Uniting Church in Australia
Synod of Western Australia
SUBMISSION TO SENATE SELECT COMMITTEE ON MENTAL HEALTH
MAY 2005

1. Introduction

The Uniting Church in Australia, through its commissions, seeks to hold up a vision of wholeness of life for all people and especially the importance of standing alongside those at the fringe of society, and to achieve this through the identification of issues of social justice, and by fostering research and theological engagement and service to enable the Uniting Church to determine the bearing of the Gospel upon these issues. Central to this work is assisting the Church to maintain relationships with people who have been marginalised or whose human rights have been violated, as a basis for acting in solidarity with them.

In a practical sense, this is expressed by advocating for appropriate changes in public policy, contributing to the public debate on directions for Australia, developing and implementing strategies to educate the Church on issues of justice, peace, and environmental concern, and nurturing links between individuals and agencies working in these areas.

It is from this position of social concern that the Uniting Church in its Western Australian context raises significant concerns about mental health in the areas the Uniting*Care* agencies work and though our interactions with the broader community.

2. The Uniting Church in Australia

In 1977 at the inauguration of the Uniting Church in Australia in its *Statement to the Nation*[1] the Church identified as principles: integrity in public life, proclamation of truth and justice, right for each citizen to participate in decision making, religious liberty and personal dignity. The Uniting Church pledged itself to seek correction of injustices, to work for the eradication of poverty and racism, and to oppose all forms of discrimination, which infringe on basic human rights.

In 1997 the Uniting Church reaffirmed this commitment in an *Invitation to the Nation*[2] which reaffirmed our commitment "to participate in the building of our nation" expressed in many attributes including truth, fair play, diversity and standing firm to our commitment to "human rights, even at cost to itself, as a responsible member of the international community."

[1] Inaugural Assembly Meeting, Uniting Church in Australia, **Statement to the Nation** June 1977.
[2] Minute 97.18.05, 8th Assembly meeting of the Uniting Church in Australia **Invitation to the Nation** July 1997.

The preceding commitments articulate a basis upon which the Uniting Church has consistently advocated for human rights in Australia and overseas. Yet we are not claiming that the issues raised are simply ones of human rights.

3. Individuals and Communities

The UCA is concerned with the way in which individuals relate together in community. We are concerned to uphold the dignity, value and human rights of all in a compassionate way, in a manner that provides protection of both individuals and the community. In this way we propose to address some specific aspects of the enquiry.

4. Addressing the Terms of Reference

Young People and Mental Health

Trinity Uniting Church has two arms of service with a focus on youth: Trinity Youth Options, a service that caters for young people experiencing or at risk of experiencing homelessness, including same sex attracted youth and Trinity Learning Centre which provides a learning environment and childcare support for teenage mothers who are completing their secondary education.

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

Prevention

Many young people that Trinity encounter have low resilience and are unaware of factors that contribute to good mental health. As many have left school early their ties to community are poor, as is their access to information about mental health. Programs in schools such as Mind Matters and others that focus on building resilience are essential from an early age. Although research has identified risk factors and strategies for increasing resilience there is no standard for implementation in schools. *Increased counselling resources in schools would assist in providing preventative and early intervention services.*

Early intervention

Early intervention relies on either the young people or the workers they are accessing recognising the early symptoms of possible mental health problems. At this stage the young person presents with multiple issues often involving crisis in relation to accommodation, money, history of abuse and relationship issues. Building relationships with the young person and dealing with their immediate crises requires intensive and ongoing support over an extended period of time. Many of the young people that we work with have substance abuse problems that have resulted in psychotic episodes. A difficulty experienced in either accessing or providing early intervention is due to the number of agencies that may be involved with a young person, particularly youth agencies, and a lack of co-operation between agencies mainly as a result of confidentiality issues. Unfortunately this can sometimes result in very limited services being received.

After Hours Crisis Services

In our experience accessing crisis care is time consuming and there is a lack of co-ordination between the services. When a young person moves from adolescent to adult services there does not appear to be a system for continuity of care.

For example, one young woman with a young child disclosed that she was feeling suicidal and did not feel safe. The Psychiatric Emergency team number was contacted and they advised that the Osborne Park Mental Health Clinic should be contacted. The number provided was incorrect and it took three phone calls before a duty officer could be contacted. This person advised that the Inner City Mental Health Service was the appropriate service. After two phone calls, the duty officer advised that our client was a client of the mental health service, however was being case managed by King Edward Memorial Hospital and they could not see her until authority was received from them. Another phone call was made to KEMH, who advised that they had not seen her for some time and had referred her to another service. The appropriate release was finally obtained and another call was made to Inner City Mental Health Services, who then advised that they could not see this young woman for two weeks. Half an hour later they called back and agreed to see her that day. The duty officer, after conducting an initial assessment, believed that she needed to see a psychiatrist. As the clinic was now closed we were required to attend Casualty at RPH. She had her child of eight months with her and we then waited in Casualty for approximately three hours. The paperwork that was to accompany her had been lost. During this period we spoke with a doctor, a psychiatric nurse and the psychiatrist. Although an admission was deemed necessary it could not occur until the next day as the specialist mother and baby unit at Graylands Hospital could not accept admissions after hours. The process of accessing services took 15 hours.

