Catholic Social Services Australia

Senate Community Affairs Committee
Inquiry into Mental Health Services in Australia

Public Hearing

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OPENING STATEMENT

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On behalf of Catholic Social Services Australia, I would like to thank this Senate Committee for the opportunity to appear today.

Catholic Social Services Australia's members operate throughout Australia and provide an extensive range of community services. These include Aged Care, Children's Services, Disability Services, Drought Relief Counselling, Drug and Alcohol Services, Emergency Relief, Employment Services, Family and Relationships Services, Financial Counselling, Foster Care, Gambling Counselling, Housing, Mental Health Services, Residential Care, School Counselling, Therapy Services, and Youth Services.

People with mental health issues or illnesses regularly present at all of these services.

Some time has passed since our original submission to this Inquiry which has afforded us some time to see the COAG's National Action Plan on Mental Health in operation. As a peak body, we have sought out our members' reflections on the implementation of the National Action Plan.

In particular, we support the mandate within the Committee's Terms of Reference which considers *"the overall contribution of the action plan to the development of a coordinated infrastructure to support community-based care"*;…..as well as *"identifying any possible remaining gaps or shortfalls in funding and in the range of services available for people with a mental illness".*

The COAG National Action Plan on Mental Health 2006-2011, "Integrating and Improving the Care System" reflects that:

> *"An effective care system will provide timely and high-quality health and community services to people with a mental illness that assists them to live, work and participate in the community……..Achieving such an integrated care system requires governments to focus on two specific policy directions: to resource adequately health and community support services to meet the level of need; and to develop ways of coordinating and linking the range of care that is provided across the continuum of primary, acute and community services by public, non-government and private sector providers."*

Whilst the COAG National Action Plan certainly provides a step in the right direction neither Commonwealth/State operations nor clinical- community-based operations are systemically coordinated. In relation to Commonwealth/State operations, this threatens the creation of gaps and overlaps as well as administrative 'red tape'. The lack of systemic coordination for clinical/community based operations means that community-based organisations are relying on their relationship building skills to ensure that they establish the connections they require with the more clinically based mental health services to ensure they are able to tap into the services their clients need.

We support and encourage the notion of the 'continuum' of services but we feel the community sector is the poorer cousin in these relationships and is

not adequately recognised as a bona-fide provider of mental health services, integral to the needs of the clients.

The community sector's involvement in Mental Health Care is essential if we are to achieve recovery for people suffering from mental illness. Therefore, being integral in the overall design of mental health responses for clients – at the clinical level – is of equal importance.

Our people at the coalface are often seeing clients with undiagnosed mental illness and often are the first to recognise their mental illness. Their skills must be recognised if people are to receive appropriate and timely access to care.

I will address the resourcing issue a little latter when I speak of gaps.

In relation to the specific programs introduced for the community sector through the National Action Plan for Mental Health – our agencies who are running these programs had very positive comments to make. In particular, the scope within each of the programs has afforded the agencies the space for creative innovation and design to ensure they are meeting their existing community need thus averting any threat to overlaps or gaps.

However, as alluded to above, this has been driven by their own relationship skills as opposed to any systemic coordination of services. Outcomes are often achieved in spite of the system rather than because of it.

Our agencies' response to the new Medical Benefits Schedule items for psychology and other allied health providers, psychiatry and GP's – is mixed. This is due partly to whether or not they have implemented the access to the MBS items as part of their overall service delivery design or whether in fact they are trying to access it. For those agencies who have overcome the administrative and organisational hurdles to make use of the new MBS items they feel quite satisfied that they have been able to fill a much needed gap in the community and the fact that they bulk-bill all their clients is an essential feature of the service they offer.

But for those agencies attempting to access external providers of these new MBS items on behalf of their clients – there are frequent reports of difficulties in accessing the services due to cost. As one of our managers reflected, *"due to the nature of our clients, it doesn't matter if the 'gap' is $5.00 or $500.00 – if they don't have it – they can't afford it"*. The cost of accessing external providers is a barrier for many of our disadvantaged clients that our agencies are seeking to assist.

