Australian Senate
Select Committee on Mental Health

Submission
from
Micah Projects Inc
20 Merivale Street
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1. About Micah Projects Inc

Micah Projects Inc (Micah) is a faith-based, social justice initiative in collaboration with St Mary's Catholic Community, South Brisbane. Micah's mission is:

> *To respond to people who experience exclusion, poverty, injustice and social isolation so that they may experience inclusion, economic well-being, justices and connection with their community of choice.*

Under the aegis of this its mission, Micah manages five key projects which provide a range of services for homeless and vulnerable individuals and families in the greater Brisbane area. The services include facilitating and enabling peer support; providing and/or brokering flexible and adaptable professional support; case-management in collaboration with other services; outreach and crisis support; and advocacy services.

Because of their socio-economic and personal vulnerability, many of the people with whom Micah works have mental health issues to contend with – ranging from mild mental illness to chronic and persistent mental illness. In particular, the work of the following Micah projects intersects significantly with mental health issues and the mental heath sector:

- **Micah Inner City Services (MICS)**

MICS is an integrated and cross-cultural response to homeless people who are vulnerable and experiencing social exclusion. MICS staff operate from a traditional centre-based service and as outreach workers in public space 'hot spots' where homeless people congregate. It is MICS objective to monitor safety in public space and pro-actively support homeless people to access and sustain appropriate and affordable housing, augmented with support services. Many homeless people, across all ages and cultures, present with mental health problems which must be addressed if a homeless person is to break the cycle that contributed to homelessness in the first place. Some are clinically diagnosed but others are not.

It is noteworthy that many MICS clients are Indigenous and that a growing number of homeless families, with multiple and complex needs are presenting as homeless. The latter reflects a worrying new trend across Queensland with significant impacts on the lives of children.[1]

- **The Esther Centre (Esther)**

Esther is an agency that supports people who have suffered abuse, either sexual, physical and psychological or a combination of these, in faith-based, state-based and human service organisations. Esther advocates with and supports people through processes to seek redress for their abuse. It also facilitates and supports peer group support and networking and is a strong voice in systems advocacy.

The 2004 Senate Report *Forgotten Australians* [2] reveals a correlation between institutional abuse of children and the development of mental health problems in later life – across a wide continuum of mental illness. Esther's work necessarily intersects with this. The agency

[1] Walsh, P, *More than Just a Roof: A Study of Family Homelessness in Queensland*, QUT Press, Brisbane, 2003
[2] Australian Senate, Community Affairs References Committee, *Forgotten Australians*, Commonwealth of Australia, Canberra, 2004, pp 314 -316

provides advocacy, counseling and support for people who need to address mental health issues as a critical part of the healing process. Esther also provides support and social linking for people who have been placed in residential facilities for treatment arising from their abuse as children.

- **Community Living Program (CLP)**

CLP is an initiative under the Residential Support Program (Disability Services Queensland and Health) to support people with a disability who live in private residential services such as supported accommodation facilities, boarding houses and private aged rental. The aim of the program is to break down social isolation by linking people in these facilities with networks and supports that are meaningful to them and which will enhance their life situation.

It is noteworthy that the sector with which the CLP works has been the one which filled the accommodation gap when people with psychiatric and other disabilities were moved from institutional care to community care.[3] Consequently, the work of the CLP frequently involves contact with many people with chronic and debilitating mental illness.

The extent of the CLP's contact is illustrated by the fact that in 2004 the program has contact with 20 of the 25 supported accommodation facilities then operating in the greater Brisbane area.

This brief description of the three Micah projects demonstrates that the agency's work is closely aligned with people who struggle with mental health issues and whose challenge is to overcome barriers, both personal and systemic, that impede their recovery. These population groups include:

- homeless people - across gender, age, race ethnicity and family composition;
- people who have been de-institutionalised and moved out of institutional care and into community care; and
- people who as children in care suffered abuse in church and state institutions.

This is the lens which Micah brings to the Senate Mental Health Inquiry. Micah is engaged on a daily basis with people vulnerable to the impact of mental illness and to the struggle to attain and sustain good mental health and well being, over and against many odds. Micah's approach in grounded in reflective service provision and facilitation of peer support mechanisms which enable the voice of vulnerable people to be heard.

