Response from Catholic Social Services Victoria

to the

Senate Select Committee on Mental Health

Inquiry into the provision of mental health services in Australia

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Submission to Senate Select Committee on Mental Health

1. Introduction

Catholic Social Services Victoria welcomes the opportunity to submit to this important Senate Inquiry. Catholic Social Services Victoria (CSSV) is the peak body for sixty-one Catholic welfare agencies in Victoria. Our member agencies see on a daily basis the ramifications of poverty and social exclusion for the people we support. Our overall mission is to address poverty and disadvantage in both meaningful practical ways, while working to effect longer term structural change. Our work is framed by Catholic Social Teaching. Its principles aim to create social, economic and political relationships and social structures and institutions which enhance human dignity, overcome poverty and promote social justice.

Our member agencies represent both large and small organisations working to engage and support people experiencing forms of disadvantage and hardship.

Member agencies offer a range of services as disparate as aboriginal mission, aged care, both residential and in home support, child adolescent and family support, criminal justice, including support to prisoners and their families, drug counselling, Disability, Family, Health Chaplaincy, Homelessness and Women's Services. The agencies have the support of over 6,000 volunteers and more than 3,000 staff.

CSSV's legitimacy and authority to speak on the issue of mental health comes from the experienced voices of our member agencies. Our agencies work directly with and support people of all ages experiencing mental health problems. This includes children, young people and families and people on their own, both young and old. Most of the people we see have underlying issues of poverty, disadvantage, disability, drug and alcohol concerns and other forms of abuse.

2. Agencies contributing to the submission

For the purposes of this submission, we consulted with several CSSV member agencies. Centacare Family Services, Ballarat and MacKillop Children and Family Services both which provide support and programs for children, young people and their families contributed their thoughts. Our Catholic Mental Health Chaplain has shared her insights on her outreach and work to support people she sees and visits as have Catholic Chaplains working within the prison system. Sacred Heart Mission, St Kilda which works with a predominantly homeless and chronically disadvantaged client group has also provided their understanding and the approach they adopt to reach out to and work with people with mental illness and often dual disabilities. Sacred Heart Mission has recently received State Government funding to establish a new, innovative mental health outreach service in partnership with the Alfred Hospital's Psychiatric Department. This model is outlined in the submission.

Our submission does not cover issues relating to older people with mental health problems such as dementia. We recognise that this is a critical group with an increasing need for a more comprehensive response to these issues. In establishing which priority areas to address in our submission, we anticipated that a number of older person-specific organisations would focus on this group and were best equipped to address their specific mental health issues.

Our submission includes reference to relevant evaluations and studies undertaken by a range of agencies to inform the views expressed in this submission. It is also important to note that the high level of concern across the Catholic Church and broader community sectors about the inadequacy of services for the mentally ill has fired a desire for agencies to work collaboratively to achieve a better deal for these people. The timing of this Inquiry coincides with a proposal initiated by the Brotherhood of St Laurence and Catholic Social Services Victoria to establish a Mental Health Advocacy Campaign. The two agencies have convened several meetings with committed agencies to focus the idea for a campaign.

3. Key issues raised at CSSV campaign meetings:

- All agencies present stated that mental health was of significant concern within their organisations.
- Recognition that the crisis in mental health system is longstanding, and that agencies have been dealing with these issues and this client group for a long period of time.
- All agencies reported that a large percentage of their client groups have a mental illness
- Agency's practitioners are not trained to deal with these issues. Some practitioners dealt well with this client group but others did not.
- General welfare services were supporting and filling in the gaps of the mental health service system.
- Welfare agencies were providing services for which they received no funding.
- There has been a shift of care on to the community yet funding and system infrastructure have not been created to deal with this.
- Frontline services are dealing with the brunt of the crisis. Emergency relief programs are acting as a buffer to the inadequacies of the mental health system.
- The relationship between housing service system and mental health system were poor.

