



Improving mental health to build a better future for all Victorians

A response from Catholic Social Services Victoria to the Victorian Government Consultation Paper *Because mental health matters – A new focus for mental health and wellbeing in Victoria, May 2008*

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4 August 2008

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Executive Summary

Catholic Social Services Victoria is a peak body for Catholic social service agencies in Victoria. A list of our member agencies is attached to this submission. We work with member agencies, as part of the Catholic Church in Victoria, to fulfil the gospel imperatives to stand with and serve the poor, disadvantaged and marginalised, and to work for a just, equitable and compassionate society. Further information about Catholic Social Services Victoria can be found on our website: www.css.org.au

Our policy analysis, and our response to marginalisation and disadvantage, builds on the principles of Catholic social teaching. These are based on gospel values and the collective reflection and experience over time of the application of those values in working with the poor, the disadvantaged and the marginalised. Our members continue in this tradition in applying these principles to contemporary issues.

Mental health is a challenge to those who espouse the principles that underpin our commitment to a just and compassionate society. Respect for the dignity of each person demands that we work to provide mental well-being for all, and appropriate services to those who are unwell - unless a person can achieve mental health, then it is much harder for them to achieve the other elements that we associate with wellbeing: education, employment, health, freedom from violence, and strong family ties and relationships generally.

Further, the promotion of the common good of our society is in the interests of all: no one section can truly flourish if other sections of society are unable to achieve their human potential. Mental health issues on the scale that persists in Australia is evidence that we have not yet achieved a fair balance.

For these reasons, mental health is a key issue for CSSV members, and is a significant focus for the work of many of the Catholic social service agencies in Victoria - it impacts on nearly all the work that our member agencies are engaged in.

Our members therefore welcome initiatives to give a higher priority to the achievement of positive mental health outcomes in the Australian community, and we look forward to services and approaches that are stronger, more comprehensive and better funded as a result of this particular consultation process. Effective and coordinated work in prevention, early intervention and acute services for mental health sufferers is crucial to a just and compassionate society. Adequate funding is one of the keys to this outcome.

General areas of concern emerged from interviews conducted with management and staff in the collection of feedback in response to the questions posed by the consultation paper. The belief is that the long-term success of the new mental health system will rest on a genuine commitment, from both the Commonwealth and State governments over the next ten years, to address the following general areas of concern:

- changing the public's perception of mental illness – breaking down the stigma of mental illness is needed if sufferers are to be encouraged to identify problems at an early stage, and if we as a community are to work more positively with those affected.
- current funding – more support is needed for community agencies, schools and specialized institutions if early intervention is to be effective and comprehensive
- the big picture – mental health difficulties arise out of a cultural setting and out of family and other institutional settings. Strengthening of the family as a safe, supportive



institution in society, and impacting on such cultural norms as living standards and desired lifestyles is a necessary part of a lasting difference to mental health outcomes.



Introduction

1.1. Catholic Social Services Victoria – focus on mental health

Catholic Social Services Victoria is a peak body for Catholic social service agencies in Victoria. Our members deliver a wide range of social services across the State. A list of our member agencies is attached to this submission. We work with member agencies, as part of the Catholic Church in Victoria, to fulfil the gospel imperatives to stand with and serve the poor, disadvantaged and marginalised, and to work for a just, equitable and compassionate society. Further information about Catholic Social Services Victoria can be found on our website:

www.css.org.au

1.2. Catholic Social Teaching – the centrality of mental health

Our policy analysis, and our response to marginalisation and disadvantage, builds on the principles of Catholic social teaching. These are based on gospel values and the collective reflection and experience over time of the application of those values in working with the poor, the disadvantaged and the marginalised. Our members continue in this tradition in applying these principles to contemporary issues.

Mental health is a challenge to those who espouse the principles that underpin our commitment to a just and compassionate society.

At the most general level, respect for the dignity of each person demands that we work to provide mental well-being for all, and appropriate services to those who are unwell - unless a person can achieve mental health, then it is much harder for them to achieve the other elements that we associate with wellbeing: education, employment, health, freedom from violence, and strong family ties and relationships generally. (Contrariwise: if these elements of wellbeing are absent, then mental health issues seem to be more likely to result.)

Further, the promotion of the common good of our society is in the interests of all: no one section can truly flourish if other sections of society are unable to achieve their human potential. Mental health issues on the scale that persists in Australia is evidence that we have not yet achieved a fair balance.

For these reasons, mental health is a key issue for CSSV members, and is a significant focus for the work of many of the Catholic social service agencies in Victoria - it impacts on nearly all the work that our member agencies are engaged in, including the following services:

- Adoption and permanent foster care
- Alcohol and other drugs (AOD) counselling and support
- Disability care and support
- Drought counselling and relief services
- Employment services and support
- Family and Relationship Services (counselling, family dispute resolution)
- Family support case management
- Homelessness accommodation and support for adults and youth
- Loss and Grief Counselling and Peer Support
- Indigenous support programs
- Marriage and relationship education
- Parenting education (community and school-based)
- Chaplaincy Services (including Prison, AIDS, Mental Health and Youth Welfare)



- Prevention and Recovery Care (PARC)
- Psychiatric Disability Rehabilitation and Support Services (PDRSS)
- School wellbeing, individual student counselling and cognitive testing
- Refugee and settlement services

Our members therefore welcome initiatives at State and Federal level to give a higher priority to the achievement of positive mental health outcomes in the Australian community, and we look forward to services and approaches that are stronger, more comprehensive and better funded as a result of this particular consultation process.

1.3. Development of this submission

This response to the Department of Human Services consultation paper, *Because Mental Health Matters*, is derived from interviews conducted with representatives of member agencies, and material provided by them; our review of relevant literature, and subsequent reflection on the issues raised in the Consultation Paper. The principal researcher and principal author of the submission is Jo Robertson.

CSSV would like to thank Jo, and to acknowledge the members and associated agencies that were most involved in the process of development of the submission, which are listed below.

- Bethlehem Community
- Catholic Education Office Melbourne www.ceo.melb.catholic.edu.au
- Catholic Prison Ministries (entity of Centacare Catholic Family Services)
- Centacare Ballarat www.centacareballarat.org.au
- Centacare Bendigo www.centacare-sandhurst.org.au
- Centacare Catholic Family Services www.centacaremelbourne.org
- Corpus Christi Community www.jesuit.org.au
- Healthcare Chaplaincy Council of Victoria Inc <http://hccvi.org.au>
- MacKillop Family Services www.mackillop.org.au
- Sisters of Charity Care Ltd www.sistersofcharity.org.au
- Villa Maria Society www.villamaria.com.au

The websites of these agencies contain further examples of programs and potential initiatives that go beyond the examples that are outlined under the various Focus Areas that are commented on in the body of this submission.

1.4. Associated material

Some members have submitted individual responses as they are directly engaged in the provision of specialist mental health and/or PDRS services. We wish to support these agencies and make reference to their individual submissions:

- St Vincent's Health
- Jesuit Social Services
- Sacred Heart Mission St Kilda Inc
- Society of St Vincent de Paul

Other Catholic Social Services submissions related to mental health issues include:

- CSSV Response, *Providing Homes for All Australians* to the Australian Government Green Paper, *Which Way Home? A new approach to Homelessness*, June 2008 <http://www.css.org.au/documents/Homelessnesssubmission27une2008.pdf>
- CSSV Response to the Senate Select Committee on Mental Health Inquiry into the Provision of Mental Health Services in Australia, Anne Tuohey, May 2005



1. Overview, and emergence of key issues

1.1 Overview

Catholic Social Services Victoria congratulates the Victorian government for their efforts in the creation of this consultation paper on mental health. We welcome the changes to the mental health system as discussed in the paper. We especially look forward to the changes proposed with regard to the government's commitment to early intervention strategies. We anticipate this will strengthen our members' existing services, and enable our members to increase their capacity to meet demand through more targeted funding for early intervention programs.

We look forward to the opportunity to grow our services in early intervention and assist the government with their objective of reducing the number of people entering acute care. However, as promising as the changes appear, we recommend the government move forward with caution so as not to disrupt the delivery of current services. Ongoing consultation with the sector, at the local level, needs to be done carefully and at regular intervals in order to maintain the continuity of present programs while we grow our capacity for providing new innovative programs in early intervention.

General areas of concern emerged from interviews conducted with management and staff in the collection of feedback in response to the questions posed by the consultation paper. The belief is that the long-term success of the new mental health system will rest on a genuine commitment, from both the Commonwealth and State governments over the next ten years, to address the following general areas of concern:

- changing the public's perception of mental illness – stigma associated with mental illness
- current funding – more support for community agencies offering early intervention
- the big picture – living standards, lifestyles and the communities in which we live.

1.2 Removing the stigma associated with mental illness

Misconceptions surrounding mental illness remains one of the most potent barriers to social inclusion due to the stigma associated with all mental illness and those with dual diagnosis. These are important, as they often lead to fear and discrimination. The paper discusses the need to provide people with information about mental illness and where help can be found, but does not address the issue of overcoming these misconceptions. Challenging of the cultural baggage attached to mental illness would help to separate fact from fiction for the general public when thinking about mental illness.

The fear that is often felt by the general public when dealing with people with mental illness is from the combination of misinformation and lack of knowledge. However, our reluctance to give people second chances is also due to a prejudice that the mentally ill have failed in some way and therefore present a poor risk for, eg, employment and housing. Such exclusion then impedes recovery, and leads to a cycle of relapse. We must move away from this cultural mindset, which often results in disadvantaging people who have a history of mental illness.

Nor does this stigma affect only third parties. Many people suffer for years from undiagnosed depression and anxiety, as well as a range of other mental disorders. It is often the case that, until the condition causes serious dysfunction in the lives of sufferers and disruption to their home life, no diagnosis is sought. The signs of illness are often apparent to family and friends, but they are helpless unless the sufferer is willing to seek help. Many people in the early stages



do not seek treatment because doing so might cause embarrassment for themselves and their families. So powerful is the shame attached to mental illness, sufferers will often try to carry on as best they can in the hope that things will get better. In doing so, they run the risk of making things worse, by deepening their condition, and avoiding treatment that might prevent their engaging in risky behaviours.

Any awareness campaign that the government embarks on needs to focus on getting the public to understand that the risk of mental illness is present in everyone – that there need be no special stigma attached to mental illness. Our attitude must change to view mental illness in the same way that we view any health risk. Positive solutions should focus on leading a healthy lifestyle and ways to identify the early signs of mental illness similar to the successful treatment of common physical illnesses.

1.3 Additional funding needed for mental health system

Among those that participated in this submission, there is positive acknowledgement of the support provided by the State and Commonwealth governments available from a variety of departmental initiatives. The government continues to offer opportunities through new initiatives that have come about to address difficulties faced by families.

However, there is a systemic shortage of funding. Existing early intervention strategies, and start-ups for new initiatives are compromised without long-term support. Many innovative early intervention programs risk closure before evidence can be gathered that show successful outcomes.

