INFORMED

Policy & practice newsletter for the community information and support sector

WINTER, 2012

Community Information & Support Victoria

Word from Executive Officer

Kate Wheller, Executive Officer, CISVic

This edition of Informed focuses on health and its impact on the lives of the vulnerable and disadvantaged. Although we have one of the best health systems in the world, there continues to be great disparities in health outcomes between the most disadvantaged and the least disadvantaged in our society. Under the Gillard government, there have been major reforms to the health system and its looks likely that these reforms will continue apace over the coming months. We welcome the trial of the National Disability Insurance Scheme (see article by James O'Brien for the Every Australian Counts campaign) and the introduction of mental health programs and reforms. However, we would like to see further reform such as the much needed dental health reform, at least to the extent that we have a system where access to affordable and high quality dental care is available to the most vulnerable people in our community (see Adam Plunkett's article). From a practice point of view, VICSERV and EACH Social and Community Health, and case stories from CISVic member agencies highlight the concerns and experiences of front line staff dealing with clients with complex needs.

We would like to acknowledge and thank the contributors to our winter edition - James O'Brien for the Every Australian Count campaign, Kim Hubber, financial counsellor from EACH Social and Community Health, Adam Plunkett for the End the Decay campaign. We would like to also thank agencies providing the case stories.

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Overview

By Minh Nguyen, Sector Development Officer, CISVic

In our work with the most vulnerable and disadvantaged, we often see the relationship between low health outcomes and poverty and/or multiple disadvantage. Low economic and social resources are the main contributors to the underlying causes of personal and financial crisis, whereby clients do not know where to go to get the right help. Women continue to present in greater numbers than men, although this too is changing as we are seeing more and more single men attending services for assistance. This newsletter gathers some of the information and discussions about the relationship between health and poverty, and highlights the observed experiences of our services that see more and more vulnerable and disadvantaged people with underlying health issues who seek help and support in times of crisis. The issue of social and economic disadvantage is fraught with questions of cause and effect. A comprehensive approach to health and education need to be factored into considerations at the policy and government level so that we could begin to see a levelling of the current differentials in health and education outcomes between the better off in our community, and those struggling to provide the basics for their families. A social determinants of health approach to social and economic disadvantage will, as the *Cost of Inaction Report* argues, lead to more equality in health outcomes between the most and least disadvantaged *and* longer term economic savings to the health system.

The Social Determinants of Health

In 2010, Catholic Health Australia (CHA) and the National Centre for Social and Economic Modelling (NATSEM) released the first report CHA-NATSEM Report on Health Inequalities *'Health lies in wealth: Health inequalities in Australians of working age'* (Brown and Nepal, 2010). The report investigated socio-economic inequalities in health outcomes and lifestyle risk factors of Australians of working age (25-64 years). It took a social determinants of health perspective and showed that inequalities did in fact exist, and that social gradients in health were common – the lower a person's social and economic position, the worse his or her health was found to be. Moreover, it found that the gap between the most disadvantaged and the least disadvantaged was often very large.

Social inequalities in health occur because of the inequalities in the conditions of daily life under which we are born, develop and mature. Material and social circumstances shape our experiences of, and access to money, power and resources at both local and national levels. These include things like, household goods and services, health care, schools and higher education, conditions of work and leisure, housing an community resources and different opportunities to lead flourishing and fulfilling lives. Evidence from social determinants of health researchers indicates that it is the social determinants of health that is mostly responsible for inequalities of health outcomes. Inequalities in the distribution of these social and economic resources mean that those with greater access will fare better.

The report argues that health inequalities cannot be tackled simply from a heath care systems analysis. Yet, this is what we tend to do in Australia, we look at the immediate problems – health workforce shortage, rising cost of care, demands on the health service sector. We need to adopt a social determinants of health approach that looks at the root causes of most illness and disease. "The change required needs to take place outside the traditional health system. We know this is where it needs to occur – we have the evidence. New thinking is required by Catholic services, and importantly, by government."[1]

The report recommended:

- Adoption of the World Health Organisation's Social Determinants of Health Framework - to be implement through the Local Hospital Networks and Medicare Locals, with publicly reportable goals and targets requiring action plans to reduce inequalities in health outcomes and access barriers to health services;
- Targeted preventive programs – preventive health initiatives to target lowest income quintile groups, developing community based initiatives the build social capacity that responds to the resources and needs of target groups, rather than a top down blanket approach;
- Fund NGOs to provide health promotion – fund social support agencies to conduct direct service role in health promotion with low income families. Additionally, health promotion NGOs (such as Heart Foundation) should target programs at lowest income quintile;
- School completion results in good health – state/territory governments should actively support high school completion as a priority for those at risk of non-completion.

In June 2012, Minister for Social Inclusion, Mark Butler indicated that the Senate Standing Committee on Community Affairs will draw on this Report, as well as international contributions to consider the social determinants of health.

A study conducted by Frederick & Goddard in 2009 found that 'complex and interacting health problems can contribute to certain people's need to receive emergency relief.' They remind us that the link between poor health outcomes and those experiencing poverty and multiple disadvantage have been well documented in recent years. Poverty can lead to heightened personal and environmental risk, lack of access to food, health care and economic and social resources can deeply impact an individual's capacity to participate in education and employment. Financial stress similarly has a spiralling impact on physical and mental health, leading to relationship breakdown, depression and anxiety disorders. In their study, they found that those seeking emergency relief who had complex health problems had "experienced abuse and neglect in childhood, [were experiencing] the effects of mental health problems, [were] going without food, lack[ed] access to and the high cost of health care, and [were experiencing the interactive aspects of health problems and poverty."[2]

More recently, the CHA-NATSEM Second Report, *The Cost of Inaction* reports that its findings

> 'confirm that the cost of Government inaction on the social determinants of health leading to health inequalities for the most disadvantaged Australians of working age is substantial. This was measured in terms not only of the number of people affected by also their overall well-being, their ability to participate in the workforce, their earnings from paid work, their reliance on Government income support and their use of health services.'[3]

This landmark report calls for government action to reduce the health inequalities between the least disadvantaged and the most disadvantaged groups in our society. It documents how these inequalities in health outcomes must not be ignored, not only on grounds of social inclusion and fairness, but also in terms of the long-term cost to society and the economy. 'Improving the health profile of Australians of working age in the most socioeconomically disadvantaged groups therefore would lead to major social and economic gains with savings to both the Government and to individuals.'[4]

The Australian government's vision of "a socially inclusive Australia is one where all Australians have the capabilities, opportunities, responsibilities and resources to learn, work, engage and have a say". The policy challenges to creating this vision rests partly on the Government's commitment to address the social determinants of health, those socio-economic indicators that continue to result in disparities in health outcomes for the most disadvantaged in our society.

How Australia is Faring: Social Inclusion

The 2012 *How Australia is Faring* Report by the Australian Social Inclusion Board applies a monitoring and reporting framework. This framework is comprised of a series of indicators including: multiple & entrenched disadvantage; material/economic resources; health & disability; social resources; housing and social participation. Using a range of latest available data, including those from OECD's 2011 *How's Life? Measuring well-being*, the 2010 ABS *General Social Survey* and the *Household, Income and Labour Dynamics in Australia* (HILDA) data, the Report seeks to measure how Australia is faring across the indicators within the framework. Across these indicators, the report found that the most vulnerable and disadvantaged lag behind average Australians. In this second edition, it was reported that

[1] Brown, L & Nepal, B CHA-NATSEM Report on Health Inequalities: Health lies in wealth, accessed at http://www.cha.org.au/advocacy/health/188-cha-natsem-report-health-lies-in-wealth.html p.vii

[2] Frederick, J & Goddard C 'Its been really, really hard':a qualitative study of the health problems of people receiving emergency relief in Australia, Health and Social Care in the Community (2009) 17(6), pp.581-589

[3] CHA-NATSEM Second Report on Health Inequalities: The Cost of Inaction on the Social Determinants of Health, accessed at http://www.natsem.canberra.edu.au/storage/CHA-NATSEM%20Cost%20of%20Inaction.pdf p.ix

[4] …

> 'there have been some noticeable improvements when we look over a longer time frame, including the key areas of health, education and employment. Significant challenges remain, including for the 640,000 (5% of working age) Australians who experience multiple and complex disadvantage. The indicators outlined in *How Australia is faring* relate to complex and persistent problems which require a long-term approach, including to measurement and reporting'[5]

Although life for the average Australian has improved such that:-

- 75% of Australians are satisfied with their life (higher than OECD average)
- Australians have a higher reported rate of self-reported good health (at 85%) than OECD average (68%)
- The supply of available housing for purchase by low-income groups has grown (6.9% to 11.5%) and there has been an improvement in the level of repeat homelessness (9.9% to 9.0% statistically not too significant though)

The areas reported to require improvement are:-

- Around 5% (or 640,000) Australians experience multiple and entrenched disadvantage.
- In 2011, 14% (or 590,000) of all children under 15 lived in jobless families.
- 7% (around 1.5 million) of people over 15 years have low economic resources and high financial stress. The bulk of these are families with children.
- Around 100,000 people were counted as homeless on Census night in 2006.
- Income inequality has increased steadily from the mid-1990s.
- Only 54% of Aboriginal and Torres Straits Islanders aged 15-24 were fully engaged in education and/or work in 2008.