Key areas of common concern that were raised by the group were in relation to:

- Housing, particularly lack of access and lack of coordination with mental health and other social support services.
- Access to treatment
- The mental health system service configuration - pathways into care minimalist
- Clients with complex needs
- Lack of funding
- The high number of mental health consumers in prison

- Safety for consumers and workers
- Women living with a mental health issues losing care of their children
- Lack of appropriate care facilities for young people

4. General insights from member agencies

In addition to the concerns articulated through the campaign meetings above, discussions with CSSV member agencies in preparing this submission raised the following issues.

4.1 Mental Illness and Poverty

People living with a mental illness are more likely than others to be living in poverty. This link with poverty, unemployment and homelessness is likely to be due to a higher causation of disorders among those with relative social disadvantage as well as the drift into poverty which occurs when people have a mental illness. This appears to be the case for the majority of people our agencies see and support through a range of programs and services.

4.2 Over-representation of mentally ill in prisons

Another significant fact relates to the high incidence of mental illness among both the male and female prison population. A recent study into the health of Victorian prisoners revealed a "prevalence of all the major mental illnesses that is found in the general population."[1] Figures from this report reveal that 28% of prisoners had been previously diagnosed with a mental illness. This does not take into account undiagnosed prisoners and therefore the actual percentage of prisoners with a mental illness is presumably higher than this figure. Indeed, a study undertaken by the Schizophrenia Fellowship of NSW in 2000 indicated that 60% of people admitted to NSW jails had an active mental illness.[2] This compares with The Australian *National Survey of Mental Health*[3] figures of approximately 20% of the general population believed to experience a mental health problem each year

Catholic Social Services questions the appropriateness of people with mental illnesses languishing in prisons where they are unlikely to receive any or only the bare minimum of appropriate treatment for their health conditions. We are seriously concerned that as is commonly stated, prisons are becoming the asylums of the new millennium.

4.3 Responding to individual need

Another primary concern is the need to recognise diversity and support each individual in overcoming their own unique issues. This is not always possible within the restrictions of a funded program.

4.4 Diagnosis: help or hindrance?

[1] Victorian Prisoner Health Study, Department of Justice (Victoria) 2003
[2] Report on the criminal justice system in Australia, Schizophrenia Fellowship of NSW Inc February 2001
[3] McLennan W. Mental health and wellbeing: profile of adults, Australia 1997. Cat No 4326.0 Canberra: Australian Bureau of Statistics, 1998

A bind agencies often find themselves in is recognising that diagnosing a mental health condition is often stigmatising and counter-productive for the person involved in relation to their health and life outcomes. This view was frequently articulated by both generalist workers and mental health practitioners in the course of gathering information for this submission. Misdiagnosis can also occur which further exacerbates the stigmatisation and lack of productive outcome for the person involved. However, in order to access a range of programs and/or assistance, a diagnosis is an essential pre-requisite. A concrete example of this is the Youth Residential Rehabilitation Program funded by the State Government, where to be eligible for housing, the person must have a serious mental illness diagnosis. Similarly, people cannot access other specialist services without a diagnosis.

Multiple mental health, psychological and behavioural issues are often undiagnosed due to the accompanying challenging behaviours, further exacerbating social isolation and a lack of engagement with the service system.

4.5 Incidence of Mental Health issues affecting our agency client groups

CSSV undertook a study of disadvantage which provides insights into the various policy implications of tackling economic and social disadvantage.[4] The study provides a snapshot of life for a group of people seen regularly by some of our agencies. Among the forty people interviewed for the study were twelve women and three men who were being treated for depression and another seven with other mental health problems. Others revealed addictive problems and issues relating to adjusting to life after release from prison. It was unclear whether these people were also experiencing mental health problems.

The study identified that depression was common across all ages and for both men and women, both in families and alone. Many suffered from low self-esteem. An inability to imagine a better future and living with a lack of hope were debilitating for many. The following is an excerpt from the report. It provides a snapshot of the unique situations many are faced with in the community dealing with mental health problems. The identity of participants is protected as real names are not used.