Shortage of early intervention funding

Since the closure of the psychiatric institutions community-based social services have grown to address local demands. The doors to Catholic community services agencies are open to everyone, regardless of a person's background or ability to pay. There has been an increase in demand over time, as a combined result of the closure of psychiatric institutions, and the lack of structures to meet emerging mental health needs of Victoria's growing population. Many agencies do their best to meet demand, but there is an overwhelming need for services, in particular for families and the homeless. In order to assure uninterrupted service delivery to the wider community, agencies are increasingly reliant on government initiatives and support from private donors to meet the shortfall.

There is concern that changes to the mental health system may introduce extra burdens and will have the potential to disrupt services as the new system is implemented. The Consultation Paper envisages that an increased focus on early intervention will result in fewer cases of serious mental illness causing a shift away from reliance on acute care. Many members feel that capacity for early intervention services will need to increase significantly to create equilibrium before changes occur that can embed best practice for early intervention to that end.

Another funding worry is that the competitive funding environment that has been created in recent decades is not conducive to the type of cooperation and coordination that the government seeks in order to achieve systemic change across all sectors in support of a better mental health system. Motivation to increase connectedness needs to be factored in to the design of funding programs.

There is currently a shortage of funding for agency services, and the unmet demand continues to grow. As the government has come to the realisation that intergovernmental (through COAG) and interdepartmental cooperation is necessary to make the new mental health strategy work, so should they assist those in the community that are filling the gaps in unmet demand to come together in partnership.



In this context, it also needs to be realised that there are potentially thousands of good programs that operate on a small scale, and which could, if funded to enable a wider clientele to be met, make a very positive contribution to the community.

It also needs to be noted that our membership currently provides the community with mental health early intervention, even if under the terms of current funding arrangements these programs are not categorised specifically as such. In one sense, these agencies provide an "essential service" to the community as they support and liaise with specialist mental health services.

Shortage of acute treatment

Funding will need to increase at both ends of the continuum of mental health service delivery to ensure that there is an equilibrium established before there can be any rationalisation of funding - any financial savings resulting from reduced numbers of acute mental health cases can only be realized once the number of cases has actually reduced. It is possible that this may never occur, and more funds will have to be added over time to meet demand. Indeed, with projected increases in the disease and population growth, it will be unlikely that even if early intervention is successful, that any cost savings will flow on from a reduction in the need for specialist mental health services before the ten year span suggested by the government to implement change.

In particular, our membership is concerned that support for early intervention will come at a direct cost to specialist mental health services. Our membership feels that current access to specialist mental health services is limited causing a significant unmet demand.

In fact, there is currently there is a shortage of acute mental health care, which impacts on the CSSV agencies that offer it as well as those that do not. The shortfall in services provides only two options for these people: they either land on the streets, or at the doorsteps of community service agencies that are not equipped to handle acute cases of mental illness. We know this to be true because of the difficulty our members have in getting those people into the specialist mental health system despite having a broad network of services under the CSSV umbrella of services.

Under no circumstances should funds be taken from the specialist mental health care system to fund early intervention for mental health. These should be treated as two separate divisions under the holistic mental health care scheme proposed by the government, and funded accordingly.

1.4 The bigger picture: strengthening families and communities

The closure of psychiatric institutions in Victoria coincided with an unprecedented growth in the population in metropolitan Melbourne, the longest running drought in memory and the closure and movement of critical manufacturing businesses offshore. The impact of these factors has placed extra financial pressure and emotional stress that affect living standards, lifestyles and the communities in which all Victorians live. With the likelihood of continued fluctuations in weather patterns due to climate change and the estimated arrival of one million new residents to Melbourne, both rural and metropolitan communities will face continued pressure and new challenges. Both the Victorian and Commonwealth governments need to support fundamental change to the underpinning structures that impact on the social determinants of good mental health.

The experience of our membership is that good mental health is overwhelmingly dependant on people having their emotional and physical needs met, which are in line with their expectations.



This is based on the early research of Maslow's theory of the pyramid of human need known as the *Hierarchy of Need*,¹ and is supported by the latest research into positive psychology by Martin Seligman et al², which looks at the theories behind wellbeing and resilience. Expectations differ depending on age, gender and ethnic background, but those living standards are basic to what we, as members of the community, expect from living in Australia.

Unfortunately, access to basic living standards is under threat for many Australians. Those suffering mental illness recently released from prison and newly arrived refugees are often denied the basics altogether. Early intervention to prevent mental illness in the general population and better access to services for those who are mentally ill should improve the current situation, however these measures can only go so far.

The actions of the new mental health strategy need to be supported by real changes to the structures that underpin good mental health. The following areas that would support real improvements to the quality of mental health in Australia overall:

- stronger families, that provide safe and loving environments for all members
- safe, affordable housing that balances community need with environmental impacts
- advancement of a broad social inclusion agenda, to build communities that support robust family and individual development
- reliable and inexpensive public transportation that does not disadvantage those living in rural areas or at the outer fringes of the City
- effective education and employment pathways for early school leavers
- workforce pathways for women and others that includes funding for updating skills to return to the workforce, guaranteed maternity leave and better childcare

According to the consultation paper the new Victorian Mental Health Outcomes Framework would seek to measure additional outcome areas, including the social determinants of good mental health. There is a significant amount of existing research linking wellbeing with living standards, lifestyle and community connectedness. One such resource is the published joint project of Jesuit Social Services and Catholic Social Services Australia, *Dropping Off the Edge*³.

More needs to be done to feed this research back into the system in order to motivate fundamental changes in government policy to keep pace with the impact these factors have on the wellbeing of individuals, families and their communities.

¹ A.H. Maslow, [A Theory of Human Motivation](#), Psychological Review 50 (1943):370-96

² Seligman, M.E.P. (2002). *Authentic Happiness: Using the New Positive Psychology to Realize Your Potential for Lasting Fulfillment*. New York: Free Press.

³ Tony Vinson, *Dropping Off the Edge – the distribution of disadvantage in Australia*, Jesuit Social Services/Catholic Social Services Australia, 2007



Focus Area 1: Prevention

Taking prevention seriously – actively promoting mental health and wellbeing

Catholic social service agencies offer a variety of programs, services and strategies aimed at promoting wellbeing with an aim to build resilience, and thus prevent the onset of mental disorders. Strategies include the provision of information and education to at risk groups.

Many offer *selective prevention* as part of programs aimed at target groups tailored to meet their specific needs. Others are also well placed to offer *universal prevention* through the Catholic Social Services Victoria network.

Goal 1.1: Creating wider opportunities for promoting mental health in local communities

Opportunities exist for promoting mental health under the Catholic social services network of agencies currently being delivered at the local level. With support from the government, many have the potential to be given broader access. This will enable evidence-based measures that have the portability to be brought to scale to the wider community.

The agencies that reported comments for this section include the Catholic Education Office in Melbourne⁴, Healthcare Chaplaincy Council of Victoria Incorporated⁵, Centacare Catholic Family Services in Melbourne⁶, which included comments from school and family relationship experts and Catholic Prison Ministry. The following comments were derived from interviews, research and via written response to the questions posed under each goal. Written responses are shaded and identified by agency.

What are the most promising avenues for further work across families, schools, early childhood settings and workplaces?

The following is a list of suggested programs (some part of larger initiatives and long-term strategies) available through the Catholic social services network that offer promising avenues for further work across families, schools, early childhood and workplace settings. The methods of promoting resilience and increasing wellbeing are offered through a variety of mechanisms including: workshops, group work, couples, peer support, seminars, training, and diversion therapy and community development projects. Some initiatives utilise a variety of resources

⁴ The Catholic Education Office (CEOM) works in partnership with Catholic schools to provide an educational foundation that develops the whole person within a school environment imbued with Christian values. The CEOM provides a wide range of advice and services for schools, teachers and members of the Catholic education community.

⁵ The Healthcare Chaplaincy Council of Victoria Incorporated (HCCVI) is an interfaith agency, whose role is to liaise with the Government and to advocate for funding to provide interfaith chaplaincy services in the healthcare sector. Among its responsibilities is a strong focus on mental health and wellbeing issues for families and individuals.

⁶ Centacare Catholic Family Services provides family and relationship counselling and education services, in addition to community social welfare programs in support of families and individuals in metropolitan Melbourne, Geelong and surrounding areas.



including print media and audiovisual aids, and are operated by trained professionals with credentials in education, counselling and psychology or trained facilitators in the delivery of a specific program. Volunteers play an important role in workshops and community development projects.

The Catholic social services network offers large numbers of the programs under various initiatives aimed at each of the groups below. The following are categories and examples of the types of initiatives under each that could possibly be supported as part of a bigger scheme to be offered to the general public in the variety of community settings mentioned above.

Families

Catholic social services in Victoria have a long tradition of providing help for families, which enable them to build better relationships and see them through difficult life transitions. These programs are aimed at building a variety of skills that assist families, individuals and couples to be confident in their abilities to have: stronger relationships, fight addiction, be a better parent and to make social connections with groups from similar backgrounds and interests. The benefits are stronger families and more well-connected communities, which creates sustainable good mental health across all age groups and settings.

- **Marriage and Relationship Education Programs:** These programs are offered in association with the Catholic Church and include a range of workshops, seminars and peer group programs aimed at couples at all stages of their relationships with many focusing on key transitions such as first marriage, bringing home a new baby, dealing with finances and empty nesters.
- **Services for Separating Families including Family Support:** There are many programs aimed at separating families, funded by both state and federal government departments, and thus have recognised outcomes necessary for continued support. However, it is within the delivery of these programs that some innovative supplementary programs have been developed that promote good mental health in families while they move toward separation.
- **Refugee Support Programs:** Under refugee and settlement support services exist a variety of initiatives aimed at assisting refugees to settle in Australia. Cultural sensitivity and social inclusion is key to successful settlement. Group initiatives for African women teach occupational skills in a comfortable social setting, while African fathers are invited to participate in parenting workshops that teach skills aimed at reducing family violence.
- **Alcohol and Other Drug Support:** Many Catholic social services offer information about drug and alcohol to students and parents. Education services are offered directly to schools, while parenting seminars are offered at a variety of community settings. Community development programs provide opportunities for cultural groups that have problematic or endemic alcohol and drug use to talk to each other to gain understanding and reduce the stigma associated with addiction so they seek help.
- **Parenting Programs:** Catholic social service agencies provide numerous parenting programs that talk about general parenting issues as well as covering specific topics such as bullying, children and the internet, body image, coping with the VCE years, just to name a few. There is a potential to further develop a registry of Catholic social service parenting programs with some of the more promising programs developed as standard packaged resources to be offered for delivery to schools, parishes and community centres. Positive parenting programs could be strongly encouraged (even made mandatory) by government at various points: pre-birth, infancy, early childhood, primary, secondary for example.

