# Personal submission to the Senate Select Committee Inquiry into Mental Health.

The areas covered relate directly to my personal experience as a physician, involvement in community medicine and public health, as member of a number of advocate non-government organisations as well as government advisory bodies and reviews.

The principal issues dealt with are: - suicide prevention, co-existing mental health and substance use disorders, homelessness, income support and disability and some observations about mental health services.

### The nature of mental health problems

Mental illness does not sit easily with the way most health problems are defined and treated. In physical illness there is an internal harmful phenomenon - disease. Disease produces symptoms and function is affected, so that, for example, the person is unable to walk, or speak, or think. When conditions persist a social value is attached to the person because of their inability to perform social roles. The conventional way of describing this cascade of disease, definitions proposed by the World Health Organisation for the International Classification of Disease, Impairment and Handicap. Disease leads to impairments (in structure and function), which in turn lead to disabilities (effects on activity and function) and finally to a social status - handicap.

The difficulty with mental illness is the evidence for disease is difficult to ascertain. To this time mental disorder is defined by clinical symptoms. However, disablement and social role is often the way mental illness is identified. In schizophrenia, for example, there are the positive and negative symptoms. The negative symptoms represent loss of functions (flat affect, alogia, apathy, anhedonia - asociality and inattentiveness).

[1] These disabling effects are frequently the major determinants of a person's well-being and impede their social roles.

These aspects should be of greater concern to mental health services and to tribunals if for no other reason that the disability of mental illness is a prime point of discrimination. Among people with substance abuse and the homeless this is particularly evident. The Report of the Human Rights and Equal Opportunity Commission catalogued this.[2]

## Mental Health Services

There is restlessness in the community and among advocates and clinicians and service managers about mental health services. The issues broadly are: -

- Intensity of workloads, access to beds and incessant media complaints.

- Prevalence of co-existing mental health and substance use problems
- High prevalence of mentally ill people in gaols.
- The dominant characteristic of the homeless scene is mental illness

**Services and mental health workforce**

There is disenchantment of the staff in mental health services at all levels.

- They feel overloaded
- Public psychiatrists are a diminishing group
- Recruitment and deployment of mental health nurses is very difficult
- Beds available for immediate admission are hard to find
- Other services such as police, GPs, NGOs complain they are not supported by mental health staff and services
- Drug psychoses are common in mental health units

**Wider public perceptions**

- Inadequate responses to mental health issues
- Suicide is seen as the marker of a failed mental health system
- Cannabis is seen as a mental health villain
- Amphetamines are seen as mental health villains, too.
- (No one speaks of alcohol in this way)

**Media Reports and Inquiries**

These inadequacies make good TV and can fill the newspapers. They are dramatic and are the essence of a story about conflict, risks and mystery (as mental health is). Four Corners, Late line, 7.30 Report, Sixty Minutes have all portrayed a poor state of mental health services. And in many ways this negative, dramatic, approach makes the situation worse. As an unfortunate negative culture is generated which in turn fuels disillusionment, worthless services and an implicit desire to re-institutionalise mentally ill people.

There is a spate of inquiries of which this Senate Inquiry is the latest.

**Public psychiatry**

The morale in public psychiatry is declining at an accelerating pace. Quite recently psychiatrists working in the public health system have identified their areas of concern:

1. Staffing: The staffing levels are low in NSW, and elsewhere in Australia, and the skill base is disappearing. In this respect they point especially to nursing staff, but I would add the number of psychologists employed within the public system.

2. Insufficient beds and overloaded community mental health services. They describe the difficulty of finding beds for acute presentations at all times but especially it seems during high intensity times such as weekends.

3. Safety: For reasons which they advance – criticality of patients, pressured environments and lower security levels – there are risks to patients and staff.

4. Complexity: The public psychiatrists believe they are increasingly dealing with an alienated underclass whose complex intersecting problems become labelled as mental illness. They point to the incidence of drug induced psychosis, notably from the amphetamines and cannabis. They criticise the "prevention push" stating that this has led to short term unsustainable projects.

5. Administration: With budgets being managed closer to the front-line there are requirements for budget accountability. In a risk adverse system there are increasing checks and assessments to be made which are burdensome, and not necessarily relevant to direct patient care. These administrative and quality control tasks are growing but support in terms of funds is not being provided.

6. Registrar training: They are concerned about the ability to train registrars, and especially how this fits into the new and demanding dynamics of mental health units. I understand that it is difficult to attract registrars and many leave before they complete training. And clearly some areas are more attractive to them than others.

7. Accountability demands: In their opinion the 'system' has become preoccupied with legalism, unnecessary codification of increasing complex disorders, and accountability requirements of other kinds. (All this seems to be a reflection of the loss of leadership and trust in the professional task and performance of clinicians.)

8. Teaching environments: They mourn the passing of the teaching hospital environment, and presumably the ability in that framework to think, research and teach as well as to practice unfettered by 'excessive managerialism'.

9. Macro issues: The public psychiatrists see real needs for new approaches to accommodating affected people, and are concerned about the lack of community structures to support people with disabilities in the community.

## Suicide Prevention

Since the 1920s the suicide rate in Australia has been in the range 10-14 per 100,000 persons of all ages. The past 40 years saw a tripling of the rates in 15 to 24 year old

males, and from 1973 a similar rise in 25 to 35 year old males. In the recent period, rural areas have experienced higher rates in the range 14.7 to 16.2 per 100,000 compared with 12.8 to 13.9 per 100,000 in capital cities.[3] That was up until 1997.

For a long time community organisations have led the response in suicide prevention. Organisations such as - Samaritans, Lifeline and Bfrienders – have aimed to prevent suicide through telephone and crisis counselling since the early 50s. But now political leaders were under pressure to respond to the crisis of suicide in young people.

The first national response occurred in 1995 with *Here For Life: A National Plan for Youth in Distress* which then expanded into the *National Youth Suicide Prevention Strategy*. How to proceed was unclear, but a response was needed.

The initial programmes aimed to trial and evaluate prevention approaches – to reduce suicide ideation and attempts, respond appropriately to groups at risk, integrate with youth health and to promote social well-being. States and territories developed their own approaches but these were shaped by national consensus. Western Australia started early in 1989 with a Youth Suicide Advisory Committee and iinternationally the *World Health Organisation*[4] and the *United Nations*[5] had recommended multi-faceted strategies prevention strategies.

There was the *Mason Report*[6] into youth suicide and the *Burdekin Report*[7] into human rights and mental illness. The Public Health Association raised the profile of suicide prevention in 1994 at a national forum. Advocate organisations such as *Suicide Prevention Australia* and parents, relatives and friends pushed for a national programme.

Young males in particular were exposed to escalating risks of suicide and opiate deaths.[8] Young women had very high rates of attempts and self harm. For young males nine out of ten leading causes of the *burden of disease* and eight out of ten young females aged 15-24 years were due substance use disorders or mental disorders and national mental health data showed that 14.1% of children and adolescents had a mental health problem.[9]

The *National Youth Suicide Prevention Strategy 1995* aimed to prevent suicide, reduce injury, self-harm and suicidal ideation and behaviour in young people, and to enhance resilience, resourcefulness, respect and interconnectedness. It acknowledged multifactorial causes, complexity and the need to operate across a range of domains. It was a public health initiative combining science, skills, human services, communities and the belief that a society can act to maintain and improve the health of all.

The Australian Institute of Family Studies evaluated that programme[10] and identified up to 1000 different projects relevant to youth suicide prevention. Their evaluation of the National Youth Suicide Prevention Strategy (1995 -1999) informed the expanded strategy to include all ages for suicide prevention *Living Is For Everyone* from 2000 (LIFE).[11]

Suicide continues to be a major public health issue. The causes of suicide are complex

and multifaceted, and due to this the National Suicide Prevention Strategy is a dynamic program concerned to be responsive to emerging trends and providing a comprehensive approach to suicide prevention. In addition to the initiatives referred to in this report new initiatives are under development and existing initiatives are evolving to meet changing demands.

The Living Is For Everyone - Framework provides the guidance, the evidence and good practice for suicide prevention activities. The National Advisory Council on Suicide Prevention (NACSP) will monitor the needs of the Australian community and provide advice to the Australian Government on suicide prevention activity, based on the principles set out by the LIFE Framework.

