SUBMISSION TO THE INQUIRY BY THE SENATE SELECT COMMITTEE ON MENTAL HEALTH

St Vincent de Paul Society
National Mental Health and Homelessness Advisory Committee

June 2005

BACKGROUND OF THE ST VINCENT DE PAUL SOCIETY

The St Vincent de Paul Society has been assisting Australians in need and in difficulty for over a century. It is now one of the largest and most cost-effective welfare organisations in Australia. The St Vincent de Paul Society was formed in Australia by concerned members of the Catholic Church and has been providing assistance to the poor since 1850.

It is a Christian organisation, seeking to demonstrate compassion and social concern for individuals suffering in modern society. The Christian faith is a motivating force behind the mission and principles of the St Vincent de Paul Society, but our voluntary membership is by no means exclusively Catholic. We assist people in need regardless of their religious or political beliefs, or situation in life. We do not ask anyone if they have religious beliefs or what they might be.

We are a lay organisation. We receive no funding from the Catholic Church, and no operative directions from the Catholic hierarchy. The St Vincent de Paul Society's funds are provided by donations, by enterprises run by the St Vincent de Paul Society and through government funding.

The works of the St Vincent de Paul Society are maintained by volunteers who give freely and generously of their time and employees as required, to assist people of low income and disadvantaged situation. The organisation is a democratic one. Major office bearers and those with voting rights are elected to their position for a limited term. Like any democratic institution, our members comprise a broad spectrum of economic, political and philosophical sectors of the community. We suffer the same advantages and disadvantages of any democratic institution.

The St Vincent de Paul Society in Australia has over 44,000 active members and a staff of nearly 3,000. These people serve in over 1,000 local parish conferences and committees around Australia.

Home visitation is the main service provided by the St Vincent de Paul Society. In response to requests for assistance, Society members see people in their homes and provide them with food, furniture, clothing, financial assistance or simply support and friendship. The St Vincent de Paul Society visits around 350,000 homes every year, helping about 1.8 million people.

We are the only charitable organisation to visit people in their homes and thus have a special perspective of the needs and situation of those in Australia most vulnerable to economic changes.

Our services include:

- Over 600 stores across the country provide clothing and household items free of charge to low income earners and raise revenue for the St Vincent de Paul Society through sales to the general public. Prices are set to provide good quality clothes at affordable prices for low income earners;
- A budget counselling service aims to provide people with the knowledge and skills to assist them to live independently and safely within their income;
- Support for people with gambling problems;
- Refuge accommodation for families, for homeless men, for refugees and migrants;
- Refuge accommodation for women (and children) in crisis;
- Emergency accommodation;
- Subsidised accommodation for tertiary students;
- Residential Aged Care Facilities, including Dementia-Specific Care;
- Self-Care Aged Units;
- Care and support centres;
- Youth drop-in centres;
- Children's activities and holiday programs;
- Child care services;
- Pregnancy counselling;
- Drug and alcohol rehabilitation services;
- Support services for the mentally ill;
- Outreach services to homeless people;
- Aboriginal support services;
- Assistance for Migrants and Refugees, both in the community and in detention centres;
- Mobile food services

Each State and Territory Council is autonomous as far as its assessment of the needs of marginalised people. State and Territory Councils therefore develop strategies which include decisions as to which services are provided and how they will be delivered. In some cases there are varying degrees of incorporation of service-delivery structures.

In all cases there is a shared vision to "cooperate in shaping a more just and compassionate Australian community."

In just about all areas of the St Vincent de Paul Society's service to the community, the issue of mental illness is increasingly evident and affecting our capacity to assist those in need. Approximately 70 per cent of people in our homeless persons' emergency accommodation suffer from a mental illness and we estimate 60 per cent of those we visit at home have a mental illness or challenging behaviours.

Our budget counselling services, nation-wide stores, residential aged care, migrant and refugee services, etc. are similarly affected.

RESULTS OF PREVIOUS REVIEWS AND REPORTS

The St Vincent de Paul Society, like others, have contributed to the many enquiries that have re-evaluated the plight of those with mental illness in our nation – especially in terms of their access to proper treatment and care, accommodation and social justice.

We totally agree with the Mental Health Council of Australia 2002 Review that current community-based systems fail to provide adequate services.

