St Vincent de Paul Society
NATIONAL COUNCIL
good works

ABN: 50 748 098 845

National Council of Australia Inc
22 Thesiger Court
Deakin ACT 2600
PO Box 243
Deakin West ACT 2600
Telephone: (02) 6202 1200
Facsimile: (02) 6285 0159
Website: www.vinnies.org.au
Donation Hotline: 13 18 12

National Mental Health Commission
PO Box R1463
Sydney NSW 2000

Submitted via email to enquiries@mentalhealthcommission.gov.au

Submission to the Review of Mental Health Services and Programmes

The St Vincent de Paul Society (the Society) is a respected lay Catholic charitable organisation operating in 149 countries around the world. In Australia, we operate in every state and territory, with more than 60,000 members, volunteers, and employees. Our people are deeply committed to our work of social assistance and social justice, and we run a wide variety of programs around the country. Our work seeks to provide help for those who are marginalised by structures of exclusion and injustice, and our programs target (among other groups) people living with mental illness, people who are homeless and insecurely housed, migrants and refugees, and people experiencing poverty.

On 24 March 2014 submissions opened for the Review of Mental Health Services and Programs. We have consulted nationally, including a survey we sent to national leaders within the Society, and we welcome the opportunity to make this contribution.

1. Executive summary

The Society plays a very large role in mental health around Australia. We do this, in part, because there is a gap that is left by public programs.

An individual's mental health crisis almost never occurs in isolation: it is intertwined with housing stress, employment options, race, gender, class, place, and the success or otherwise of previous mental health interventions. We call for a new approach to mental health in Australia, that recognises these intersectional issues, and focuses on community education and early intervention.

2. The role the St Vincent de Paul Society plays

Assisting over 2 million Australians each year, members of the Society inevitably come into contact with a large number of people experiencing mental illness. The rates of mental illness that our volunteers witness vary hugely between the programs we run. Across all programs, we estimate that 15-25% of the people we see have a diagnosable mental illness. However, this number rises to more than 40% of those we assist with emergency relief funding. The fact that people require emergency relief may be a symptom, a cause, or both, of their mental illness. At even higher levels, for those who we assist who are experiencing chronic homelessness, for one service 88% of clients were predicted to meet the criteria for a mental health disorder.

To meet this need, the Society runs a range of tailored mental health services around the country. For example, we run private rental brokerage programs for people living with mental illness, as well as specific mental health courses within some of our broader homelessness services. For example, in Tasmania we run Bethlehem House, a residential facility for homeless men with a strong focus on case management and mental health treatment. In the ACT, we run Samaritan Services: Community Based Case Management Support for adults with diagnosed mental illness. There is also the Compeer program, which is a volunteer friendship program for people recovering from mental illness. Many states run other programs in coordination with government, and some of our local Vinnies conferences have a particular mental health focus. In addition to these formal programs, there is a large amount of informal counselling, advice, and referring on that our volunteers have to provide on a daily basis when we visit people in their homes, and do other work within our local conferences. These programs and initiatives help promote the mental health of hundreds of thousands of people each year.

3. The efficacy and cost-effectiveness of programmes, services and treatments

It is reasonable for the Australian community to expect that there are reciprocal and complimentary public health services in place to meet the needs of disadvantaged groups such as the mentally ill, those with drug and alcohol dependency, people experiencing severe housing deprivation, etc.

However, in our experience, while in some regions programs are excellently managed and coordinated (for example the ACT), in others public mental health systems appear stressed and understaffed. Our volunteers have reported that acute referrals are a particular problem, as are issues around dual and triple diagnoses. The intersectionality of housing services and mental health services also comes up time and time again: however effective mental health treatment is, it will fail without safe and secure housing in which someone can complete their recovery. Another big problem that was raised in our survey was the lack of services to support our volunteers who visit people in their homes.