Another young mother, also in a highly suicidal state, was accompanied to Royal Perth hospital casualty section and waited six hours for treatment. She could not be admitted as there were no beds, although it was indicated that this was the appropriate treatment. She was given valium with no further recommendations or follow-up suggested. This was her first encounter with the mental health system and she was extremely distressed by the process.

The current mental health service appears to be under-resourced with limited time to address the concerns of young people.

Community Care

Community care requires young people to attend appointments, which they often overlook or fail to attend follow-up and then as a result receive no care. One client stated that she did not like her case manager, however there was no suggestion of an alternative choice or building relationships. Appointments are often short and do not always address the issues of concern.

Acute Care

Acute care services for young women with children is very limited, usually requiring separation from their children resulting in shortened stays because they become anxious about their children. At other times we have found that

although acute care has been recommended it has not been available due to shortage of beds.

d) the appropriate role of private and non-government sectors

When workers from our agency attend appointments with young people they are rarely acknowledged as fellow professionals. Often it is the worker who has commenced the intervention by discussing the issues, assisting with obtaining the appointment and accompanying the young person to the appointment. Young people accessing mental health services are often required to tell their story to a doctor, a psychiatric nurse and finally a psychiatrist. They usually become impatient and by the time they speak to the psychiatrist they are angry and/or withdrawn. Miscommunication occurs and young people can be deterred from seeking further help. In our experience adult services are not particularly good at communicating with young people. No communication occurs with the worker from the mental health service, except when the process has broken down.

Youth agencies are usually the frontline workers with the young people, understand the issues, know the background and are involved in supporting the young person. Co-operative working relationships and discussion with all parties would result in better outcomes for young people. Young people with mental health issues consume considerable resources within agencies and a better understanding by the mental health profession of the roles played by workers needs to be developed.

f) the special needs of groups such as children, adolescents, the aged, indigenous Australians, the socially and geographically isolated and people of complex and co-morbid conditions and drug and alcohol dependence

Young people need friendly, accessible services and in accessing and receiving treatment need to be able to relate to the person providing the service. Intake procedures that require them to discuss their issues with numerous people increase their levels of anxiety and frustration and can result in premature termination of services. Several young have stated that they find the stress of one to one interviews too difficult and therefore they only 'chat'. This results in other support agencies having the information necessary to understand the complexities of the young person's situation.

A particular area of concern is teenage parents with very young children. Accessing services is more difficult for this group and there is an increase in risk for the child. 40% of the young women accessing our service have stated that they are depressed, with 20% being on medication. As this group is more connected to community and services than other young mothers in the community we have concerns about how the mental health issues of teenage parents are being addressed.

Physically accessing the Inner City Mental Health service with a pram is difficult as there is no ramp. One client has discharged herself on two occasions, as she has been concerned about being separated from her child. On the first occasion the child was being breastfed and despite extensive negotiations with

the ward staff, appropriate visits to breastfeed the baby could not be arranged resulting in the termination of breastfeeding and increased levels of stress for the mother.

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

As many of the young people for whom Trinity Uniting Church provide services have left school early they have received very little education on mental health issues and to our knowledge schools are only providing limited education in this area. In our experience, for a number of young people, mental health issues originate in schools as a result of bullying and harassment, homophobia and low self-esteem due to poor academic performance. Our research with our gay, lesbian and bisexual clients indicates that for many the school is an unsafe place and their experiences result in depression, suicidal thoughts and mental health problems.

One of our clients has a sibling with a severe mental illness and has received very little information or support from the mental health service. Sadly, the family is angry with the young person and blame her. There appears to be no contact between the service and the family of the young person, which is resulting in further stress in the system. The client, herself an adolescent, withdraws from her sibling in order to cope.

Prisons and Mental Health

The UCA has had a long involvement with prison justice issues and works closely with the Prison Reform Group WA, the Institute of Restorative Justice & Penal Reform WA and the WA Heads of Churches in addressing these matters.

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.