The National Suicide Prevention Strategy (NSPS) implements this strategic framework for suicide prevention across all levels of government, the community and business. This framework is known as the LIFE Framework.

The LIFE Framework sets the parameters for national activities to reduce suicide and promote mental health and resilience. It has a universal approach to the whole population and also aims to support the capacity of Australian communities to respond to these issues.

The LIFE Framework emphases building partnerships to strengthen, focus and integrate existing programs and organisations across many sectors; it promotes good practice and a consistent approach through complementary planning and joint projects between programs with related social justice, community development and health promotion goals.

There are four broad aims: -

- reducing deaths by suicide across all age groups in the Australian population, and reduce suicidal thinking, suicidal behaviour, and the injury and self-harm that result;
- enhancing resilience and resourcefulness, respect, interconnectedness and mental health in young people, families and communities, and reduce the prevalence of risk factors for suicide;
- increasing the support available to individuals, families and communities who have been affected by suicide or suicidal behaviours; and
- extending and enhancing community and scientific understanding of suicide and its prevention.

Areas for Action is the key document which outlines the Framework and describes Action Areas and strategies for suicide prevention. Six Action Areas are proposed based on a population health model for promoting mental health and preventing mental illness. This document sets out principles, priorities and directions for suicide prevention activity,

and provides broad performance indicators for measuring progress in each Action Area.

The six Action Areas are:

- Promoting well-being, resilience and community capacity across Australia
- Enhancing protective factors and reducing risk factors for suicide and self harm across the Australian Community
- Providing services and support within the community for groups at increased risk
- Providing services for individuals at high risk
- Partnerships with Aboriginal and Torres Strait Islander peoples
- Progressing the evidence base for suicide prevention and good practice.

There are two companion documents - *Learnings about Suicide* and *Building Partnerships*.

**National Suicide Prevention Strategy Funding**

The Australian Government commits around $10 million annually under the NSPS since 1999 for the development of national and local suicide prevention models. The funding has been used to fund over 25 national suicide prevention projects and approximately 170 community level suicide prevention projects.

Most of the national initiatives use population-based approaches with an emphasis on community capacity building, and operate in a range of settings. An important aspect of national initiatives is the network of strategic partnerships that allows projects to be implemented across sectors and with different target audiences. Considered together, the national initiatives provide a basic national infrastructure for the implementation of the NSPS.

Over 170 community level suicide prevention projects are being implemented across each of the States and Territories, and target locally identified suicide prevention priorities. Community-level projects funded under the NSPS fall into three broad categories:

- <u>Community initiatives</u> – partnerships within and between agencies that aim to foster community resilience and reduce risk factors that may contribute to suicide and self-harming behaviours.

- <u>Strategic development</u> – covers organisational and broad educational and

training projects that may be undertaken to increase awareness of suicide prevention activities.

· Indigenous communities – targeted funding towards addressing issues specific to Indigenous communities.

The current community based projects are diverse and address a broad range of target groups including young people, men in early to mid adulthood, Culturally and Linguistically Diverse (CALD) communities, people with same-sex attraction, rural and remote communities, Indigenous Australians and those who have been bereaved by suicide. The projects have a range of aims, examples of which include promoting help seeking in younger people, the provision of suicide intervention skills training, the development of educational resources for various target groups, the development of community capacity to respond appropriately to suicide, and the development of support mechanisms for people at risk, such as support groups. (Further information on community projects is available at: www.community-life.org.au/nsps.php . This information will also be available on the National Suicide Prevention Website (www.livingisforeveryone.com.au ) once launched in mid 2005.)

**The National Advisory Council on Suicide Prevention**

The National Advisory Council on Suicide Prevention (NACSP) is a non-statutory authority commissioned to provide advice to the Australian Government on suicide prevention and related matters. The role of the NACSP is to monitor the implementation of the NSPS promotes use of to the LIFE Framework, and provide strategic advice to the Australian Government.

The NACSP is made up of a Board, the Community and Expert Advisory (C&E) Forum and eight State and Territory Advisory Committees, one for each of the Australian jurisdictions. The C&E Forum provides advice to the NACSP Board on community and expert needs and activities for community based approaches to suicide prevention under the NSPS. The 8 State and Territory committees provide advice to the C&E Forum and the Australian Government Department of Health and Ageing on aspects of suicide prevention that are relevant to each jurisdiction.

The structure is designed for effective communication and streamlined pathways for gathering community feedback and providing timely, relevant and appropriate advice and input to the Government on the NSPS.

NACSP members come from a range of backgrounds including business, health, academia and community sectors as a means of ensuring a mix of perspectives are included in NACSP activities. The NACSP Board makes recommendations to the Australian Government for future directions and activities for the NSPS.

## Examples of National Projects

Access to Means

Access to means strategies are based on research which shows that reducing access to 'acceptable' lethal means leads to reductions in overall suicide rates, and also may create opportunities for intervention. Reducing suicide by motor vehicle exhaust gas has been identified as a priority for NSPS activity. Suicide by motor vehicle exhaust gas is the second most common method of suicide and for example accounted for 574 suicides in 2000.

Under the National Suicide Prevention Strategy (NSPS) a range of strategies are currently being explored for both new and used vehicles, including the development of a cabin air quality monitor.

Research has shown that the most effective way to detect a change in cabin atmosphere and to reduce exhaust gas suicides in vehicle cabins is by developing gas sensors that trigger alarms when dangerous changes are detected. This can be achieved by developing a vehicle cabin air quality monitor that monitors cabin atmosphere and identifies high risk driving scenarios. Following a recommendation from the NACSP, funding for Access to Means was approved for the following activities:

- Further development of the Cabin Air Quality Monitor (AQM) by the Royal Melbourne Institute of Technology University (RMIT). This activity is being undertaken in conjunction with the Department of Transport and Regional Development (DOTARS),
- Monash University Accident Research Centre (MUARC) is extending their preliminary work to address whether new vehicles are involved in motor vehicle exhaust gas suicides through further data collection and analyses,
- Testing of EURO 4 compliant vehicles to confirm emissions performance and collect data on the changes in emission concentrations of a number of gases which occur in a vehicle cabin by Orbital Australia Pty Ltd.

Strategic Partnerships – National Mental Health Prevention and Promotion

A key emphasis of NACSP activity is the development of strategic partnerships.

The process of developing links between work progressed under the NSPS and the NMHS has been informed by the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000, and its companion document the Promotion,

Prevention and Early Intervention Monograph 2000. These documents outline a theoretical and conceptual framework for action, and a series of strategies to promote mental health disorders through enhancing protective factors, and reducing risk factors. Early intervention as a means of minimising the impact of mental health problems is outlined as a key goal for action within these documents.

**Case Studies**

The following sections presents 3 case studies of national projects jointly funded under the NSPS and the NMHS. Each project has important implications for the goals for both the NMHS and the NSPS. These projects have been selected as they also show important work of the NSPS.

**CASE STUDY 1 - Mindframe** – The National Media Initiative

The Mindframe National Media Initiative seeks to influence the media industry to report mental illness and suicide issues responsibly, accurately and sensitively. Projects under the initiative have included: media monitoring research, resources for media professionals, resources for community action against stigma, and curriculum resources for journalism and media studies students and educators.

The National Media and Mental Health Group composed of representatives from the media industry and regulatory bodies, Indigenous media, consumer representatives, and mental health and suicide prevention experts, guides the Mindframe initiative. This group engages a range of interest groups including:

- media groups: radio, television, newspapers, advertising, internet, regulators; and
- experts in mental health such as professionals, consumers and carers.

A number of resources have been developed to provide media professionals with high quality tools to report in a timely, accurate, sensitive and responsible manner in relation to mental health and suicide. This set of resources includes a media kit and a web site that disseminate good practice information .

There are also a number of media resources aligned with the Mindframe Initiative, including:

- The reporting suicide and mental illness: a resource for media professionals provides practical advice and information to support the work of media professionals. The resource is designed to inform responsible and appropriate reporting of suicide and mental illness in order to reduce harm and copycat behaviour, and reduce the sigma experienced by people who experience

a mental illness. It provides current contacts, resources, facts and statistics, and suggestions about issues to consider when reporting suicide and mental illness.