2. Addressing Selected Terms of Reference

It is not Micah's intention to respond to all the Terms of Reference (ToR) but, rather, to address those that best fit with the work it undertakes though the three projects described above. Consequently, this submission will address ToR – a,b,d,e,j,l,m

Term of Reference (a)
The extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress

[3] Horan, M, Mullar, J, Wincour, S, Barling, N, 'Quality of life in boarding houses and hostels: A residents' perspective' in *Community Mental Health Journal*, Vol 31, Issue 4, August 2001, pp 323-334

Micah supports the objectives of the *National Mental Health Strategy* and its reformulation in the *National Mental Health Plan 2003-2008*. The latest plan articulates a progressive philosophy and vision for promoting mental health and for addressing mental disorder. On the positive side, it is an aspirational document that commits all levels of government to a set of outcomes which, if achieved, would improve the mental health of many in the community considerably.

In particular, Micah applauds the population health framework in which the plan is embedded for its emphasis on the understanding that the determinants of mental health status are complex, multi-faceted and occur in everyday life. This understanding is reflected in Micah's day to day engagement with people with fragile mental health – who are financially poor, socially isolated, lacking confidence and skills to enter the labour market, whose family history has been marked by violence and substance abuse and who may have been institutionalizes at some point in their lives. Under the framework adopted in the 2003-2008 plan, the pathway to recovery must necessarily engage with the 'whole person' and all the circumstances facing them in their lives.

Notwithstanding this, the crunch comes in two ways.

Firstly, the issue of resources is obviously the key to guaranteeing the success of the *National Mental Health Plan 2003-2008*. Without resources the grand theory falters. This has been demonstrated with the policy of de-institutionalisation; the theory was wonderful but the policy execution has left much to be desired. For example, the prevalence of people with mental illness and on our streets and in our prisons is an indictment of a policy doomed to failure because resources have not matched need.

A recent Queensland study of Queensland prisons noted that:

> *perhaps the most serious health difficulty affecting prisoners and ex-prisoners is mental illness. Around 30% of male prisoners and 50% of female prisoners suffer from diagnosable mental illness, and incarceration often results in an exacerbation of their symptoms.* [4]

While not condoning criminal behavior, this report and other literature on the subject raise issues pertaining to (i) why so many prisoners have a mental illness; (ii) to what extent is mental illness a determinant in the anti-social behavior that led to a criminal conviction; and (iii) what treatment are prisoners receiving to assist in the pathway to recovery. Clearly, resources are a key factor in responding to this population group. Similarly with homeless people. To adequately address the determinants of mental illness in the homeless population requires the involvement of mental health services in a continuum of care service system. Regrettably, mental health professionals are not often at the frontline of services to homeless people. In Micah's experience, the efforts that have to be made to access mental health services and secure a clinical diagnosis place considerable pressure on frontline outreach services. Again, the failure to resource adequate mental health services undermines the 'theory'.

Secondly, it is imperative that there be a consistent dedication of resources and standard of service provision across all the state and territories of the Commonwealth. The Productivity Commission's *Report on Government Services 2005* [5]shows considerable disparity in expenditure on mental health services across Australia. In 2002-03, Queensland and the NT were at the bottom ($89 per person) compared to Western Australia at the top ($119 per person) – a $30 difference.

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[4] Walsh, T, *Incorrections: Investigating prison release practice and policy in Queensland and it's impact on community safety*, QUT Publications, Brisbane, 2004, p 66

[5] Productivity Commission, *Report on Government Services 2005*, Canberra, Chapter 11.4, pp 33- 67

Further, there is a variation among the states and territories in the configuration of the mental health service system. For example [6]:

- while most have arrangements for community residential services Queensland does not;
- some states have psychiatric hospitals and others do not;
- expenditure on ambulatory care per state ranges from $2048 per unit cost in WA to $703 per unit cost in Tasmania;
- consumer and carer participation varies in quality and extent across states and territories.