Schools and Early Childhood



The Catholic Education Office Melbourne (CEOM) in collaboration with Catholic social service agencies offer a variety of initiatives and a long-term strategy aimed at the well-being of school aged children in order to build long-term resilience in support of good mental health. This collaborative service offers an excellent example of an innovative strategy that lays the groundwork for systematic delivery, and which has the potential to be brought to scale across the state and Catholic school systems. The CEO's Wellbeing Strategy⁷ exists alongside the CEO's Social and Emotional Development Program.⁸ These initiatives provide outcomes based and thus have evidence that can be fed back into the planning process.

Under the CEOM there is potential for further connections to be developed that can form a structure inclusive of the full range of service delivery linking promotion (prevention) with specialist early intervention for students in at risk groups. Assessments have revealed that the Strategy is successful, and cost-effective enough to be delivered to all schools. That limitation is not simply based on finances, but could also be centred on an approach aimed at the needs of students from different socio-economic backgrounds, and thus have different expectations for their outcomes upon school leaving.

In order to achieve a fully coordinated and seamless approach to whole school mental health programs, schools could be given assistance to fund mental health professionals who would help implement whole-school programs. One of the weaknesses of whole school programs is care coordination for students with specific problems. The transition from the focus on wellness to when a student requires more intensive assistance, and possibly a case-managed approach needs to be better coordinated. This coordination need is brought into focus when one considers the range of needs-based programs in place provided at school level by Centacare Catholic Family Services:

- School Counselling Services
- Cool2b@school School Refusal Counselling, Training and Referral
- Seasons Loss and Grief Peer Support Programs
- Alcohol and Other Drug Education
- Healthy Relationships for VCE Students Relationship Education programs

In addition, the Healthcare Chaplaincy Council Incorporated (HCCVI) suggests their Mental Health Chaplaincy could be expanded to offer support within the wider schools system. School chaplains would also have a role in supporting student wellbeing initiatives in addition to assisting in the identification of students and families requiring individual care. School chaplains might also be able to take on a greater role of care coordination for these students and their families within the context of a whole school strategy using the CEOM model.

'We offer education and training in Mental Health and Spirituality. With the growing number of school chaplains, it would be beneficial to extend this part of our work into the education sector, to enhance awareness of risk factors for families, children and young people.' (Healthcare Chaplaincy Council)

Workplace

Catholic social service agencies offer a variety of opportunities to promote good mental health in the workplace. ACCESS, a program of the Centacare network, offers employer sponsored personal counselling to employees and their immediate family members - Employee Assistance

⁷ CEOM Student Wellbeing Strategy Plan 2006-2010 Poster (Sept 2007), Catholic Education Office, East Melbourne, Vic

⁸ CEOM Annual Report (2007), Student Wellbeing Initiatives, Student Wellbeing Coordinators, Catholic Education Office, East Melbourne, Vic.



Programs (EAPs) - in addition to supplementary services including: critical incident response, group and training programs, management assistance and workplace mediation.

It is under the supplementary programs that avenues exist for the promotion of good mental health as training and education is available to workers and management that cover a variety of issues including workplace bullying, anger management, loss and grief, conflict at work and maintaining work/life balance, just to name a few. Other qualified organisations offer EAP contracts to employers. The EAP network of service providers could be utilised in the systematic delivery of those supplementary services, under a bigger scheme supported by the government to small employers that do not offer an EAP.

EAP's could also be part of a scheme to provide mental health screening as part of an ongoing program to catch problems before they occur and focus energies on prevention under the Worksafe Victoria's Work Health Initiative.

For those workplaces that cannot afford, or do not have access to an EAP, HCCVI suggests that they could provide education and training about mental health issues similar to the services offered to schools.

'Such training for workplace/industrial chaplains would also increase attention to mental health risk factors in the workplace.' (Healthcare Chaplaincy Council)

Are there other settings that should be considered?

The landscape of Australian society has changed dramatically over the past 30 years. This is indicated by statistics that show in 1980 workforce participation by married women was 46%, which rose to 60% by 2005.⁹ The majority of these women worked in part-time jobs in order to meet family commitments. In the seventies, the majority of married women stayed at home or worked in positions that allowed them the flexibility to manage their households and raise their families. During this time, women were available to participate in unpaid voluntary activities that created social networks in support of schools and local communities. Commentary pinpoints the loss of the traditional community as a causal factor in the deterioration of values among a general population that is becoming increasingly disconnected due to the nature the lives we lead today.

If we accept this trend will continue as the population ages, more women will return to the workforce through desire or need and men will extend their working years, we must attempt to reach people using innovative ways in a variety of environments. We need to strengthen connectedness in the settings where people spend their time in order to increase the chance of reaching those who may need help. More and more, school settings can act as a means of connecting with families, but individuals who are not involved with school aged children need other avenues.

Communities continue to develop connectedness in non-traditional settings (both virtual and real) that attract large users. These settings could include:

⁹ Abhayaratna, J. and Lattimore, R. 2006, *Workforce Participation Rates — How Does Australia Compare?*, Productivity Commission Staff Working Paper, Canberra.



- Online models like the Melbourne Laneways project¹⁰, which co-exists on the [ABC Island](#) and is part of the virtual world known as Second Life, a 3-D virtual world created by its residents. Sponsored by the Victorian government, according to its website the project has “grown explosively and today is inhabited by millions of residents”. Other opportunities exist using social websites like My Space, Facebook and You Tube. While there are some potential negatives associated with these applications, the positive dimensions need to be explored, and strategies developed to manage the negatives.
- Municipal shopping centres like Chadstone have become communities within a shopping centre. Shopping centres present an opportunity for mental health assessments similar to diabetes and blood pressure checks. There could be mobile wellbeing centres that offer preliminary mental health assessments in the form of questionnaires, resources and brochures could be available and a mental health professional on hand to answer questions or refer people to the appropriate services. Shopping centres are also a good place to call attention to body image issues and address questions about eating disorders. Fashion shows could be sponsored using real models taken from the audience and fitted by fashion consultants from major department store chains.
- The federal and state governments need to examine whether it would be appropriate to review labelling on products to children that could influence weight or body image. Warning labels are already on video games that depict violence as a result of research into its effect on children’s emotional wellbeing. With the rise in anorexia and other body image issues, the need has now been recognised to more innovative ways to inform parents of the risks to some children who use dolls and other products to fantasize about a look that is associated with a lifestyle.
- Similar issues arise with other depictions of popular culture, through, for example, television shows. The recent winner of ‘Australia’s Next Top Model’ was sixteen at the time of the competition. This is part of an extremely popular franchise viewed by millions of young girls around the world. Throughout the competition she was told that she needed to lose weight, as it was part of an industry standard that models must fit into a size 8. The average size for an Australian woman is 14-16. The contestant lost the weight and won the competition. This was not a positive contribution to societal wellbeing.
- We need to re-invigorate our commitment to strengthening support to build community through fun activities that can integrate a message of good mental health by supporting open days, fetes, festivals and other celebrations within traditional settings like schools, churches, maternal child and welfare centres and municipal multi-use centres. Children’s out of school activities such as scouts, girl guides, sporting clubs, cooking and art classes could be supported to offer programs that teach skills that enhance resilience. These activities already do this, but may not be promoted in that way. Information about how these activities promote good mental health could be supported be offered to these groups for distribution to parents and children.
- Church and other faith communities are among those that strive to be open to and aware of people who may experience isolation. This is already a priority for many congregations.

¹⁰ Second Life, ‘Melbourne Laneways project’. July 2008 (online) <<http://www.mmv.vic.gov.au/VirtualWorlds>>



What partnerships should be developed to support a coordinated approach to progress in the above settings?

One of the biggest problems with promoting good mental health and the means to achieve it is that there is no single high profile mechanism for the delivery of the vast amount of information that exists on the subject. Better partnerships need to be established with the community organisations that are doing the work at the frontline of service delivery. They have a vast amount of information; expertise and resources that could be fed into a more comprehensive and better-funded information delivery system offered through federal and state government media outlets.

The consultation paper discusses the new Headspace initiative and Beyond Blue as sources of information for young people and adults that offer information about mental health issues. However, a greater focus on promoting general wellness could be achieved through government support for an additional ABC television channel that is dedicated to general health and wellness modelled after the newly launched ABC Health and Wellbeing website <http://www.abc.net.au/health/>. The new channel could have programming wholly dedicated to encouraging both physical and mental wellness with shows on how to achieve good overall health and discussion programs that have experts that offer information and advice to the public. This channel could be linked to the ABC Health and Wellbeing website where information could be obtained as well as providing a directory of organisations that offer services under various categories.

A major issue for community organisations is the lack of funds dedicated to raising their profile in order to make the community aware of the work they do and where they can gain access. The above mentioned ABC channel and website could offer small community groups opportunities to advertise their services for free or at a reduced cost to enable them to offer the community information and ways to access their services.

Another opportunity for promoting understanding of mental illness while providing information about good mental health would involve the print media. An example of an effective program is the Victorian water conservation Myths and Facts campaign, which regularly features in community newspapers such as the Leader group. This campaign seeks to debunk myths about water usage and conservation and at the same time provide the correct facts and information. A similar model could be used to increase understanding about mental health issues by debunking myths that cause misunderstanding and discrimination against people with mental illness. Readers could be directed to the ABC Health and Wellbeing website, Beyond Blue, or some other appropriate departmental website for more information on mental health.

Other opportunities for partnerships include:

- Support partnerships with social welfare agencies that tap into their expertise to develop and implement promotional information and resource materials on particular issues e.g. alcohol and other drugs, youth homelessness etc.
- Support community organisations that have contact with children (e.g. sporting groups) that may support broader programs to give out the information and resource materials produced from partnerships with community welfare groups in that region or locality. The development of partnerships between mental health training providers for workers in family and early childhood settings. (HCCIV)

Goal 1.2: Strengthening social inclusion efforts to protect and reduce inequalities in mental health



Within the Catholic community services sector there are many examples of community development work that effectively promotes social inclusion toward reducing inequalities in mental health outcomes. Community development initiatives act to promote greater understanding, not just between specific groups and the community, but also within the group itself. These initiatives create opportunities for specific groups to meet and associate with the wider community through special events at schools and community venues.

Mental health chaplains have focused on this in their reflections on this consultation:

A strengthening of family support services, not focused on families in crisis, but rather offering to all families support: parenting education; affordable quality childcare; age appropriate activities and programs for children promoting resilience, self esteem, confidence and wellbeing; support and counselling in times of difficulties, e.g. relationship difficulties or breakdown, financial stressors, behavioural concerns, loss, grief and bereavement events, social inclusion concerns, etc.

In general, family/carer support is limited and a neglected area within the MH sector. Families living with the impacts of a young person exhibiting MH concerns are in particular need. Again, due to the lack of pastoral/spiritual care in CAHMS, this mode of support is usually not available to them.

What aspects of current work can most effectively be built upon to promote social inclusion and reduce inequalities in mental health outcomes?

'[HCCVI] has a commitment to MH specialist community chaplaincy. This model is outreach focused, offering support and enhancing the development of social and community linkages for people affected by MH concerns (and their carers).