The report indicates that although we are faring well, on average, levels of inequality remain high. We now have the ninth highest level of income inequality in the OECD (out of 26). For the small group of Australians who experience multiple and entrenched disadvantage, the risk of social exclusion is increasing.

Since the mid-1990s, Australia's level of inequality has increased by more than the OECD average, resulting in Australia's ranking moving from being more equal than the OECD average to being slightly less equal (not a statistically significant difference) in the latest period. There was no significant change in the overall levels of income inequality between 2007–08 and 2009–10. However, over the past 15 years there has been a significant increase in income inequality in Australia.

The HILDA longitudinal survey shows that 2.3% of people had low economic resources and financial stress in 2006. Tracking this group over time shows that 0.8% of people continued to have low economic resources in the following year and 0.4% continued to have low economic resources two years later.

The HILDA survey shows that women are more likely than men to have low economic resources and financial stress. The gap between men and women continues when rates of persistent low economic resources are compared. In 2006, 2.5% of women had low economic resources and financial stress compared to 1.9% of men. Two years later, 0.5% of women continued to have low economic resources, compared to 0.3% of men.

People with a long-term health condition are more likely to have persistent low economic resources than people who do not have a long-term health condition. In 2006, 3.8% of people with a long-term health condition had low economic resources and financial stress, compared to 1.7% of people who did not have a long-term health condition. Two years later, 0.8% of people with a long-term health condition continued to have low economic resources, compared to 0.1% of people without a long-term health condition.

The cost of seeing a doctor

Medicare was introduced in 1984, where schedule fee payable by the Federal Government was set for consultations with general practitioners (GPs). Although there was an initial limit to how much a doctor can charge over the scheduled fee, this is no long the case. The percentage of GPs charging gap fees peaked between 2000-2004, with levels now moving toward the pre-peak period. In 2010, 1 in five people visiting doctors are charge gap fees (compared to 1 in 3 during the peak period). In their policy brief on bulk billing, The Australia Institute (TAI) argued that Medicare is moving away from its initial intention of provision of 'fair and affordable' health care through the bulk billing system. It estimated that Australians are paying more than $1 billion in extra charges to access primary and diagnostic medical care. In their survey of 1,411 Australians, the TAI found that of the respondents, 20% of health care cardholders and 18% of pensioner concessions cardholders indicated they had to pay to see their GP. This, despite the government offering incentive payments to encourage GPs to bulk bill appointments with concession cardholders.[6]

Other issues identified by the brief that contribute to rising costs of health care include GP prescription rates for generic medications, referrals for diagnostic testing and the additional costs this may entail. The government have adopted a range of approaches to funding health services in order to limit the charging of additional fees. Thus, in 2004, bulk billing incentive payments were introduced which included payments to doctors who bulk billed certain services to children and concession card holders, including:

- Medical services

[5] How Australia is Faring Report, accessed at http://www.socialinclusion.gov.au/sites/www.socialinclusion.gov.au/files/publications/pdf/HAIF_report_final.pdf, p.3

[6] Baker, D 'Bulky Billing: Missing out on fair and affordable health care: Policy Brief No. 28' (October 2011), The Australia Institute p.9 accessed at https://www.tai.org.au/index.php?q=node%2F19&pubid=925&act=display

- Diagnostic imaging services
- Pathology services
- Out of surgery hours

In the 2009-2010 period, the proportion of bulk-billed, GP services in Victoria was at 78.2%, and 79.5% nationally. In the same period, gap costs were on average $47.27 (below the national average of $48.66).[7]

Since 1 August 2008, an incentive payment has been paid to all Friendly Societies and community pharmacies, dispensing doctors and hospitals (not public hospitals participating in the pharmaceutical reforms in public hospitals) that dispense a subsidised PBS medicine, which costs the patient no more than the standard patient contribution. The incentive supports pharmacist promoting the use of generic medicines where they are available and ensures customers are aware of their right to pay no more than the patient contribution for their medicine and encourages greater public use of generic medicine.

The TAI brief estimates that, even with these incentives "Australians are paying more than $1 billion in extra charges to access primary and diagnostic medical care it is evident that current health policies are producing an inequitable health care system. The dominance of private providers delivering primary health care, dispensing medication and providing diagnostic services influences this situation."[8]

Medicare Safety Net and the PBS Safety Net. A government policy response to the costs associated with out-of-hospital care is the introduction of the safety nets. The Medicare safety net gives families and individuals financial assistance for out-of-hospital medical services (diagnostic testing, regular visits to doctors). Once the threshold is reach, they may be eligible for additional Medicare benefit (in 2012, the threshold is $1,198 per calendar year, after which 80% of out of pocket costs will be covered by Medicare). Couples and families need to register (individuals don't). With the 2012 PBS Safety Net, general patients contribute $5.80 once they reach the threshold ($1,363 per calendar year) whilst concession car holders obtain medication for free (when they reach the $348 threshold).

The cost of seeing a dentist

In 2011, The Brotherhood of St Laurence released a report analysing the costs of poor dental health on the economy and those least able to afford dental care. Millions of people are financially locked out of Australia's expensive dental health system, undermining their capacity to gain and keep employment and at an annual cost to the economy of more than $1.3 billion.

The report, *End the Decay: The cost of poor dental health and what should be done about it*, analysed existing data to estimate the disease burden of untreated dental conditions - and the resulting economic burden.[9] The report's authors, Professor Jeff Richardson from Monash University and Bronwyn Richardson from Campbell Research and Consulting, found that the direct and indirect costs to the economy are significant.

Among the report's findings are:

- The direct and indirect costs to the economy of poor dental health are between $1.3 billion and $2 billion annually.
- Hospital admissions from dental conditions are the largest category of preventable acute hospital admissions, costing the health system $223 million each year.
- At least 1 million work days and at least 600,000 school days are lost each year because of poor dental health costing the economy at least $660 million in lost productivity.
- Children in the lowest socioeconomic areas had 70% more decay in their teeth than children in the highest socioeconomic areas.
- Adults on the lowest incomes were almost 60 times more likely to have no teeth than those on the highest incomes. While the prevalence of people without teeth has fall to almost zero (0.3%) in the top 25% of incomes, 17.3% of adults in the lowest 25% of incomes had no natural teeth.
- Indigenous people were twice as likely to have untreated decay in comparison to non-indigenous people.
- Nearly a quarter of adults report feeling self-conscious or embarrassed because of oral health problems.

Public dental services are provided to eligible Victorians through community dental clinics in community health services, rural hospitals and the Royal Dental Hospital of Melbourne. Given the stress in the system, there is normally a waiting list for patients. The length of the list varies between each clinic. An individual cannot be on more than one wait list at a time, but they can be transferred between clinics without penalty. Those eligible for public dental services include:

- All children aged 0-12 years.
- Young people aged 13-17 years who are health care or pensioner concession card holders or dependants of concession card holders.
- Children and young families up to 18 years of age in out-of- home care provided by the Children Youth & Families division of the Department of Human Services.
- Youth justice clients in custodial care, up to 18 years of age.
- Adults, who are health care or pensioner concession card holders or dependants of concession card holders.
- Refugees and Asylum Seekers.