A key question arising from these differences include whether the states and territories each have the right mix and balance of services to respond to mental health issues effectively. Micah would recommend that this be factored into the ongoing evaluation of the *National Mental Health Strategy* so that all Australians, regardless of where they live, can access a range of quality mental health services consistent with best practice.

This latter point touches on issues raised under **ToR (o)** regarding the establishment of and compliance to a set of national standards. States and territories should be subject to national benchmarks on the outcomes set in the *National Mental Health Plan 2003-2008*.

Term of Reference (b)
The adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care

In responding to this ToR, Micah is drawing mainly upon the knowledge of staff of the CLP. The emphasis here is upon **community care** for people with fragile mental health in private supported accommodation. Issues related to the adequacy of modes of care in this context are as follows:

- Due to poor staffing and lack of case-management, prevention and early intervention strategies are non existent in private supported accommodation.
- Staff rarely have the knowledge or skills to recognize early signs of exacerbation of mental illness and visits from health services of any kind are inadequate to fill this gap.
- Very low levels of case-management exist in this sector (most residents do not have case managers at all).
- Most residents are solely under the care of a local GP for their mental health. Many GPs have little experience or interest in this marginalised group.
- There is a lack of clear understanding regarding the role of case managers (clinical role and crisis response only now practiced by most case managers).
- There is a lack of community based services right across sector and poor awareness by service providers of needs and eligibility of people who live in private sector accommodation.
- Disability Service Queensland (DSQ) and HACC workers often have limited skills and knowledge in dealing with this sector and the residents who live in it.

As a way of addressing the huge gap that exists for people with fragile mental health in this accommodation sector, Micah suggests that there be (i) compulsory fully funded training about mental illness for all private sector workers; and (ii) that facility based case-management for hostel residents be developed as this allows flexibility and relationship building in the most cost effective way.

[6] The Productivity Commission notes incompleteness and difficulties with comparability of some data in the 2005 report

Finally, the experience of Esther in facilitating peer support and consumer-led advocacy among former residents of abusive institutions suggests that this, 'peer support', is an important strategy for social connection and for nurturing and enhancing well-being. Micah proposes that this approach be validated.

Term of Reference (d)
The appropriate role of the private and non-government sectors

There are both strengths and limitations in the provision of mental health services by both sectors – private and public. One of the concerns facing Micah is that some people fall through the cracks of both. For example:

- the capacity to pay is beyond the means of many who present to Micah with mental illness so private providers are not an option for the poor, those living below the poverty-line;
- privately-owned and managed supported accommodation industry is not resourced to train staff in dealing with mental illness so residents receive less than adequate support;
- public sector funded agencies are so stretched and under-resourced that their capacity to case-manage complex cases is limited – there are well documented cases within the Supported Accommodation Assistance Program (SAAP) of exclusion of homeless people made on the basis of the perception and reality of mental health disorder.[7]

The risk here is that some will continue to fall through the cracks of each sector - with no where to go except onto the streets and into prisons.

Another concern is that a two-tiered mental health system is emerging – one based on a user-pays regime and one based on resource-strapped public provision. This has serious implications for access and equity.

Term of Reference (e)
The extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes

Better mental health outcomes are contingent upon an individual's ability to access to a range of supports which meet their social, financial, emotional and physical needs. Many of the people who present to Micah - to MICS, Esther and the CLP, bring with them unmet needs which undermine their capacity for sustaining and/or improving their mental health.

- In relation to vulnerable people in supported accommodation, the CLP notes that assistance in such basics as personal grooming and hygiene can mean the difference between social acceptance and rejection. Poor social acceptance impacts on self-esteem and well-being, contributes to social isolation and, ultimately, on mental health outcomes. Resourcing for programs such as the CLP is imperative in meeting these very basic needs.