- SANE Australia's web-based StigmaWatch program promotes accurate, respectful and sensitive reporting of mental illness and suicide in the media in all its forms – print, broadcasting, film, advertising and internet. Members of the public can alert StigmaWatch to examples of reports in all forms of media that they consider inaccurate or include discriminatory references to mental illness. StigmWatch collects complaints and provides a list of the reports and responses and a 'Good News' section acknowledges positive and appropriate reporting of mental illness and suicide.

- ResponseAbility seeks to facilitate the integration of mental health promotion, prevention and early intervention and suicide prevention issues into undergraduate curriculum for journalism students.

This initiative has shown each sector of the media has its own culture and language, and successful interventions need to account for these. Achieving media ownership of the project has taken two years. This has involved six meeting days, a large amount of work and research activities, and the establishment of a reporting mechanism available to the public. Research indicates that there has been a significant uptake of this project by the media and, for example, the uptake of the Journalism CD-ROM kit is currently estimated at 90%. Further information is available at: www.mindframe-media.info/

**CASE STUDY 2 – MindMatters and MindMatters Plus**

The Mental Health Promotion and Prevention Action Plan identified schools as a key setting for activities promoting mental health. The Australian Government has developed the MindMatters group of initiatives to promote positive mental health in the whole school community. The MindMatters initiatives are jointly funded by the NSPS and the NMHS.

The Australian Principals Associations Professional Development Council (APAPDC) is responsible for the national MindMatters infrastructure, management of the demonstration schools, development of training materials, the professional development and ongoing support of staff and the evaluation.

MindMatters has been developed as a comprehensive and complementary set of promotion, prevention and early intervention mental health and suicide prevention components to fit a 'whole school' framework. The MindMatters 'whole school' framework focuses on how a school can enhance protective factors for its students by: firstly, providing an environment which is safe, inclusive and supportive; secondly, ensuring a curriculum that promotes wellbeing, provides opportunities for participation, achievement and communication; and thirdly, working in partnerships for the wellbeing of the total school community. MindMatters provides a range of resources that are supported by professional development activities and a dedicated website ( www.curriculum.edu.au/mindmatters ).

MindMatters Plus builds on and operates within the framework established by MindMatters. This initiative focuses on better mental health outcomes for students with high support needs by using best practice prevention and early intervention programs for mental health, educational and vocational programs as well as a range of supportive processes and strategies.

The Australian Guidance and Counselling Association (AGCA) is managing the program, processes and strategies, providing support to schools and local partnerships, and developing links with services and systems to increase the local infrastructure to support students with high support needs.

MindMatters Plus uses the Health Promoting Schools Framework particularly: -

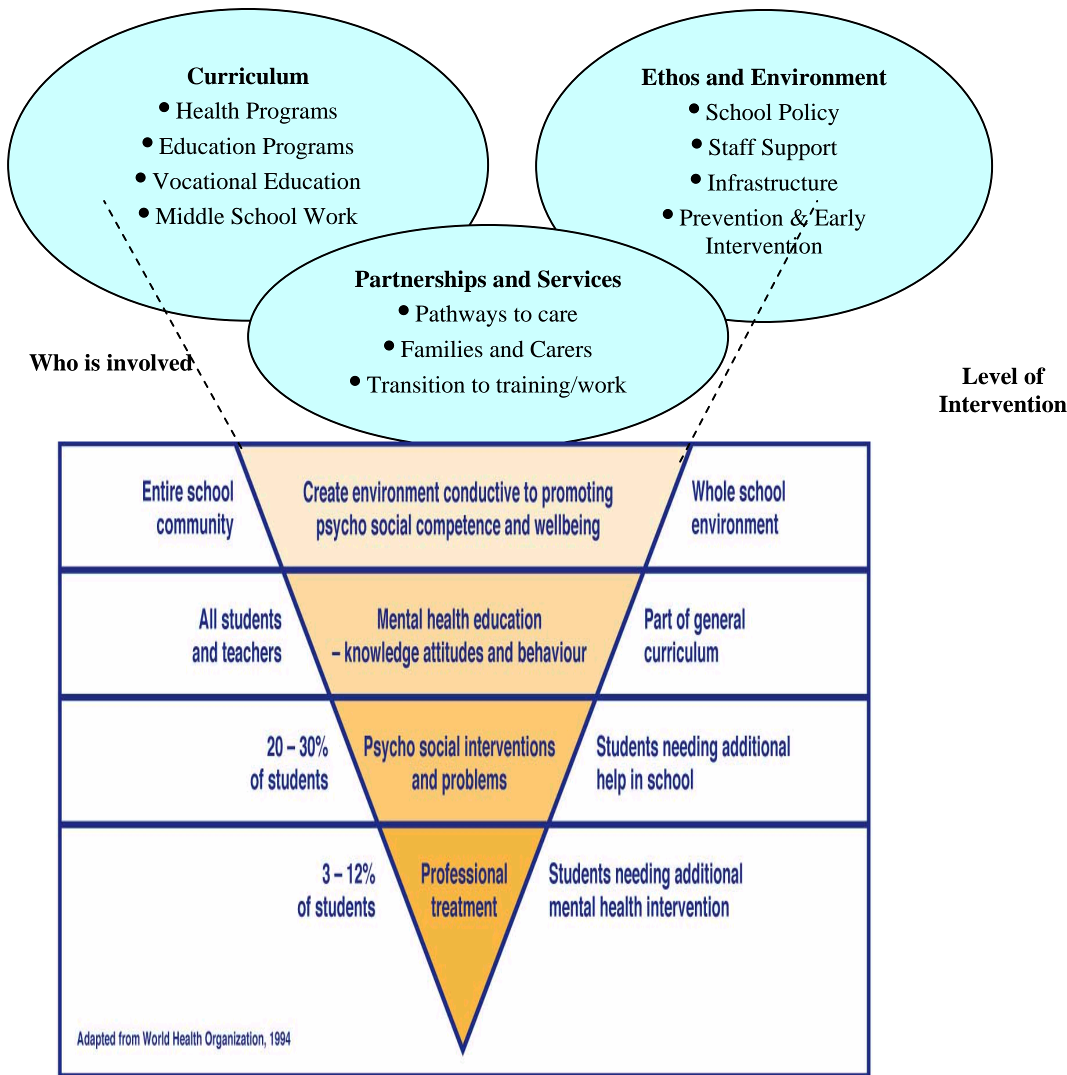
1. Ethos and environment: greater depth of school policy to include prevention and early intervention

2. Curriculum: will now include health programs as well as education, vocation and middle-school programs; and

3. Partnerships and services: this develops care pathways and networks with general practitioners and community services for students, parents and carers who need extra support.

Figure 1 is a graphical representation of the Health Promoting Schools Framework.

Figure 1 – The Health Promoting Schools Framework




MindMatters has been successful in placing mental health and suicide prevention firmly on the agenda of Australian secondary schools. Further information on the MindMatters initiatives is available at: www.cms.curriculum.edu.au/mindmatters/ .

## CASE STUDY 3 – Support for telephone help lines

Telephone help lines have been used extensively as a strategy for preventing suicide and promoting positive mental health. They are generally staffed by trained volunteers and are accessible to a large proportion of the population. Telephone support lines provide an excellent opportunity for support assistance in the development of problem solving, coping and help-seeking behaviours. These services provide information, telecounselling, support and referral.

The NSPS and the NMHS provide support to two nationally recognised telephone help lines. These are:

- Lifeline Australia: There are 42 Lifeline Centres around Australia which provide services from 59 locations, half of which are in rural and remote areas. Lifeline Centres maintain the free 24 hour telephone counselling service (131114) in addition to providing information, referral and associated services in local areas. Lifeline has also developed Just Ask, a mental health information telephone service with a particular focus on rural and regional areas of Australia (phone: 1300 13 11 14), and Just Look, a single web-based access point for national referral information (www.justlook.org.au ). Just Look enables access via the Internet and CD-ROM to all members of the community, carers, consumers and service providers throughout Australia.
- Kids Help Line: This is a free 24-hour national telephone help line (toll free number 1800 55 1800) and online counselling service (www.kidshelp.com.au) for children and young people aged 5 to 18 in Australia. Kids Help Line seeks to assist young people develop strategies and skills that enable them to more effectively manage their own lives. Professional staff deliver phone- and web-counselling services. The option to refer a caller to alternative assistance or to peer support networks in the client's local area is available.