Of this eligible group, those with priority access are:

- Aboriginal and Torres Strait Islanders
- Children and Young People
- Homeless people and people at risk of homelessness

[7] Mark Metherll 'Bulk-bill increase has come at a cost' The Sydney Morning Herald, May 24, 2012 accessed at http://www.smh.com.au/national/health/bulkbill-increase-has-come-at-a-cost-20120523-1z5m0.html on 15 August 2012

[8] … p. 1

[9] Richardson B & Richardson J, End the decay: the cost of poor dental health and what should be done about it, Brotherhood of St. Laurence, 2011 accessed at http://www.bsl.org.au/pdfs/Richardson_End_the_decay_2011.pdf

- Pregnant women
- Refugees and Asylum Seekers
- Registered clients of mental health and disability services, supported by a letter of recommendation from their case manager or staff of special developmental schools.

Fee exemptions apply for:

- Aboriginal and Torres Strait Islanders
- Homeless people and people at risk of homelessness
- Refugees and Asylum Seekers
- Children and young people aged 0-17 years who are health care or pensioner concession card holders or dependants of concession card holders
- All children and young people up to 18 years of age, who are in out-of-home care provided by the Children Youth & Families Division of DHS
- All youth justice clients up to 18 years of age in custodial care
- Registered clients of mental health and disability services, supported by a letter of recommendation from their case manager or staff of special development schools
- Those receiving care from undergraduate students
- Those experiencing financial hardship.

Victoria's dental voucher schemes: private dental clinicians provide care through three schemes:

- Victorian Emergency Dental Scheme
- Victorian General Dental Scheme
- Victorian Denture Scheme

These schemes can be accessed via Dental Health Services Victoria (DHSV) or local community dental clinic.

Policy challenges

The Australian health system is facing a number of challenges. These include: an ageing population; increased rates of chronic diseases; the development of new treatments and technologies; and rising health care costs. Fragmentation and inequities in the system further contribute to the challenge of service gaps, inequities in access and inequalities in health outcomes between sections of the community.

The ending the decay report identified some barriers to reform of dental care funding. Economic modelling indicates that if out-of-pocket payments were reduced from 95% to zero, this would increase demand by 46%. With an across-the-board co-payment of 15% demand would decrease to about 24%. In terms of economic feasibility, an increase of 24% in dental expenditure is equivalent to 1.4% in total health expenditure, or 0.13% of GDP, which is trivial. However, there is the question of limited supply of dentists to meet this demand, and the introduction of reforms that do not inflate dental fees. One solution is to divert services to those most needing them, which would be politically difficult to do. The longer-term solution therefore is to increase the supply of dentists with coordinated measures to direct increased capacity to those in need. Navigating the intricacies of how a universal dental scheme would look like poses some challenges and issues for the government. The report proposes that a targeted scheme may cost less

> "but only by leaving some group or groups with less access to care, so that the national saving is achieved by their below-average use of services. Targeted schemes cost less to the government, which means that taxes will be lower and there will be less transfer from wealthy taxpayers to disadvantaged low-income earners. However, in exchange for the (lower) tax burden of the targeted scheme, there will be no explicit benefit for the majority of Australian and this may increase, not decrease, the political problem of funding the program over the longer term."[10]

Another challenging area is the national disability insurance scheme. As a result of years of community, carer and disability advocates' activism, the call for a national disability insurance scheme is finally yielding some results. While all levels of government (and political parties) are in support, political and economic arguments are still being made as to the extent to which the scheme can be implemented. As recently as last month, there was still uncertainty as to a trial to roll out in Victoria. Having now secured agreement on the roll out, this is merely the beginning. More will need to be done to make the NDIS a reality (please see the contributing article by James O'Brien in this issue).

The social inclusion framework, and the case for a social determinants of health perspective on the interaction between poverty and health outcomes are building the momentum for a longer-term view of Australia's health care system. A view that seeks to tackle the underlying causes and contributors to poor health outcomes for the most vulnerable and disadvantaged in our community. Moreover, a perspective of poor health outcomes that takes into account issues such as access to housing (and housing instability), lack of social and economic resources during times of financial and personal crisis, and the increasing cost of health care will enable policy and decision makers to respond more effectively to the root causes of social exclusion. The studies outlined below are building the evidence needed for a more coordinated and systemic policy approach to health care.

Key findings in the 2012 ACOSS Report *Who is missing out? Material deprivation and income support payment*[11] include:

- Housing tenure is likely to be a key contributing factor to multiple deprivation. Rates of multiple deprivation among private tenants generally (36%) are more than double those for all households (15%).
- Among people whose main source of income was News Start Allowance (NSA), Parenting Payment (PP) or Disability Support Pension (DSP), at least one third lacked $500 in emergency savings (compared with 21% of all households) and over 40% could not obtain dental treatment when needed (compared to 17% of all households).

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[10] … p.17-18

[11] *Who is missing out? Material deprivation and income support payments*, ACOSS Paper 187, March 2012 accessed at http://acoss.org.au/images/uploads/Missing_Out_2012_ACOSS.pdf

- Around one fifth or more of children living in households relying mainly on PP or NSA lacked up to date schoolbooks and uniforms and over one quarter lacked a hobby or leisure activity, compared with 3% and 5% of families with children generally.

The Australian Institute of Family Studies' report *The influence of unstable housing on children's wellbeing and development: evidence from a national longitudinal study* provides national data that begins to fill the gap in Australian evidence on the issue.

> "Having a "home" is a fundamental need of all children. Findings from this report suggest that while residential mobility does not undermine children's development, living in types of housing tenure associated with instability—such as "doubling up"—is associated with some adverse effects. Even more substantial is the role played by the type of housing tenure, with those children living in public housing having much worse receptive vocabulary and much higher rates of behavioural or emotional problems."[12]

The report concluded with a call for further work to be done to examine the role of financial stress on parents' ability to provide resources for their children.

Government policy and response

In 2009, the national Health and Hospitals Reform Commission (NHHRC) undertook a comprehensive review of the health system (excluding private health insurance) and made 123 recommendations. Although the majority of these were not implemented, they had a significant influence on the current health reform agenda.

In 2011, states, territories and the federal government secured a national agreement to direct changes to Australia's health system which include:

- New framework for funding public hospitals (investing additional $19.8 billion in public hospital services over this decade);
- Focus on reducing emergency department and elective surgery waiting times;
- Increase transparency and accountability across the health and aged care system;
- Stronger primary care system through the establishment of Medicare Locals; and
- Federal government taking full policy and funding responsibility for aged care services, including the transfer to the federal government of current resourcing for aged care services from the Home and Community Care (HACC) program (except in Victoria and WA).

Mental health: In the May federal budget (2011-2012 budget package), the government announced a $2.2 billion mental health package to fund National Mental Health Reform over the next 5 years. Over the next 12 months, the federal government is reviewing submissions to the draft Ten Year Roadmap for national mental health reform. Submissions indicate that there has been broad support in the community and across sectors for the aims, priorities and vision for ongoing reforms detailed in the draft. The reforms will focus on five key areas:

- Better care for people with severe and debilitating mental illness;
- Strengthened primary mental health care services;
- Prevention and early intervention for children and young people;
- Encourage economic and social participation, including jobs, for people with mental illness; and
- Improving quality, accountability and innovation in health services

Several federal departments are involved in mental health reform activities, including:

- Department of Families, Housing, Community Services & Indigenous Affairs (FaHCSIA)
- Department of Education, Employment and Workplace Relations (DEEWR)
- Department of Veteran's Affairs (DVA)

Access to Allied Psychological Services (ATAPS) - the program was given significant funding increases in the 2011-2012 budget with to increase capacity to hard to reach groups, including children and their families, Indigenous Australians and those living in low socioeconomic areas.

Partners in Recovery initiative – a coordinated care and flexible funding program for people with severe, persistent mental illness and complex care needs, providing 'wrap around' support, improved referral pathways and an embedded community based recovery model of support through a 'no wrong door' approach.

Early Psychosis Prevention and Intervention Centres (EPPIC) – there are plans to establish 1 new early psychosis services. This is an integrated and comprehensive mental health service model aimed at addressing the needs of people aged 15-24 with early psychosis.

Headspace – funded was provided for expanded services through the headspace program, including 90 fully sustainable sites across Australia by 2014-2015. *eheadspace* was launched in October 2011, providing free, confidential and anonymous counselling services over the phone and online to young people with, or at risk of developing, mild to moderate mental illness.