Just relating back very briefly to what I referred to as 'administrative and organisational' hurdles in accessing the new MBS items. The criteria by which social workers and occupational therapists can register for a Medicare Provider Number to deliver services under the new Medicare Item numbers 80125, 80135, 80150, and 80160 is viewed by some of agencies as being too limiting. You have to be able to prove that you have been seeing people with mental health issues for some time. However, as I mentioned previously, many clients walking through our doors are not referred specifically for mental health issues but once our agencies start working with them, this becomes obvious. It is difficult if they have not been referred for mental health issues

to ‘prove’ that the social workers seeking registration have actually met the competency standard as set by AASW.

Further, one of the unintended consequences of the introduction of the new MBS Items relating to psychologists and social workers is the added strain it has placed on community agencies in terms of their capacity to attract psychologists and social workers as salaried staff – as opposed to psychologists, in particular, now opting to work in private practice.

Given the limited resources caused by difficulties with the recruitment and retention of staff, a system must be in place to ensure that the sickest people are first in line to get access to these services.

I would like to turn my attention very briefly to identified gaps. These relate both to availability of services and funding – given that the two go hand in hand. Of particular note – one of our agencies delivering services in North West Queensland reports that there are absolutely NO mental health services available in their part of the country through the Commonwealth, either through COAG arrangements or independent of the COAG. To quote them directly,

> *“We are receiving clients with significant acquired brain injury, largely from alcohol, foetal alcohol syndrome and even sexually transmitted diseases and there are essentially no services for them.”*

One case illustrates the disarray in the system.

> *“Our community agency was battling to assist a person who was very prone to violence. Our facility is not set up to provide secure care and our workers are not able to provide all the services required (we have no access to nurses, doctors, medication, and other resources). We eventually learned that the client had previously been the subject of a forensic order, had escaped, the forensic order had been lifted because he escaped and here we were trying to work with him in Mt Isa. The state services never revealed his history to us.*
>
> *“The state program in Mt Isa has told us they will only service three homeless clients per month, and we have 120 on our books. We estimate there is something like 300 or more in the area. We are also concerned that the wave of sufferers of foetal alcohol syndrome is only just beginning to hit and will get a lot worse as the kids become teenagers.*

More broadly identified gaps include:

- Youth Mental Health Education and Awareness
- Housing/Accommodation: access still remains a major issue for the mentally ill – there is a lack of options or availability for suitable and appropriate accommodation (increased risk of homelessness);
- One-on-one case managed services to people with a mental illness designed to deal specifically with their own unique issues (as opposed

to one-on-one assistance to assist an individual integrate into community life).

- Information sessions designed to address common issues for participants such as mental health, financial counseling, stress management, life skills and personal development, personal grooming and transitioning to specialist providers.
- Advocacy and report writing to assist clients with practical needs such as securing housing, dealing with financial institutions applying for alternate benefits and assistance with legal issues;
- Visits to local community activities and external providers
- Interpreter services;
- Opportunities for social networking and relationship building
- Access to services to address substance abuse issues;
- Access to mental health services due to long waiting lists – demand always outstrips availability
- Limited capacity of services to support people with dual diagnosis.

Two more quotes from our members might highlight their unique perspective on those issues:

> *"After receiving funding and initial set up the programs were at capacity within four weeks of operation and now each area has over 20 people on the waiting lists. This was without advertising the program in any way and with referrals coming only from local GP's originally. Not unusual for clients to wait a few months for a space on our program to become available. In the funded areas we are the only service providing mental health personal and social support in the community.*

> *"We can fill this gap (in Mental Health Services in the community) in part; however the availability of professionals to deliver the requests and the costs involved with staffing and or staff development within Mental Health, places limits on available groups/education programs. We are also experiencing a trend that out of the community groups we are running, at least one participant within a group is in a situation of distress and in need of counselling/therapy referral. We again can fill the gaps to a degree as we have employed a few counsellors who are available and the availability of psychologists; however our service as per other mental health services within rural areas have waiting lists for psychologist appointments and our counsellors can only take on so many clients.*

As a final point, COAG's National Action Plan also makes specific note of *"Participation in the Community and Employment, including Accommodation"*. We are acutely aware of and involved in a number of current reviews and processes, including the National Mental Health and Disability Employment Strategy, Job Seeker Classification Instrument, and the Job Capacity Assessment. It is important for these processes to be well coordinated to avoid further gaps and duplication of services.

This flows out of our initial call in our written submission for a national project, mapping mental health services.

Thank you/Questions.