**Data on Suicide and Mode of Suicide**

Figure 1 – Total number of suicides in Australia – 1997 -2003

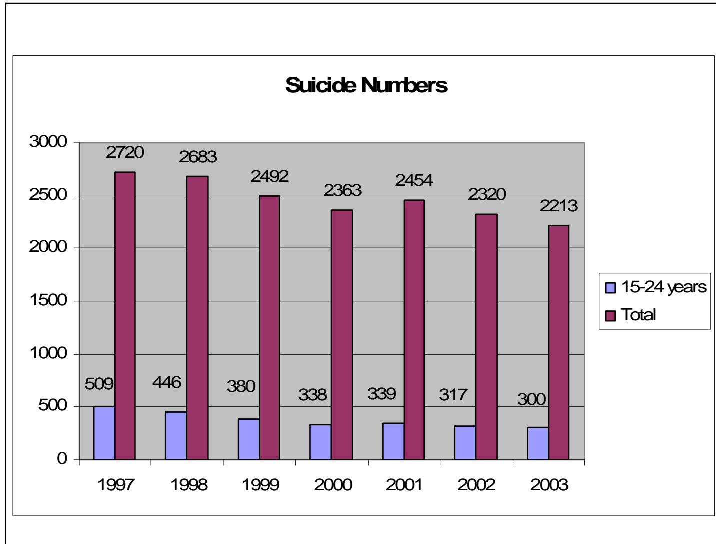



Figure 1 shows total suicide numbers for Australia from 1997 – 2002, and corresponding total suicide numbers for Australians aged 15-44. The graph shows a noticeable peak in 1997, where the overall suicide rate for all Australians climbed to 14.7 per 100,000 persons. Figure 1 also shows that total suicide numbers have continued to decline since this peak in 1997. The latest suicide data available from the Australian Bureau of Statistics (ABS) show that there were 2,213 registered deaths that were attributed to suicide in 2003. This is a continuing decline from the 1997 figures.

Suicide statistics relating to Australians aged 15 -24 remain encouraging and indicate continuing downward trends from 1997 data. 2003 ABS data show that the suicide rates for people aged 15-19 was 8.3 per 100,000 persons and that the overall suicide rate for persons aged 20-24 was 13.7 per 100,000 persons. Both of these rates corresponded to the lowest recorded rates for these age groups in the past decade (ABS, 2004).

Figure 2 – Suicide by method 1992 and 2002 Australia

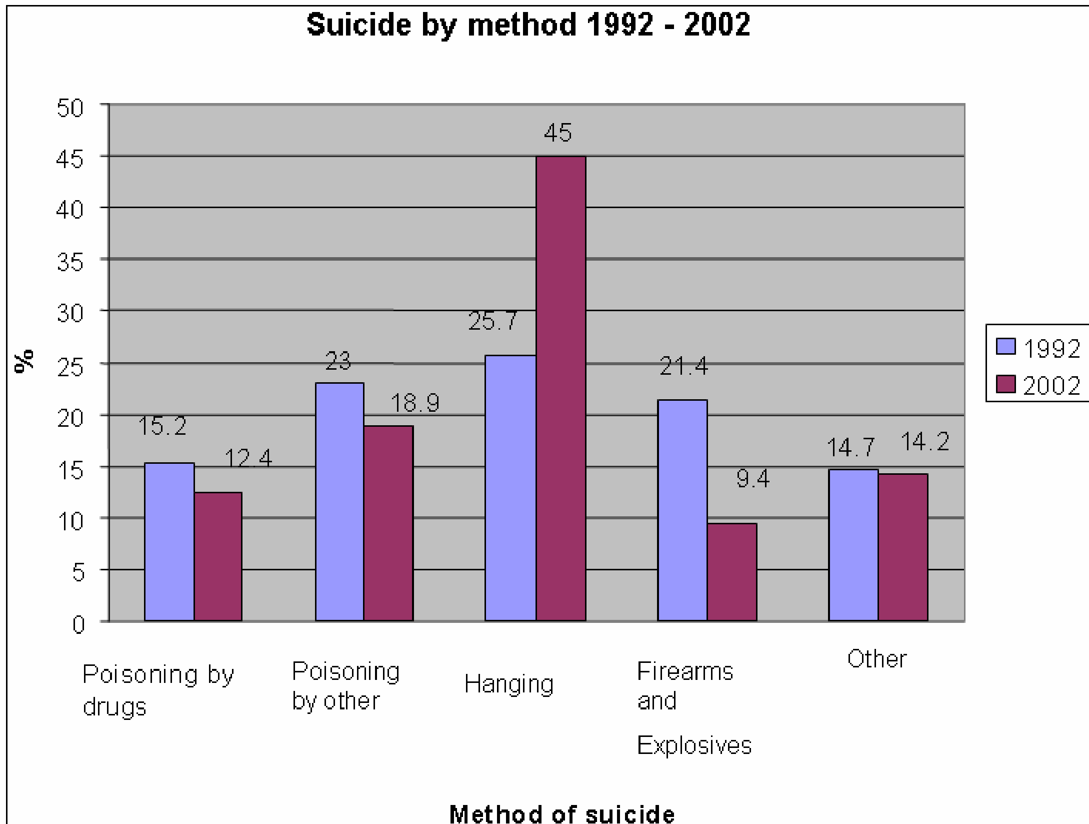



Figure 2 is a comparison of suicide methods between the years 1992 and 2002 in Australia. This figure shows that during this period, suicides attributed to the use of firearms and explosive devices have fallen substantially, while suicide by hanging has increased. The latest available ABS suicide data from 2003 show that hanging remains the most common method of suicide (45%), followed by poisoning by other (including motor vehicle exhaust gas) (19%), other (15%), poisoning by drugs (13%), and suicide through the use of firearms (9%) (ABS, 2004).

**Bibliography for Suicide Prevention**

Australian Bureau of Statistics (2004). Causes of Death 2003, Canberra: Australian Bureau of Statistics.

Commonwealth Department of Health and Aged Care (2000 a). National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000. Canberra: Australian Government Department of Health and Ageing

Commonwealth Department of Health and Aged Care (2000 b). Promotion, Prevention and Early Intervention – Monograph 2000. Canberra: Australian Government Department of Health and Ageing.

Commonwealth Department of Health and Aged Care (2001). LIFE: a framework for prevention of suicide and self-harm in Australia, Commonwealth Department of Health and Aged Care: Canberra.

## Co-existing mental health and substance use problems and disorders

In this section advanced and compounding relationships between mental health and alcohol and other drug use problems is dealt with. It is recognised that prevention and early intervention are the most important parts of the causal chain that should be given the highest priority, but focus here is on complexity.

There exist prejudices between organic disease and mental illness. Mental illnesses are in some ways seen as less legitimate than the organic diseases; as if the people who have them have suffered a failure of self-will. This gainsays the fact that many of the organic diseases represent failures of self-will through smoking, alcohol and other drug abuse, lack of physical activity and inappropriate diets.

### Risks and harms – alcohol and substance misuse

Mental health legislation has progressively attempted to confine its ambit to closely defined risks and mental illness, so that the net effect is not to trap persons without serious mental illness and/or injury risks in a compulsory system against their will. This was an appropriate development driven by concern for human rights.

Modern mental health legislation in some states is progressive and has notable features to protect the rights and sensibilities of the individuals involved. However, with the tight definition of mental illness and especially in defining the risks and the need for protection so closely (to risks of physical injury and death) led to other persons with risks of other harms being excluded from involuntary treatment. But it is clear that there are these other persons

with mental disorders who also need treatment and on occasion coercive powers may be needed.

The human rights perspective started to shift some years ago from the focus on risk of physical injury and preservation of rights of the person as the criteria for access to mental health treatment to entitlement to treatment and care. Indeed the current mental health legislation reflects this wider focus on care in the least restrictive environment and the ability of magistrates to authorise community counselling or community treatment.

When reviewing and monitoring the NSW Mental Health Act implementation in 1992, the Committee recognised that there were other needs/rights that had to be accommodated.

- One, was the concern for the person's welfare
- Second, that harm to a person or others could be more than physical harm, and,
- Third, if effective treatment is available then there are rights of access to treatment to be addressed.