Coordinated primary health care: Through National Health Reform, the Federal Government is shifting focus of the health system away from hospitals to primary health care. This will allow the system to provide patients with the health care they need, when and where they need it, and help patients manage their health conditions in the community and prevent disease. The strategy identifies key priority areas to be addressed in implementing health care reform, including:

- Improving access
- Better management of chronic conditions
- Increasing the focus on prevention; and
- Improving the quality, safety and accountability of primary health care services.

[12] Taylor, M & Edwards B *The influence of unstable housing on children's wellbeing and development: evidence from a national longitudinal study*, Australian Institute of Family Studies accessed at http://homelessnessclearinghouse.govspace.gov.au/files/2012/07/AIFS-Final-Report-the-influence-of-unstable-housing-on-children_s-wellbeing-and-development-Publi-3.pdf

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WINTER, 2012

Community Information & Support Victoria

Medicare Locals were established by the Federal Government to be vehicles for fostering reform and improvement of the primary health care (that is, out-of-hospital health services) sector across 61 catchments. These are primary health care organisations which are independent legal entities with strong links to heir local communities, health professionals, service providers, consumers and patient groups. They will work with general practice, allied health and community health care providers to improve and integrate primary health care to ensure services are better tailored to meet needs of local communities. Medicare Local have an important role to play in not only making health services more accessible, but working towards reducing health inequalities through its focus on preventive health and service gaps.

The roles of Medicare Locals could include:

- facilitating allied health care and other support for people with chronic conditions
- working with local health care professionals to ensure services are integrated and patients can easily access the services they need
- planning to ensure the availability of face-to-face after hours services for their region
- identifying groups of people missing out on GP and primary health care, or services that a local area needs, and responding to those gaps by targeting services better
- working with Local Hospital Networks to assist with patients' transition out of hospital, and if required, into aged care, and
- delivering health promotion and preventive health programs to communities with identified risk factors (in cooperation with the Australian National Preventive Health Agency, once it is established).

Dental health care: since 2007 the Federal Government has made a range of important investments in dental health, including:

- the establishment of the Medicare Teen Dental Plan which provides up to $163.05 per person towards an annual preventative dental check;
- $11 million for Indigenous dental services in rural and regional areas (and further $78 million over four years in relocation and infrastructure grants)
- $52.6 million over four years in the 2011-12 Budget to establish a Voluntary Dental Graduate Year Program to help boost the dental health workforce (extended to 2016 by the current budget)

Additionally, in the 2012-13 Budget, the Federal Government has committed $515.3 million for dental health reforms, including:

- $345.9 million over three years to alleviate pressure on state and territory public dental waiting lists;
- $10.45 million over three years for oral health promotion activities, including the development of a National Oral Health Promotion Plan;
- $450,000 over three years to support *pro bono* dental services for disadvantaged Australians;
- $45 million over four years to introduce an Oral Health Therapist Graduate Year Program to support 50 graduate placements per year from 2014 in public dental services and areas of need.

In Victoria, the Dental Health Program commenced on 1 July 2011. It covers all Dental Health Program funded activity, including public dental services delivered by public and private providers. The model is activity based, the activity measure is a completed course of care. There is a two-year transition phase to allow adequate time for validation of the new funding model.

Useful Resources:

PRACTICE

ADAVIC www.adavic.org.au community based support, information and resources to help individuals manage anxiety and depression issues

Anxiety Recovery Centre Victoria www.arcvic.org.au providing support, self-help, recovery and education to sufferers of anxiety disorders, their families and mental health professionals

Autism Awareness www.autismawareness.com.au not-for-profit providing education and advocacy organisation to increasing awareness and understanding of Autism Spectrum Disorders

Autism Victoria www.amaze.org.au a member based not-for-profit organisation that is also the peak body for Autism Spectrum Disorders in Victoria. Trading under the name of Amaze. Services include InfoLine, AdviceLine, education and training and family counselling. **03 9657 1600 (metro) or 1300 308 699 (regional)**

Beyond Blue www.beyondblue.org.au information, resource & policy on issues surrounding depression & anxiety. **Youth Beyond Blue** www.youthbeyondblue.com aimed at young people with anxiety or depression.

Headspace www.headspace.org.au

eheadspace https://www.eheadspace.org.au/ **1800 650 890**

Lifeline www.lifeline.org.au **13 11 14 (24hr crisis hotline)**

Kids Help Line www.kidshelpline.com.au (includes online counselling) or **1800 55 1800**

Mensline www.menslineaus.org.au **1300 78 99 78**

Mind Australia www.mindaustralia.org.au supporting people with mental illness to live well in the community. **9455 7900**

Mental Illness Fellowship Victoria www.milfellowship.org not-for-profit member-based organisation providing support to people with mental health through services, advocacy and community education.

Suicide Call Back Service (free nation wide counselling) **1300 659 467** www.suicidecallbackservice.org.au

Full listing of mental health programs (federal) can be found at

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www.health.gov.au/internet/main/publishing.nsf/Content/mental-progs

Mental health service by suburb & type of service (Victoria): http://www.health.vic.gov.au/mentalhealth/services/index.htm

Victorian Mental health services Directory can be accessed online at http://www.health.vic.gov.au/mentalhealth/services/index.htm

Disability Information & Resource Centre www.dircsa.org.au provides a range of services, information & resources, including disability directory.

Disability Advocacy and Information Service Inc. www.disability-advocacy.com.au provides a range of individual and systemic advocacy services, community education and outreach to people with disability in rural Victoria and NSW.

Community Health Directory – find a community health service by suburb or organisation/service online at http://www.health.vic.gov.au/pch/commhealth/directory.htm

Community Dental Clinics – find a clinic by suburb online at http://www.dhsv.org.au/clinic-locations/community-dental-clinics/

Emergency dental health care
http://www.dhsv.org.au/emergency/

Dental health services www.dhsv.org.au/ The patient information portal of the dental health services victoria website is very instructive and easily navigable.
Fee schedule can be found at http://www.dhsv.org.au/patient-information/fees/

EACH Social & Community Health www.each.com.au

Womens' Health West family violence and health promotion action service servicing women in Melbourne's western region http://whwest.org.au/

POLICY & ADVOCACY

Social Inclusion www.socialinclusion.gov.au

Health Issues Centre www.healthissuescentre.org.au an independent health policy research and action centre, promoting consumer perspectives and participation in the health system.

End the decay www.dental.bsl.org.au information & support for the campaign to add dental care to Medicare

Office of the Health Services Commissioner
http://www.health.vic.gov.au/hsc/index.htm is an independent statutory authority established to receive and resolve complaints about health service providers. The service is impartial and confidential, and does not charge fees.

Other relevant bodies related to health include:

- **Ombudsman Victoria** http://www.ombudsman.vic.gov.au/
- **Private Health Insurance Ombudsman** http://www.phio.org.au/
- **Aged Care Commissioner** http://www.agedcarecommissioner.net.au/
- **Disability Care Commissioner** http://www.odsc.vic.gov.au/
- **Child Safety Commissioner** http://www.ocsc.vic.gov.au/
- **Victoria Human Rights and Equal Opportunity Commission** http://www.humanrightscommission.vic.gov.au/
- **Chief Psychiatrist, Victoria** http://www.health.vic.gov.au/chiefpsychiatrist/
- **Mental Health Review Board** http://www.mhrb.vic.gov.au/
- **Health Services Liaison Association** http://www.hsla.com.au/

People with Disability www.pwd.org.au national peak disability rights and advocacy organisation.

Multicultural Disability Advocacy Association www.mdaa.org.au peak body for people from non-English speaking backgrounds with disability, their families and carers in NSW. There are a great number of resources in other languages from their website.

National Disability Insurance Scheme www.ndis.gov.au

Social Determinants of Health

- World Health Organisations' social determinants of health website http://www.who.int/social_determinants/en/
- Canadian and international information to help plan approaches to address the social determinants of health http://cbpp-pcpe.phac-aspc.gc.ca/public-health-topics/social-determinants-of-health/

VICSERV www.vicserv.org.au peak body for community managed mental health services in Victoria

Victorian Mental Illness Awareness Council www.vmiac.org.au peak body for people experiencing mental illness or emotional distress. Provides information, advocacy and education.

Victorian Healthcare Association http://www.vha.org.au is the major peak body representing Victoria's public healthcare sector.

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The National Disability Insurance Scheme – a good start but a long way to go…

By James O'Brien for the Every Australian Counts campaign

The National Disability Insurance Scheme (NDIS) will transform the way disability services are funded and delivered in Australia - from a charitable and welfare model, racked by underfunding and rationing of services, to one driven by people with disabilities making real choices about the supports and care they receive.

