Senate Select Committee on Mental Health

Submission by Jesuit Social Services to the Senate Inquiry into Mental Health

At Jesuit Social Services we strive through our actions to pursue our Mission of '*standing in solidarity with those in need, and expressing a faith that promotes justice*'. Over the past twenty-seven years Jesuit Social Services has provided assistance to troubled young people to reintegrate into the community after release from a correctional institution, through its Brosnan Centre Program. More recently our work with young people has expanded its focus to the complex needs of young people in the community that are related to mental health issues and substance misuse, through the Connexions Program. Another disadvantaged group receiving our attention is Vietnamese communities in public housing. This submission draws upon the experiences of staff and clients of the Vietnamese Welfare Centre in Flemington.

Young people involved with the Jesuit Social Services programs have typically experienced many years of marginalisation from family and community, with a history of childhood neglect, abuse or trauma. In many cases these young people's lives are characterised by hopelessness, chaos, challenging behaviour and mistrust with their emotional, social and educational development being fragmented and delayed. Those with mental illness often resort to excessive drug use and self harming behaviour as tools to calm the psychological distress. Jesuit Social Services uses a holistic approach to form relationships and work with these young people through a range of activities including counselling, assertive outreach, case management, housing assistance, education and training assistance, outdoor activities and health promotion activities such as arts and culture. Through these activities Jesuit Social Services has developed substantial experience in providing services and advocacy for some of the most disadvantaged people in our community.

This submission to the Senate Select Committee on Mental Health will draw on the experiences of Jesuit Social Services to comment on the mental health needs for three groups of Australians:

1. Young people aged 16-25 years with coexistent mental health issues and problematic substance use
2. People with mental illness in the criminal justice system
3. Culturally and Linguistically Diverse communities, represented here by the Vietnamese community

1.0 Young people with coexistent mental health and substance misuse problems

Coexistence of mental health issues and problematic substance misuse (often termed comorbidity or dual diagnosis) has received substantial attention within Australia and internationally over recent years with young adults aged 15-24 years being a particular group for concern. The Australian burden of disease and injury study found that mental disorders (including alcohol abuse, heroin abuse, depression, bipolar, suicide and self inflicted injuries) accounted for 55% of the total disease and injury burden for young adults aged 15-24 years[1].

There are many combinations of mental disorders and substances that co-occur and comorbidity has become the rule rather than the exception in many mental health, drug and alcohol and primary care treatment settings. High rates of substance misuse are seen in people with serious mental disorders such as schizophrenia and with more common mental disorders such as anxiety and depression. For people with schizophrenic disorders rates of substance abuse have been estimated as high as 70%, with substance abuse more common in young males with low educational attainment[2]. In an early psychosis service, cannabis use by young clients was estimated at around six times the rate in the same age group in the general population[3]. Coexistence of mental illness and substance abuse has a severe impact on young people with a range of possible sequelae including homelessness, familial problems, poor support networks, poor physical health, HIV infection, low education levels, poor social skills, violence, suicide ideation, crime and incarceration. There is a tendency for clients with comorbidity to relapse and it has been shown that persons with coexistent mental disorders (whether this is schizophrenia, anxiety or depression) and substance use problems have poorer outcomes than persons with a single disorder.

1.1 Jesuit Social Services response

Jesuit Social Services has provided care for over 700 young people (aged 16-25 years) with coexistent mental health and substance misuse problems since 1996. The Connexions program provides assertive outreach, counselling and case management for dually diagnosed young people. On a broader level the Gateway program provides an arts and culture program, an outdoor program, social enterprise schemes, vocational learning and employment program that focus on health promotion and experiential learning for young people with high risk factors including mental illness, substance misuse problems,

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[1] Mathers C, Vos T, Stevenson C, The burden of disease and injury in Australia 1999 AIHW cat. No. PHE 17. Canberra: AIHW

[2] NSW Association for Adolescent Health. *Caught in the gap*: Dual Diagnosis and Young People, A report on the issues, August 2003

[3] Hinton, M, Elkins, J., Edwards J, Donovan K, *Cannabis and psychosis: An Early Psychosis Treatment Manual.* State of Victoria, Department of Humans services, 2002 p7-8.

offending, extreme risk behaviours (such as train surfing), unemployment and early school leavers.