This year a pilot project in Geelong has been initiated through a partnership with HCCVI, All Saints Anglican Church, Newtown and Karingal Disability Services. This partnership has enabled the appointment of a full time MH specialist community chaplain. This work involves both centre-based chaplaincy at Karingal and, community outreach to people affected by MH concerns who may be isolated and/or less able to access mainstream services.

Although at this stage we only have anecdotal evidence, there is no doubt that this work enhances an experience of social inclusion and access. Further, it is preventative in that it supports people to attend to MH and spirituality concerns whilst living in the community, decreasing the risk of need for institutional care.

Of course, the extent that we can carry out this work is limited by the smallness of our service. An expansion and study of this outreach model of PC and C would give an opportunity to offer this support more widely and to develop an evidence base for its effectiveness. (HCCVI)

Other suggestions to promote social inclusion include:

- Work with community welfare agencies that provide assistance to immigrants and refugees to offer language translation of programs, and training of volunteers to work with these groups.
- Provide funding for the production of audio-visual resources that promote greater understanding of issues, to be distributed as DVDs or web-based for use in schools and community settings



- Support groups that exhibit innovative community development initiatives with incentives, such as the Community Idol Award given each year by Our Community at the Communities in Control conference.

Goal 1.3 Reducing risk factors for poor mental health associated with substance abuse

Many CSSV member agencies deal with individuals and families affected by alcohol and other drugs. Helping families understand what is happening and how it can affect relationships within the family helps prevent family breakdown, reduces the stigma associated with have a family member with a substance abuse problem and can help to prevent depression and anxiety for the non-using family members.

Who are the priority target groups in the community for providing education and support on the risks of mental health risks of substance abuse?

- Education should be targeted to children at an early age, possibly as early as prep introducing the concept of some chemicals being dangerous such as household cleaners. Then the program could be integrated into a health curriculum that eventually would directly deal with alcohol and other drugs.
- Adolescents, with special support programs in year 7, 9 and VCE years.
- Children suffering grief and experiencing feelings of loss as the result of death of a parent, parent with a serious illness, divorce or separation.
- Aboriginal youth in the context of an overall community education program that includes family and elders who assist in the design and are trained in its delivery.
- Homeless youth, especially those who have been sexually or physically abused or who already exhibit cutting and other self-harm
- Recently released prisoners, especially 24 and younger.



What are the opportunities for better integration of mental health and substance abuse prevention efforts?

- School settings integrated into the curriculum, parent education sessions, utilise education programs that travel to schools that use theatre and music to send the message
- University Student Union services
- Community development programs, especially for ethnic groups that experience particularly high risk from substance misuse
- School-based education programs for parents and students

How can relevant service systems be supported to identify and respond at an early stage to mental health risks arising from substance misuse?

- Greater professional development in identifying early substance misuse issues.
- Greater connection between groups that identify substance abuse and agencies that treat mental health issues (e.g. hospitals referring to community organisations for counselling). This would involve professional development regarding availability of services in the community.

Goal 1.4: Renewing Victoria's suicide prevention focus through a wider range of government programs

What are the best opportunities to embed suicide prevention activities in universal and specialist services?

- Early, broad (not just risk groups) intervention providing education to young people regarding resilience and what assistance is available to them.
- General practitioners should be better trained to recognise the signs leading to suicide
- Schools, especially focus on adolescent boys, same sex attracted adolescents
- Programs for young offenders, prisoners on remand, ex-prisoners especially between the ages of 18-24 similar to those offered to homeless youth
- Maternal child and health care facilities to identify mothers at risk of post-natal depression
- Homeless youth need alcohol and other drug education, counselling and support to be able to become independent through programs where they can gain skills and confidence.

What aspects of the current approach to suicide prevention need further improvement?

- It seems that the current approach is reactive. Individuals are identified as suicidal and treated. I believe proactive programs that promote resilience in youth and encourage young people to seek assistance before their problems seem insurmountable. (CCFS school psychologist)
- The extension of programs across the social service and education sectors which enhance the development of both community and individual resilience. This of course would include promotion of the importance of spirituality for well being. (HCCIV)



Focus Area 2 - Early Intervention

1.5 *Coordination of early intervention*

The Department of Human Service's consultation paper, "Because Mental Health Matters" provides a broad analysis of the increase in the incidence of mental illness in our society. The consultation paper discusses a two-pronged approach in its vision for a new integrated mental health system for Victoria.

- Early intervention, including preventative work, is proposed as the key mechanism for prevention of mental illness by: the promotion of factors that protect wellbeing and instill resilience; and identifying difficult emotional issues for early treatment, in particular for at risk groups.
- The other key mechanism for change is the reorientation of the current specialist mental health system to provide those suffering severe mental illness with better services and outcomes while reducing the burden on the public hospital system from the rise in crisis intervention.

CSSV supports moves toward establishing a coordinated approach to early intervention and strengthening the interface our services have with specialist mental health care services.

These moves are particularly supported because of their potential to address the needs of clients earlier and thus more satisfactorily; and also because of a potential reduction in the burden on the current specialist mental health care system.

However, there are important caveats to be entered.

- The first is that there is currently no scope for reducing funding to acute services. These are currently underfunded, with resultant added suffering for clients who cannot be readily treated, and thus for their families and carers.
- The second caveat is that a coordinated approach to early intervention will be most effective once there is in place a comprehensive program of early intervention support. To that end, this submission outlines the role that our membership currently has in providing comprehensive early intervention services through a variety of initiatives - these initiatives have the potential to be scaled up for use by relevant sectors across the State.

Our members can contribute to development of a coordinated system. Catholic Social Services Victoria represents a network of clinical and non-clinical interventions that cover the continuum mental health service delivery – from early intervention to acute treatment and care. These members' services act to intervene at the critical points in a person's life including difficult transitions. Early intervention focuses on those who are at risk of developing a mental illness, and for those who have been previously diagnosed with a mental illness and are at risk of relapse. Some of our members provide treatment in the form of counselling and other strategies including holistic case management, which would also be defined as early intervention as it acts to prevent clients from entering the specialist mental health care system. Clients who experience episodes of severe mental illness are referred to appropriate specialist mental health services for treatment, making use of our membership network or via specific case-managed programs.



As a network, our membership possesses the knowledge and expertise about the interface between clinical and non-clinical service provision and can offer advice on ways to strengthen that bond. Our members look forward to the opportunities presented by the changes to the mental health system to exchange information and increase understanding about the role non-clinical services have in reducing the numbers of people in need of specialist mental health care. This cooperation and collaboration fits with the government's objectives to create a more systematic and cohesive mental health system inclusive of all stakeholders.

CSSV members engage in early intervention services across all areas mentioned in the consultation paper. We welcome the commitment the government made to give special focus to support community-based-mental health services for children, young people and families. It is this interface that is essential to the success of community service agencies' engagement with clients in order to be there at the "right time" to prevent the development of mental illness in these target groups. Much of the struggle our members face is the increase in clients presenting with serious mental health issues and nowhere to go to be treated. With appropriate treatment from specialist mental health care, our agencies can work better toward early intervention to prevent relapse leading to episodes of mental health crisis.

Goal 2.1 Strengthening the capacity for early identification and intervention through universal services, including early childhood service and schools.

Some agency providers of services to students speculated that changes to the education system over the past thirty years might have contributed to a decline in the wellbeing of some students. These changes, in combination with increased pressure on the family unit have created a mental health crisis for school-aged children, in particular for those in secondary school, who are at a vulnerable time as a result of physical changes and emotional upheavals.

The focus on university entrance and away from traditional TAFE pathways has limited curriculum choices in some schools. That is in part due to demand by students, who are convinced by parents and their school that university entrance is the goal or a superior choice. More must be done to shift the pendulum toward non-academic career pathways that lead to TAFE courses and apprenticeships. This would build confidence for non-academic students and give them more choices to study outside the traditional academic curriculum framework.

The pressure put on students can be unbearable, especially when facing the VCE years. Society needs to be persuaded to place less emphasis on performance targeted toward university entrance into professional degrees, in the interests of long-term student interest and well-being.

Goal 2.2 Providing earlier and age appropriate treatment and support to children and young people with emerging or existing mental health problems and their families

What should be the respective roles of universal, secondary and specialist mental health services in a system of care focused on early identification and intervention? Why?

With more information being available by promotion of the mental health message through universal services, more awareness will be generated, and this will continue through secondary services and on to specialist mental health services. The system needs to ensure that silos are not created and that there is communication and networking in systematic ways among the three roles. An example is that promotion of good mental health is just as valuable to people who have mental illness as it is for those who have never experienced it. All people must be viewed with having the potential to experience mental illness within their lifetime, and therefore



services need to be flexible enough to help people whatever the state of their mental health – first diagnosis, in recovery, relapsed or with a complex diagnosis. The following are the specific roles suggested:

- **Universal:** promotion of the mental health message, educating youth in resilience, early identification and referral of kids at risk
- **Secondary:** assessment and early intervention with 'at risk' youth, referral of more serious mental health issues
- **Specialist:** treatment of individuals diagnosed with a serious mental illness plus support for themselves and their families using a case management approach.

The reasons given for the separate roles are:

- Training and education can be specialised for people in each role to assure best practice, professionalism and innovation
- Outcomes could be more readily monitored to allow for evidence-based planning specific to each role. This could assist in funding of initiatives that target specific at risk groups
- It may allow consistency in the mental health message and continuity across the whole mental health system if the main responsibility for certain roles was separated
- Clarity in roles may result in some efficiencies and encourage specialisation.

An additional workforce should be responsible solely for care coordination and have knowledge of the system as a whole in order to ensure flexibility, cohesiveness and cooperation. Individuals could be professionally trained in a systems management role. This role could be supported by a new degree that combines medical and organisational management qualifications.

Further comment was offered surrounding mental health chaplains as having a universal role that supports spiritual and pastoral care for early intervention and for those with serious mental illness and their carers.

Currently within CAHMS there is basically no intentional attention to spiritual/pastoral care, and there is definitely no consideration of the need for this work to be undertaken by specialist MH chaplains. This means it is not until/unless young people move into the AMHS that this part of their experiencing is attended to toward their recovery. An example of evidence of this need emerges in our work in acute AMHS. We often encounter young patients (17, 18, 19yo's), particularly young women with eating and mood disorders, who demonstrate a yearning for spiritual exploration, growth and meaning-making as part of their psycho-social development toward recovery.

School chaplains present as a profession that have an opportunity to offer such care to young people and carers/families as an early intervention strategy. This further evidences the need for MH education to be an essential part of their training. (HCCVI)



What are the appropriate and viable options for structuring services for adolescents and young adults?

Are there distinct groups, defined by age or mental health problems that need different interventions?