It will ensure that people with serious disabilities, their families and carers get a decent level of support and it will help fix the current system last year condemned by the Productivity Commission as '*"inequitable, underfunded, fragmented, and inefficient and gives people with a disability little choice".*

At a macro level, the diagnosis by the Productivity Commission is spot on. However, when you delve into the 1000+ pages of their landmark report, the true impacts of the broken system are laid bare.

The dire rationing of services, the eternal waiting, the 'confusopoly' of red tape and untold stories of distress, anxiety and suffering for many people with disabilities, their families and carers, children waiting years for a wheelchair, young people with disabilities being consigned to a life in a nursing home and people with disabilities living with only two showers a week.

Pretty grim stuff and no Australian would make a conscious decision to let these things happen. But as a consequence of disability being out of mind, out of sight for too many, for too long, it has happened.

People with disabilities are also locked out of the social and economic mainstream - about half live in poverty, compared to 22% for other OECD nations, as a result of a stubborn and pervading unemployment rate; Australia rates 21^{t} out of 29 in the OECD for employment for people with disability.

Expectations have been building across the disability sector for some time now that the NDIS must be introduced as a priority for the Gillard Government.

The Opposition Leader Tony Abbott has also on a number of occasions re-affirmed the Coalition's support for the NDIS by declaring that it was 'an idea whose time had come' and sought to quarantine the NDIS from the raft of other bitter policy debates by declaring that when it comes to the NDIS, he was *'Dr. Yes'*.

On Monday 30 April 2012, the broader Australian public got a sense of why the NDIS mattered when more than 15,000 people rallied in capital cities in support of the NDIS, generating widespread and positive media coverage.

The rallies were a culmination of 18 months of grassroots political activism through the *Every Australian Counts* campaign and were the biggest show of strength in the history of the disability rights movement in Australia.

Shortly thereafter on Tuesday 8 May, the Federal Government confirmed its commitment to the NDIS, allocating $1 billion over four years to kick off the first stage of the NDIS across four 'launch sites' covering 10,000 people from mid-2013, rising to 20,000 by mid-2014.

This investment provides for a very solid foundation from which to build the NDIS. It is also the first time in living memory that disability has been the centre-piece of any Federal Budget (particularly one handed down in such a tight fiscal environment) with the Treasurer Wayne Swan dubbing the NDIS in his budget night speech as 'the biggest social policy reform since Medicare'.

As part of the Budget announcement, the Federal Government is asking the States to contribute to the NDIS moving forward, with the envisaged split being approximately 78% Commonwealth and 22% State. This effectively turns on its head the current arrangements under the National Disability Agreement, where the States fund the majority of the current $7 billion spent on disability services around Australia.

However, the funding from the Federal Government doesn't extend beyond the initial 20,000 places announced as part of the four NDIS launch sites.

Clearly, funding certainty is needed to ensure that the NDIS extends beyond 2014, however the Federal Government is yet to commit beyond the four launch sites, until negotiations conclude with the States and Territories about the long-term funding and governance of the NDIS.

Some States have attacked the Budget announcement arguing a lack of consultation and a lack of capacity to meet the Federal Government's demands of a co-contribution, whilst the Federal Opposition have pointed out that the $1 billion over four years announced in the Budget is well below the funding recommended by the Productivity Commission.

The Federal Government needs to, as a matter of urgency, detail how to fund its share of a fully-implemented NDIS beyond the launch sites. The Productivity Commission estimates that once the NDIS is fully operational, this additional extra funding will be an extra $6.5 billion per year, but in reality it may be in the order of $8 billion.

Whilst some politicians and policy makers may shy away from the quantum of money required to establish the NDIS, it is a vital investment to make the disability budget sustainable into the future. Without the NDIS, accountancy firm Price Waterhouse Coopers projects that the current national disability spend of almost $7 billion per year will blow out to $45 billion per year by the year 2035 as Governments continue to funnel taxpayers money into a busted, crisis-driven system, rather than the less expensive early intervention approaches at the heart of the NDIS.

The NDIS will also provide a long term boost to workforce participation and productivity, with the Productivity Commission concluding that the NDIS combined with other labour market reforms could see and estimated extra 320,000 people with a disability employed by 2050. This could boost Australia's gross domestic product (GDP) by $32 billion per year by the year 2050 – a massive return on investment.

Despite recent advances, the NDIS is still very much in its infancy. We need to keep the pressure on, so it does not get derailed by politicking, particularly as we inch closer towards a Federal election.

Making the NDIS real relies on a long term bipartisan commitment to funding and reform and the ongoing co-operation of the States and Territories. Despite some fraying at the edges, the bipartisan approach has stuck with the Prime Minister, all States and Territory Governments plus the Leader of the Opposition Tony Abbott and the Greens and Independents all backing the NDIS.

This bipartisanship must be maintained so people with disabilities, their families and carers can be certain that the NDIS as recommended by the Productivity Commission will be introduced as soon as possible, regardless of the political volatility in Canberra.

To provide this certainty, the Government must as a priority

- provide a detailed long term funding plan,
- create the independent National Disability Insurance Agency and;
- legislate the NDIS so it is enshrined in perpetuity.

Keeping our political leaders accountable to their promises on the NDIS requires ongoing vigilance and sustained community and political pressure.

Please keep spreading the word and getting people to sign up to: www.everyaustraliancounts.com.au

Managing Financial Stress – A Financial Counselling Perspective

By Kim Hubber, Financial Counsellor, EACH Social and Community Health

Managing the household finances can be extremely challenging. Even under the most favourable circumstances, it can be difficult to make ends meet with ever increasing costs and demands. In today's economic climate, with the casualisation of the workforce and cost of living increases –accommodation, utilities, food, petrol and clothing to name a few- it can be a struggle to balance the budget. Add to this the financial burden of debt – be it through mortgages or loans, credit cards, children's needs, medical costs, car expenses etc – and financial stress can easily become reality.

How do people get into financial difficulty? Financial hardship is not merely the outcome of a series of bad decisions, wasting money, or lack of desire to work. The reality is that circumstances can change quickly and this may seriously affect a previously stable financial situation. Just because someone's personal circumstances may change overnight, does not mean that their financial commitments and responsibilities do.

There are many reasons why financial difficulties can arise and none of us are immune to financial crisis which can cross ***ALL*** levels of intelligence and socio-economic groups. Financial decision or indecision can make or break a household. As a community, we need to be aware of the financial impacts of loss of work, ill health and other factors that make financial survival so difficult. We need to know that this can happen to ***anyone*** and is rarely a planned event.

Sudden or unexpected life changing experiences such as job loss, sudden disability, death of a spouse, separation / divorce, physical or mental ill health can significantly affect the ability to be financially stable. Other factors can also impact such as regular habits, for example, the use of alcohol, cigarettes, gambling, drugs, and excessive use of credit.

Financial inclusion or exclusion can impact on the ability to cope with financial difficulty– those who are financially excluded will typically incur greater loss- this may be due to poor financial literacy or simply because financial exclusion is as a result of stretched financial resources. For example, irrespective of whether accommodation cost is for rent or a mortgage - if these costs equate to more than the 30% of household income, then it is considered to be a situation of housing stress. Furthermore, properties at the cheaper end of the market (both rental and purchasing) often have less energy efficient appliances and are not well insulated resulting in higher energy costs – exacerbating financial difficulty.

Financial exclusion (typically experienced by vulnerable, disadvantaged and marginalised groups such as those on low incomes, single parents, CALD communities, and people with disabilities/ill health) increases financial pain. Those affected often lack the ability to access appropriate financial services resulting in higher interest credit, lack of insurance, lack of suitable banking products, and higher costs for essential services.

Financial exclusion reinforces social exclusion – this is not just an individual problem, a whole community can suffer from under investment in financial services.

Community agencies and community health services such as EACH Social and Community Health are often privy to the impacts of financial exclusion and financial stress as experienced by clients accessing their services.

EACH Social and Community Health offers a range of services which aim to improve the physical, mental and social well-being of individuals, families and communities and as such, it actively participates to enhance and promote social inclusion across a range of communities. EACH adopts a social model of health -this involves providing a range of diverse services including allied health services, counselling and employment services, services for young people, older adults, families and carers, indigenous services, disability and mental health services, and housing and homelessness services.