In, 2003-2004, the Connexions program provided assertive outreach and/or counselling to 108 clients of whom 100% had a history of mental illness and substance misuse and 75% an offending history. In the same year, of 119 clients participating in the Gateway program, 85% had a history of mental illness (many with coexistent substance misuse) and 60% had an offending history.

The key mental health needs for these young people as experienced by Jesuit Social Services are access to appropriate services, engagement and continuity, integration of care, holistic care and destigmatisation. This section of the submission will draw on Jesuit Social Services experience with young people with coexistent mental health and substance use problems to address the Senate Inquiry Terms of Reference.

1.2 Access to appropriate services

Young people with coexistent mental health issues and problematic substance misuse have difficulty accessing mental health care appropriate to their illness and age.

> *Jesuit Social Services Connexions program had 78 clients (aged 16 to 29) with coexistent substance misuse problems and a mental disorder that met diagnostic criteria including affective disorders, personality disorders, anxiety disorders, schizophrenic, schizoaffective or eating disorders. 80% of these clients did not have an active case manager in the mental health system[4].*

A number of gaps preclude access to care:

- Separate service systems for mental health and drug and alcohol often attempt to identify a 'primary diagnosis' before acceptance
- Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS) focus on severe mental illness, precluding high prevalence disorders such as anxiety and depression
- Age limits of 18 years for CAMHS and 21 years for Youth Substance Abuse Service (YSAS) and a focus of AMHS on severe mental illness creates difficulty for clients in their twenties to access care. The Connexions program receives most referrals for 20 to 25 year olds (many from YSAS when clients reach 21 years) and has difficulty assisting clients between 26 to 30 years to access mental health services
- Poor recognition of mental health needs in primary healthcare. General practitioners did not recognise mental disorders in 56% of patients with mental health needs and were less likely to recognise mental health needs for common mental disorders or

[4] Jesuit Social Services, Connexions Annual Report 2001-2002

if the client was less than 25 years old, male or not born in Australia[5].

The opinion of one 19 year old female about mental health services was "They don't help when you need them and they won't go away when you don't want them". With a history of drug induced psychosis, depression and abuse of heroin, cannabis, amphetamines, benzodiazapines and alcohol, this young woman was an involuntary patient at age 15 and 17. She felt CAHMS was too intrusive and too quick to diagnose. The diagnosis of psychosis became a label that did not fit. She was later diagnosed with depression and has been unable to access mental health care through an AMHS [6].

Recommendations

- Improve the capacity of mental health services to treat substance abuse in clients with serious mental disorders by providing increased funding for treating co-morbidity
- Improve the responsiveness of adult mental health services to the needs of adolescents and young adults
- Improve the capacity of general practitioners to assess and treat mental health and substance misuse problems in young people, by providing them with additional training
- Improve the links between the specialist mental health sector and the primary care sector, and between public mental health and private mental health services[7]

1.3 Engagement and continuity

Many young people with coexistent mental health and substance misuse problems who seek help do not stay in treatment.

The mental health and substance misuse issues in many young people arise out of a history of childhood neglect, abuse or trauma that results in marginalisation from family and community and delayed emotional, social and educational development. Yet mental health services are often based on appointments in a clinical environment that may be threatening to a young person in chaos. Treatment is focussed on mental health interventions and ignores needs that may be more pressing to the client[8]. Moreover individuals with more than one illness may have multiple contacts with various services within the system and may drift into and away from services unpredictably[9].

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[5] Hickie IB, Davenport TA, Scott EM, Hadzi-Pavlovic D, Naismith SL, Koschera A, Unmet need for recognition of common mental disorders in Australian general practice, MJA 2001: 175; S18-24
[6] Jesuit Social Services, Interview with Connexions client, 2005
[7] Australian Health Ministers, National mental Health Plan 2003-2008. Canberra: Australian Government, 2003
[8] Op. Cit. *Caught in the gap: Dual diagnosis and young people*, August 2003
[9] Commonwealth of Australia, Responding to the Mental Health Needs of Young People in Australia: discussion paper, principles and strategies, February 2004, p 16

A male in his early twenties was suffering from an undiagnosed mental health issue compounded by poly drug use including cannabis and amphetamines. He had issues relating to poor hygiene an inability to form social or professional networks, long term homelessness in which he traveled between rural areas and Melbourne. Despite past CAT assessments and hospital admissions, his transient lifestyle and poor confidence created difficulties in keeping appointments and engaging in long-term support.