The NSW Mental Health Act was amended by the Parliament to reflect this perspective and emphasis on a wider appreciation of the nature of harm to a person and to others.

**Contemporary responses to chronic "inebriation".**

At one time psychiatric illness and the problems of dependence (inebriation) were regarded as closely related and care was provided in the same institutions and through similar sets of services. Australian health care saw these two areas separate several decades ago. That was a positive change at the time, however, with the increasing recognition of the coexistence of mental health and substance use problems, this separation needs to be re-thought, and new organisational and professional approaches devised to respond to this area of serious unmet need more appropriately.

The prevalence of co-existing mental health and substance use problems is leading to an active re-think at many levels in contemporary Australia. Amongst families, professionals, politicians (federal and state) there are many proposals being canvassed.

Modern mental health acts deliberately exclude the effects of alcohol and other substances from their definitions of mental illness. A person demonstrating the characteristics of a mental illness as defined in a Mental Health Act may be held as a disordered patient for a short period of time.

This provision is to do two things. First, to provide an initial level of care and security to a

person disordered by drugs with mental disturbances in the same was would apply to a person with a serious mental illness. And, second, to ensure that a person whose mental state was the result of alcohol or substance use is not treated indefinitely as a mentally ill person. Unfortunately that begs the question of what should happen to such a person, and, indeed, what in practice does happen.

However when there is complexity and compounding need the current human service systems are found wanting.

The community is concerned about alcohol and other drug problems and the link with mental Illness:-

- The decline in access to suitable accommodation for disadvantaged people; in this case by persons severely affected by alcohol, drugs and related disorders.
- Pressure on mental hospital beds.
- The recognition that complex problems of health and related social issues are poorly managed compared with the focus and effort devoted to single diseases and issues.

Two important areas of concern are where: -

- alcohol dependence and brain impairment co-exist and cause severe disability and disordered behaviour, such that the person's general welfare is severely comprised and their very survival threatened, and,

- alcohol dependence (and other substance dependence) creates abnormal, potentially threatening and unpredictable behaviours subjecting other persons to risk of harm.

It is as if the problems surrounding these people are a set of intersecting risks and harms which are also seen in other conditions and health states of severe brain damage or dementia, and the major psychotic illnesses.

**Provision of services for this group:-**

The central question in providing services is the resources needed. While, as a general rule, dependence can be treated effectively and there are particular issues in implementing effective programmes to treat dependence, the main resource issues will be in the following domains: -

- housing - appropriateness and costs

- staff for support - workforce availability and costs
- nutrition and costs of living - access to welfare benefits
- special needs - for example, mobility, transport, various aids
- rehabilitation, and,
- ensuring a 'chain of care'

**Inebriates Acts and parallels to Mental Health Acts**

Coercive action will only be justified at a point of severe inebriation (dependence) where the person has totally lost the capacity to make rational decisions affecting their own welfare and/or control of their alcohol (or substance) use. And when those actions are in interests of preventing severe harm or to avert the risk of death, and to ensure the person can survive in dignity and in decent conditions of life.

Apart from the similarities already noted to mental illness, mental illness can co-exist in its own right with dependence (inebriation). This is the perplexing issue of co-existing mental health and substance use problems which is now being faced by government, professional organisations and community groups.

**Examples of some high prevalence mental health and alcohol and other drug use problem populations:**

a. Homeless: Elsewhere in this submission the homeless population is discussed with its massively high rates of co-existing mental health, alcohol and other drug and physical health problems.

b. Prisoners and justice systems:

A study done in 1997 and repeated more recently with even more alarming results shows that prison population is exposed to massive health and mental health risk:

1. Health data point high health risks in childhood and adolescence.
    - dental disease
    - hearing impairment
    - exposure to violent relationships
    - abusive relationships
    - sexual abuse
    - emotional disturbances

- mental health problems

2. <u>There is high exposure in adult life.</u>
   - substance abuse
   - tobacco
   - alcohol
   - illicit drugs
   - STDs
   - blood borne viruses
   - mental illness
   - self harm

3. <u>Women prisoners have problems of an order of magnitude greater</u>.
   - self reported illness
   - more disability
   - medications - pain, sleep, asthma, epilepsy, mental illness
   - worse emotional health
   - more depression
   - self harm & suicidal behaviour
   - substance abuse
   - alcohol higher than males
   - more illicit drug use
   - higher intra-venous drug use
   - higher blood borne viruses
   - higher herpes simplex-type 2
   - carbohydrate diets

Women prisoners are casualties from harmful early life experiences and social deprivation showing mental health and other harms to a very high degree. They are truly outsiders.

<u>In adolescents</u>: Catherine Spooner from the National Drug and Alcohol Research Centre has shown that female adolescents attending the PALM programme at the Ted Noffs Foundation have high scores on:

- Phobic anxiety
- Psychoticism

- Somatisation
- Anxiety
- Paranoid ideation
- Obsessive-compulsive
- Hostility
- Depression
- Global severity index[12]

c. Alcohol and related brain damage (ARBD)

The characteristics of mental illness, dementia and alcohol and related brain damage (ARBD) are contrasted below and the social programmes developed for each of these groups of conditions (see table). All have behavioural disturbances. These examples are important since mental health legislation seems to separate into different categorical responses like conditions in the lay and medical mind. These inequalities in treatment reify the 'mystery' of mental illness and the division between mental and physical health.

ARBD has the behaviour problems of brain dysfunction with added drug seeking of chronic inebriation. Aggression and violence can occur in all three, but is probably greatest in ARBD. Each has associated physical illness and much associated disability. Often there is substance abuse. Physical disability interacts with mental disablement. In two of these conditions there is memory loss and disorientation. The defining characteristics of mental illness - delusions, hallucinations, disorder of thought, mood disturbance, and sustained irrational behaviour may be shared by all the conditions - although substantially different in character.

There are social deficits and need for income support, accommodation and social support are shared between them. But it is significant that the social responses are different in magnitude and character. For two of these groups of conditions society makes provision and for the other - none!

**Table ARBD – Dementia – Severe Mental Illness**

| | DEMENTIA | ALCOHOL (& other) BRAIN DAMAGE (chronic inebriation) | SEVERE MENTAL ILLNESS |
|---|---|---|---|
| Age | Very old | Middle aged | All ages |
| Sex | F>M (larger numbers of elderly women) | M>>F | F=M |

| | DEMENTIA | ALCOHOL (& other) BRAIN DAMAGE (chronic inebriation) | SEVERE MENTAL ILLNESS |
|---|---|---|---|
| Behavioural disturbance | Yes, mainly wandering. | Continuing dependence + severe behavioural problems | Yes |
| Aggression/ Violence | Rarely | Common | Occasional |
| Physical illnesses | Chronic diseases | Usual - chronic lung disease, and severe brain & liver etc. impairments of alcohol use | Smoking diseases often; and where there is the double diagnosis of alcohol and other drug use |
| Disabilities | Debilitation | Pre-existing disabilities e.g. developmental and epilepsy. Plus disabilities due to life-style of AI & drug use | Yes, in the case of double diagnoses; smoking induced and life style if destitute |
| Brain impairment | Severe loss of memory & concentration, confusion, disorientation | Severe loss of memory & concentration confusion, disorientation, confabulation | Memory unaffected |
| Symptoms of mental illness * | Occasionally | Common - hallucinations, depressed often, irrational behaviour | Always in the acute phase. |
| Accommodation needs | At home; or in a hostel or nursing home | Rarely at home; usually homeless; no group homes; often in NGO homeless refuges | Sometimes at home; sometimes in group homes; quite often in NGO homeless refuges |
| Family support | Quite often has family support; but females often unsupported | Family usually alienated. Sometimes a close family member such as an elderly mother | Family sometimes alienated. Likely to have family support |
| Social security - income support | Age pension | Unemployment benefits; sickness benefits; disability support pension; special benefit | Unemployment benefits; sickness benefits; disability support pension; special benefit |

* delusions, hallucinations, serious disorder of thought, a severe disturbance of mood or sustained repeated irrational behaviour indicating the presence of any of these symptoms.

In the vexed cases of chronic alcohol and substance use to the point of chronic inebriation, there is a need for careful legislation to intervene in the interests of the person's welfare and health when there is strong and unequivocal evidence of a serious risk of harm, continuing survival or death.