Yes, youth can be identified by specialist services based on criteria that assess their risk at particular ages and within certain environments. There are transitions that occur at certain ages that, in general, can make youth particularly vulnerable, and their reaction can be different depending on gender. Mental health problems are occurring at younger ages so interventions need to be more specific to the environment that they have come from, such as homelessness, detention, and family violence.

What service arrangements should deliver these interventions?

All efforts should be made to deliver these interventions in the context of service arrangements that offer safe housing and continuing education while access to specialist treatment is given. Schools in cooperation with community service agencies could be avenues for the provision of a program model that could case manage individual youth as together they have the structures to provide holistic care

An outreach model of service emerges as an essential element. As part of our service, we regularly offer follow up outreach support to patients upon discharge from acute care, at least on a transitional basis. This assists clients' transition to living back in the community, provides support for their access to community based care and support, enables continuity of support toward recovery, and provides monitoring of well-being post hospitalisation. (HCCIV)

What would be the key features of accessible and effective service models?

- develop more community hub initiatives
- create more drop in centres for youth within community hubs
- offer information and recreational activities free of charge
- located on or in close proximity to secondary/tertiary education outlets enabling a continuing connection
- have counsellor on call 24 hours: an example is the Whitehorse Counselling Services Alliance that provides contact numbers for 24 hour help lines and several local family counselling services.

How should such services be located in the broader service system?

The Office for Youth under the Department of Planning and Community Development could include these services as part of its overall agenda.

How could family-centred practice be better embedded in models of care?

Support for a case management approach within a holistic school community model for mental health that is inclusive of the family, not just the child. Schools are appropriate and effective as a means to assess, identify and organise intervention in support of the student and their family. In the delivery of educational services was seen as the limit of responsibility for administrators and teachers. However, schools represent the main universal setting where accesses to services that support families can be logically and cost effectively offered in a structured and systematic way.



In striving toward a holistic model of care, the family system needs to be considered and supported. In acute clinical settings where focus tends to be on stabilisation, very little attention is available to work in a family-centred manner. Yet, it is often in these settings where family members are also at their most vulnerable and in need of support. Having workers who can intentionally give support to families in these settings, ensuring appropriate on-going supports, exploring the family's capacity to care for and cope with the member with MH concerns, assess risk factors of other members; enhancing family functioning can only assist in the recovery progress of the patient. (HCCIV)

Goal 2.3 Delivering appropriate mental health support for particular groups of vulnerable young people

What would be the important key features and functions of a service offering dedicated mental health support to vulnerable young people?

Features:

- targeted to youth culture
- low or no cost
- easily accessible (close to hubs)
- operated by staff and volunteers of similar ages who they can relate to and who can act as mentors
- offer counselling and peer support groups
- offer careers counselling and information about education and training

Functions:

- support them to continue getting and education/and or training
- identification and intervention of mental illness in young people
- referrals to appropriate mental and general health services, shelter for homeless youth and other material assistance.

Goal 2.4 Building a stronger, more resilient families where there is risk related to mental health problems or a combined mental health and drug and alcohol problem

Families where a parent with a mental illness (FaPMI) Strategy has been employed by our members to great advantage to those families in need of assistance. The proposed change to broaden the scope to include parents with problems with alcohol and other drugs is welcome. There is also support for the partnership with Child FIRST/Family Services, which will strengthen the delivery of these services in a holistic way.

What supports should be in place for young people who are carers of parents with mental health problems, or with combined mental health and drug problems?

- Individual counselling, group support (with other youth in a similar situation).
- Contact with school counsellor or well-being coordinator if the family is not accessing Family Support services. Case managed Family Support services would provide better contact in the home environment. Possibly, a link with both services would be able to help the child on both the school and home fronts.
- Increase Family Parent with a Mental Illness (FaPMI) support as this has proven successful in assisting young people
- Training for community agency professionals in assessment and safety planning, which will help to maintain support for families with a member with severe mental illness
- Increase outreach to rural areas, which are under funded leaving gaps in support



- Enhance consultation opportunities/services to professionals (i.e. PSP practitioners, family support case workers, and housing support)

What models would be most effective?

We refer back to the CEOM model mentioned earlier in Focus Area 1. Schools provide the greatest opportunity to identify problems at home through observation of students. The CEOM model promotes the Schools as Social Centres model, which attempts to create community connectedness in a school environment. With the disconnection that is occurring within local communities, schools provide the best opportunity to develop relationships with families and build an inclusive community setting surrounding the education of their children.

Families with pre-school children could also benefit from this model. Schools could have outreach programs aimed at school preparedness and early education that could include interaction with families aimed at developing relationships prior to school entry. Maternal and Child Health Centres, kindergartens and early learning centres could participate in a local partnership that brings them in contact with local schools. There may be opportunities to establish connections that may identify problems for these children early and get support for their families.

The model needs to establish cooperation between agencies assisting adults with mental illness and those that support their children, in addition to offering appropriate referral services from adults and children's' services.



Focus Area 3 - the right service at the right place

Access is an important issue for all CSSV members. As mentioned earlier, some members offer specialist mental health services and will be providing comment from that perspective in their submissions. This submission will focus on community agencies as a "point of entry" to specialist mental health services. Our experience is that access to specialist mental health services are difficult to negotiate, and at times difficult to gain entry even after assessment by trained professionals. This has the potential to put staff at risk, especially those without training in dealing with clients with severe mental illness. This also inhibits access to their family members via outreach because there may be a risk posed by the mentally ill family member during a visit. In consideration of this, there is no way around the problem of access except to grow its specialist mental health services capacity to meet the demand and relieve community agencies from the responsibility for their care until they have been treated appropriately.

How do we enhance access points to the specialist mental health system and what critical issues should be considered?

There is a need for a universal system to refer individuals to the right service after a brief assessment as suggested in the consultation paper in the form of a 24/7 caller hotline. The Department of Human Services Nurse-on-Call initiative focus (according to the website) is on physical health, however callers could be directed to a trained professional to answer questions relating to mental health. Contact details or referrals to the appropriate mental health service could be provided. This will allow caller anonymity for those who do not wish to be identified. It also links to GP services that have chosen to promote the service with their patients. People in crisis or emergency cases could have their calls transferred to ambulance services.

There should be a public mental health education campaign that offers information sent to all households about the system and where entry points are in a particular locality. Schools, early learning and maternal and child health centres could also be involved in an awareness campaign. This would coincide with promotion of the Nurse on Call (or similar) service as a means of making contact with appropriate services, which may involve referral to a GP or mental health care specialist for an assessment depending on whether it is a crisis situation.

Specialist mental health care services should support community services agencies with information, training, education and advice. Within the Catholic social services network, MacKillop Family Services and Centacare agencies offer counselling and family services across Victoria. These and other agencies, that offer similar services, have qualified psychologists, counsellors and social workers with the potential to offer assistance on behalf of public specialist mental health services. With proper funding, opportunities exist for these agencies to offer the community and other professionals, education and professional development in mental health and the identification of mental illnesses.

What role should GPs and other primary care providers play in this?

GPs should take a greater role in assessing people with mental illness and referring them on to appropriate entry points. It is partly training and the need for better support from specialist mental health services, but their focus is not mental health. Under current Medicare arrangements, time dedicated to each patient is limited to diagnosing physical illness, which can be accomplished in shorter time frames and definitive diagnostic techniques. It is often difficult under these circumstances for patients to be assessed in short timeframes and many go through with no attention paid to their mental state. GPs need to be trained to ask the right questions and have the time to make appropriate assessments and referrals.



Focus Area 4 - Specialist Care

Meeting the needs of people with severe mental health problems – building responsive specialist public mental health services

The collected comments from members under this Focus Area were derived from interviews and supplied written comments. Written comments are reproduced under each question and identified by the agency within quotation marks.

Villa Maria¹¹ and Healthcare Chaplaincy Council of Victoria¹² offered written comments.

Goal 4.1: Building a more proactive system of specialist community-based mental health care that is geared to early intervention, relapse prevention and recovery

Key gaps in service

What reforms are required to improve the early identification and treatment and continuity of care of people of all ages with eating disorders?

Eating disorders

Eating disorders in children and young people could effectively be addressed early in the school environment in the context of a whole school Wellbeing Strategy suggested in Focus Area 1. Adults would need to rely on better recognition of the symptoms from GPs and information campaigns targeted to specific at risk groups.

- Advice and information from specialist mental health services should be provided to schools about eating disorders and how to recognise them early
- School's could make nutrition and healthy eating part of the core curriculum and include food preparation and cooking under a health unit
- School nurses need to be trained and supported when a diagnosis is made and act in a care coordination role
- GPs need to be trained and supported in early identification of eating disorders. There is a need to be able to refer patients to appropriate specialist care for eating disorders. This could utilise the telephone hotline similar to the Nurse on Call system.
- Health and sports clubs could become part of an initiative that provides health checks and information to people about eating disorders linked to weight restrictions for participation in particular sports including gymnasts, boxers and jockeys and dancers.

¹¹ Villa Maria is a provider of aged and disability care and accommodation.

¹² The Healthcare Chaplaincy Council of Victoria Incorporated's (HCCVI) role is to liaise with the Government and to advocate for funding to provide interfaith chaplaincy services in the healthcare sector. Among its responsibilities is a strong focus on mental health and wellbeing issues for families and individuals.



School Refusal

Another key gap in services surrounds students that fall under the category of “school refusal”¹³. These students are not truants and often suffer from depression, anxiety and other forms of mental illness. They cut themselves off from school preferring to stay at home. This is sometimes related to a change in their life at key school transitions and is associated with family breakdown, the birth of a new child or change in living circumstance in a blended family situation. Prof Bruce Tonge from Monash Medical Centre has investigated school refusal, finding that long-term school refusal can lead to serious mental health problems later in life. The number of students experiencing school refusal is on the rise. Centacare Melbourne has an innovative program know as cool2b@school¹⁴, which uses case management to help the student and family in addition to supporting the school with consultation and training and education for administration and staff.

How can we achieve a more integrated clinical and psychosocial rehabilitation response?

“In our experience in acute clinical settings, there is quite a divide between clinical practitioners who attend to the medical treatment of patients and allied health practitioners, of which we are aligned, who strive to offer therapeutic psycho-social care. There appears to be little promotion of the essentiality of a holistic therapeutic model of care among clinical staff in these environments, and there are opposing pressures such as lack of beds, minimum length of stays and inadequate nurse-patient ratios. In our experience, patients who have a positive engagement with psychosocial programs during their hospital stay are more likely to continue to access community based programs upon discharge.” (Healthcare Chaplaincy Council of Victoria)

Goal 4.2 Accessing a wider range of bed-based care options that are well integrated with both clinical and social supports

What reforms are required to improve the efficiency and effectiveness of Victoria’s specialist adult and aged mental health bed-based service system?

“Again, the key here is the emphasis on the medicalisation of mental health care, treating the symptoms in isolation from social, developmental, emotional and spiritual concerns, with the sole aim to stabilise for discharge is key. This model of care has failed. There is a desperate need to raise the status and commitment to holistic psycho-social approaches to be considered as equally essential as, and offered in tandem with, medical treatments.” (Healthcare Chaplaincy Council of Victoria)

What are the characteristics of our current service system, which results in recourse to practices such as seclusion? If we want consumers to be regarded as a partner in their recovery, what would need to change?