"John was severely depressed and received psychiatric care. Anna had such severe depression that her hair had fallen out:
'Before I had my daughter I was just starting to get on top. I haven't felt well since then. Mentally I feel a basket case.'
Amanda was depressed and pessimistic about her future. Loneliness was a major problem for her. Mario was on anti-depressant medication. Chloe suffered from bipolar disorder and was at times suicidal. She was on her own. Connie suffered from distress and anxiety about life's problems. Sue's depression limited her attempts to find work. Her mother's death was a major issue for her. Tanya felt depressed and lonely. She had a mental health problem that qualified her for a disability pension and a caseworker. She attended a mental health clinic but felt she needed more counselling and support. Spider's depression was linked to unemployment. Tom related his depression to not seeing his child."[5]

[4] Surviving not living. Catholic Social Services Victoria. (2001).
[5] Surviving not living. Catholic Social Services Victoria. (2001). p 17.

4.6 Defining Mental Health

There is also disagreement about what constitutes a mental health condition. A grey area is where there is a need for anger management, an area, particularly in relation to children and youth that workers see as a growing need. Another mental health issue which seems to be increasing for young people relates to social anxiety disorders. Agencies also reported seeing more children with low I.Qs. These groups are often falling between the gaps of mental health, school support and disability services.

4.7 Need for more outreach services

Also in relation to children and young people requiring support and interventions, agencies believe a much greater outreach capacity is required to enable workers to go into people's homes. Children in a fragile position are unlikely to make or keep appointments with an agency. They often feel there are already too many experts running their lives such as social workers, possibly child protection workers, to actively seek engagement with more.

4.8 Specific issues relating to homelessness

We know there is a strong correlation between mental illness and homelessness. Data from a survey of Sacred Heart Mission clients confirms this belief. Details are outlined in this submission.

In relation to working with homeless and transient people, it is difficult to provide ongoing treatment, particularly as this group is likely to have a significant level of distrust and suspicion towards authority and institutions. Attempts to meet this group's needs often results in the provision of an often fragmented service response that is crisis-driven and short-term. While this client group are generally considered difficult to engage, the level of contact with services such as Sacred Heart Mission confirms that the approach adopted at Sacred Heart Mission which is one of assertive engagement has a high level of success.

5. Specific programs

The submission will now consider some specific programs, innovations and agency approaches in place in our agencies and their success and applicability to agencies and their clients.

In relation to young people

Mental health issues are responsible for 65-70% of the overall burden of disease for young people between 15-24, according to the Youth Mental Health Coalition. Seventy five per cent of mental illnesses occur in people aged 15 to 24.[6] Increasingly, our agencies are seeing young people with a range of mental health issues. These include depression, schizophrenia, reaction to severe stress, anxiety and eating disorders.

5.1 The Making a Significant Change (M.A.S.C) Program.

[6] Mental Health Council of Australia

The M.A.S.C program is one of the State Government funded services that aim to support young adults in improving their psychosocial functioning. Centacare Ballarat is one Catholic agency which provides this program from Centacare's psychiatric disability rehabilitation and support service.

Being a relatively new program, interest lies in how the program is functioning to support young adults in overcoming or managing their mental illness and related issues. An evaluation of its effectiveness was conducted in 2004 by Centacare Ballarat . The evaluation sought to determine perceptions about:

- the role of rehabilitation within the recovery process
- the effectiveness of interventions in supporting clients to identify realistic goals
- changes to lives from rehabilitation
- what participants believe the future holds for them.

Participants are both clients and staff.

5.1.1 Perceptions about role of rehabilitation

Participants see rehabilitation as restoring self-esteem and confidence through support and education on precipitating factors.

Rehabilitation is also viewed as a form of prevention and intervention which can overcome high-risk behaviour.

The links to other agencies which occur through rehabilitation were seen as important. The promotion of well being worked to re-build trust and overcome fear. There was a sense that the process of rehabilitation had assisted people to tackle homelessness. The process also encourages positive family relationships and re-establishes social networks. The participation in recreational activities, vocational and educational support also assists.

5.1.2 Perceptions about what assists participants of MASC program to turn their lives around.

- Expansion of social networks
- Improved family relationships
- Restoration of confidence
- A sense of belonging
- Attachment and acceptance and the development of positive outlooks which include hope for the future, aspirations and goals.

"….That was the most important thing, finding companionship and good friends really."(Client participating in study.)