Prevailing research (Butler & Allnutt 2003, Goulding 2004) indicates alarmingly high levels of diagnosed mental illness amongst people held in custodial settings in Australia. For example, seventy eight percent of sentenced women in prison in New South Wales and ninety percent of remand women (also NSW) had been diagnosed with some form of mental illness, ranging from affective disorders such as clinical depression through to bipolar and severe psychoses such as schizophrenia and antisocial personality disorder. Similarly, recent research in Western Australia indicates that approximately seventy five percent of women in prison had recently been diagnosed as being mentally ill. Also, according to Butler and Allnutt (2003) the proportion of male prisoners with diagnosed mental illness is only slightly lower than that of women.

The human rights of all prisoners, particularly those with a mental illness, are often ignored within the prison environment. This is the nature of total

institutions where one group, prison staff, has total power over the other group, prisoners. Within the West Australian jurisdiction prison officer training does not currently include training in human rights although a training manual in human rights for prison staff exists; *A Human Rights Approach to Prison Management: Handbook for Prison Staff (Coyle 2002:Foreign and Commonwealth Office, London).* Also, prison authorities throughout Australia routinely ignore the guidelines from human rights instruments such as the Convention Against Torture and Other Cruel and Inhuman or Degrading Treatment or Punishment. For example, the routine use of strip searches and enforced orifice searches upon prisoners who themselves have high victimisation rates of childhood and relationship abuse (Goulding 2004) can only be seen as a form of degrading treatment or punishment.

Prisons are inappropriate places in which to house the mentally ill, unable as they are, to provide necessary treatments and supports. In addition, the disturbing reality of prison life, with its sudden disruptive impact, is likely to exacerbate psychological and/or psychiatric conditions and there is some disturbing anecdotal evidence to suggest that prisons may, in certain respects, be becoming substitutes for mental hospitals, largely because of the trend, in past decades, towards deinstitutionalisation and the consequential closure of psychiatric institutions (Beyond Bars: Fact Sheet 9). Yet in Western Australia, for example, there is no formal assessment tool used across the board at prisoner reception centres which diagnoses specific mental illness amongst those entering prison.

There are many explanations for the high proportion of mentally ill men and women in prisons. These include chronic homelessness, substance abuse, lack of appropriate community diversionary programmes as sentencing options, the deinstitutionalisation of psychiatric patients and the high incidence of arrests of the mentally ill (Butler & Allnutt, 2003). Prisons, furthermore, are simply not equipped to respond to mental illness and assist prisoners in this respect. The situation is made worse by the fact that there is a fundamental conflict between the priorities of health care systems and those of prison systems. Within prisons security considerations have always prevailed over all others and reasons can always be found for not implementing some new way of doing things or for delaying change. The custodial priority of security over 'the prisoner', therefore, is almost always in conflict with the health care priority of the clinical needs of 'the patient', ensuring that health care practitioners within prisons are 'obligated to operate in accordance with the correctional ethos' (Butler & Allnutt, 2003).

In relation to prisoners and mental health, it is recommended that:

1. Appropriate screening and treatment programs exist both at the point of reception and for those who are sentenced.
2. Where men and women are in receipt of prescribed medication prior to imprisonment, that prison-based health care professionals discuss treatment with the prescribing doctor before changing or withdrawing medication.
3. There is a comprehensive overhaul of prisoner health care to ensure that the mental health of prisoners is treated in complete accordance with community standards both in initial diagnosis at the beginning of imprisonment and ongoing treatment during sentence.

4. Suitable diagnostic tools such as those recommended by the National Survey of Mental Health and Wellbeing (NSMHWB) and the recent study of psychiatric morbidity in New Zealand prisons should be implemented in all prisons.[3]
5. That prison health services be removed from the Department of Justice and placed in the hands of a separate entity which receives adequate, stable funding, enabling it to provide health care to prisoners that is equivalent to health care in the community (Allen, 2000: 7).
6. Men and women charged with relatively minor and non-violent offences who are found to be mentally ill should be diverted out of the criminal justice system to community treatment programs.
7. Those found to need involuntary psychiatric treatment, are unfit to stand trial, or found not guilty of an offence by reason of diagnosed mental illness should be held in secure treatment facilities rather than prisons.

Asylum seekers, Refugees and Mental Health

The Uniting Church, together with our partner Coalition for Asylum Seekers, Refugees and Detainees (CARAD), has extensive experience with asylum seekers, refugees and detainees. We work with both those who arrive on the humanitarian program and those who arrive on our shores seeking asylum. We work closely with Assisting Torture and Trauma Survivors (ASeTTS) and CASE for Refugees.

f. the special needs of groups such as children, adolescents, the aged. Indigenous Australians, the socially and geographically isolated and of people with co-morbid conditions and drug and alcohol dependence;