Jesuit Social Services Connexions program developed a rapport with this man when he began making sporadic visits to the Artful Dodgers studio (now with the Gateway program). After a month or so he accessed counselling and outreach support through which he was assisted into accommodation, explored the issues that led to the breakdown of his family and was subsequently able to take an active role in seeking solutions to his mental health and drug dependency issues. Over eighteen months he has maintained stable accommodation, participated in art exhibitions, completed a wilderness journey and worked on life skills such as self-care, hygiene and social skills. His mental health and alcohol and drug use is currently stable and he is looking at options around employment and training[10].

A discussion paper from the National Mental Health Strategy states that "engaging young people in treatment – especially young people with the most complex and disabling mental disorders – requires sensitive, creative and innovative approaches that transcend many existing service boundaries"[11]. With this in mind we stress the importance of engagement and continuity of care for dually diagnosed young people.

Recommendation

- Expansion of existing mental health services to accommodate a flexible approach to treating young people with mental illness, with a focus on youth specific issues such as engagement and continuity of care.[12]

1.4 Integration of treatment

Young people with coexistent mental health and substance misuse problems have treatment needs spanning the Mental Health and Drug and Alcohol service systems, both with different expertise and different models of care.

Integrated treatment of mental health and substance misuse problems has been demonstrated to be more effective with better patient retention than consecutive or parallel treatment and to be more effective in reduction of substance abuse, particularly when delivered for 18 months or longer. Over 60% of patients with schizophrenia and a substance use disorder dropped out of non integrated treatment after four months compared with 30% of

[10] Op. Cit. Connexions Annual Report 2001-2002
[11] Op. Cit. *Responding to the Mental Health Needs of Young People in Australia*, 2004, p IX.
[12] Ibid p19

comparable patients who received integrated treatment[13]. Yet mental health services may not have the resources or training to assess and treat drug and alcohol issues and similarly drug and alcohol services may not have the resources or training to detect and treat mental health issues.

> *Discussion with Connexions staff around the impact of dual diagnosis teams in Victoria, considered positive outcomes to be the increased capacity of drug and alcohol staff or mental health staff to recognise mental health issues or substance use issues in their respective clients. They considered the harm minimisation and extended outreach approach used by drug and alcohol services to be youth friendly and effective in client engagement, while the cognitive behaviour techniques used by mental health can be effective with behaviour change. Whilst solution focussed therapy and motivational interviewing has been noted to be effective with dual diagnosis clients at Connexions. On a negative side it was felt that the problem of staff in each sector not wanting to work with dually diagnosed clients persists. They also expressed concerns that dual diagnosis was in danger of becoming a niche market and services were becoming more fragmented as organisations within different sectors establish dual diagnosis specific services. Coordination was seen as a key component of integrating treatment.*[14]

Recommendation

- Better coordinate all mental health care service providers, including GPs, private psychiatrists, private psychologist, private hospitals, state inpatient and community services and non-government charitable organisations,[15] and better integrate them with mainstream health services.

1.5 Holistic care

Young people with coexistent mental health and substance misuse problems have complex needs that span multiple sectors including public health, housing, welfare, social and employment.

60% of disability costs in 15-24 year olds are due to mental health problems[16] and 80% of people with a mental illness in Australia are unemployed[17]. Over 90% of new Connexions and Gateway clients were unemployed at the time of referral. A high proportion of people with mental illness do not complete education with the average highest educational attainment being year 8 and year 9 for Connexions and Gateway clients respectively[18]. Homelessness is a major barrier to accessing health care and 80% of new Connexions clients

