ANGLICARE
TASMANIA

Submission on mental illness and income adequacy to the National Advisory Council on Mental Health

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Contact: Dr Chris Jones
Chief Executive Officer
GPO Box 1620, HOBART TAS 7001
(03) 6231 9602
c.jones@anglicare-tas.org.au

Introduction: on thin ice and in hard times

Anglicare welcomes the opportunity to provide information to the National Advisory Council on Mental Health to assist it in its preparation of advice to the Minister. We welcome the attention being given to the financial plight of people with a serious mental illness and their families.

In 2004, Anglicare published *Thin ice*, a major research report on the experiences of people with serious mental illnesses (Cameron & Flanagan, J 2004). The report explored the intersection between mental illness and poverty among Tasmanians with 'low prevalence disorders' such as schizophrenia, bipolar disorder, depression and severe anxiety disorders. The research included detailed focus group discussions with 78 people, 52 people with a serious mental illness and 26 family members or carers. The research found that financial hardship was a common experience for both the people with an illness and the people who cared for them.

Participants with a mental illness reported severe difficulties in affording the essentials of life, including housing, food, clothing, transport and telephone services. They relied heavily on emergency relief. The symptoms of some mental illnesses, such as disordered thinking, confusion, lack of motivation and limited capacity for planning, made it difficult to budget effectively, especially during an episode of severe illness. Participants also reported considerable difficulty in their dealings with Centrelink, particularly those participants who were on Newstart Allowance rather than the Disability Support Pension, and difficulty in affording the costs of financial administration through Tasmania's Public Trustee, a corporatised government service. Financial difficulty rebounded onto carers, with many carers interviewed during the research reporting considerable levels of financial hardship arising as a result of providing financial assistance to the person with the illness – which included covering fines and debts and the cost of lost possessions, providing board, subsidising the cost of groceries and caring for grandchildren – and as a result of marriage breakdown and lost earnings caused by the stress and obligations of caring (Cameron & Flanagan, J 2004, pp. 38-46, 48-56, 70-77, 94-101).

More recently, in 2009, Anglicare conducted a survey of emergency relief and financial counselling clients in Tasmania, published as *Hard times: Tasmanians in financial crisis* (Flanagan, K 2010a). The clients of these services are people in urgent financial need. They represent the extreme end of the spectrum of hardship and poverty in our community. What is of particular concern is that there are so many of them – in 2007-08, 15,900 people used emergency relief services in Tasmania alone (FaHCSIA, cited in Adams 2009, pp. 26, A1.39). Anecdotally, providers of services for people in financial crisis report that many of their clients are affected by mental illness, either directly or indirectly through having a close family member directly affected. This was certainly borne out by Anglicare's survey. A third of the participants (32.4%) said that they or someone in their household had experienced mental illness in the previous year. A quarter (25.1%) of the participants were receiving the Disability Support Pension, and of these, 33.3% had a psychiatric disability and a further 17.2% had a psychiatric disability combined with another form of disability, including physical disabilities, intellectual or learning disabilities and acquired brain injuries (Flanagan, K 2010a, pp. 33, 147).

The findings of this survey shed some light on the specific financial difficulties facing people with a mental illness and form the basis of this submission. Most of the data is from the published survey findings, but some is drawn from unpublished findings. The survey was conducted in April and May 2009, prior to the recent pension increase. Presumably this increase will have eased some of the financial pressure on people with a mental illness who are receiving the Disability Support Pension. However, not all of the participants in the survey who were affected by mental illness did receive the pension. Of those participants who said that they or someone in their household had had a mental illness in the previous year, only 39.7% were on the Disability Support Pension. A further 17.6% were on Newstart Allowance and another 17.6% were receiving the single rate of Parenting Payment. Other participants were receiving Youth Allowance and the partnered rate of Parenting Payment. These participants would not have benefited at all from the increases to the pension (Flanagan, K 2010b).