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Financial inclusion can contribute to a pathway out of poverty. Basic understanding of financial concepts (financial literacy) and the ability and motivation to plan finances, seek out information and advice and apply these to personal circumstances, can be critical to the opportunity to creating financial sustainability. People can be empowered to take control of their finances and make constructive, informed decisions –it is possible to get 'on track' even in the most difficult of circumstances.

There are solutions to many situations of financial hardship. Financial Counsellors can help with money management advice, advice and options around bills, fines and debt repayments, assistance to negotiate payment plans for creditors, information on bankruptcy, legal issues, consumer issues and government assistance, as well as referral to other agencies. Financial counselling is a means by which individuals can learn how to empower themselves to successfully manage their finances, and take steps to overcome issues that may seem unsurmountable.

Financial counselling offers individual confidential support for those who are suffering financial difficulty.

EACH Social and Community Health offers financial counselling services in the Eastern Metropolitan Region of Melbourne, specifically to clients living or working in the local government areas of Maroondah and Knox, and in Healesville and Yarra Junction and the surrounding areas. EACH also offers problem gambling financial counselling to gamblers &/or others affected by gambling behaviour in all 7 local government areas in the Eastern Metro Region.

Financial Counsellors in other areas can be found by contacting 1800 007 007 or via Consumer Affairs Victoria on 1300 55 81 81

VICSERV – a peak body representing community managed mental health services

VICSERV is a membership-based organisation and the peak body representing community managed mental health (CMMH) services who received psychiatric disability and rehabilitation support services (PDRSS) funding in Victoria. These services include housing support, home-based outreach, psychosocial and pre-vocational day programs, residential rehabilitation, mutual support and self-help, respite care and Prevention and Recovery Care (PARC) services.

Many VICSERV members also provide Commonwealth funded mental health programs such as the Personal Helpers and Mentors program (PHaMs) and Day2Day Living.

The majority of CMMH organisations are funded to provide services for predominately adults 16-64 years of age with serious mental illness and/or significant psychiatric disabilities as well as their families, children and carers. Some of the key barriers facing many of the people accessing these services include lack of stable housing, interrupted education trajectories, finding and keeping a job, physical health problems as well as social isolation/exclusion. CMMH organisations strive to support people in their recovery efforts and provide the appropriate services and linkages in overcoming these barrriers.

VICSERV as the peak body looks to support these organisations in their efforts by undertaking two key state-wide support functions, namely, through policy development and training.

With the sector currently engaged in a major reform process with the release of the Victorian Department of Health's *PDRSS Reform Framework Consultation Paper*, VICSERV seeks to provide leadership in this uncertain policy landscape. It also seeks to set the agenda, with its major policy document published this year, *An Agenda for the Future*.

At the Commonwealth level, further changes are headed the sector's way particularly with the trend being towards individualised approaches to services delivery and funding via the National Disability Insurance Scheme as well as the *Partners in Recovery* initiative aimed at providing care coordination packages for those with complex needs.

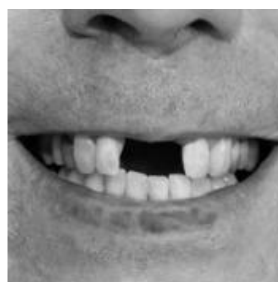
The VICSERV training unit has been pleased to work in partnership with CISVic in the delivery of 'Mental Illness Awareness' training to staff and volunteers. This one day workshop is designed for people who do not need to be experts in psychiatric treatment, but need to know basic information about mental illness and how it affects people's lives. This workshop gives participants a better understanding of mental illness and the confidence to communicate effectively and refer people to appropriate services.

Participants in the workshops acknowledge that a high proportion of people seeking Emergency Relief appear to have issues with their mental health. This is to be expected, as many factors that contribute to, or exacerbate mental ill-health, such as social isolation, poor physical health, domestic violence and abuse, underemployment, and trauma, may also be the factors that contribute to the housing stress, homelessness, and poverty. Training participants learn that all of the above factors, including mental ill health, can lead to distress, and practice techniques in the workshop that can help them to communicate effectively with people in need.

www.vicserv.org.au,
http://www.vicserv.org.au/training2/training-calendar.html

End the decay – a Brotherhood of St. Laurence campaign

By Adam Plunkett for the End the Decay Campaign, Brotherhood of St. Laurence



Recently a young man, Brett, was referred to the Brotherhood of St Laurence by his job service provider. He couldn't work because his impacted wisdom teeth kept getting infected so badly it made him ill and

there was a 30 month wait for treatment at his local public dental health clinic. The job service provider had heard that the Brotherhood could help. Through a small philanthropic fund we were able to pay for private treatment and Brett is now actively looking for work.

Bad teeth or no teeth have long been synonymous with poverty. Visit any social welfare agency on any day of the week and you are likely to come across numerous people with bad or missing teeth and poor oral health. These conditions can be painful, making it difficult to eat and speak and unsightly, eroding confidence and reducing job opportunities.

A strange historical anomaly has meant that Medicare has never covered dental or oral health leaving consumers with higher out of pocket costs than any other form of healthcare. While up to a third of the population may be eligible for assistance from public dental health clinics, the waits are often very long – commonly three to five years, and this only for those actually on their list – not everyone who is eligible for their services. Others may be eligible for treatment through the Chronic Disease Dental Program but many Australians on low or even middle incomes struggle to afford dental care.

Lack of access to dental care also results in presentations to general practitioners and emergency departments in hospital. Dental admissions are the largest category of acute preventable hospital admissions, resulting in about 50,000 admissions with an estimated cost of $223 million per annum. It is estimated that dental problems comprise between 7-10% of total GP services. Untreated oral health problems can also lead to a range other illnesses including cardiovascular disease, stroke, peripheral vascular disease, pre-term birth and pancreatic cancers among others. Overall untreated oral health problems are estimated to cost the economy between $1.3 and $2billion in terms of lost productivity.

So as politicians argue about the costs of making dental care universal, it is worth remembering the costs of not doing anything is also high, both in economic terms and in human costs. It is also worth reflecting on why we are asking questions about the 'affordability' of universal dental care when most of us accept Medicare, Australia's taxpayer funded universal healthcare scheme, as part of the furniture.

The National Advisory Council on Dental Health concluded in its report to the Federal Government that Australia's long term goal should be "universal and equitable access to dental care for all Australians" but that in the current environment Australia should start with dramatically improving access to dental services for children and the most disadvantaged adults. There is nothing wrong with prioritising some vulnerable groups within the community but the Brotherhood believes that continuing to limit reform to narrow means tested systems is not the answer. In the Federal Budget the Federal Government gave Australians a down-payment on dental care, but now we need a timetable and plan for universal dental care.

For more information on the issues or to send an email of support go to www.dental.bsl.org.au.

To contact us for assistance please call Adam Plunkett on 03 9483 2489 or email aplunkett@bsl.org.au.

Case stories from CISVic agencies

Fiona, 38 years

Family composition: Single parent with 13 year old son.

Complex issues include: Fiona presented with a range of complex issues, which includes post-traumatic stress from workplace sexual harassment, and a previous history of depression. Fiona had worked full time for several years up until late last year, but has not received entitlements. The sexual harassment experienced by Fiona is now a matter before the courts, for which she has engaged lawyers on a no-win no-pay basis. Fiona is currently in receipt of parenting payment

Client History: Fiona was referred to the Case Worker (CW) as her gas has been disconnected for 2 weeks with overdue bills for both gas and electricity. There is also a large amount of unpaid Utility bills which had been referred to a debt Collection Agency.

Fiona lives in private rental and pays $300 a week which leaves her with $200 for all other expenses. Fiona feels overwhelmed both financially and emotionally with presenting issues.

Ongoing going support include: On-going counselling from CASA (Center Against Sexual Assault)

Agencies referred to: Energy Ombudsman, Money Help

Resources used: Fiona initially was provided with a food voucher by a volunteer prior to referral to CW. Brokerage funds was utilised to assist with educational costs for her son.