“One concern that emerges is the inflexible nature of the system; staffing levels are fixed, rather than responsive to the needs of the current patient community; as mentioned earlier, the mix of patients in acute settings is greatly disparate, creating tensions and conflicts in providing a sense of safety and security. And, there is an innate punitive character in an environment where hospitalisation is commonly forced and patients are held in a secured (locked) ward. The taking

¹³ Young Children and Teenagers ‘Dropping Out of School’ (2007), Centacare Catholic Family Services, Flame newsletter Vol 1, No 1.

¹⁴ ‘cool2b@school, School Counselling, Consultancy and Training program’ (2007). Centacare Catholic Family Services, East Melbourne, Vic.



away of liberties sometimes appears to be done with little sensitivity, and the impact on this for patient attitude is given little consideration.” (Healthcare Chaplaincy Council of Victoria)

Goal 4.3 Improving consumer and carer experiences, making sure that expectation with regard to access, rights, equity and respect are met

The paper did not adequately address the needs of mental health carers except in a few places under Focus Area 2.

The unmet needs for mental health carers and families are many and varied. DHS publications give loose guidelines to services regarding response to carers and only make 'practice' and service provision suggestions with no prescriptive resources allocated for implementation. This makes it very difficult to create a culture of carer responsiveness and participation within DHS funded services.

Mental health Carers find it very difficult to navigate the sector – there is no mediating body to assist with this.

Mental Health carers often experience vicarious trauma and mental health services providers do not have the resources to provide a comprehensive counselling service directly to carers and families. Many of the concerns for families and carers are related to the care and treatment being received by the consumer. Thus, these concerns are often left unaddressed. There are brokerage funds to support 6-8 free counselling sessions for carers, but this is delivered by a service that is not overseeing the treatment and care of the family member with a mental illness. (Villa Maria)

What strategies/mechanisms are required to better support the active involvement of consumers in their treatment and care?

“There is currently a very adversarial character in the relationship between patients and hospital staff. We are in a unique position as pastoral carers and chaplains. Of course we work alongside clinical and allied health, but patients often view us as different, somehow 'straddling' the in between place. We offer a focus on them as people, rather than on their disorders and can support them to be heard. We often encounter patients who speak of feeling they have no voice in their treatment, that they are misunderstood by practitioners and, feel powerless and coerced in decision-making about themselves. Patients are commonly viewed by practitioners as manipulative, where they speak of just needing to play the game so that they can regain some of their liberties.

This attitude, promoted in a culture of practitioner-expert, patient-victim of illness, must be overcome to enhance consumer involvement in their treatment and care. This is particularly essential in clinical settings, wherein there is an unavoidable experience of disempowerment. Further, if patients are to continue treatment post-hospitalisation, there is surely a requirement for them to hold some ownership over decisions regarding treatment.” (Healthcare Chaplaincy Council of Victoria)



What are the best models for supporting a carer sensitive approach in the mental health system?

“Carers commonly express a sense of powerlessness in clinical settings; the care is taken out of their hands. There seems to be minimal inclusion of carers in clinical and treatment discussions and decision-making. Carers feel excluded from the basic daily decisions that they would usually negotiate with the patient.” (Healthcare Chaplaincy Council of Victoria)

How can we best promote culturally sensitive practice with mental health services and in broader social support services?

“With the increasing diversity of cultural make-up of service providers, cultural sensitivity is improving. There needs to be however, continued professional development in this regard. Further, cultural concerns require intentional attention throughout treatment/service process from assessment to provision of care. An increase in involvement of consumer and families/carers in the provision of care is also an essential element in hearing needs that may be specific to culture.

A role for pastoral/spiritual carers in this regard is the assessment of spiritual and/or religious needs, which can be extremely diverse depending on culture. The spiritual/pastoral care providers also need to be actively attracting a greater diversity in their profession.” (Healthcare Chaplaincy Council of Victoria)

Goal 4.4 Tailoring services for clients with particular needs, especially forensic clients, including both bed and community-based support

What reforms are required to improve the efficiency and effectiveness of the community- and bed-based forensic service system? How can AMHS and PDRSS better support and provide treatment and care for clients with a forensic mental health history?

“We provide pastoral care services to a bed-based forensic facility. The time we are given to each ward is very limited (2 hours) and there are limited opportunities for us to input pastoral concerns into professional forums.

We would like to extend our work in the forensic area, expanding our capacity to offer transitional outreach support upon release and for community-based MH forensic consumers. Further, we would like to offer specialist support and education to prison-based chaplains; the percentage of the prison population with MH concerns is somewhere around 65-80%, and on the increase.” (Healthcare Chaplaincy Council of Victoria)



Focus Area 5 - Complex Clients

Catholic social service agencies offer assistance across all complex needs sectors. Consumers of these services can only survive having access to an intensive case management approach, which is well funded, flexible and extended. Our members offer many models, but the complexity of the clients' problems leads to the need for complex solutions in order to maintain funding from multiple departmental streams, all with different requirements and boundaries for continuing care. For these clients, in particular, the joining of these streams could simplify a system that is currently difficult to negotiate.

Goal 5.1: Promoting a more coordinated approach to people who require support from multiple services

Case management interventions are only effective when based on a comprehensive multidisciplinary approach that develops case/care planning that addresses bio-psychosocial needs. Approaches need to be based on thorough case-formulation that accounts for predisposing factors, precipitating factors, maintaining factors and social supports. These dimensions look at the person's social context including family supports, social activity involvement, financial, housing, transport, and social history; biomedical/organic factors: current health status including formal diagnosis of mental and physical illnesses, cognitive functioning; intra-psychic resources: psychological motivation to change, resilience, emotional coping style and capacity to respond to change including loss.

Interventions flow from the assessment and case-formulation and are closely matched to different mental illnesses. For example, individuals who suffer dementia and other cognitive functioning impairments are likely to require significant personal care services and personal monitoring/supervision in activities of daily living. Behavioral management is a key issue and so is managing its vicarious effects: turnover of paid/volunteer supports, family carer stress. Individuals with mood or disturbances of thought disorders often function independently with the physical activities of daily living, and require less care coordination support but require intensive emotional case management support. These conditions often have strong cyclic features that continue into old age, though may attenuate with increasing age, and these require significant case management time providing personal support. Individuals with anxiety disorders are often more socially isolated and are less engaged with social/community life. This often brings a corresponding demand on case managers to spend time providing reassurance and implementing strategies (with cognitive-behavioral features) to assist clients. (Villa Maria)

What key system reforms are needed to support the effective coordination of care across multiple service systems?

A State government funded case management strategy could be established for clients with complex needs as a standard model of care using eligibility criteria for an individual or family to receive holistic case management services. Care coordination could be regionally coordinated to make it easier to find the "right services" at the "right time". This could be an alternative mechanism to multiple departmental funding streams as many complex clients and their immediate family are associated with a critical mass of relevant indicia, including:

- family member with a mental illness (parent or child)
- homelessness
- unemployment
- financial collapse or bankruptcy



- CALD background
- Indigenous background
- released from prison
- disconnection from family and as a consequence living alone
- refugee or humanitarian entrant with post traumatic stress
- family member with a problem with alcohol or other drugs
- family member with gambling problem
- family member with acquired brain injury or physical disability
- family member with terminal illness or recently deceased
- victims of violence and sexual abuse

"I think the case-management system was an attempt in this regard. However, there needs to be a more hands on approach, maybe a conferencing forum of involved service providers on a regular basis, also involving the consumer." (Healthcare Chaplaincy Council of Victoria)

How could existing service platforms be used to support local partnerships and linkages in the delivery of age-appropriate coordinated care?

Gaps at present are the failure to target mental health with community care packaging. The Aged Care Act does not recognize it is a special needs unlike veterans, rural & remote etc as it has obviously been seen historically as a state-based healthcare issue. This translates to mental health not being given priority in terms of how CACP & EACH programs profile, market and resource themselves. Linkages are not made with public health adult psych services and recruitment strategies are not pitched at attracting workers with mental health experience. Hence we have a big disconnect between traditional mental health services and the community and residential aged care sectors. Agencies could dedicate a percentage of packages for example to individuals with mental health issues in the community and this could drive behavioral." (Villa Maria)

How can family or carer supports be most effectively incorporated into integrated care planning?

We use carer satisfaction surveys at Eastern Health to get feedback about service provision. We also keep well-documented records of consumer and carer compliments and complaints. There is a network of local service providers and carer support group conveners that act as an advisory body to Adult Mental Health Service. This information is fed back to the managerial level via our various consultants who sit on these networks.

We have been developing feedback mechanisms for the service. These are displayed at all service sites where families, consumers and carers can see them. They outline how to give feedback and what happens with the feedback given (i.e. at a local and systemic level).

The AMHS has developed a range of initiatives to be more responsive to the needs of carers and families. These include information sessions, packs, a peer support program and psycho-education and coping skills training. (Villa Maria)

Family and care supports could also be included in the above and where appropriate, be involved in the provision of services and care. (Healthcare Chaplaincy Council of Victoria)

What statewide guidance and support is required to support any new model of care coordination?



Focus for community service providers should be on delivering a social model of health that emphasizes and facilitates individual clients and group connections with others including opportunities for renewing and generating new connections. Thus issues of social isolation and disconnection that often gradually develop as people age or as their disability advances can reduce or prevent the likelihood of subclinical mental health issues developing into full blown clinical disorders requiring acute services. Hence community case management services like HACC/CACPs that are not specialist mental health (or mental illness focused services) psych services, nevertheless play a key role in addressing the social environmental context. Models of care that allow a lead agency to coordinate the majority of services, bringing specialist consultant and practitioner support in as required overcome the lack of continuity that currently exists where people get bumped from one service to another based on which individual issue has priority rather than look at the totality of the individual.

Models of care that are matched to the individual's mental health diagnosis are essential to improve mental health. For example an individual with depression may need in addition to pharmacological interventions, some externally oriented socialization involvement such as Programmed Activity Groups (PAGS). On the other hand, an individual with a social anxiety disorder may benefit from smaller scale community activities with only one carer, or a telephone social connection program. Another individual with a thought disturbance disorder is likely to have burned many family and other social relationships and may require fairly intense involvements from very few trusted carers and professionals. So matching is vital. (Villa Maria)

Goal 5.2 Improving access to stable and affordable housing, together with appropriate and scaled support to reduce homelessness and sustain tenancies

The consultation paper confirms what our membership who assist the homeless have known for many years, that most homeless people – youth; older women and men – suffer from mental illness that is compounded by lack of access to appropriate treatments and availability of safe long-term housing. This group needs permanent assistance and continuing care to avoid the need for specialist mental health care.