5.1.3 Perceptions about positive changes achieved through rehabilitation and prospects for the future

- Improved employment prospects
- Relocation from place of origin demonstrating capacity for making a change and/or achieving greater independence
- Obtaining a sense of achievement,
- Establishing family relationships where they previously did not exist.
- Improved overall functioning
- Improved nutrition and diet.

- Improved physical health, overcoming fears and improved levels of life satisfaction.

Participants were realistic about societal pressures adding additional challenges for them to overcome in the future.

4.1.4 Other important observations from the evaluation

Clients feel particularly vulnerable during initial stages of entry into the program and immediately after discharge from acute inpatient hospital admission. It is very important to establish rapport with clients during these stages.

The evaluation identified areas which would benefit from future research:
The prevalence of dual diagnosis
A comparison of the effectiveness of alternative interventions
The impact of rural issues and stigma on the recovery process for young adults and the relationship between acute psychiatric services and psychiatric rehabilitation and support services.

While the evaluation involved only a small sample of participants, the overall conclusion which can be drawn is that it is an effective intervention approach for young adults experiencing mental illness.

4.2 Mental Health Chaplaincy

A key aspect of all chaplaincy work performed by the Church is to focus on the person not their problem(s). The Mental Health Chaplaincy utilises Austin Hospital as a base, and provides outreach pastoral care to as many as can be assisted. Chaplains maintain contact and are available to anyone interested in spending time with them. One person has remained in contact with the chaplain for 17 years. Even where a person with a mental illness has family and friends, these may not be the best support at particular times, as the person may feel judged by those close to him or her. The chaplain's role is non-judgemental. The chaplain agreed with other agency perspectives that diagnosis can be too defining and limiting and reduce a person's sense of hope that positive change can occur. Diagnosis can detrimentally affect a person's identity and self-respect.

The chaplains believe the spiritual dimension of their work is critical as an integral part of mental health care. In times when human beings are very fragile and experiencing despair, loss and grief, there is a capacity to provide comfort and soothe troubled minds by attending to the person's spiritual needs. It is also critical that the person being assisted is dealing with someone who is personable, trustworthy and non-judgemental.

The Chaplain also emphasised the importance of stable housing for a person's recovery and sense of safety. A homely environment with access to support and companionship is important. Often, people with mental illness live in settings, which are socially isolated. This works against the possibility of recovery and positive life improvements.

5.3 MacKillop Family Services

Many of our member agencies have had ongoing concerns about the high and/or increasing levels of mental health issues experienced by the groups of people assisted and seen by the agencies. MacKillop Family Services is one of these agencies. MacKillop provides a range of services and programs relating to family support, out of home care and specialist educational programs.

MacKillop conducted a survey in 2004[7] to ascertain the level of diagnosed and undiagnosed disability and mental health disorders within their client group. The results have not been published but preliminary findings are offered for the purpose of this submission. The survey also aimed to establish the usefulness and availability of services to which our clients were being referred. For the purposes of the survey, 'undiagnosed' was defined as judged on practitioner perception; 'disorder' was defined as something that occurs over time and causes major distress and disruption to their lives.
Survey information was collated from 248 clients, (client includes students); 130 in education or out of home care and 118 in family services.

5.3.1 General findings

- 16% of clients in the survey have a diagnosed disability;
- 9% of clients in the survey have an undiagnosed disability;
- 17% of clients in the survey have a diagnosed mental health disorder;
- 13% of clients in the survey have an undiagnosed mental health disorder;
- 14% of the clients in the survey diagnosed are accessing a mental health service.

In summary, around 25% of MacKillop clients have a diagnosed or undiagnosed disability, and around 30% of clients have a diagnosed or undiagnosed mental health disorder. Further, these categories are not mutually exclusive: it is possible for one client to have both disability and mental health issues.

5.3.2 Education and Out of Home Care results

Of the total number of young people reported on in the survey (130) from education, and out of home care services:

- 19% have a diagnosed mental health disorder;
- 13% have an undiagnosed mental health disorder;
- 20% are accessing mental health services.