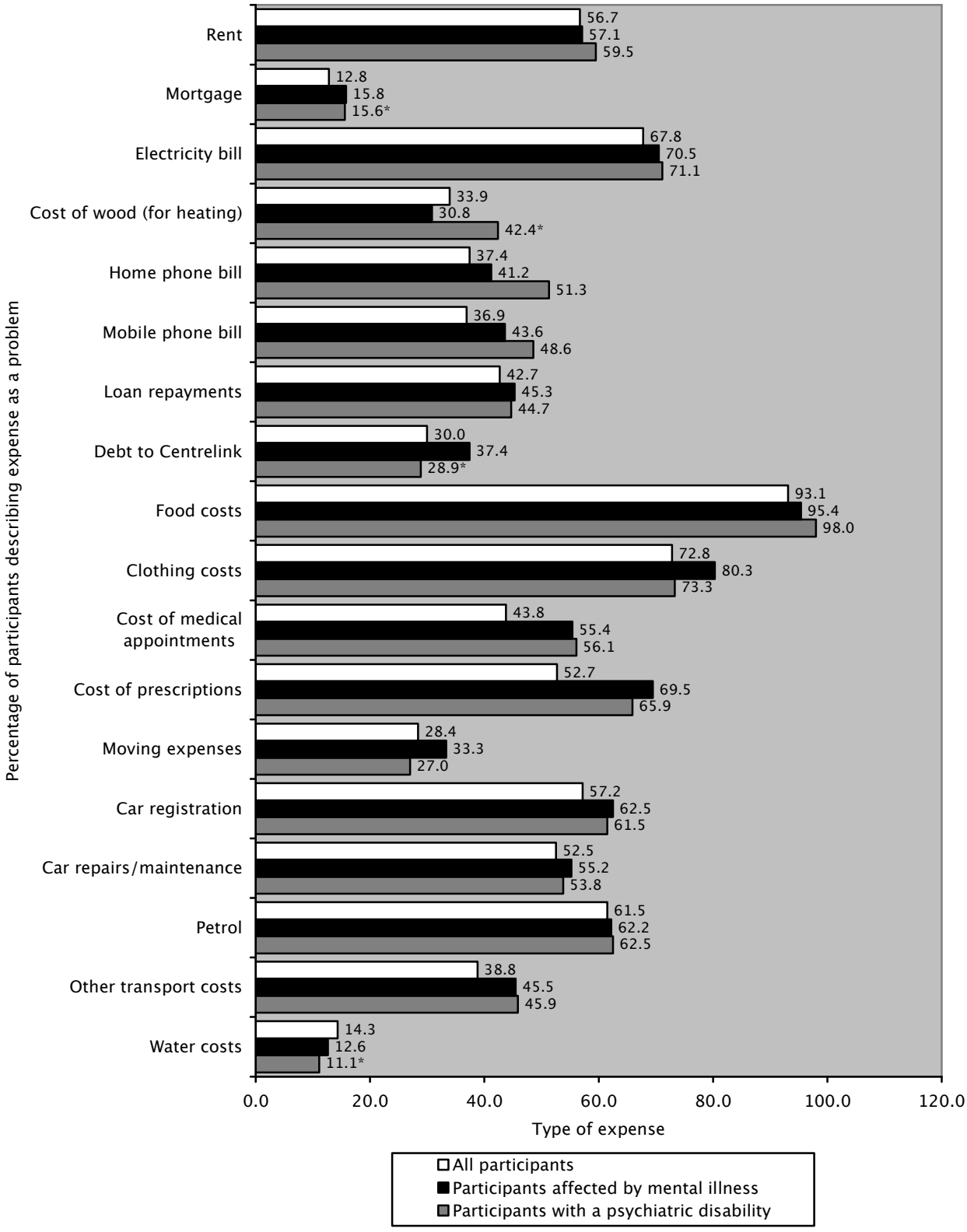
Mental illness and the cost of living

Anglicare's survey listed 18 common household expenses, and asked participants to indicate whether each expense was a problem or not a problem for their household. If a person identified a large number of these expenses as problems for their household – that is, it was not just one expense causing disproportionate and perhaps isolated financial problems – then it is reasonable to assume that the household is experiencing chronic problems with the cost of living. Overall, a third of all of the participants in the survey (33.6%) identified five or more common household expenses as problems for their household (Flanagan, K 2010a, p. 61). However, among those participants with or affected by a mental illness, the proportion reporting problems with multiple expenses was much higher: 46.6% of participants affected by a mental illness and 50.0% of participants with a psychiatric disability identified five or more expenses as problems for their household (Flanagan, K 2010b). This suggests that households where there was someone with a mental illness were more likely to have problems affording day-to-day essentials.

Among all participants, the costs most commonly reported to be a problem were the cost of food, clothing, transport and electricity. However, as shown in Figure 1 below, while these expenses were problematic for people with a mental illness as well, there were some expenses which people affected by mental health problems were disproportionately likely to report caused difficulties for their household. These were telephone costs, especially the cost of mobile phones, medical costs – both the

'gap' fee for medical appointments and the cost of prescription medication – and 'other' transport costs, which would include public transport, taxis and community transport.

Figure 1: Percentage of participants describing expenses as a problem for their household, by selected population groups



**Estimate has a relative standard error of 25-50% and should be used with caution.*
Source: Flanagan, K 2010a, p. 59, 2010b.

Participants were also asked how often their household experienced financial problems. A third of the participants (32.6%) said their household had financial problems regularly and 14.6% said they always had financial problems, 47.2% in total. However, households where someone had a mental illness reported more frequent difficulties. In total, 52.7% of participants affected by a mental illness and 56.3% of participants with a psychiatric disability said their household had financial problems regularly or always.