[13] Drake RE, Mercer-McFadden C, Mueser KT, McHugo GJ, Bond GR, Review of integrated mental health and substance abuse treatment for patients with dual disorders, *Schizophrenia Bulletin,* 1998: 24(4);589-608
[14] Jesuit Social Services, Connexions staff interview 2005
[15] Andrews G, the crisis in mental health: the chariot needs one horseman, MJA 2005; 185(8): 372-373
[16] Op. Cit. Mathers C, Vos T, Stevenson C, 1999
[17] National Survey of Mental Health and wellbeing Bulletin 5, National Mental Health Strategy 2002 (in senate info)
[18] Jesuit Social Services, Annual Report 2003-2004

had been homeless for 6 months or more[19]. Lifelong physical health problems can arise out of the cycle of mental illness, substance abuse, poverty and homelessness that these young people exist in. Tobacco smoking and physical inactivity are major risk factors that contribute to the burden of disease in Australia. There is a higher proportion of current daily smokers (32%) in people with mental and behavioural problems compared to 21% in people without mental health and behavioural problems[20]. Many services such as primary healthcare, education and training, housing, have difficulty accommodating young people with substance misuse, mental health, and criminal justice and trauma issues. The needs of these young people span many sectors and it is common for client case meetings to have the client and up to 10 workers representing different aspects of their care. These young people are often without family support or other social networks while their mental illness and drug use create disruption in crucial family relationships. Families can feel at a loss about how to help.

> *A 22 year old female experienced sexual and physical abuse as a child and was raised in child protection from age 8. She completed year 8 at school and has had long periods of homelessness. She suffers depression, anxiety and has been a chronic cannabis and sporadic heroin user. She has attempted suicide on multiple occasions and has also had hospital admissions for drug induced psychosis. She is a smoker with physical problems including hepatitis C, chronic tooth decay and impaired motor skills following an overdose. She is currently on a disability pension.*
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> *The Jesuit Social Services Gateway program provided initial support to this young woman through the Wilderness Therapy program and she now regularly attends multiple skill development programs (visual arts, metal work, wood work and cottage industry jewellery production). She is working toward a metal and wood work certificate and will commence a part-time traineeship in June 05. Over her 18 month involvement with Gateway, she has ceased heroin use and is stable on methadone, is on antidepressants and reports less anxiety symptoms and has had no psychotic symptoms. She has had one hospitalisation due to an overdose in the last 12 months but does not believe this was an attempt to kill herself. She has decreased her cannabis use (although still excessive) and has secured long-term public housing. She has concerns about financial security and coming off the disability pension[21].*

Recommendations

- Improve linkages between mental health and drug and alcohol services, and housing, welfare, employment, primary health care services
- Increased emphasis on psychosocial rehabilitation that creates viable options for people with mental illness to work and study when they are well

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[19] Jesuit Social Services, Connexions annual report, 2001-2002
[20] Australia Bureau of Statistics, National Health Survey: Mental Health Australia, 2003
[21] Jesuit Social Services, Gateway report, 2005

1.6 Destigmatisation

Young people with coexistent mental health and substance misuse problems encounter stigmatisation at a community and health service level.

Addiction and alcoholism is often viewed in society as a moral or legal issue. Consequently individuals with substance misuse problems are viewed as bad people who lack willpower while stigma and shame are also associated with mental illness. Consequently the dually diagnosed individual may feel shame about their mental illness and/or their substance use. This viewpoint transcends individual, family, community and beliefs and also the services that come into contact with dually diagnosed people. The shame felt by dually diagnosed clients and their families, increases the likelihood that they won't seek treatment. Young people with mental illness take drugs for a multitude of reasons including to treat their disorder, to reduce anxiety, peer group activity and to "assume an identity as drunk or drugged rather than mad because this is socially acceptable" [22].

> *Case Study 1: Clients participating in a group program for young people with coexistent mental health and substance misuse problems discussed the perceptions they encountered with having a dual diagnosis. They felt they were commonly seen as criminals, junkies and worth less than others. One client said he would prefer to be seen as drug affected than labeled a 'nutter'* [23].

> *Case Study 2: A young client with paranoid psychosis and substance abuse problems was assessed as an extreme suicidal risk. He talked to his counsellor about his suicide plan, was saying goodbyes and volunteered for a psychiatric admission. A Crisis Assessment Team (CAT) also assessed him as a suicide risk and referred him to the emergency department of a hospital with a psychiatric ward. The psychiatric registrar assessed the patient as not requiring admission because he 'just had a drug induced psychosis' and the counsellor was sent away as they were not needed at the hospital* [24].