Successful advocacy and support strategies include: The CW contacted the Utility Ombudsman to reconnect Gas on the same day. She also contacted the utility provider to negotiate affordable payment plan to be set up through Centrepay, and made application for Utility Grant for outstanding accounts (which was subsequently approved). The CW also sent a letter to the Debt Collection Agency as advised by Money Help. The CW also provided on-going phone support to keep Fiona informed and supportive listening. Fiona was also enrolled into a TAFE OH&S course, and the CW contacted on Fiona's behalf to negotiate change of dates with course structure due to personal issues. This provided Fiona with relief and eased pressure that there had been successful communication with the College to enable continuation of the course.

General comments: Many clients become so overwhelmed (often they are experiencing a depressive illness) that they are not clear on how to manage a financial crisis on their own. The situation then continues to deteriorate. A Case Worker can work with a client to make the presenting issue 'manageable' by working with them step by step and also provide the information needed so the client can hopefully prevent similar situations presenting again.

John

August 15, 2011 (Monday)

John suffers severe depression, and had been a client *of P Mental Health* and is now being cared for by a psychiatrist and GP. Had recently seen his psychiatrist who thought he was coping quite well and didn't need to see him for a month.

John came to the service requesting assistance with food, utility bills and rent. He appeared very depressed and stated he was suicidal. John stated he had started a job on the weekend but couldn't cope and had to go home. The service Coordinator directed the worker to call *P Mental Health* who advised that the Crisis Assessment Team (CAT) would call client on his mobile in two hours. As the local housing service were out of funds, and due to the John's fragile state we assisted with one week's rent. It was also noted during the interview that John was on New Start. After rent, gas and electricity were paid he had $8 a fortnight to live on. Due to his mental illness he was asked if he had ever applied for the Disability Support Pension (DSP). John stated that his doctor had filled the form in a month ago but John had not lodged the application with Centrelink as he had been told it was too hard to change from New Start to DSP.

John also had a Disconnection Notice for gas and electricity and had made a payment plan of $85 a fortnight as he was not eligible for a Utility Relief Grant. We told John that once the first payment is made today at the post office he is to notify the utility company with the receipt number and the disconnection will be prevented. The service interviewer suggested he contact *P Mental Health's* financial counsellor.

The service Coordinator directed the worker to link John with our Centrelink outreach worker who made an appointment for John to bring the DSP application in the next day. Interviewer also suggested that he contact his psychiatrist and explain that he had a relapse on the weekend and wasn't coping.

August 16, 2011 (Tuesday)

John returned after his appointment with the Centrelink outreach worker stating that the CAT team hadn't contacted him so the worker contacted his psychiatrist and an appointment was made for the Thursday.

Our worker also contacted *P Mental Health* regarding a financial counsellor to assist with the gas and electricity accounts. She was advised that John was discharged from their service in July. The worker then rang triage and re-registered John due to his relapse, and advised that John would be contacted by *P Mental Health* today. The worker advised that John could return tomorrow if he had not been contacted and that our worker would call the utility companies on his behalf.

August 17, 2011 (Wednesday)

John returned with utility bills at 11.50am, the worker contacted the utility company to put bills on hold until the outcome of his disability application was known. The worker was put through to three different customer service workers who were unable to assist as John was registered with their Credit Management Department but did state that his utilities would not be disconnected. Unable to contact the Credit Management Department, a message was left for them to return our call. John was given a meal voucher for lunch and asked to return in an hour's time.

The service Coordinator contacted the financial counsellor at *P Mental Health* who stated that John may not have access to her as depression is not considered serious enough to have access to a case worker. She suggested that if there were difficulties with the company to let them know that it would be referred to the Ombudsman.

John returned to the service and another call was made to the Credit Department. There was no answer. Another call was made to the utility call centre who emailed the Credit Management Department to ring ASAP, during that call the worker mentioned that matter was going to be referred to the Ombudsman. There was no call by 4.00pm when our service closed.

August 18, 2011 (Thursday)

The service Coordinator discussed John's case with the Good Shepherd Financial counsellor (co-located in the Centre part-time) to see if it was time to take the matter to the ombudsman. The Financial counsellor agreed and stated that it would be a good idea to get the worker to ask to have the case escalated and a conciliator assigned.

Centre Coordinators discussed the case and a referral to the Mental Illness Fellowship was recommended.

John returned to our service for follow up on bills. The utility company's Credit Department had called John on his way to our service and John asked if he could call back in 15 minutes to talk to our service worker. The utility company's worker stated he would not be there then but we could talk to one of his colleagues. Our worker called the utility company and they stated there could be no alteration to the payment plan.

The service Coordinator directed the worker to call the Ombudsman (EWOV). A conciliator will take 3 weeks to investigate and all bills were put on hold until then. John was told that he and our service are to have no contact with the utility company during this process and if John receives any letters from the utility company, he is to bring them to the service. Our service Coordinator will talk on John's behalf with EWOV. (Authority to Act form downloaded)

Our worker reminded John to get the letter from his psychiatrist for Centrelink and referred John to Mental Illness Fellowship.

August 26, 2011

Letter received from Ombudsman regarding the complaint.

September 1, 2011 (Monday)

Our service Coordinator received a phone call from EWOV Ombudsman requesting that income/expenditure and Authority to Act form to be emailed. We were also told a date for when a fortnightly payment of $10 gas and $10 electricity can start.

Coordinator phoned John and made an appointment for him to visit our service the next day to establish a payment plan and to sign Authority to Act form.

September 2, 2011(Tuesday)

John signed the Authority to Act form and wanted to wait for the outcome of his disability claim before setting up a payment plan which he stated would take 3 days. Coordinator emailed EWOV paperwork and advised them of John's wishes, stating the claim for DSP would be discussed with the Centrelink Outreach worker the following Monday and then contact them.

September 5, 2011 (Monday)

Coordinator spoke to Centrelink Outreach worker who stated that the outcome could take up to 5 weeks depending on how "backed up" Centrelink were, although there was a flag on his card dated the 7th.

September 7, 2011 (Wednesday)

EWOV called our service Coordinator regarding the outcome of discussion with the Centrelink outreach worker and stated there would need to be a payment in by Wednesday 14th September to enable John to move forward.

September 8, 2011 (Thursday)

Coordinator contacted John who stated he had been approved for DSP by SMS and would wait for the letter, which he is expecting in two days, before coming in. John stated he would be in touch before the 14th.

September 12, 2011 (Monday)

John presented at the centre and cheques ($10 gas & $10 electricity) were given to John for his first payment. John will receive his first DSP payment on the 14th and he has elected to pay $15 electricity and $25 gas a fortnight through Centrepay.

Coordinator faxed paperwork and updated EWOV via email.

September 22 – November 2

Numerous phone calls were made to John and received from EWOV by volunteers and Coordinator.

Outcome:

The utility company credited $50 to each account and offered an apology for the inconvenience experienced. A Centrepay deduction of $74 gas and $23 electricity was set up and once the case has been closed with the Ombudsman, John will be put onto the hardship team and an energy audit will take place. The utility company will also reassess John's usage and adjust his Centrepay deductions if necessary in a few months time.

John asked if we could set up Centrepay for his water and rent, which we did.

General comments: This case is one example of the complexity of client situations, the difficulty in dealing with utility companies and of the frustration experienced in finding appropriate support services for clients with mental health issues.

This one case demonstrates the time involved, assisting clients seeking ER.

Without a coordinator to guide and direct volunteers in these complex cases there is a risk of extremely bad outcomes.

Clive, late 40s

Clive is in his late 40s and presented at our service requesting financial assistance. He had recently been hospitalized due to heart problems which were ongoing and he was unable to return to work as a subcontractor. He had no sick pay to access and was receiving no income. He also had tenancy rental arrears which he was unable to pay. His problems were exacerbated by the fact he had not lodged tax returns for a number of years and was not able to get Centrelink benefits.

Issues: Clive had been a subcontractor, hence was not entitled to annual leave, sick leave and had failed to lodge tax returns for a number of years. Other complications included:-

- ongoing health issues;
- debts relating to utilities and medical expenses and no source of income;
- tenancy rental arrears and was at risk of losing his tenancy;
- limited support from family;

Assistance provided: the caseworker was able to advocate on Clive's behalf with his real estate agent to avoid eviction, and with his utility providers to avoid termination of service. Advice was sought from housing support agencies and via tenancy support on Clive's legal rights and obligations. Information was provided on lodging tax returns so that Centrelink benefits could be accessed. Since the tenancy was not salvageable, Clive was assisted into supported accommodation for a short period until alternative accommodation could be accessed and his health stabilized.