New measures along these lines should include oversight by independent persons with the range of skills and perspectives represented by (1) interests of citizens, (2) medical and mental health professions, (3) law, and (4) social welfare.

However the problem for government is the continuing and growing problem of how to accommodate and support persons so affected. There will need to be a re-think of how government provides accommodation for persons at risk of homelessness, and those who are seriously impaired in their physical or mental capacity.

There will also need to be a re-appraisal of the relationship between government and the non-government sector with an emphasis on stronger partnership and bilateral accountability and support.

## Homeless people and mental illnesses

The Covenant of the United Nations Universal Declaration of Human Rights (Article 11) states - parties *"recognise the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions."* [13] The right to adequate housing derives from the right to an adequate standard of living and from economic, social and cultural rights. And the UN Committee on Economic, Social and Culture Rights has said that the right to housing is not a narrow or restrictive interpretation of shelter as merely being a roof over one's head or of shelter being seen exclusively as a commodity; rather it is the right to live in security, peace and dignity.[14] Further the Commission on Human Settlements and the Global Strategy for Shelter to the Year 2000 said: "Adequate shelter means ... adequate privacy, adequate space, adequate security, adequate lighting and ventilation, adequate basic infrastructure and adequate location with regard to work and basic facilities - all at a reasonable cost." [15]

But there are many homeless people in Australia among whom the mentally ill and otherwise impaired and disadvantaged people are numbered. It is not sufficient in this context to think only of the homeless visible on the streets but the many others who are constantly in a state of insecure and uncertain accommodation. There are degrees of homelessness: [16]

| Characteristics | Degree of homelessness |
| --- | --- |
| People without a roof over their heads, living on the streets, under bridges and deserted | Absolute homelessness. |

| | |
|---|---|
| buildings. | |
| Housed but without conditions of a "home" e.g. security, safety, or adequate standards. | Third degree - relative homelessness; inadequate housing; incipient homelessness. |
| People constrained to live permanently in single rooms in private boarding houses. | Second degree – relative homelessness. |
| People moving between temporary or medium term shelter such as refuges, boarding houses, hostels or friends. | First degree - relative homelessness. |

What needs to be said is how quickly a person on becoming homeless adapts to, accepts these circumstances, and develops a tolerance that leads them to give and sink into a state of helplessness. In the UK this is known as the 'three week rule" graphically described in Still dying for a home a report from the UK.[12]

**Who are the homeless?**

People lose their homes from a cascade of interactions - lack of affordable housing, high rates of poverty and the disabilities in their personal lives. Homelessness is a continuum of the insecurity of a single room to an absolute state of 'rooflessness'.

Our homeless population is now changing from being comprised largely of single men, to include more families and children. This started in the late 1980s.[17] Over one third of people accommodated in services funded under the Victorian Government's Supported Accommodation Assistance Program in 1993-1994 were children and adolescents.[18]

> In 1985, the Federal Government Department of Housing and Construction estimated that 40,000 slept out of doors and that 60,000 people were inadequately housed and had no security of tenure or income.[19] I have not been able to find recent estimates for Sydney. (There are more recent data which I have not had time to include here.)

Many point to the increasing number of young people. This is indeed true but hides the many older homeless people. The younger people appear to swamp them. A relatively higher proportion of these young people have problems of mental illness and drug abuse.

Among the homeless - immigrants, refugees, minority groups such as Aboriginal people, people from rural areas, the poorly educated and the illiterate – are over-represented.

**Interactive effects of mental illness.**

There are the primary symptoms - hallucinations, delusions, and disorders of thought and mood. These interact with substance abuse, physical illness, reproduction and child rearing, ageing, sexuality and so on. Then, there are the secondary consequences of depression and bodily and psychic retardation; lack of drive, poor social skills, stigma, loss of esteem and confidence, concentration and focus and application and so on[20].... These are the disabling consequences which lead to further social disadvantage.

Such attributes compound with substance use and abuse, neglected health, poverty, poor nutrition, social isolation, segregation and discrimination; and to these ethnicity is a further compounding factor. It is no wonder we speak of the downward social drift of people with mental illness. Of all medical conditions, mental illness has one of the strongest correlations with unemployment. The night refuges bed a disproportionate number of people with mental illness and very many require social security support.

**The Vicious Cycle of Rejection**

Many years ago the Director of Health, Education and Welfare in the US said: “If you have one problem there is about 60% chance that it will be picked up on presentation to the human services; if there are two, there is 60% chance that the problems will not be picked up at all, and three .......” It is an exponential decline.

Many studies show how rarely the long-term problems of people with mental illness are engaged by human services. At the first level, it is simply a question of the laws of probability, that is, that agencies and services operate independently of each other - and do not look to person’s broad health and welfare needs. If there is mental illness or a drug and alcohol problem, the services can be even more dismissive as the person can be said to be not motivated.

In the age of specialisation there is a reluctance of agencies to look beyond their immediate remit. They prefer “clean skins”, “our sort of problems”. To this exclusivity must be added the thrust of modern government to be efficient through targeting resources and services to defined need areas. And now as many of the functions of the public sector are to be “out sourced”, this leads to even greater fragmentation of services and an immense loss of accountability.

**Some examples:**

A man has schizophrenia, which requires on-going medication and develops a large hernia. The mental health services will not treat the hernia; in fact they are more than likely to be unaware of it. The general hospital is reluctant to admit a man with schizophrenia to a general surgical bed.

A person smokes heavily (as people with mental illness often do) again a barrier to surgery if he/she has lung disease. He/she maybe is on a Disability Support Pension. He/she may then be placed on a public hospital waiting list competing with others for priority. If he/she is homeless, is there likely to be aftercare, can there be follow-up? How will they be contacted? Will anyone advocate priority for this person?

**Illness, disease, disability and injury.**

Mortality

Life is short. The mortality of homeless people 15-74 years of age in Philadelphia was four times the general population.[21] Among rough sleepers in London, Bristol and Manchester between 1995 and 1996, death rates were 3.6 to 5.6 times the general population, with an average life expectancy of 42 years. [22]

Diseases

The above study of rough sleepers in London found they suffered from the same conditions as the general population, but more often and more severely.

In New York City the rates of common diseases in the homeless were two to fourteen times than in a matched sample of urban respondents in a National Ambulatory Medical Care Survey.[23] A more recent study 2004 showed that in a New York street clinic, the homeless people have on average 9 concurrent medical conditions.(*** ref.)

There are high rates of illness and delayed development in children of homeless families. The mothers have higher rates of mental illness.[24]

Diseases of Destitution

The diseases so characteristic of this group are similar to other severely impoverished populations and represent the end point of destitution. The extremes of impoverishment and social deprivation and the downward pressures of chronic disability amplify the adverse influences on health seen in the general population.

| **Conditions** | **Factors** |
|---|---|
| Malnutrition | Lack of food, poor diet |
| Multiple injuries | Violence, falls and MVAs |
| Substance abuse | Tobacco, alcohol & other drugs |

| Conditions | Factors |
| --- | --- |
| Respiratory disease | Smoking and exposure to infection |
| Skin conditions | Contamination and exposure |
| Brain and nervous conditions | Injury, alcohol, nutrition |
| Mental illness | Onset of disabling psychosis |
| Mental impairment | Brain damage & disease, and developmental |
| Physical disabilities | Childhood disabilities, injury and disease in adulthood |
| Cancer | Life-style and exposure e.g., smoking and alcohol |
| Feet problems | Injuries, poor hygiene and inadequate shoes. |

**Mental illness and substance abuse**

In Sydney and Melbourne, a high proportion of the city homeless have been shown to have a mental illness or impairment.[25 26] At Matthew Talbot Hostel in 1993, 41% of the men had mild to severe cognitive impairment.[27] At the medical clinic it is estimated that 25% attending for primary medical care have a mental illness.[28] The general impression is that 50% of the men presenting have a serious problem of the mind or brain.