Recommendations

- Community education that promotes an understanding of mental illness and substance misuse
- Conduct professional education training to promote a shift in attitude within mental health and drug and alcohol services toward recognising clients with concurrent substance use and mental health problems

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[22] Op. Cit. *Caught in the gap: Dual diagnosis and young people*, August 2003
[23] Jesuit Social Services, Connexions client group, 2005
[24] Jesuit Social Services, Connexions staff interview, 2005

2.0 The overrepresentation of mental illness among Australia's prison population

> *"It is becoming obvious, that people who previously were treated within the mental health system are increasingly being shunted into the criminal justice system. People with mental illness must not be criminalized as a result of inadequate funding for the mental health system."*[25]

The prison industry is booming while Australia spends far less on mental health services than comparative countries.[26]

During the last decade, there has been a 50 percent expansion of the Australian prison population.[27] On an average day during 2003, over 22,000 persons were detained in Australian prisons. The national rate of imprisonment reached 147 per 100,000 this same year.[28]

The rate of undiagnosed mental illness in the community is a huge challenge. The *National Survey of Mental Health and Well Being* (1997) conducted by the Australian Bureau of Statistics found that almost one in five Australians aged 18 years or over met a criteria for a mental disorder at some time during the 12 months prior to the survey. Alarmingly, only 38% of those surveyed with a mental disorder had accessed health services.[29] This suggests a large unmet need for mental health services. Indeed, this indicates that 62% of people with a mental illness are receiving no clinical assistance.

The existence of a mental disorder is an often-unidentified factor when responding to the health needs of young people using illicit drugs. In fact, heroin and other illicit drugs have become the drugs of choice of many young people experiencing mental health problems. These drugs are used as a form of self-medication to alleviate the symptoms of mental illness.

Much of the dramatic increase in the Australian prison population can be explained by the relationship between untreated mental health needs, subsequent illegal use of drugs as a form of self-medication, and the eventual intervention of the criminal justice system.

Professor James Ogloff, director of psychological services at Forensicare (Victoria's prison mental health service provider) estimates that 55 percent of male and 33 percent of female inmates had regularly used Cannabis in the 12-months prior to their incarceration.[30] Similarly, 27 percent of male and 50

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[25] Police Association of New South Wales, submission #59 to "Not for service: experiences of injustice and despair in mental health care in Australia," Mental Health Council of Australia
[26] SANE Mental Health Report, 2002-03
[27] Australian Bureau of Statistics 4512.0 26/06/03 www.austats.gov.au
[28] Australian Bureau of Statistics 4517.0 23/12/04 www.austats.gov.au
[29] Australian Bureau of Statistics 4326.0 30/09/98 National Survey of Mental Health and Wellbeing, Profile of Adults Australia, 1997
[30] Professor James Ogloff, Presentation at 'Prisoners' and Public Health Workshop' VicHealth 30/11/2004

percent of female inmates had regularly used opiates in the 12-months before being sent to prison.[31]

Mental illness is common among inmates. In New South Wales, 41 percent of male and 54 percent of female inmates, and in Queensland 61 percent of female inmates, reported some form of treatment for mental illness during their lifetime.[32] Major mental disorders, such as psychosis, were present in 8 percent of all male inmates and 14 percent of all female inmates in Australian prisons in 2004[33].

The Prisoner Health Study, completed in February 2003 on behalf of Corrections Victoria, reported that while 28 percent of prisoners had a diagnosed mental illness, only 15 percent were receiving medication.[34] The report concluded that the identified mental health needs of the Victorian prisoner population could not be adequately dealt with through prison-based programs alone.

An investigation of prison-based mental health services reveals that the level of treatment available ranges from 2 to 6 hours per month. This is, in many cases, inadequate.[35] Recommendation 8 of the Prisoner Health Study asked Correction Victoria to place greater emphasis on the importance of mental health services for prisoners by urgently investing additional resources, as well as by cooperating with a range of government departments to develop an effective strategy to address this problem.[36] Despite this recommendation, only one bed has been added to Psychiatric Unit of the Melbourne Assessment Prison. No other provision has been made.