- MICS has adopted a continuum of support framework in its work with homeless people. One of the key strategies for assisting people into sustainable tenancies is being able to link them to mainstream support services; for people vulnerable to mental illness these connections are imperative. A study of boarding houses[8] revealed that continuing high cost

[7] Jeannet, S, 'Exclusion in Practice; The Doctrine of Pre-emption', in *Parity*, Vol 18, Issue 1, 2005, pp 33-34 (There are several other articles in this edition of *Parity* which take up a similar theme.)
[8] Bolden, R, Tansky, M and Walsh, K, *Boarding House Blues*, Micah Inc, Brisbane, 1998

levels of support are not necessary to connect vulnerable people to support services if resources are targeted appropriately and flexibly from the start. Investment in initial up-front support services can, if underpinned by planned support that is client focused and adaptable, lead to long-term positive outcomes for the individual and community – such as sustainable tenancies and management of mental illness. Initial investment can lead to a long-term social dividend.

- Based on the findings of the recent Senate Report *Forgotten Australians*[9], Esther would advocate that the recommendations of this report be integrated into the National Mental Health Strategy as a priority.

Term of Reference (j)
The overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people

Reference was made in ToR (a) to a recent Queensland report on prison release practice and policy. [10] This drew attention to the fact that many in the prison population suffer a mental illness and that treatment is inadequate if not non-existent; the conclusion drawn from the report is that when people are released from prison without treatment they may pose a risk to the community. Clearly, for both the individuals involved and for the wider community, there is a need to address the prevalence of mental illness in prison populations as a matter of urgency rather than continuing to play a cost-shifting game between bureaucratic silos. One solution is to invest in diversionary programs that combine community safety with adequate mental health interventions that have as their objective a pathway to recovery and reinstatement in community life.

From Micah's perspective, inadequate post-release planning means that ex-prisoners often present as homeless, with a mental illness condition and with a range of other needs that require attention. This shifts both costs and risk to the community services sector where resources are already stretched.

Term of Reference (l)
The adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers

No preparation or education of the community took place prior or during the de-institutionalisation process leaving communities ill prepared to accept people with mental illness who often look and behave differently. This, combined with the media focus on the occasional incident of violence involving a person with mental illness, has led to increased fear and stigmatization. Ongoing significant multi-media education is needed to address this issue.

Local area strategies designed to de-stigmatise mental illness are also required as a way to break-down fear and misunderstanding in communities.

[9] Australian Senate, Community Affairs References Committee, op cit, pp 314-316
[10] Walsh, T, op cit, pp 66 and 143-145

Term of Reference (m)
The proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness

Issues raised under **ToR (l)** are relevant here. The stigmatization surrounding mental illness is pervasive and, without adequate training services can fail to adequately deal with people in this situation.

3. Key Recommendations

The following key recommendations have been distilled from the body of this submission:

- The Commonwealth, state and territory governments, through the collaborative efforts of all Australian Health Ministers, ensure that there is consistency in funding, quality and standards of mental health care across jurisdictions; notably, that each jurisdiction provides the right balance and mix of services to respond to mental health issues effectively. It is imperative that all Australians, regardless of where they live or socio-economic status, can access quality mental health services consistent with best practice.

- The private supported accommodation hostel sector to which many people with fragile mental illness gravitate for accommodation, be assisted to ensure that (i) workers in this sector have some training in mental health issues; and that (ii) facility based case-management for hostel residents be developed to maximise recovery in all its personal and social dimensions.

- That the *National Mental Health Strategy* take account of the insights about the correlation between mental illness and institutionalization in the recent Senate Community Affairs References Committee report *Forgotten Australians*. The former residents of government and church institutions must be seen as a group of people with special needs and propensity to vulnerable mental health.

- The service mix of public and private providers must not be allowed to develop into a two-tiered hierarchical system that aligns quality with the capacity to pay and relegates disadvantaged people to less than best care.

- The cost shifting that is evident from government to community services in inadequate post-release planning in the corrections sector must be averted and proper mental health care provided to people with mental illness exiting prisons. People with mental illness should not be in our prisons or living on our streets.

  Improved post release planning also applies to hospitals.

  Both matters pertain to the previous key recommendation about consistency in funding, quality and standards of service across jurisdictions.

- The continuation of education about mental illness and the determinants of mental health is strongly supported. Ignorance continues to be a contributing factor in the stigma attached to this human condition.

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