"Specifically these services are characterised by: restricted access; variable quality; poor continuity; lack of support for recovery from illness and, protection from human rights abuses. In the view of consumers, carers and health professionals who provide services, this does not represent a failure of policy. Instead, it is a failure of implementation through: poor administration; lack of accountability; lack of ongoing government commitment to genuine reform; and, failure to support the degree of community development required to achieve high quality mental health care outside institutional settings."

And that *"despite the efforts of many committed politicians, government officials, service providers and community advocates, we do not have a system of effective or accessible mental health care. At all levels of government, within some of the professions and out in the wider community, there is a perception of general apathy, lack of accountability and lack of commitment to real change. While public understanding of mental health has begun to improve, the wider community remains relatively ignorant of the service crisis. Only when a family member needs care are they made aware of the gross deficits in (mental health) care."*

Key issues of the Mental Health Council of Australia Review were grouped: unmet need for basic mental health services; inadequate growth in expenditure; restricted access to existing services; ongoing human rights abuses and neglect and increasing demand for mental health care. The most recent glaring example was that of the incarceration in a detention centre of Cornelia Rau by Queensland and Federal Agencies.

Similarly, the New South Wales Legislative Council Select Committee on mental health in its 2002 inquiry stated:

"The rate of homelessness and imprisonment of people with a mental illness must not be allowed to continue." and "The weight of evidence presented to the Committee highlights that mental health services in New South Wales need revolutionary improvement. Deinstitutionalisation, without adequate community care, has resulted in a new form of institutionalisation: homelessness and imprisonment."

In Victoria, JW Cameron, Auditor General (2002) reported:

"This audit identifies a range of concerns about the timeliness of service provision, the completion of key service delivery processes in compliance with relevant standards and guidelines, and the burden placed upon carers and families. In making these findings, I do not wish to impugn the many dedicated professionals providing mental health services. It is clear that the service system is under significant stress, due to the demand pressure, work force shortages and the increasing complexity of mental disorder in our society."

The SANE Mental Health Reports 2002-3 and 2004 found:

- Mental health services are in disarray around the country, operating in crisis mode and with numerous official inquiries under way;
- Proven effective treatments for mental illness are not routinely available under Medicare;
- Untreated mental illness is a leading contributor to Australia's suicide rate;
- The cost of schizophrenia alone will spiral to $10 billion a year this decade unless services are improved;
- The current Mental Health Plan is faltering, and there is an urgent need for action to maintain the impetus of the National Mental Health Strategy.

And that there are no coherent national strategies covering key issues such as dual diagnosis, rehabilitation, supported accommodation, education and training for family and other carers.

The Bensemer Review (2003) commissioned by the Northern Territory Government found that:

"Despite the production and subsequent non-implementation of a series of reports and studies over the past decade" the Territory's mental health services were "under-resourced, fragmented and poorly supported."

These are just some of the various reviews and reports from around Australia on our mental health system. In varying degrees they all seem to say the same thing – we have a system in crisis and even in areas with good models, good intentions and committed innovative health professionals, there is insufficient funding to implement services properly. The evidence is compelling – some states have not made substantial moves planned under the National Strategy and most have failed to implement the National Mental Health Standards or report significant increases in funding.

KEY DEFECTS IN THE CURRENT SYSTEM

From Institutional Neglect to Community Neglect

The problems associated with mental illness are complex – with biological, psychological and social ramifications, which often sadly continue over many years.

The reduced reliance on stand-alone psychiatric hospitals and the expansion of community-based and primary mental health care as outlined in the National Mental Health Strategy are to be applauded, however, structural reform has been patchy and very uneven and the "felt" reality of consumers, carers and the Non Government Sector who provide the bulk of accommodation, rehabilitation, outreach, social and recreational programs in the community is that the situation is deteriorating rapidly.

The stampede by Government Health Departments towards hospital-only based care services and an exit wherever possible from direct involvement in social programs, rehabilitation and accommodation is tragic.

The thinking that drives the "shared care" model that leaves general practitioners responsible for primary mental health care in the community is unrealistic. To discharge patients prematurely from acute care and expect general practitioners to be responsible for the ongoing management of their mental illness is irresponsible.