Continued focus by Governments and communities at all levels in addressing homelessness is a pre-condition for meeting the mental health needs of this marginalised population.

Questions

What are the key reforms required to improve access to social housing and private rental for people with mental health problems?

The numbers of individuals experiencing a serious threat to their health and wellbeing as a result of long-term homelessness is increasing in an aging population. Many people suffer difficult life transitions and as they age find it harder to overcome the combined effects and regain independence. The incidence of co-occurring substance misuse and experiences of abuse and violence from living on the streets or time in prison galvanise mental illness to a point where managing it is part of everyday life. There have been many government investigations into homelessness. CSSV's latest response to the Australian Government's Green Paper on homelessness is provided in Part I, Sec 1.3. It goes into detail about the issues and has recommendations for change and suggested initiatives.

This is a tricky issue. There is a desperate need for an increase in social housing and for a broader range of options that can respond to the diverse levels of care/support needs. CSSV have some very good models, e.g. Bethlehem Community, Corpus Christi Community, The Way etc. In my experience these places enable equal focus on the individual and the provision of a



sense of community that enhances resilience and wellbeing. Further, residents in these settings are encouraged to be as self-supported as possible, whilst being provided with care and support where needed. Its hard to even speak of private rental at a time when there is so little and rents are at such a level. However, a strengthening of advocacy and/or brokerage on behalf of people living with a mental illness, if something like that is available in the employment sector would be advantageous. (Healthcare Chaplaincy Council of Victoria)

What role could or should Housing Associations and other areas, such as local government, play in the provision of social housing for various age groups with mental health problems?

Older homeless people benefit from programs that offer long-term safe accommodation with access psychosocial rehabilitation that includes recreation and social enterprise programs supported within a case management framework.

Questions

How can we more effectively support people of all ages with mental health problems and/or psychiatric disability who are at risk of or are homeless?

Care coordination is an issue with complex clients, especially those who have episodes of homelessness due to their mental illness, which results in lack of continuity and relapse without intensive effort. Intensive support and social support models are available, but there is not enough capacity and people must be turned away without adequate support.

Lack of funding is a big stumbling block as there is not enough money to support the extra hours it would take to provide accommodation referral and referral to other support services. There are currently initiatives that are cost effective and successful at diverting the homeless from entering mental health specialist care. With better overall funding of this sector, more could be achieved in holistic care for the homeless.

What reforms can be implemented to improve responses to young people who are homeless and who require treatment and support from mental health services?

Overall, our membership commented that there needs to be longer-term packaged care that is case-managed and age/gender specific in consideration of the fact that different ages and different genders offer different challenges. Homeless youth have the greatest opportunity for becoming independent and contributing members of society.

There have been some promising initiatives, that indicate that adequately funded efforts in this area can be productive. 'Pomegranate House' is an early intervention model, which is a good example of a model of collaboration between private, public and NGO sectors to meet identified needs. The initiative targeted those who are not eligible for public mental health services (ie not assessed as SMI) but could not afford private psychology services. It began as a therapeutic facility for marginalised and financially disadvantaged people who have a psychiatric illness and/or their families. It was supported by St. John of God Health, Centacare Ballarat, Ballarat & District Division of General Practice and the University of Ballarat. It demonstrates the cooperation of stakeholders with different strengths to work collaboratively to provide support for individuals that would have fallen through the gaps of the current government funding system.

Goal 5.3: Focusing on the needs of people from particular vulnerable and disadvantaged groups



Adults and young people with serious mental health problems engaged in the criminal justice system

The Catholic Prison Ministry and Youth Welfare Ministry offer pastoral care for people who are incarcerated or on remand awaiting trial or sentencing. Many of these prisoners are young, between the ages of 18 and 24. Consistent with other research, comments from those involved with prisoners indicate that many have suffered physical and sexual abuse, had experienced homelessness, were undereducated and had symptoms of mental illness with co-occurring problems with alcohol/other drugs and/or acquired brain injury. As a result many have low self-esteem and anger management problems making them vulnerable to victimization and the reverse while they are in prison.

Prisons have the responsibility for preparing prisoners for release into the community. However, lack of transitional programs to assist young prisoners for release is a barrier to successful reentry and finding accommodation is difficult to achieve leaving many unemployed, homeless and thus vulnerable to re-offend.

How can we most effectively support people with serious mental health problems at each transition point in the criminal justice system to reduce the risk of them re-offending or being re-victimised?

Rehabilitation programs are lacking, in general, within prison for both young and older inmates. The lack of industry within prison is cited as the biggest barrier to successful rehabilitation in combination with appropriate psychiatric care. Of the programs that are available, which are few, participants are selected naturally on the basis of potential to complete the program. Without adequate psychological screening of prisoners and treatment many are prevented from ever accessing available programs and are released with little or no rehabilitation, and only the criminal contacts they have made during their stay in jail. This lack of demand feeds into reduced support for such programs and limits its availability as a means of rehabilitation. More funding support for programs that identify, diagnose and treat prisoners must be done in concert with rehabilitation programs that include opportunities for occupational therapy and skills building. An example of a successful social enterprise program is the "Doin Time" Youth Unit project¹⁵ at Port Phillip Prison conducted by Anne Hooker and her team. This is a model that already exists and could be expanded to assist others in the prison system. The Fulham Correctional Centre offers Industries and Training Workshops for young prisoners and is supported by the GEO Group Australia.¹⁶ This is another successful working model that is an example of a successful industry sponsorship program. Other programs currently supported by the government, Street Socceros and the Homeless World Cup, are programs mentioned that could be expanded or used as models to reduce youth recidivism.

For those young people, who do get into trouble more flexible sentencing options should be available based on age, up to 24 years. Research shows that brain development continues until 24 years of age. Up to that point, young offenders should be offered sentencing options that account for the fact that their brains have not fully matured. Research has also shown that three years of daily smoking of marijuana can cause acquired brain injury (ABI), which for many of these youth is a factor, in addition to excessive alcohol abuse. These mitigating factors should be considered when sentencing youth with dual diagnosis to allow appropriate treatment and residential care.

¹⁵ "Doin Time". 27 July 2008 (Online). <http://www.servingtime.org/>

¹⁶ 'The Journey of Change Exhibition' (2008), South Gippsland Sentinal Times, 1 April.



How can we reduce the risk of offending behaviour by, and victimisation of, people with a serious mental illness (including those with a co-existing substance misuse, disability or other complex problems) and their engagement with the criminal justice system?

Preventing young people from entering the prison system is a key concern of our members. Earlier assessment of mental problems, support for families in crisis, and for the children leaving the foster care system (often with nowhere to go – no home, no education or training) will help to stem the flow into the prison system. The CEOM School-based programs mentioned in Focus Areas 1 and 2 can identify troubled youth early using assessment tools that consider a range of personal (cognitive testing) and environmental risk factors may divert these youth from the first instance of trouble. The government could sponsor school-based diversion programs that are part of a family case managed approach.

This is a preventative concern and a lot of the above impacts upon this. If people have access to effective supports and have basic needs provided they are less likely to offend. If people have safe and secure housing and care, they are less likely to be in a position to be victimised. Also, there is a growing number of young people exhibiting mental health concerns who do not engage successfully with mainstream education, and a broader range of options need to be offered, and possibly from a younger age. Obviously, family support is also an essential element in reducing this risk. There needs to be some continuity. This is something a service like ours can offer. A strengthening of a mentor program in this area may also contribute. (Healthcare Chaplaincy Council of Victoria)

Better care for those with dual diagnosis

How can we better respond to the needs of people with mental health problems and co-occurring substance misuse across the continuum of need? What are the areas for priority action and why?

Youth are the group that should be targeted in a massive campaign that includes:

- better and more targeted education programs in schools that begins in Prep (see answers under Focus Area 2, Prevention)
- eliminate youth homelessness as a priority, but not within an institutional setting – case-managed care with mentoring
- try to find ways to encourage re-connections with supportive members of family and friends
- develop opportunities for youth to mix with other youth, not mentally ill (perhaps volunteers), in community settings like youth centres, and community work projects – festivals, market gardens, theatre productions etc.

If we were to develop a more integrated response to the needs of people with dual diagnosis, what would this response look like and who should it target?

It is important to assist the person with the dual-diagnosis in the context of their families, wherever possible. This is especially the case in communities where there is the preponderance for substance misuse in addition to cultural issues that exacerbate shame for family members, such as in some ethnic groups. Centacare Catholic Family Services, Mary of the Cross Centre focuses on supporting the family of people with alcohol and drug problems. They work with the local community to develop trust and resilience and reduce the stigma associated with having a member of the family with a substance misuse problem. Counselling, group work and community development work assist in strengthening the family unit so that the individual can



gain support and eventually mend ties. This is can often be a springboard for recovery or prevention of relapse.

Several CSSV member agencies provide Family Support Services funded by DHS. These services provide excellent examples of holistic case management approaches to handle families in crisis with complex needs. Many of these families have a member suffering from mental illness with problems that are compounded by family breakdown, unemployment and have children as carers. Case managers coordinate every aspect of the family's life including arranging material assistance and referrals to specialist mental health services. In CALD communities, when necessary, case managers are supported by social workers that can translate and offer assistance around culturally sensitive practice.

How can we more effectively support refugees, including children and young people, who have, or are at risk of mental health problems?

Comments have been made in support of recent changes to AMHS, which has developed a range of initiatives to be more responsive to the needs of carers and families. These include information sessions, packs, a peer support program and psycho-education and coping skills training. It is believed that extension of these services would assist in providing case managers with important information about mental illness in support of families, in particular refugees and the newly arrived.

Goal 5.4: Maximising the individual's potential for recovery by supporting their social and economic participation in community life

How can Victoria better support people with mental health problems to become job ready and secure meaningful employment?

Many CSSV agencies provide support services to the long-term unemployed and their families. These programs offer material assistance and employment support as part of the Federal Government's Personal Support Program, in addition to independent employment services for special needs groups that fall outside of the Job Network, which include refugees and humanitarian entrants. There are several community service agencies that provide employment services to refugees and humanitarian entrants. An example of an initiative is Centacare Catholic Family Services' *Building Independence Program*, which offers refugees services that make them job ready and arrange placement utilizing a network of employers willing to take refugees on after training, which is facilitated cooperatively within the network.

What role should the specialist mental health service system play in this regard?

Secure employment with opportunities for further education and promotion to higher-level positions is probably the most important social determinant for good mental health. Employment provides people with dignity, self-esteem and opportunities for growth and movement away from difficult circumstances, which provide the groundwork for a better future for themselves and their families. Individuals with multiple barriers to employment can overcome difficulties through a well-resourced case-managed approach to re-entering the workforce supported by the specialist mental health services system. There should be a better interface with employers through Worksafe and Employee Assistance Programs supported by the government.

What role could local and regional partnerships play in achieving this outcome?