When these services are not available, as is frequently the case in regard to community mental health and alcohol and other drug services, it places significant stress on the Society and its members who are not usually equipped to meet these complex needs either in a crisis situation or where there exist longer term mental health conditions. The Society is deeply concerned that services as they currently stand are inadequate, as many people are left totally on their own.

4. Duplication in current services and programmes

It is difficult to see any duplication in current services and programs. All of our survey respondents believed that duplication was not an issue. It seems that current programs general have well-defined target groups, and almost all are already at full capacity. While some programs have similar aims, there are already not enough resources to go around. There is no space for cuts to mental health services in Australia.

5. The role of factors relevant to the experience of a contributing life such as employment, accommodation and social connectedness (without evaluating programs except where they have mental health as their principal focus)

As mentioned above, mental health is a highly intersectional policy issue. It is intimately connected to housing, employment, and community, as well as to race, age, and gender. Asylum seekers, for example, experience far higher rates of mental illness than non-asylum seekers. This is particularly true when their right to housing (and to freedom) is being violated by being kept in detention centres.

On the other hand, employment is a strong protective factor against mental illness. With rising unemployment, the impact of environmental change (droughts and floods), downturns in the mining and manufacturing sectors, and fewer opportunities for education and retraining in some industries, rates of mental illness will continue to escalate. With

support payments such as Newstart inappropriately indexed, and not increasing in real terms, it is getting harder and harder for people to pick themselves up.

Housing is another major factor relevant to a contributing life. There are significant levels of itinerant behavior, with homeless people experiencing an enduring mental illness moving from suburb to suburb, town to town with little or no intervention from public mental health services. This also places these individuals at risk of being assaulted, falling physically ill, or engaging the criminal justice system while being very mentally unwell. The Society's crisis accommodation services can go part of the way, but not all of them are able to provide the intensive mental health care required.

The Society is also concerned by the ageing population, and the increasing physical health problems that it brings. We fear we will see a growing group of Australians who are increasingly socially isolated, as their communities shrink, their health worsens, and government-supported programs are cut.

These concerns are particularly grave in the case of individuals with a preexisting, chronic, serious mental illness, such as schizophrenia or bipolar disorder. Here, the impacts are magnified dramatically, as there is even less opportunity for employment and social connectedness. There is a widening gap in community supports for these persons. Whilst a positive step in consumer choice, the move towards individualised funding packages under the NDIS raises serious concerns that the reduction in block funding will reduce the capacity for important supports such as case management and intensive support to persons who are very unwell.

We support and would like to see more investment in 'step down' facilities, which develop and provide environments of recovery for persons during that vulnerable period when they have exited from an institutional setting. These services not only have a proven record of improving life skills and self-esteem, they also greatly reduce the use of expensive hospital and psychiatric unit visits for the people they support.

6. The appropriateness, effectiveness and efficiency of existing reporting requirements and regulation of programmes and services

Our survey shows that most Society members feel current reporting and regulation is improving, although there is still some way to go.

Two-way dialogue is being promoted, and there is an increasing focus on outcomes rather than outputs, which our members rate as positive. However, there are still improvements that need to be made. For example, use of the Psychiatric Outcomes Measurement Tool has been highly variable, largely due to the absence of suitable and affordable software, lack of user support, and inconsistent use of the tool across the sector.

7. Funding priorities in mental health and gaps in services and programmes, in the context of the current fiscal circumstances facing governments

While the Society accepts that the government has a revenue shortfall, we do not believe that the answer is to cut services. Instead, we believe that revenue – which is falling in large part due to very recent tax cuts and additional concessions – must be raised.

As identified in our recent report 'Two Australias',[1] there are a wide range of ways in which government could increase its income, without damaging the economy or business confidence. ACOSS has also done a lot of work on taxation reform.[2] Simple measures that could increase revenue include cutting tax exemptions on large superannuation contributions and on investment housing purchases, along with other measures that would rein in some of the government hand-outs to the rich. In addition to this, some of the personal tax cuts of the last 10 years could be undone. This would comfortably resolve the "current fiscal circumstances" facing federal government.