Early intervention is the key to reducing the overrepresentation of mental illness among Australia's prison population. It has been estimated that 60 percent of cases of alcohol or other substance misuse could have been prevented by earlier treatment of common mental health problems.[37] Thus, there is a window of opportunity for intervention in the lives of the mentally ill.

The establishment of a Mental Health Court to assess the cases of the mentally ill is critical. The Mental health Court would be an extension of the Magistrate's Court and be presided over by a specially appointed magistrate with experience of mental illness and impairment. Such a court would adopt a less adversarial approach than a traditional court, and focus of 'diverting' the mentally ill away from the prison system and into care. The primary focus of a Mental Health Court should be on treatment and rehabilitation in order to reduce the rate of re-offending.

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[31] Ibid
[32] Australia's Health No. 9, Australian Institute for Health and Welfare 2004, Canberra, p. 219
[33] Op. Cit. Prof. James Ogloff
[34] *Victorian Prisoner Health Study*, Department of Justice, February 2003 pp 28-31
[35] Op. Cit Prof. James Ogloff
[36] Op. Cit. *Victorian Prisoner Health Study* p.6
[37] Kendall and Kessler "The impact of childhood psychopathology interventions on subsequent substance abuse: policy implications, comments and recommendation." *Journal of Consultative Clinical Psychology* 2002; 70: 1303-1306

However, often when Victorian courts found defendants had a mental impairment and should not be sent to gaol, they are imprisoned because there is a shortage of beds at the Thomas Embling Hospital, (one of the few 'approved mental health service' hospitals in Victoria). This is because Thomas Embling was designed to cater for a Victorian prison population of approximately 2,200, while the present prison population hovers at around 3,600.[38] Thus, there remains an urgent need for additional investment in the mental health services available to the Courts if the overrepresentation of mentally ill offenders among the prison population is to be addressed.

Recommendations

To reduce the overrepresentation of Mental Illness among Australia's prison population, it is important that the Senate Inquiry recommend:

- Establishing a Mental Health Court in every State and Territory, working in concert with the Magistrates Court to assess the cases of mentally ill offenders; and
- Expanding the availability of approved mental health service beds that can be accessed by both the courts and the prison system, to provide treatment and rehabilitation to mentally ill offenders.

[38] Op. Cit. ABS 4517.0

3.0 Culturally and Linguistically Diverse Communities: Melbourne's Vietnamese Community

A program of Jesuit Social Services, the Vietnamese Welfare Resource Centre (VWRC) supports the Vietnamese communities living in Melbourne's inner north and west regions. The Centre is located on the public housing high-rise estate at Flemington and provides a range of direct services. For example, during the last financial year, the Centre conducted 801 face-to-face interviews providing information, referrals and counselling to families and individuals; 804 telephone information and referrals; 28 special activities including forums, education/vocation training programs and community festivals; and organized ten transitional houses for young people and single parent families. In addition, the Centre runs ongoing support groups for families, young people, single mothers and the elderly. Some of the major social issues confronting the Vietnamese communities in these areas are: lack of accommodation/employment; low income; parenting problems, migration and acculturation problems; domestic violence; gambling and drug addiction.[39]

Mental Health Care issues encountered by VWRC

Given their difficult circumstances, not surprisingly, many members of these Vietnamese communities suffer with mental health issues with a significant number presenting with symptoms of depression and anxiety disorders. The elderly, young people and single mothers are among the most vulnerable groups. Isolation and lack of family support are the primary causes for the poor mental health of single mothers. Young people experience high anxiety due to opposing parental and peer pressure. For the elderly, deterioration of mental health owing to ageing is exacerbated by acculturation and language problems.

Despite the obvious prevalence of mental health issues within these communities, staff at VWRC note that program participants generally deny the existence of a mental health problem and avoid seeking professional help. The explanation given for this is that the stigma attached to mental illness within the Vietnamese community is so profound that the mere association with a mental health professional is believed to bring shame and disgrace upon the self and family – *for example, at one of the information sessions, the mental health worker asked to be introduced as a general health worker for fear of being rejected by the group*. Mental health disorders are often somatized and advice on treatment sought from family members or the local general practitioner. In chronic cases where professional mental care is required, participants prefer to consult private psychiatrists who are familiar with the Vietnamese language and culture. However, this option is costly and therefore used as a last resort. Language difficulties and lack of cultural sensitivities are identified as significant barriers to seeking help from the public mental health care system. Individuals with untreated mental health

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[39] Jesuit Social Services. *Annual Report 2004*, Victoria: Jesuit Social Services, 2004, p. 13.

disorders invariable try to find relief by engaging in risk taking behaviours like drug usage and gambling, often with dire consequences.