In other words, between 19% and 32% of young people in MacKillop's non-disability programs have mental health concerns. This is considerably higher than the national average for young people aged 13-17, where 13.4% of males and 12.8% of females

[7]Disability and Family Services Draft Report, MacKillop Family Services

were diagnosed with a mental health problem.[8]

Virtually all the young people in education or out of home care with a diagnosed mental health disorder (19%) are accessing a mental health service. However, another 13% are undiagnosed and without services.

5.3.3 Family Services Results

Of the total number of families in family support programs (118):

- 13% have a diagnosed mental health disorder.
- 13% have an undiagnosed mental health disorder;
- 8% are accessing services

This indicates that less than half of those with mental health concerns are accessing services. While the numbers appear to be lower in this program grouping than others this could be partly because some of the children in the family groups are too young to have any diagnosis.

5.3.4 Residential Care Services

The main area of concern is the young people with mental health disorders represented in residential care services where 29% have diagnosed and another 24% have undiagnosed mental health issues.

5.3.5 Generals areas of concern identified

Qualitative information gained from practitioners working in the agency identified a number of useful points.

Efficacy of diagnosis

Both staff and mental health services are reluctant to give a formal diagnosis when services are limited or because of stigmatisation. This is problematic because these services cannot be accessed without a formal diagnosis.

Effective services

Workers believe that services which include the client, family and agency are the most helpful.

Referrals

There is a high level of concern about referrals to services needing to be made by the Department of Human Services (DHS). There is a belief that DHS has too much power and agencies should be able to directly refer clients to services themselves.

Managing clients with a mental health disorder or a disability.

Many workers are not specialists in the mental health field and are therefore ill-equipped to distinguish between a mental health disorder and other disabilities such as autistic spectrum disorders.

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[8] Australian Institute of Health and Welfare 2004, *Australia's Health 2004*, cat. No. 44, AIHW, Canberra, p.187. Quoted in http://www.youthfacts.com.au/index.php?option=displaypage&Itemid=265&op=page

Workers have a genuine desire to assist clients as best they can and will often need a more detailed understanding of a mental illness in order to set appropriate goals for the client.

5.4 Sacred Heart Mission (SHM), St Kilda

A client profile survey[9] was undertaken by SHM staff over a 2-week period in 2004. Among the aims of the survey was to identify the number of clients who present to the Mission with complex and challenging behaviours.

Complex Needs

Table 8: Presenting issues of the clients

Presenting Issues	**Total No. of clients**	**% of Total (n=169)**
Drug and alcohol misuse	88	52%
Depression	85	50%
Diagnosed mental illness	35	21%
Drug Induced Psychosis	20	12%
Undiagnosed but appears to have mental illness	20	12%
Housing	19	11%
Diagnosed Personality Disorder	17	10%
Abuse issues, confidence/self-esteem, social isolation	18	10%
Physical Health	14	8%
Diagnosed with schizophrenia	11	7%
Undiagnosed but appears to have a personality disorder	12	7%
Diagnosed with ABI (Acquired Brain Injury)	8	5%
Family/relationship breakdown/child custody	8	4%
Domestic Violence	6	3%
Undiagnosed but appears to have ABI	1	1%
Appears to have 2 or more of the above	92	54%
Total no. of clients with one of the above	**162***	

**Data missing where staff identified the client as having two or more of the conditions and the nature of the conditions were not specified.*

This data specifies the number of presenting issues of the client group, relating to drug and alcohol misuse, mental illness, psychiatric disorder, ABI, depression, and personality disorders. In circumstances where a formal diagnosis was not known to have occurred, staff identified the condition as undiagnosed and the client as appearing with the condition. The assessment was made based on staff knowledge of

[9] Client Profile Survey, Sacred Heart Mission, 2004

the presenting conditions due to past knowledge of the condition and the presenting characteristics.

A total number of 88 clients (52%) presented with issues related to drug or alcohol misuse, a significant proportion of the total presenting issues. A further 50 percent of the client group presented with depression, 21 per cent with a diagnosed mental illness and a further 12 per cent were identified as having an undiagnosed mental illness.

A total number of 92 clients, representing 54% of the total number of clients were assessed as having two or more of the presenting issues specified at table 8.

Presenting Issues Relating to Mental Health

A number of significant factors emerge from this data regarding the mental health related issues of the client group.