Recent legislative changes have resulted in a class of refugee visa being developed known as Temporary Protection Visas (TPV). While there is considerable research into the mental health implications and effects of detention on people seeking asylum, there is little on the ongoing effects of both the detention and original trauma on the ongoing mental health of refugees. Studies of TPV holders have shown that most TPV holders have experienced torture/trauma in their countries of origin and/or in their journey to Australia. These experiences are compounded by their detention upon arrival in Australia or upon their detention and removal to centres in Papua New Guinea or Nauru. The grant of the Temporary Visa is perceived as another failure that adds to the trauma in this sequence of multiple traumas. The resultant levels of anxiety, depression and post-traumatic stress observed amongst this group are substantiated by numerous research studies that indicate a decrease in mental

[3] (According to Butler and Allnutt (2003: 10) both Australian and New Zealand studies utilised *'the Composite International Diagnostic Interview [CIDI]'* together with a psychosis screener. *The advantages of using the NSMHWB instrument are threefold: (1) it enables direct comparisons to be made with both national and international community samples, and (2) it generates both ICD-10 and DSM-IV diagnoses, and (3) it is computer-based and can be administered by a layperson following training*).

health and social functioning with increasing amounts of traumatic events. References are included below. [4]

The UCA and the organizations we work with have experienced first hand the distress of refugees as they go though the establishment of a refugee claim again in the application for permanent protection visas following three years of temporary protection. Care volunteers have observed increases in bedwetting, night terrors, behaviour difficulties in children, and increased referral to mental health professionals, increased use of anti-depressant and other psychotropic medications, disturbed sleep patterns and depression in adults.

An aspect of our current work load, assisting the Department of Immigration house asylum seekers in Alternative Places of Detention, has exposed us to firsthand knowledge of the trauma of ongoing uncertainty faced on a daily basis by those housed in the community, but in effective detention. Small imposts on older children and teenagers, like not being able to leave home without an escort, have been observed to have significant effects on the participation and behaviour in school activities. The long term effects of these home detention arrangements are yet to be the subject of significant research, but the observation of professionals in the area leads to a judgement that the likelihood of long term detrimental effects on children and young people is high. This at least raises the need for the application of the precautionary principle. Professional treatment for mental distress and depression in these young people is restricted by funding and limited professional expertise. Specialised treatment and activities for children and adults are provided by ASeTTS, but places are limited.

5. Human Rights Conventions

The UCA has been strongly committed from its inception to human rights conventions and instrumentalities. In this context we highlight the following conventions.

The *Universal Declaration of Human Rights (1948*) and the *International Covenant on Civil and Political Rights (1966) Convention Against Torture and Other Cruel and Inhuman or Degrading Treatment or Punishment (1984),* to which Australia is a signatory, signifies the right for political and civil freedom and defends the right of all to be treated with dignity and respect, no matter which institution in Australia a particular person finds themselves interacting.

The *Universal Declaration of Human Rights* states that everyone is entitled to rights and freedoms without distinction on the basis of "race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

[4] (References: Multicultural Affairs Queensland Report (2001) on the impact of the 785 Visa *Temporary Protection Visa Holders in Queensland.* Available on line at http://www.premiers.qld.gov.au/about/maq/index.htm
Deakin University and the Victorian Arabic Social Services Research Report (2002) *Politics of Social Exclusion: Refugees on Temporary Protection Visas in Victoria.* www.vass.org.au.
Fernandes, P (2002) *Trauma strikes the soul: An attempt to explore and understand the impact of the temporary protection visa on clients in New South Wales.* http://www.arts.uwa.edu.au/MotsPluriels/MP2102pf.html)

(Article 2) In particular we note with regard to the children and young people using our services the *Convention on the Rights of the Child, Article 39 that*

> State Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health self respect and dignity of the child.

6. Conclusion

The UCA and our partners work in welfare services such as housing, befriending programs for people with mental illness, services to prisoners, services to children and young people and asylum seeker and refugee work which see us involved with those who experience mental illness. We have continued to be distressed at the lack of community mental health services in all areas of our work. We remain concerned at the lack of access to after hour's services, which often see our staff and volunteers operating outside of their particular area of expertise. The UCA looks forward to positive recommendations arising from this enquiry and would be pleased to make further verbal submissions were the committee to sit in Perth.

Rosemary Hudson Miller
Social Justice Consultant
Uniting Church in Australia
Synod of WA

Contributors
Dr Dorothy Goulding
Postdoctoral Research Fellow
Centre for Social & Community Research, Murdoch University.
Spokesperson for Prison Reform Group WA
Board Member of Institute of Restorative Justice & Penal Reform WA

Helen Burgess
Development Officer
Trinity Youth Options
Trinity Uniting Church

Wendy Longworth
Project Officer
Social Justice Unit
Uniting Church in Australia
WA Synod

Rosemary Hudson Miller
Social Justice Consultant
Uniting Church in Australia
WA Synod