There are several key funding priorities that need to be addressed, although this is just the tip of the iceberg. First, the Society believes that more must be done on early intervention in mental health care. We have consistently argued that early intervention and education is far more beneficial – personally, economically, and socially – for a range of social issues, including homelessness, and criminal justice engagement. Moreover, from an early intervention point of view, the Society is often in an excellent position to step in early. We are there, along with other community-based organizations, at the coalface, and if more resources flowed to this level then we could stop situations escalating out of control. This in turn would reduce demand on hospital emergency departments once a full blown crisis occurs.

Secondly, while there has been great emphasis placed on the development of remote 24 hour help lines, these do not substitute for local responses. Too frequently the advice is to call the police, who become first responders and defacto mental health workers. In many major metropolitan centers (not just regional areas) around Australia, both crisis teams and assertive community teams have largely disappeared, leaving Society members, the police, or the community to deal with quite unwell people. More must be done to support front-line emergency services for people in crisis.

Finally, high turnover (discharge) rates from psychiatric in-patient units mean that patients return to the community with only temporary accommodation, inevitably leading to their presentation at Society facilities. Often their needs for healthcare and accommodation support are complex, requiring specialized interventions. The Society can and does play an important role at certain points in this continuum of support, but clearly cannot and should not be the sole provider of all services. Strong, responsive partnerships are essential with other agencies, and more must be done to ensure that people have supportive housing arrangements in addition to their mental health treatment plans.

[1] http://www.vinnies.org.au/icms_docs/169073_Two_Australias_Report_on_Poverty.pdf.
[2] Eg http://www.acoss.org.au/policy/economics_and_tax/ .

8. Specific challenges for regional, rural and remote Australia

Because the Society operates across the country with almost 1200 conferences and 58,000 members and volunteers, its geographical spread is unique and unparalleled. In rural and remote areas, these Society conferences with their related services are often the only option available to people, particularly with the decline in services and centralizing of government departments and agencies in regional Australia. There is often geographic isolation from secondary supports such as hospitals and community health centres, as well as isolation from family and friends. In Victoria in recent years we have been told it has also been very hard to get primary care from psychiatrists in regional areas. Support workers are often required to travel large distances to reach clients, which poses another problem.

Case study: Lismore (provided by a volunteer)

The present frontline services in the Lismore Diocesan Central Council are well below an acceptable standard. The Society opened a homeless intervention and prevention facility at Tweed Heads in June last year. Since then, the mental health services that we have tried to coordinate with have been severely lacking. Morale appears to be low among workers, and local services are not receiving adequate funding. One of our clients died recently as a result of inadequate mental health care. The Coroner was advised of our concerns surrounding this death. We have met with the Minister but little has changed. We will continue to advocate strongly on this issue.

9. Specific challenges for Aboriginal and Torres Strait Islander people

The Society frequently encounters individuals from a CALD or Aboriginal and Torres Strait Islander background. This experience highlights for us the need for culturally appropriate services and cultural awareness training both in terms of immediate public mental health interventions for a crisis, and longer term care and support.

10. Recommendations

1. A Fifth National Mental Health Plan be developed, for the period 2014 – 2019.
2. Any policy changes to mental health be underpinned by an intersectional approach, with proper consideration of the relationships between mental health and employment, housing, poverty, race (including ATSI, migrants, and refugees), gender, class and place (regionality).
3. A strong emphasis be placed on early intervention and prevention, and mental health across the lifespan, rather than only at points of crisis.
4. More focus be placed on community education around mental health, to:
    a. Reduce the stigma of mental health, and encouraging people to seek help where needed; and
    b. Support volunteers (of the Society and other organizations) who interact with people experiencing severe mental illness on a frequent basis, and need the skills to recognize, manage, and refer.

The Society would welcome the opportunity to engage regularly with the National Mental Health Commission and equivalent state and Territory based organizations to ensure good communication including the exchange of information and exploration of potential joint initiatives.