Firstly, a total of 21% of the total number of clients were identified as having been diagnosed with a mental illness. A further 12% were identified as presenting with a mental illness but staff could not confirm whether the person had been formally diagnosed with an illness.

A significant total of 79% of clients presented with either a diagnosed or undiagnosed mental illness, a drug induced psychosis, diagnosed schizophrenia, a diagnosed or undiagnosed personality disorder or issues resulting from past abuse that affected confidence and self-esteem. Further, a total of 50% of the client group presented with depression and 52% with drug and alcohol misuse related issues.

A significant proportion **(54%)** of the client group were identified as presenting with two or more of the issues listed in the data survey under presenting issues available at Table 8.

Behaviours

Table 9: Behavioural issues

Behavioural Issues	**Total No. of clients**	**% of Total (n=150)**
Antisocial behaviour	59	39%
Aggressive behaviour	51	34%
Deliberate self-harm	27	18%
Other#	13	9%
Total no. of behavioural issues	**150***	100

* A number of clients were identified as presenting with more than one of the behavioural issues above. A total number of 97 clients were identified as exhibiting at least one of the three behaviours of antisocial or aggressive behaviours, or had participated in behaviours of self-harm.

A total of 39% of the behavioural issues were identified as antisocial behaviours, whilst 34% of the behaviours were identified as aggressive. The total number of

clients who presented with either antisocial or aggressive behaviours is 84, representing just under 50% of the total number of clients.

Behaviours specified under "other" are:

1. Anxiety
2. Depression
3. Attention seeking
4. Violence and harm towards another client or partner (Total no. of clients: 2)
5. Refusal of medical attention
6. Attachment issues – (Total no. of clients: 3)
7. SHM services used to maintain quality of life/ drug replacement therapy (Total no. of clients: 2)
8. Uses service as community/friendship/social contact
9. Behaviours resulting from domestic violence/sexual abuse
10. Paranoia

A number of these factors were identified as presenting issues and presented at table 8 and some, including the client's refusal to seek medical attention, presented with other mental health related issues. Overall, these behaviours reflect the dislocated and socially isolated lives of the client group which are emblematic of their state of homelessness.

Presenting Issues and Behaviours

Table 10: Presenting issues and behaviours of clients

Presenting Issues (2 or more)	**Percent**	**Behaviours**	**Percent**	**Total number presenting with 2 or more issues and Behaviours**	**Percent**
92	54%	97	57%	95	56%

The above data summarises data relating to the number of clients identified as presenting with two or more presenting issues of drug and alcohol misuse, mental illness, psychiatric disorder, ABI, depression etc, as specified at table 8. The total number of clients identified with two or more presenting issues was 92 (54%). The table also identifies a total of 97 clients, representing 57% of the total number of clients, as having displayed behaviours of aggression, self-harming or assessed as anti-social.

Summary

In summary, whilst the survey does not fully capture the range of complex, inter-related and multi-varied issues that affect the clients to Sacred Heart Mission, the data

above provides an overview of the range of issues of the clients who were provided with services by Sacred Heart Mission.

As the clients surveyed were initially identified as being those clients who were considered by staff to present with a number of issues, this data demonstrates that a large number of clients who present for Sacred Heart Mission services can be assessed as having a number of multiple and complex needs that require a multi-faceted, coordinated service response from a range of service areas, including alcohol and drug, services, mental health and psychiatric services, counselling services relating to sexual assault and violence, housing and support services, as well as specialised services relating to ABI, personality disorders and dealing with aggressive behaviours.

The correlation between mental illness and homelessness is strongly confirmed by this data. The clients presented with a number of issues ranging from drug and alcohol misuse, depression, ABI, personality disorders and schizophrenia. Whilst this client group are generally considered difficult to engage, the level of contact with SHM services confirms the SHM approach of assertive engagement as succeeding in overcoming this issue.

The range of multiple and complex needs of the client group demonstrates that SHM should access the DHS Multiple and Complex Needs Service Model for certain clients where it is assessed that the clients would benefit from a referral to the Multiple and Complex Needs Panel and to the subsequent detailed assessment and coordination of services. However, given that the total intake of the DHS Multiple and Complex Needs Initiative is a total of 50 clients across the State, alternative service strategies need to be considered for the client group.