The situation is made even more disastrous because of the increasing number of general practitioners not bulk billing. What inevitably happens is that those general practitioners who bulk bill have very long waiting times, the mentally ill person (who needs a quick response) does not wait, goes back into the community untreated to have another unmanaged episode of his/her illness.

The National Mental Health Report 2002 may give the impression that outcomes are improving but this does not match the reality experienced in the community.

A decade plus after the National Mental Health Strategy, there is only one inescapable conclusion:

There is no real commitment by governments, state and federal to provide adequate funding for government and non government services. This is particularly evident regarding the non government service providers who provide the bulk of community support to mentally ill people.

Medical intervention is only one factor in regaining and retaining wellness. It is critical that there are social and emotional supports available to people with a mental illness in the community as that is where people actually live. Very few live in hospitals, nor do they spend much time at community mental health facilities getting medicated!

The system we now have is setting people up to fail. Social isolation and loneliness are guaranteed to trigger episodes of mental illness and suicide and the vicious cycle starts all over again.

The St Vincent de Paul Society is most concerned that proposed changes to the Disability Support Pension. Disability welfare reforms will further disadvantage people with a mental

illness by making them more vulnerable to payment suspension and increased risk of homelessness.

The Buck-Passing to Stop

Mental illness is the most significant health issue in the country. Governments and the medical profession have failed dismally to provide adequate services. Recently that failure was sensationally highlighted in the Cornelia Rau case.

The failure was again highlighted by Justice John Dunford of the New South Wales Supreme Court who said:

"To think that in the 21st century persons who are mentally ill are locked up in prisons in solitary confinement is a matter that must disgust any right-minded citizen."

"The man (Mr Mohamad Ayoub) is obviously mentally ill, he has already been found unfit to be tried… he is probably suitable for admission as an involuntary patient to a mental hospital but nothing has been done."

Mr Ayoub has been incarcerated for 14 months, is in solitary confinement and the appropriate assessment from the Mental Health Review Tribunal has been neglected for eight months.

The St Vincent de Paul Society National Mental Health and Homeless Advisory Committee unequivocally supports the submissions, recommendations and findings of the various inquiries and reviews mentioned above and joins in the common cry for a "Fair Go" for people suffering from mental illness. Many of the statements of shortcomings, unfulfilled promises and of needs have been repeated from previous occasions and expresses the global disappointment at inaction and lack of resolve on the part of governments and policy makers.

There needs to be more resources as well as a better use of existing resources and an acknowledgement that all Australian governments must work together to provide adequate services for the mentally ill.

The statement by Christopher Pyne, Australian Government Parliamentary Secretary for Health:

"Australia's States and Territories stand condemned for their failure to deliver adequate mental health services"

indicates a buck-passing mentality that is part of the problem.

The Need for Additional Funding and Research

Obviously resources are a major issue. The assumption at the time of the National Mental Health Strategy was that the proportion of health expenditure allocated to mental health would increase. We find that approximately two thirds of additional Commonwealth expenditure is related to the increase in pharmaceutical costs, and growth in State and Territory expenditure is minimal compared to the increased need.

The St Vincent de Paul Society would like to emphasise that even though expenditure in mental health has increased since the National Mental Health Strategy, there is no evidence that the proportion of total health expenditure exclusively allocated to mental health has increased.

The result is that, with the broader mix and expansion of services required by government under the National Mental Health Strategy, evidence is that there are actual declines in the number of clinical services available.

There certainly is a need for more funding for research into both medication and therapy. Effective treatments not only boost the quality of life of those with a mental illness - in the long term they can minimise health and economic costs.

The St Vincent de Paul Society believes that a drastic rethink is needed about what services are available and who and how these services and resources should be provided and allocated.

It's Time for Radical Rethinking

As a result of their illness and/or the side effects of medication it is vital that people with mental illness have access to support services in the community when they need them. They also need access to services that will advocate on their behalf, be a voice in their wilderness, as well as provide opportunities to establish and maintain social and emotional relationships.

The problem in Mental Health cannot simply be reduced to bed numbers for patients needing acute care. This indeed is a real problem but only a part of the overall need and solution. The real issues are in the community and include lack of resources for adequate housing, easy access to properly resourced community based services and access to independent advocacy services. Good mental health is not just a matter of clinical service provision but requires ongoing support from both government and non-government community-based services.