The inner city agencies in 1997 said their staff estimated:

- 25% have cognitive impairment,
- 20-25% had psychotic disorders,
- a high level of major depressive symptoms in the past 12 months,
- a high level of anxiety symptoms in past 12 months, and,
- many have more than one disorder.[29]

**Reasons for the high prevalence of mental disorders in homeless people**

The high rates are not because people who were previously in mental institutions are being discharged as is commonly believed, but due to a range of factors.[30] There is the increase in poverty.[31 32] The remarkable statistic from New York is that 3.3% of its population spent some time in homeless centres between 1988 and 1993 (24 000 each night).[33] High

unemployment, retreat from welfare, targeting of services often excluding those with mental illness and the scarcity of low cost housing all contribute.[12 34] Males with schizophrenia and substance abuse disorders tend to be concentrated in the disintegrated communities of the inner city.[35] Effectively what happens is that the most vulnerable in tough times get squeezed by a pincer movement into lower and lower cost housing. Thus, those who are most vulnerable – including especially those with mental illness – are concentrated in the night refuges and the streets.

**Substance abuse**

Substance abuse is a major part of the work of the health and welfare agencies involved with the homeless. Death rates are highest in this group.[11]

The importance of alcohol dependence is unfortunately exaggerated and masks personal and social pathology, such as chronic pain, mental illness and disablement. The UK study of rough sleepers considered that alcohol misuse affected between one third to a half of rough sleepers.[11] One in five of the men at the Matthew Talbot Hostel in 1974 said alcohol was the cause of their present situation.[7]

The health risks and vulnerabilities change over time. In the 1970s a Melbourne study made no reference to HIV/AIDS, little reference to drug abuse and passing mention only of mental illness.[36] These are major issues today.

**Causes**

It is easy to attribute the problems of homelessness to an individual's failing. This is especially the case with the public face of homelessness as "alcoholism". But "alcoholism" is not as common as people believe it is just more visible. The viewpoint is more about what is visible.

In 1994 the Royal College of Physicians said,

*"there is growing support for the argument that the health problems associated with homelessness are primarily an indication of the failure of housing policies. To date, effort has been focussed on improving access to health and social care, but such special schemes can only have a limited effect on the long-term health profile of homeless people if the root cause of their ill health, homelessness, persists."*[37]

In 1995 the main reasons for homelessness in families in Melbourne was the fact they could not afford housing.

**Reasons given by 31 families for their current housing crisis[38]:**

| | |
|---|---|
| Inability to find or maintain affordable housing. | 17/31 |
| No money | 11/31 |
| Relationship breakdown | 8/31 |
| Family violence | 7/31 |
| Eviction | 6/31 |

**A study of Sydney's Homeless Population (1997)**

75% had at least one mental disorder. (This is four times the rate in the general population. The question is, to what extent is this a key factor in becoming homeless, or is it product of being homeless?)

23% of men and 46% of women have schizophrenia. This condition occurs at less than 1% in the general population.

49% of men and 15% of women have an alcohol use disorder. This is as much as 5 times the rate in the general population.

36% of people have a drug use disorder. This is as much as 15 times greater than in the general population.

The same questions apply to these conditions as to mental illness. How much of this is a cause or a result of a person's circumstances? It is difficult to generalise. People with mental illness drink alcohol to control their feelings and thoughts, alcohol "blots our time" it "takes time away", and it is not always the primary cause of person's circumstances. And when you have chronic pain from an early injury or chronic disease, alcohol is not a bad analgesic when no one will refer you to a pain clinic. If sleep is hard to get when living rough, or when trying to sleep in a crowded dormitory - alcohol is a cheap sedative.

33% of people have a mood disorder.

26% of people have an anxiety disorder.

These finding should be no surprise in such and insecure and threatening environment and would result as well from the traumas of early life.

10% of people have a cognitive impairment.

Impairment of this kind, can be a contributory cause of homelessness, and with the high rates of injury and alcohol and other drug use, it can be an important outcome of homelessness.

Finally, in these findings there was a marked discrepancy between observed health of this group and their subjective experience of it. There is no doubt that homeless people have low expectations. When there has not been much in life you don't expect much from it. When your mind or brain does not work, physical symptoms are accepted. Men and women in this environment regard places as home, and situations as acceptable, which to the general population would be totally unacceptable. The mentally ill person prefers their freedom and this life, than containment in a mental hospital.

## Disability (especially mental disability) and income support

### Determination and decisions about Income Support

There is a preoccupation around testable medical states, a search for objectivity and a philosophy which seems to accept that the prime task is to protect the social welfare system against fraud and malingering.

(There had been a Royal Commission into welfare fraud in Britain some forty years ago which found there was indeed fraud, but it represented a small percentage of the whole. And most of the fraud was by officials rather than the claimants. Also, during that period the Annual Reports of the Department of Social Security where data were published on fraudulent claims (or similar) these were of the order of 1-2%; hardly a sign that preventing fraud should be a major goal of the Government.)

There is a constant theme - that persons receiving disability pensions are either, undeserving or that they were 'malingering'. In these processes those with mental health and related problems are inappropriately excluded adding to their already severe disadvantage.

### Assessment Process – Determination of Eligibility

In assessing disability or incapacity a range of skills and appreciation of the person's predicament

are needed. Assessment has to be true to the needs and requirements of the person and needs, and to embrace aspects of mental and body function and functional capacity in a social sense. As already indicated above, there has been constant and recurring attempts to harden up the assessments to tightly focused medical impairment criteria.

There is a further problem - that those who make assessments of the person's health or incapacity need to be able to re-evaluate and follow-up that assessment/determination, as the accuracy and validity in the end needs to be re-evaluated and followed-up. Essentially that means that professionals engaged in practice who are involved in the follow-up of particular patients are in the best position to make a judgment about the severity or otherwise of a persons disability.

Contrarily, there have been attempts to establish specialised assessment centres and specialised assessment groups for disability. These will never work with any justice.

Such an approach removes the decisions from reality and causes those who have a defined role as an 'assessor' and a vested interest in demonstrating they are doing a good job – to appear firm, hard-nosed and rigorous in the decision-making. The pressure then is on the side of exclusion from income support benefits.

Furthermore, medical specialists unfamiliar with real-life situations of people in their communities make hard indeed punitive decisions about a person's incapacity. I have noted this especially in the area of respiratory disease where certain physician specialists rejected individuals for access to disability support with a prejudiced judgment about the level of respiratory impairment; a degree of impairment which in many instances reflected terminal respiratory disease the extreme end of disablement.

**Homeless people with Mental Health Problems**

For homeless and mentally ill people current requirements are too often punitive and counter-productive.

**A true story: --**

"In a clinic for homeless people a rather vulnerable soft-faced young man in a state of bewilderment was referred to me. I found it hard to work out the underlying problem. He had mental symptoms, obviously distressed and vulnerable.

I learned he was of South American descent and had been back to South America for several years with his mother. Until coming to Sydney he had lived with his mother in Melbourne. He did not stay at school. He had a limited circle of acquaintances and was unable to get work in Melbourne. I understood his mother had encouraged into go to Sydney looking for work. And so he ended up homeless.

He clutched a tattered piece of paper which listed the few places he had approached to obtain work. This was a requirement for an income support payment (NewStart or

JobStart). He had to show he had sought a sufficient number of jobs. Yet he lacked confidence, had high levels of anxiety -- indeed panic, was depressed and had few skills -- social or personal.

I referred him to a psychiatrist who did a thorough assessment. He did not think the young man had the type of mental illness I had considered, rather he had delayed development."

This is the experience of so many. Very frequently the homeless and other marginalised people are depressed, have great difficulty in personal contact, and lack confidence in their own capacity to relate to other people or indeed to initiate contact with them. The way income support arrangements are implemented at this level does far more harm than the intended good (namely encouraging people back to work).

**Another example - access to responsible officers:**

"I visited a patient who was under my care in Liverpool Hospital; he was a long standing patient. He was very poor and had major health problems and depended totally on income support for bare survival. He was extremely disabled.

When I arrived at the bedside he was weeping. He showed me a letter he just received from Centre Link which had cancelled his Disability Support Pension. I can't recall the exact reason but it was a trivial requirement of failing to respond to a request of some kind. I tried there and then to contact the Department to find out what was going on. From my point of view, indeed of anyone who could see, he was a person with severe disability which was unchanged, indeed deteriorating."

That was frustrating. All I achieved was going into a "pushbutton" queue in ever increasing circles. Later in the day I decided to visit the CentreLink office in Liverpool to speak directly to a responsible officer. That did not work either. There was an apologetic somewhat embarrassed officer who did not know what to do: the most that could be offered was a form to fill in.