The data further demonstrates the need for mental health services that are readily accessible to SHM clients to ensure access to clinical assessment and on-going care and support from a mental health provider.

An Integrated Mental Health Service.

Sacred Heart Mission and the Alfred Hospital developed a joint proposal to provide a holistic, integrated service response to people experiencing homelessness who present with challenging and complex mental health needs. This service has been approved for funding by the State Government.

A specialist mental health team will provide an early intervention treatment response to predominantly homeless persons who present to Sacred Heart Mission with severe mental health illnesses or conditions. In conjunction with the Mission's assertive engagement model, the on – site mental health response will increase opportunities for immediate and long - term interventions.[10]

The Service

[10]Specifics of the model outlined in *An Integrated Mental Health Service Response- a joint proposal of Sacred Heart Mission and the Alfred Psychiatry Department.2004*

The service will run out of Sacred Heart Mission within a non-clinical setting to address the range of identified mental health issues in the client group who present at Sacred Heart Mission. The service emphasises working together to achieve optimal client outcomes.

The model is underpinned by the principles of a social model of health, recognising the impact of the social and environmental determinants as well as the medical and biological factors, on an individual's mental health and general well being. The proposed service model aims to provide a longer-term solution to people experiencing homelessness with complex needs by reducing the significant numbers of crisis presentations to mainstream health services and by minimising the cycle of crisis-oriented responses.

Specifically, the model proposes that a mental health service team be established on–site at Sacred Heart Mission, underpinned by the following principles:

- Relationship building with clients through the adoption of an assertive engagement model;
- Ability to comprehensively assess the client on site and develop a care plan that systematically addresses the multiple and complex presenting issues;
- Ongoing review and monitoring of care plans in partnership with clients;
- Outreach support that maintains on-going contact and sufficient levels of engagement with the client to minimise or eliminate crisis trajectory;
- Adoption of a care team approach.

Staffing Requirements

The mental health team will consist of staff from both Sacred Heart Mission and the Alfred Psychiatry Department, working as an integrated care team with shared client information and support systems.

It is estimated that over 300 people will benefit from this proposed service in the first 12 months of operation. In particular, individuals who are normally resistant to formalised mental health responses will be engaged and connected into this service through a client engagement approach that focuses on relationship building in a community based setting.

6. Recommendations

CSSV makes the following recommendations to the Inquiry. CSSV is aware that many of these are also contained in the response of Catholic Welfare Australia to the Senate Select Committee Inquiry into Mental Health.

CSSV recommends that:

Recommendation 6.1
As the stigma associated with mental illness often leads to unnecessary alienation and segregation of those with mental illness, every effort be made by State and Federal Governments and relevant agencies to dispel the stigma with practical and effective strategies.

Recommendation 6.2
Early identification and greater community awareness and understanding of mental illness be a strong focus of any ongoing or new initiatives.

Recommendation 6.3
Improved training in mental health awareness be provided to general staff in the community sector as well as an adequate level of access to mental health specialists for referrals as required.

Recommendation 6.4
Capacity for more coordinated partnerships between community based agencies, community health services, General Practitioners and specialist mental health services be enhanced.

Recommendation 6.5
Availability and access to appropriate housing linked to relevant types and levels of support be increased.

Recommendation 6.6
Broader access to mental health servicing in rural and remote areas be developed to ensure a better coverage and capacity to meet need in these areas.

Recommendation 6.7
The level of outreach services particularly for young people better reflect the actual demand level in the community.

Conclusion

This Inquiry has afforded a timely opportunity to re-emphasise that much remains to be done to address the burden of mental health affecting so many people in our communities. We trust that the experience of our agencies outlined in this submission provides some practical examples of steps that can be taken.

The kind of approach instituted by Sacred Heart Mission in conjunction with the Alfred Hospital is an example of a collaborative attempt to better address an unmet need. CSSV would like to see more opportunities for this kind of innovation to occur. We hope that the exploration of issues afforded through the Inquiry assists with the identification of a way forward and a better deal for people living with mental illness.

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