Despite 12 years of a National Health Strategy services are failing the mentally ill. The problem is well summed up by Professor Ian Hickie of the Mental Health Council in the Medical Journal of Australia 2005:

"We think it's time for a radical rethink, to set some real new targets that impact on suicide, disability and delivery of services,"

"We think unless there's really genuine national leadership, we won't see any genuine improvement in the services delivered on a day-to-day basis, particularly to those people with severe illnesses, particularly those people who need early intervention and ongoing care."

"There is a mish-mash of services; poor coordination, many gaps in services and it requires both levels of government to get their acts together to deliver proper services,"

On the one hand we have these grim assessments from the likes of Professor Ian Hickie of Sydney University, Professor Patrick McGorry of the University of Melbourne and Dr Grace Groom of the Mental Health Council of Australia. On the other the conflicting assessment from Professor Harvey Whiteford that while mental health services reform had been uneven, it was progressing and "the system has big problems but it is a hell of a lot better than it was ten years ago". Professor Whiteford, an architect of the current National Strategy comments

on the six per cent increase in acute beds for people with a mental illness and a 65 per cent increase in federal government funding. He says the systemic pressures are partly due to community education campaigns highlighting mental illness.

The St Vincent de Paul Society welcomes community education because it has in fact shown a mental health system in gross disarray after 12 years of a National Health Strategy. Community education has highlighted that at least 20 per cent of the community at any given time is suffering from mental illness. In addition there is an unknown quantity of people affected by mental illness (carers, parents, children, friends, employers, employees, etc.).

WHAT IS TO BE DONE?

The following recommendations are part of the radical rethink process that must take place if current inadequacies are to be addressed and rectified.

These recommendations focus on the issues encountered by Vincentians in their front-line work. The fact that the mental health system in Australia is failing many with a mental illness has dire ramifications for this substantial portion of our community, their families and society as a whole. We firmly believe the recommendations we have listed will bring a measure of fairness and justice to all Australians.

Recommendation 1

Establish Federal and State Ministries of Mental Health to coordinate and improve services.

This mirrors Recommendation 1 of the Inquiry into Mental Health Services in New South Wales by the New South Wales Legislative Council Select Committee on Mental Health.

A Ministry of Mental Health should be established in the Federal government and Offices of Mental Health should be established in the Premiers' Departments of all States and Territories.

These offices would be involved in policy development as well as coordinating mental health and other relevant services both nationally and state by state. Namely:

-Housing;
-Community Services;
-Health;
-Police;
-Corrective Services;
-Non Government Organisations and Community Service Providers.

Currently the system is poorly coordinated between the six major mental health service contributors namely, general practitioners, private psychiatrists, private psychologists, private hospitals, state inpatient and community services and non-government organisations. The current system has been likened to a chariot with six horses and six horsemen. Focussed direction will only come when there is one horseman.

Recommendation 2

Establish Departments of Mental Health and Disorders in each State and Territory to address all areas of mental health.

A department responsible for Mental Health and mental health disorders should be established in each State/Territory responsible for the mentally ill. While mental health continues to be linked to mainstream health departments, the waters will be very muddied – particularly with respect to finances. It is just too easy to allocate mental health dollars to other health areas. As one non government organisation service in New South Wales (totally Department of Health funded) commented recently, "If at the end of the financial year $300,000 specifically earmarked for mental health has not been spent, what's wrong with

using it to buy a new piece of cardiac equipment?" That is an indication of how confused the thinking can become when mainstream health has control of mental health and has the capacity to siphon off mental health dollars.

We believe the department should be named "Mental Health and Disorders". This department would be responsible for all areas of care for people with mental health disorders. A clear example of an area that is currently administered unsatisfactorily is that of licensed boarding houses in New South Wales. The majority of people in licensed boarding houses have a mental illness and should be the responsibility of the Department of Health however, licensed boarding houses are oversighted by the Department of Ageing, Disabilities and Home Care. The unfortunate result is that many licensed boarding houses are a blight on society and indicate a gross lack of commitment towards social justice by government.

Recommendation 3

Introduce Integrated Service For Dual Diagnosis To Prevent People Falling Through The Gaps.