Outcomes:

- Advocacy with Centrelink to obtain sickness benefits;
- Submission of ATO tax returns;
- Clive was given financial aid during case work, assistance with medical and relocation costs;
- Clive was referred to a financial counsellor regarding debt management and advocacy regarding his medical debts and tax liability;
- Housing assistance and support was accessed resulting in supported accommodation for clive;
- Advocacy with a number of agencies resulting in intake for Clive with MI health and complex care for ongoing health support;
- Clive was given access to information regarding his return to work and support systems within the building industry.

Client feedback: Clive was unable to complete the feedback form at interview but stated by telephone that he greatly appreciated the service provided by the caseworker and would be happy to re-engage with her services if he moved back into the area.

Jane

Jane is a young mother of 4 attended our service requesting financial assistance and support. She was struggling since she had split with her partner who had a gambling problem. Jane has a 5 week old baby and an 8 year old with autism. Since her husband had left, she had inadequate income to cover her mortgage and bills and was unsure about what to do. This was having a deteriorating

effect on her mental health and ability to cope with the parenting of the children

Issues: Jane felt overwhelmed, and was finding it difficult to deal with her financial crisis. She had:-

- recently split with her partner;
- financial budgeting issues and lack of income;
- been in mortgage arrears;
- health issues;
- limited knowledge of community supports.

Assistance provided

The caseworker identified areas of assistance that could be offered and identified referrals to community supports that would be useful in encouraging greater social inclusion and assist in stabilizing Jane's home life. Assistance provided included:

- Christmas hamper list and financial assistance with food and utilities
- Advocacy with utility providers to ensure bills in client's name only
- Access to Marriage counselling with Anglicare
- Access to Personal counselling
- Access to financial counselling, budgeting tools and financial information regarding debt management
- Access to parenting course information
- Access to autism support

Outcomes

- stabilized financial situation
- Emotional stability restored resulting in improved health and lower depression levels
- Improved relationship with partner
- Improved financial literacy

Dianne

Dianne is a single mother of three who contacted our service requesting assistance with her teenage son who had a diagnosed disorder of autism. Recent retesting meant that his intellectual disability funding had ceased and he was forced to join mainstream schooling and apply for autism funding. The growing teenage boy was not coping well in the new setting and Dianne was struggling to manage his aggressive outbursts due to his stature. Dianne had significant health issues requiring medication and yet was looking at home schooling options rather than sending him to school.

Issues

- Suitable school setting for teenager with autism
- Dianne's health issues
- No relevant service support (service gap)

Assistance provided

The caseworker identified areas of assistance and offered referrals to educational & community supports that would be useful in stabilizing Dianne's home life. Assistance provided included:

- Advocacy with providers
- Information on educational supports available for son
- Information on autism supports
- Referral to psychologist for mental health care plan
- Access to budgeting tools for unexpected financial items
- Single parent resource pack
- Practical and supportive help

Outcomes

- Linked in with alternative school with autism appropriate learning
- Improved financial literacy and education
- Increased knowledge/access to services
- Improved emotional outlook

contact Us:
INFORMED is a publication of
Community Information Victoria (CIVic)
Suite 209, Level 2
343 Little Collins Street
Melbourne VIC 3000
T: 03 9672 2000
F: 03 9672 2099
admin@cisvic.org.au
http://www.cisvic.org.au
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INFORMED

Policy & practice newsletter for the community information and support sector

WINTER, 2012

CISVic FULL MEMBERS

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Bayside Community Information & Support Service	BRIGHTON	9596-7283	www.bayciss.org.au
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Bayside Community Information & Support Service	SANDRINGHAM	9598-0422	www.bayciss.org.au
Box Hill Citizens' Advice Bureau	BOX HILL	9285-4801	www.whitehorse.vic.gov.au/Community-Directory.html?id=473
Camcare Inc - Ashburton	ASHBURTON	9809-9100	www.camcare.org.au
Camcare Inc - Camberwell	CAMBERWELL	9831-1900	www.camcare.org.au
Casey North Community Information & Support Service	FOUNTAIN GATE	9705-6699	www.caseynorthciss.com.au
Chelsea Community Support Services	CHELSEA	9772-8939	www.chelsea.org.au
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Dandenong Community Advisory Bureau	DANDENONG	9791-8344	www.dcab.org.au
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Diamond Valley Community Support	GREENSBOROUGH	9435- 8282	www.dvsupport.org.au
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Lilydale & District Community Information Centre	LILYDALE	9735-1311	
Living Learnin Pakenham	PAKENHAM	5941-2389	www.llinc.com.au
Maroondah Citizens Advice Bureau Inc - Croydon	CROYDON	9725-7920	www.mcab.org.au
Maroondah Citizens Advice Bureau Inc - Ringwood	RINGWOOD	9870-3233	www.mcab.org.au
Maryborough Community Information Centre Inc	MARYBOROUGH	5461-2643	
Mentone Community Assistance & Information Bureau Inc	MENTONE	9583-8233	
Monash Oakleigh Community Support & Information Service	OAKLEIGH	9568-4533	
Monash Waverley Community Information & Support Centre	MOUNT WAVERLEY	9807-9844	www.monashwaverleycis.org.au
Mornington Community Information & Support Centre	MORNINGTON	5975-1644	www.morninfo.org.au
Mt Alexander Community Information Centre	CASTLEMAINE	5472-2688	http://users.vic.chariot.net.au/~cic/
Port Phillip Community Group Inc - Port Melbourne	PORT MELBOURNE	9209-6350	www.ppcg.org.au
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Port Phillip Community Group Inc - St Kilda	ST KILDA	9534-0777	www.ppcg.org.au
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South Gippsland Citizens Advice Bureau Inc	LEONGATHA	5662-2111	www.sgcab.org.au
Southern Peninsula Community Support & Information Centre	ROSEBUD	5986-1285	http://humanservicesdirectory.vic.gov.au/SiteDetails.aspx?SiteID=40951
Springvale Community Aid & Advice Bureau	SPRINGVALE	9546-5255	www.scaab.org.au
Sunraysia Information & Referral Service	MILDURA	5023-4025	www.vicnet.net.au/~sirs
UnitingCare East Burwood Centre	EAST BURWOOD	9803-3400	www.uebc.org
Western Port Community Support	HASTINGS	5979-2762	www.wportcomsupport.org.au
Whittlesea Community Connections	EPPING	9401-6666	www.whittleseacommunityconnections.org.au

CISVic ASSOCIATE MEMBERS

Ardoch Youth Foundation	ST KILDA	9537-2414	www.ardoch.asn.au
Australia Help	NARRE WARREN STH	0428366220	www.australiahelp.org
Bendigo Family and Financial Services	BENDIGO	5441-5277	www.ourcommunity.com.au/directories/listing?id=28346
Diamond Valley Foodshare	GREENSBOROUGH	9432-8274	www.ourcommunity.com.au/banyulegives/donate/org_details.form?orgId=1583
Dingley Village Community Advice Bureau	DINGLEY VILLAGE	9551-1799	dvcab.org.au
Eastern Emergency Relief Network	MITCHAM	9874-8433	www.easternemergency.org.au
Endeavour Ministries	ENDEAVOUR HILLS	9700-4944	www.andrewscentre.org.au
Healesville Interchurch Community	HEALESVILLE	5965-3529	
Jesuit Social Services	RICHMOND	9427-7388	www.jss.org.au
LINC Church Services Network Yarra Valley	YARRA JUNCTION	5967-2119	www.lincnational.org.au/affiliates.html
North East Region Volunteer Resource Centre	HEIDELBERG	9458-3777	www.volunteersofbanyule.org.au
Somali Australian Council of Victoria	HEIDELBERG WEST	9459-6333	
Swags for Homeless	KNOXFIELD	9764-9422	www.swags.org.au
The Gianna Centre	BENDIGO	5442-4644	www.gianna.org.au
The Migrant Hub	WERRIBEE	9731-7877	
Transworld Aid	NARRE WARREN STH	0411 714 885	www.transworldaid.org
United Way Ballarat Community Fund	BALLARAT	5331-5555	www.unitedwayballarat.com.au
Victorian Youth Mentoring Alliance	MELBOURNE	0423929601	www.youthmentoringvic.org.au
Volunteering Geelong	GEELONG	5221-1377	www.volunteeringgeelong.org.au
Wimmera Information Network Inc	HORSHAM	5382-5301	wimmerainfo.org.au