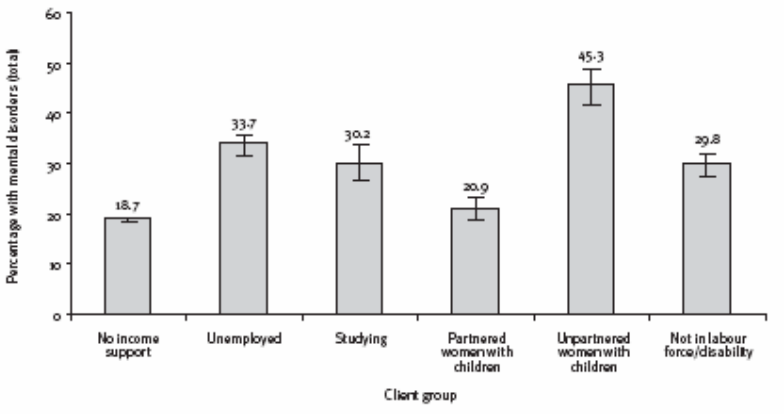
[5] Waghorn, G., Chant, D., & Whiteford, H., 2002, *Clinical and non-clinical predictors of vocational recovery for Australians with psychotic disorders*. The Journal of Rehabilitation, 68(4), 40-51

[6] Mathers, C., Vos, T., & Stevenson, C., 1999, *The Burden of Disease and Injury in Australia*, Australian Institute of Health and Welfare, Canberra.

[7] Butterworth, P., 2003, *Estimating the prevalence of mental disorders among income support recipients: Approach, validity and findings,* Department of Family and Community Services Policy Research Paper No. 21, Centre for Mental Health Research, Australian National University, p. 31

client segments ranged from 1.9 (for students and the NILF group) to 3.6 for unpartnered women. Thus, recipients in the unpartnered women with children group are 3.6 times more likely to experience a mental disorder than those people not receiving income support.[8]

Figure 3: Prevalence of any mental disorder (substance use, anxiety or depressive disorders) within client segments (with standard errors)



Senator SCULLION - The other issue is that it would be very useful to identify the sorts of mental health illnesses that have long periods between the presentation of symptoms and the final diagnosis, what the conditions are, how are they identified and what percentage of the mental health demographic are they.

Catholic Welfare Australia - It is the experience of those working on the ground in the Catholic Welfare Australia Member Organisation Network that people with personality disorders (which range in type and degree so impact on a person's capacity to function and participate in employment to different extents) are, at least in some States, not eligible for government funded mental health services. For these people it is often not the case that they are simply treated with medication but rather that they need behaviour modification therapy which is usually only available through specialists. This is not generally a free or low cost option but rather usually a very expensive and hard to access option especially in rural and remote areas.

One of our Member Organisations, a regional Centacare office, has worked to overcome these barriers in their community. A case study of Pomegranate House is presented below to illustrate the problem, and how organisations have worked together at the local level to find a collaborative model of service delivery.

[8] Ibid, p. 33

Case Study: Pomegranate House, Ballarat, Victoria

In early 2001 Centacare Ballarat approached the Chief Executive of St John of God Health Care Ballarat to discuss the potential to establish a community-based mental health program. St John of God has a long history of involvement in mental health.[9] The first documentation of a plan to establish the Service is a Discussion Paper *Proposal to Establish an Innovative Treatment Facility for People who Have a Psychiatric Illness* prepared for St John of God Health Care and Centacare dated March 2001. The stated aim of the proposal was "to develop innovative strategies addressing the needs of disadvantaged people and their families." According to Annie Re, who produced this report, the motivating idea was "about community based psychology services for those who don't fit the public system, who are ineligible and for those who can't afford to pay for the private system."

Following this Discussion Paper, Centacare approached the University of Ballarat, the Ballarat and District Division of General Practice and others to involve them and a more formal planning process was initiated. According to Steering Committee members who were involved in the initial stages, the process "evolved over time."

Pomegranate House, was the result of these discussion and now operates as a partnership between Centacare Ballarat, St John of God Health Care, University of Ballarat, and Ballarat and District Division of General Practice.

This is a very collaborative model. Under the Federal Government Department of Health and Ageing, Access to Allied Health Program, Centacare in collaboration with the Division of General Practice provides one and a half staff people; St John of God provides the actual building, Pomegranate House, and one and a half staff; and the University of Ballarat as one of the partner organisations involved in Pomegranate House has a number of students in the Psychology Masters and Doctoral Programs who form an integral part of the counselling team.

Pomegranate House provides psychological interventions in relation to mental health issues for children, young adults, adults and/or their families. Priority is given to marginalised and financially disadvantaged people and those who are otherwise unable to access therapeutic psychological intervention services. This may include individuals and/or their families and carers who:

- Experience significant barriers to maintaining quality of life and/or family relationships, due to a mental health problem;
- Are at risk of experiencing significant psychological problems;
- (as mentioned earlier) Experience high prevalence disorders (such as anxiety and depression) which do not meet the eligibility criteria of public mental health services and who cannot afford to access the private system;
- Have recently experienced a first episode of psychosis or other serious mental health problem and may have multiple risk factors but do not, or no longer, meet the eligibility criteria of public mental health services;
- Are experiencing difficulty in living with a long-term mental health problem, particularly those who have experienced the impact of deinstitutionalisation.

Client referrals come from General Practitioners, community services such as Family Relationship Services Program, and self referral.

Another problem that has been identified by our Member Organisations is that many mental health issues remain undiagnosed or are denied by the people, who do not want to take medication or have the stigma of a label.

[9] Conley Tyler, M., Shrimpton, B., Bornstein, J. & Hider, K, 2005, Evaluation of Pomegranate House, Centre for Program Evaluation, University of Melbourne