The problem here is the lack of meaningful access of persons such as physicians representing the interests of their patients for advice or of any way of exploring this aspect of the predicament of the people under their care.

**In sum:**

The concerns are that persons with problems related to mental health and substance use, and others, such as the homeless and the borderline homeless get treated unreasonably by the current income support systems. The way people are assessed is not comprehensive, more especially the processes do not take account of the significant and

real behavioural and mental disorders that many people who need income support face.

Furthermore, the bureaucratic processes often exacerbate and affect negatively the already marginalised position of people with complex and compounding needs (medical and social). The system is unduly punitive and judgemental.

There are of course many arguments about the adequacy of income support payments. My experience is that for a large number of people with the needs (referred to above) their impoverishment is cemented into Catch 22 predicaments. Their very survival is compromised.

## Concluding comments about mental health services

At a macro level - mental health should be the central focus for health care and public health

Mental health is not solely the responsibility of the defined mental health services – it is the core business of primary care, and general practice indeed of all the human services. It should not be left only to a group with a defined perspective and techniques in mental and behavioural interventions.

The unresolved problem is the question of "place'.. for people affected by mental problems and I would say increasing for the many groups with impairments, disabilities of all kinds and social exclusion.

Non-government sector needs a re-appraisal of the relationship between government and the non-government sector with an emphasis on stronger partnership and bilateral accountability and support rather than the client/supplicant relationship of the present time.

Leadership: There is a compelling case for a new style of leadership, leadership which will generate energy and enthusiasm. Leadership is where others are led and supported, not a defensive focus on management and risk aversive practice. Others need to be entrained in this enthusiasm for mental health – teachers, police, lawyers, playwrights and everyone concerned with health and human services.

**Ian W Webster**

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[1] American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th ed. Washington, DC: American Psychiatric Association, 1994.

[2] Human Rights and Equal Opportunity Commission Report of the National Inquiry into the Human Rights of People with Mental Illness Vol. 2 Commissioner Brian Burdekin AGPS, Canberra 1993 page Mental Illness and Substance Abuse.

[3] *Suicides Australia, 1921-1998* 2000 Canberra, ABS.

[4] World Health Organisation *Program on Substance Abuse,* 1998. Geneva, WHO.

[5] United Nations *Prevention of Suicide Guidelines for the formulation and implementation of national strategies,* 1996. New York, UN.

[6] Mason G. *Youth Suicide in Australia: Prevention Strategies,*1990. Canberra: Youth Bureau, Department of Employment, Education and Training.

[7] Burdekin B. *Human Rights and Mental Illness: Report of the National Enquiry into the Human Rights of People with Mental Illness,* 1993. Canberra: Human Rights and Equal Opportunity Commission.

[8] Hall W, Degenhardt L and Lynskey M. *Trends in Opioid Overdose and Suicide Mortality in Young Adults in Australia 1964-1997* 1999 National Drug and Alcohol Research Centre, The University of New South Wales NDARC (Technical Report No.67)

[9] Sawyer MG, Arney FM, Baghurst PA et al. *The Mental Health of Young People in Australia: The Child and Adolescent Component of the National Survey of Mental Health and Wellbeing*, 2000 Canberra, AGPS.

[10] Mitchell P. *Valuing Young Lives: Evaluation of the National Youth Suicide Prevention Strategy.* 2000 Melbourne: Australian Institute of Family Studies.

[11] *Living Is For Everyone (LIFE): a framework for prevention of suicide and self-harm in Australia. Areas for Action*. 2000 Canberra, Commonwealth Department of Health and Aged Care.

[12] C Spooner (NDARC & Ted Noffs Foundation, 1997)

[13] Official Records of the General Assembly, Forty-third session, Supplement No. 8, addendum (A/43/8/Add.1).

[14] Official Records of the General Assembly, Forty-third session, Supplement No. 8, addendum (A/43/8/Add.1).

[15] Official Records of the General Assembly, Forty-third session, Supplement No. 8, addendum (A/43/8/Add.1).

[16] Burke 1993 adapted from Chamberlain and Mackenzie, 1992 quoted in Shadow People: The Reality of Homelessness in the 90's Sydney City Mission, July 1995 p.6

[17] Efron D, Sewell JR, Horn M and Jewell F Children in homeless families in Melbourne: health status and use of health services. Medical Journal of Australia 1996; 165: 630-633.

[18] Victorian Supported Accommodation Assistance Program. Annual Report, July 1993 – June 1994. Melbourne: Department of Health and Community Services, 1994.

[19] Department of Housing and Construction. Study into homelessness and inadequate housing. Vol 1. Canberra, AGPS, 1985.

[20] American Psychiatric Association. *Diagnostic and statistical manual of mental disorders. 4th ed.* Washington, DC: American Psychiatric Association, 1994. Schizophrenia has three groups of symptoms: psychotic (positive) - delusions and hallucinations; negative symptoms, representing loss of normal functions (flat affect, alogia, apathy, anhedonia - asociality and inattentiveness); and disorganisation symptoms (bizarre or disorganised behaviour, disjointed speech or formal thought disorder, incongruous affect).

[21] Hibbs JR, Benner L, Klugman L, Spencer R, Macchia I, Mellinger MD and Fife D Mortality in a cohort of homeless adults in Philadelphia *New Eng J Med* 1994; 331: 304-9

[22] Grenier P *Still dying for a home* Crisis, Challenger House, London 1996.

[23] Wright JD and Weber W *Homelessness and Health* McGraw-Hill Healthcare Information Centre, Washington DC, 1987, p.103.

[24] Wood DL, Valdez RB, Hayashi T and Shen A *Pediatrics* 1990; 86: 858-866.

[25]Doutney CP, Buhrich N, Virgona A, Cohen A and Daniels P. The Prevalence of Schizophrenia in a Refuge for Homeless Men *Aust NZ J Psych* 1985; 19:233-238.
[26]Herrman H, McGorry P, Bennett P, van Riel R, Wellington P, McKenzie D and Singh B *Homeless People with Severe Mental Disorders in Inner Melbourne* Council to Homeless Persons, Melbourne, 1988.
[27] Teeson M and Buhrich N Prevalence of cognitive impairment among homeless men in a shelter in Australia. *Hospital and Community Psychiatry*, 44:1187-1189, 1993.
[28] Nurse Practitioner evaluation Matthew Talbot Hostel, New South Wales *Department of Health Nurse Practitioner Project Stage 3, Final Report of Steering Committee*, December 1995.
[29] Shifting the Deckchairs Homeless People and Mental Health Services in Inner City Sydney report by Sydney City Mission, society of St Vincent de Paul, Salvation Army, Wesley Mission and the Haymarket Foundation, August 1997.
[30] Geddes J, Newton R, Young G, Bailey S, Freeman C and Priest R Comparison of prevalence of schizophrenia among residents of hostels for homeless people in 1966 and 1992. *Brit Med J* 1994; 308:816-9.
[31] Wilkinson RG Socio-economic Differences in Mortality in Wilkinson RG (ed.) *Class and Health*, Tavistock, 1986: 1-16.
[32] Saunders P, Smeeding M, Coder J, Jenkins S, Fritzell J, Hagensers Alkki JM, Hauser R and Wolfson M. *Noncash Income, Living Standards, Inequality and Poverty: Evidence from the Luxembourg Income Study.* Social Policy Research Centre, The University of New South Wales, 1992.
[33] Against the culture of contentment Editorial *Lancet* 1993; 342:1373-1374
[34] Shadow People: The Reality of Homelessness in 90's Sydney City Mission, 1995: 10-14.
[35] Klusmann D and Angermeyer MC Urban Ecology and Psychiatric Admission Rates: Results from a study in the City of Hamburg in *From Social Class to Social Stress New Developments in Psychiatric Epidemiology* Angermeyer MC ed. Springer-Verlag Berlin Heidelberg New York pages 16-45 1987.
[36] Jordan *A Going Bad: Homeless Men in an Australian City* Published by The Council to Homeless Persons in Victoria, 1994.
[37] Homelessness and ill-health (1994) Report on a working party of the royal College of Physicians.
[38] Efron D, Sewell JR, Horn M and Jewell F Children in homeless families in Melbourne: health status and use of health services. Medical Journal of Australia 1996; 165: 630-633.