Substance abuse should be managed by the same department as mental illness (The Department of Mental Health and Disorders). We must stop ignoring the huge issue of "dual diagnosis" – in particular that of mental illness and substance abuse (mainly drug/alcohol). The current demarcation of responsibility and lack of integrated services must cease.

People with dual diagnosis tend to "fall through the cracks" of our mental health and drug and alcohol services. They are shuffled back and forth between services which treat only half the condition. Overseas experience indicates a need for integrated treatment. There are two groups:

- People with schizophrenia, bi-polar disorder or major depression who self-medicate with alcohol and drugs in an attempt to lessen the symptoms of their illness, eg to stop the voices;
- People with personality disorders who may use a cocktail of drugs: marijuana, amphetamines, cocaine, heroin as well as alcohol. The members of this group cause enormous problems in hostels, homeless shelters, psychiatric units, jails and on the streets. They can develop toxic psychosis, become acutely disturbed, can be suicidal and extremely violent. They require secure accommodation, therapeutic counselling services and medication given with care.

Overseas, dialectical behaviour therapy (DBT) has been found effective in treating people with personality disorders.

Both groups often require a rehabilitation program which includes the development of living skills. A residential component may be necessary for this to be successful.

Recommendation 4

Establish National Mental Health legislation to allow uniform management of the mentally ill across the nation.

The St Vincent de Paul Society would support a National Mental Health Act. The multiple State Mental Health Acts lack uniformity and have no validity outside their respective State or Territory. This has allowed many seriously ill patients to become lost to treatment and

care. A National Mental Health Act would allow treatment/management of persons with significant mental illness in their own communities and across all borders.

Recommendation 5

Change the non-government organisation funding process to provide funding without bias.

Charitable and Non Government Organisation funding should be one step removed from the State department responsible for mental health clinical service delivery. He who pays the piper calls the tune. The offices created in Recommendation 1 would be responsible for non government organisation funding allocation and accountability.

Recommendation 6

Increase funding to non-government organisations to provide crucial non-clinical services.

There must be a massive increase in resourcing of non-government and charitable organisations that provide assistance to the mentally ill in the community. The threefold increase in funding to non-government organisations over the last ten years is totally inadequate. Accommodation, rehabilitation, outreach and other forms of community support are generally supplied by non-government organisations which receive five per cent of the mental health budget nationally (SANE 2002 – 03 Report). Most mentally ill people do not live in hospital – they live in the community. Non-government organisations can deliver some services more effectively and efficiently than government. As government agencies exit, non-government organisations are fast becoming the only providers of social and recreational services, effective and relevant advocacy, living skills training and rehabilitation.

Recommendation 7

Return to recurrent funding to guarantee continuity of services.

There needs to be a review of the increasingly common practice of funding programs by calling them pilots or one-off capital grants (even though the money is not spent on capital works). Governments are reluctant to embrace recurrent funding as it means an ongoing financial commitment.

The problem with "pilot" programs are obvious. How does one ensure that a service provider commits a 100 per cent effort when the program has a life of only one or two years? Similarly, how can the provider attract quality staff with such a short-term employment commitment? One-off capital grants in lieu of recurrent funding have the same issues.

Recommendation 8

Establish a task force to address the accommodation/support crisis.

A task force should be established as a matter of urgency to investigate all aspects of the massive accommodation crisis. This should include short, transitional, medium and long term accommodation. There needs to be a commitment to create at least 1000 accommodation places nationally per year for the next five years. It should be recognised that the accommodation crisis applies to both metropolitan and rural/remote areas.

The same task force should find a solution to the chronic shortage of adequate, continuous multi-faceted (in all areas of life) support for both those people who require accommodation and those who currently reside in Department of Housing properties and other living situations.

Recommendation 9

Establish a special task force to address crisis in rural and remote areas/indigenous communities.

A separate task force should be established to focus on and provide practical and economically sustainable solutions to mental health issues in rural and remote areas in general and Aboriginal communities in particular.

Much work and many reports have been done that show a prevalence of depression, anxiety, heavy use of psychoactive substances and high risk behaviours in Aboriginal communities. Issues of high suicide rates, substance abuse and feelings of demoralization and despair are of great concern.