Recommendations

The VWRC experience suggests that the following areas could be much improved within the mental health care system to make it more accessible and attractive to the Vietnamese community (and other ethnic groups):

- Considerable attention needs to be paid to the de-stigmatising of mental illness if change in attitude and belief toward mental illness is to be effected.[40] It is recommended that a culturally and linguistically appropriate media campaign, similar to that of the highly successful domestic violence campaign, be launched as a matter of priority.[41]
- Provide more culturally appropriate information and support services for people with mental illness and their families.[42]
- Provide bulk-billing facilities for private mental health care services.[43]
- Increase cultural and linguistic competencies within the mental health workforce through further specialized training.[44]

The overall benefits for implementing these recommendations are self evident and well articulated in the Commonwealth Government's *Framework for the implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia*.[45] The Framework was developed in consultation with many individuals and organizations including the Transcultural Mental Health Network and the Multicultural Mental Health Australia Consortium. Its broad four-point action plan adopts a 'whole of government' approach and is designed to deliver a population-based (rather than specialist-based) mental health care system. If successfully implemented, the Plan will do much to improve the mental health status of all Australians. However, as the literature reviewed suggests, what is urgently required first, is the shift from rhetoric to action.

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[40] Torrico, J. Forum Report: *How do Ethnic Communities perceive mental health, illness and services*? Summary of proceedings on forum held in October 1999, Victoria: Northern Area Mental Health Service.

[41] Moore M, Lane D, Connolly, A. *Raising awareness through culturally tailored media campaigns*. Paper presented at the 'Diversity in Health' conference in 2001, NSW: South Western Sydney Area Mental Health Services and NSW Department of Health.

[42] Multicultural Disability Advocacy Association. *Mental Health Care: the needs of people from a non-English speaking background with mental illness*, NSW: MMDA, 2004.

[43] Whitford H, Buckingham W. Ten years of mental health service reform in Australia: are we getting it right? *Medical Journal of Australia* 2005, 182 (8), p. 396-400

[44] Op. Cit. Multicultural Disability Advocacy Association

[45] Commonwealth of Australia. *Framework for the implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia*, Canberra: Australian Government Publishing Service, 2004.

Final Recommendations

1. Improve the capacity of mental health services to treat substance abuse in clients with serious mental disorders by providing increased funding for treating co-morbidity

2. Improve the responsiveness of adult mental health services to the needs of adolescents and young adults

3. Improve the capacity of general practitioners to assess and treat mental health and substance misuse problems in young people, by providing them with additional training

4. Better coordinate all mental health care service providers, including GPs, private psychiatrists, private psychologist, private hospitals, state inpatient and community services and non-government charitable organisations, and better integrate them with mainstream health services

5. Improve linkages between mental health and drug and alcohol services, and housing, welfare, employment, primary health care services

6. Conduct professional education training to promote a shift in attitude within mental health and drug and alcohol services toward recognising clients with concurrent substance use and mental health problems

7. Expand the number of approved mental health service beds available to the courts and the prison system, to provide treatment and rehabilitation to mentally ill offenders

8. Establish a Mental Health Court in every State and Territory, working in concert with the Magistrates Court to assess the cases of mentally ill offenders Launch a culturally and linguistically appropriate media campaign, similar to that of the highly successful domestic violence campaign, to de-stigmatise mental illness among Australia's CALD communities

9. Provide bulk-billing facilities for private mental health care services

10. Provide more culturally appropriate information and support services for people with mental illness and their families

11. Increase cultural and linguistic competencies within the mental health workforce through further specialized training

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22. Police Association of New South Wales, submission #59 to "Not for service: experiences of injustice and despair in mental health care in Australia," Mental Health Council of Australia

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