Suggestions to further this approach seek to formulate better partnerships within the specialist mental health services, community service agencies, employers and adult education:



- Funding support for the delivery of employment support services in partnership with homelessness, PDRSS and PARC services.
- Evidence suggests that better mental health is an outcome, even for those with severe mental illness. Structure models of care for those individuals with mild or moderate mental illness where employment is the primary goal. Employer networks and tertiary institutions would work with community service agencies to assist with job readiness, mentoring and job placement.



Focus Area 6 - a high quality and sustainable workforce

Since the closure of psychiatric institutions, Catholic social service providers have increased our workforce to meet the demand for both clinical and non-clinical services in the community. Better funding for training and education of the specialist mental health workforce is needed, in addition to providing more funding to community agencies to pay for the services of qualified staff. This will be especially important if we are to grow our capacity to deliver early intervention services in the prevention of mental illness.

Over the intervening years, Catholic social services in Victoria have evolved into professional, high quality, outcomes-driven providers, which keep pace with the latest developments by continuous attention to quality improvement. We do this by supporting our workforce with regular supervision, and professional development to update skills – based on the latest research and methodologies in their fields. We establish partnerships with universities in the design of specialist courses and provide opportunities for students to gain experience through internships and work experience. Those partnerships also extend to working with PhD candidates on research, which provides the industry as a whole with valuable knowledge that feeds into models of care.

The shortage in the specialist mental health workforce is predicted to grow as the overall population ages. This shortage currently has a negative impact on the ability of some agencies to address the need for early intervention services. Lack of specialist staff in public services means access points to specialist mental health services are cut off or reduced leaving non-specialist community service agencies to deal with clients with serious mental illness.

The availability of adequate specialist care is an essential component in workforce development, as it is not practicable or desirable to provide training for staff and volunteers in non-specialist settings to enable them to deal with clients requiring specialist mental health treatment over extended periods of time. This creates potentially unsafe working conditions and unproductive interventions for the client, as real treatment cannot begin until access to specialist care is obtained. This further interferes with the delivery of early intervention services, thus costing time and money while staff deal with clients in crisis rather than focus on those who would benefit from assistance at the early stages.

Community agencies welcome the opportunity to be in consultation with a strengthened specialist mental health workforce. We agree that it is important for all staff working in nongovernmental and related mental health fields to be trained to identify serious mental health illness, but only to the extent of referral to appropriate specialist care. An overall expansion of specialist mental health services supported by greater staff numbers needs to happen in order to prevent the need for community agencies, not directly engaged in specialist care, to be responsible for “minding” the seriously mentally ill while they sit on waiting lists for specialist care.

Accessing funding to pay for mental health staff is just as important as having a sustainable supply from which to draw a skilled and qualified workforce. Funding models aimed at community agencies need to better account for the costs associated with hiring highly qualified and skilled mental health staff, in addition to training social workers and other staff that come in contact with clients who are mentally ill. Programs are often understaffed because of lack of available funds to hire qualified staff in the first place, not necessarily as a result of the limited stock of skilled candidates.



To achieve the goal of making mental health an attractive career path for school leavers and encourage women, having left the field for family reasons, back into the mental health workforce – more needs to be done to relieve the pressure across the board in all clinical, non-clinical and related community services by creating incentives to choose a career in mental health as a path.

Goal 6.1 Building a knowledgeable, skilled and sustainable specialist mental health workforce with an ensured supply

What other means could be used to grow the Victorian mental health workforce, both in the short- and long-term?

- Expansion of Commonwealth programs such as “Access to Allied Health Services” and General Practitioner (GP) training in “Better Outcomes in Mental Health Care”, with incentives to increase availability in regional and rural areas
- Increase the number of Commonwealth Supported (HECs) places for existing tertiary course programs
- Promote mental health as an interesting career path that offers options for growth and flexibility in training and education that allows women to blend work and training with family commitments.

How can we encourage more workers to practice in rural areas?

- Client/staff ratios and subsequent targets adjusted/reduced in consideration of regional and rural factors, including:
 - tyranny of distance and resultant time taken to provide service to clients
 - relatively lesser access to multidisciplinary resources/consultation
 - relative scarcity of general practitioners and other “gatekeepers” in rural areas
 - fewer GPs likely to be trained in “Better Outcomes in Mental Health Care” initiative
 - less access to “Access to Allied Health Services” and similar initiatives in more rural and isolated areas
- Offer scholarships that pay full fees for tertiary degrees in lieu of a commitment of time working in a rural area. Once the time is up employment packages could be offered that include discounted housing and education vouchers for children of staff.

What incentives do we need to attract experienced and trained staff back to mental health services?

- Ease and enhancement of access to refresher/re-registration training, especially in relation to those in regional and rural areas
- Review of the relative status of Psychiatric Nurse and Registered Nurse qualifications and parity of remuneration
- Strategies as outlined above in regard to retention of existing staff through improvement of work environments
- Proactive supervision and support aimed at minimisation of potential for burnout of workers
- Evidence that co-operative relationships between clinical mental health services and community based services are/will be enhanced
- Guaranteed flexible work hours, co-located childcare



How can public mental health services work better with private providers to improve client care and enhance workforce development?

- Firstly public mental health services could improve their relationships and co-operation with NGO providers through better consultation arrangements
- Memoranda of Understanding between public and private providers which detail agreed actions rather than relying on good will of individuals and verbal "gentleperson" agreements in development of co-operative relationships
- The public mental health service could engage in a "Listening Tour" about the needs of NGOs and how to interface more effectively
- From that a "Road Show" initiative could be implemented that demonstrates examples of: how professionals can refer, get information on latest initiatives and start-up procedures, and links to networking opportunities and partnerships by region.

Goal 6.2 Embedding a culture of service quality to evidence based practice

How can we facilitate best practice in client care by mental health workers?

- External evaluation of service models to bring objectivity into evaluation of evidence based practice
- Costs for both external and internal evaluation of programs/projects built into funding levels/service agreements
- Encouragement and show-casing of innovative models of service, e.g. MASC (Making A Significant Change) model of Residential Rehabilitation for Young People With A Mental Illness in Ballarat/Grampians Region – which challenged the tender brief and successfully proposed an alternative service model to creatively address the needs in a regional/rural area with long distances to communities of origin
- Increased emphasis on training, expertise and practice in management of dual diagnosis
- Committed and consistent adherence to the Cornerstone Protocols by both public mental health services and NGO providers
- More structured methods of gaining consumer and carer input which is empowering to those groups and avoids being tokenistic
- Training specific to cultural sensitivity and heightening awareness of cultural norms in mores and folkways, for example some Asian cultures are generally by nature and custom quite superstitious and have beliefs in such things as ghosts, visions and supernatural occurrences which could be interpreted by mental health workers as delusions and hallucinations thus a manifestation of a psychotic condition, whereas they could be quite within the norm in that particular culture.



What could we do to strengthen direct care governance in mental health services?

- The strategies outlined above under Goal 6.2 should be instrumental in strengthening direct care governance
- In organisations providing a diversity of services, mental health reference groups and/or sub-committees advising the Board can bring specific expertise and specialist knowledge to decision-making level. Such reference groups/sub-committees should include consumer and carer representation, in addition to mental health practitioners.

How can we facilitate continuous quality improvement in mental health service provision?

- CQI requires resources, training, expertise and time commitment of both service delivery and management staff – thus requires consideration in budgets and projected targets in funding and service agreements
- DHS currently has a range of quality assurance standards and requirements of different programs/funding streams – uniformity of core standards across programs would enhance ability to undertake more cost-effective CQI in organisations providing a diversity of programs, including mental health services, and meeting the current diversity of quality assurance requirements
- Uniform core standards would assist in achieving accreditation from external bodies such as QICSA (Quality Improvement & Community Services Accreditation) or EQUiP (Evaluation & Quality Improvement Program) and reduce duplication of effort across a range of programs and services within one organisation.

Goal 6.3 Systematically improving the capability of the broader health and community services workforces through education and training

How can we support other health and community services to better respond to mental health problems and achieve better recovery for people affected by mental health illness?

- Improvement in responsive secondary consultation from local specialist mental health services
- Increased profile and function of Primary Mental Health & Early Intervention Teams
- Education and training in the broader health and community services sector as outlined above, particularly in core competencies as outlined above from Human Capital Alliance 2007 report
- Many frontline workers in community service organisations are regularly dealing with high prevalence disorders such as anxiety and reactive depression, however they often lack the knowledge and ability to assess for more serious mental health issues
- Cultural awareness and sensitivity in relation to mental health issues needs to be included in frontline worker training, both in mental health and generic services, as noted above under Goal 6.2
- An Alcohol & Other Drug Work Gap Training program provided through University of Ballarat TAFE Division in the Grampians Region during 2000 demonstrated that many frontline workers in regional and rural areas were faced with mental health and substance abuse issues on a regular basis, but without specific training or support, and reported limited access to secondary consultation
- Encourage the Commonwealth government to allow Medicare rebates for services provided by trained counsellors, in addition to psychologists. This would assist in areas where there is no access to Family Relationship Centres, for families and individuals who find it difficult to afford fees. Alternatively, the same arrangement



available at FRCs for limited free counselling could be offered from any accredited community services agency.

Goal 6.4: Strengthening leadership within the mental health system and across the broader health and community services system

Are there ways that we can strengthen leadership within the mental health services and across the broader health and community services system?

- Management and leadership training for mental health practitioners who are promoted to management positions – good practitioners do not necessarily or automatically make good managers
- As detailed above under Goal 6.2 - in organisations providing a diversity of services, mental health reference groups and/or sub-committees advising the Board can bring specific expertise and specialist knowledge to leadership and decision-making level
- Not all community service organisations providing frontline services are involved in Primary Care Partnerships – perhaps a drive to increase membership of PCPs would be of benefit to improve coordination of client care with public services



Attachment 1 – List of CSSV members

Bethlehem Community
Catholic Chaplains Association for Health Care
Catholic Solo Parents
Centacare Ballarat
Centacare Bendigo
Centacare Catholic Family Services
Centacare Gippsland
Corazon
Corpus Christi Community
Early Education Program for Hearing Impaired Children
Good Shepherd Aged Services
Good Shepherd Youth & Family Services
Jesuit Social Services
John Pierce Centre for Deaf Ministry
Justice Unit, Archdiocese of Melbourne
Kewn Kreestha - Rest Home for Mothers
Larmenier
MacKillop Family Services
Marillac House
Mercy Health and Aged Care
Nazareth House
Project Dreaming Tracks
Regina Coeli Community
Sacred Heart Mission
Sisters of Charity Community Care Ltd
Society of St Vincent de Paul
Southern Cross Care (Vic)
St Mary's House of Welcome
St Vincent's Health
Villa Maria Society



Attachment 2 – Acronyms

CCFS	Centacare Catholic Family Services
CEOM	Catholic Education Office, Melbourne
CSSV	Catholic Social Service, Victoria
EAPs	Employee Assistance Programs
FaPMI	Family Parent with a Mental Illness
HCCVI	Healthcare Chaplaincy Council of Victoria Incorporated
PSP	Personal Support Program