"Problems are exacerbated (in Aboriginal communities) by severe socioeconomic adversity, lack of basic requirements for healthy lifestyle in terms of housing and nutrition, frequent and repeated losses through high levels of premature mortality, high prevalence of major physical illness such as diabetes, heart disease, infectious diseases and so forth. Racism and other aspects of social stigma add additional risk factors for mental disorders and psychological burden." (National Consultancy Reports, Aboriginal and Torres Strait Islander Mental Health Policy 1995.)

Recommendation 10

Establish asylums as secure retreats for people with a severe mental illness who cannot be cared for in the community.

The word asylum has taken on meanings far removed from the definition of a "secure retreat". The St Vincent de Paul Society encounters many people every day with a chronic mental illness and severe depression who need a secure retreat. Because of the severity of their illness they cannot live successfully in the community but are forced to. Their illnesses have a frequent episodic nature and some eventually resort to suicide under the current system.

Recommendation 11

Review existing systems and services to reduce the rate of imprisonment of people with a mental illness.

A separate section of the offices established in Recommendation 1 and the new State Departments of Mental Health and Disorders should focus on our prison systems. Unfortunately prisons have turned into de facto institutions for the mentally ill. The St Vincent de Paul Society would advocate that no one with a mental illness should be in mainline prisons, however, under our existing system many are locked up for their own protection there being no other reasonable method of housing them. For those that are in prison and have a mental illness, there needs to be a pre-discharge plan which includes adequate financial resources, budgeting and living skills and linkage to exit housing with appropriate supports.

Recommendation 12

Increase funding for social/recreational and friendship programs to help prevent people from failing.

Develop, promote and fund social and recreational facilities and friendship programs across the nation. A recent Society survey in Victoria found that over 16 per cent of the people they see in their homes have a diagnosed mental illness (Our experience is that approximately 60 per cent have undiagnosed mental illness – page 2). Of the group, 92 per cent experience loneliness and lack of social contact, 98 per cent have difficulty with financial stress, 73 per cent can't properly manage their household (hygiene, shopping, cooking, etc.) and 75 per cent had problems maintaining physical well being. We believe this to be an accurate sample of what is happening across the nation. Can you imagine waking up every morning with nothing to do, nowhere to go and no one to see or visit… every day… day after day?

The success of the Active Linking Program in New South Wales (with a very restricted client group), the St Vincent de Paul Society's social/recreational/living skills/vocational programs, the Compeer Friendship Program and the Clubhouse movement all reflect the importance of this type of community support service in maintaining wellness. Without such support the system is yet again setting people up to fail.

Recommendation 13

Allow for modifications to Privacy legislation to enable medical and welfare organisations to be more effective.

Another look at privacy issues is needed. St Vincent de Paul Society members are often the only ones to care for people living in the community with a mental illness. We visit them, befriend them and try and help them access resources there can improve their quality of life. One of our centres, near a major mental health acute care hospital in New South Wales, often has people coming in who were discharged 30 minutes earlier with instructions that if they have nowhere to go, 'Vinnies down the road will look after you'. When faced with these cases it is essential to know the nature and extent of people's illness and whether they are on medication and what side effects to expect. We are told by their clinician (if we can find him/her) or mental health worker that no information can be divulged because of recently introduced Privacy Legislation. If we are to maximise our assistance it is crucial that we know what we are dealing with. We do not in any way want to manage their illness but need to know certain facts currently denied to us under Privacy Legislation, to enable us to provide the appropriate assistance that no one else in the community currently provides.

Recommendation 14

Provide respite accommodation to prevent carer burnout.

There needs to be respite care for the mentally ill. Families often deal with incredibly stressful situations and the St Vincent de Paul Society increasingly seeing signs of chronic strain and mental illness amongst carers themselves (ARAFMI findings).

Ideally, such respite centres should not be in an institutional setting – rather there should be adequately resourced group homes in the community.

Recommendation 15

Extend community education to deal with the stigma of and help the community to understand people with a mental illness.

This entails a commitment to more comprehensive community education on all aspects of mental illness. While there has been some progress made in this area there is still a long way to go before those with mental illness are truly understood and accepted. More education enabling people to identify the early warning signs of mental illness is vital. For example, research has linked marijuana use and schizophrenia. Issues such as this and any other "triggers" should feature predominately in any community education program.