Mental illness and financial hardship

The survey also explored the levels of financial hardship among participants. The indicators of hardship used in the survey are adapted from work by Bray (2001), and similar indicators have been used in previous Anglicare research (Madden 2004; Madden & Law 2005; Hinton 2006, 2007) and by other researchers (Lobo 2009, pp. 25-6; Marks 2007, p. 3; FaHCSIA 2009i, p. 3). A household was considered to be experiencing hardship if they had in the previous year, due to a shortage of money, had any of the following experiences: been unable to pay a utilities bill, been unable to pay rent or meet home loan repayments, pawned or sold possessions, missed meals, been unable to heat their home or had their telephone disconnected or their power off.

As shown in Table 1 below, while the levels of hardship reported by all participants were unacceptably high, among people affected by a mental illness and people whose psychiatric condition is so severe that they have qualified for the Disability Support Pension, experiences such as being unable to pay bills, selling possessions, going without food and warmth and being disconnected from essential services are appallingly common.

Table 1: Percentage of participants reporting that their household experienced financial hardship, by selected population groups

Indicator of hardship: this happened to participant's household in previous year due to a shortage of money	Group of participants		
	All participants (%)	Participants affected by mental illness (%)	Participants with a psychiatric disability (%)
Could not pay electricity or phone or gas bill	67.9	76.0	71.1
Could not pay rent or home loan	47.9	50.4	48.7
Pawned or sold something	64.6	72.0	73.8
Went without meals	75.1	88.5	87.2
Unable to heat your home	57.4	70.1	78.0
Had the phone disconnected	40.8	51.4	44.1*
Had the power off	28.3	34.0	33.3*

**Estimate has a relative standard error of 25-50% and should be used with caution.*
Source: Flanagan, K 2010a, p. 44, 2010b.

Participants were also asked to what extent the following statement was true: 'I worry about whether the amount of food I can afford to buy for my household will be enough'. Three quarters (76.8%) of the participants said that this statement was always or mostly true (Flanagan, K 2010a, p. 49). However, 84.2% of participants affected by mental illness and 80.0% of Disability Support Pensioners with a psychiatric disability said it was always or mostly true (Flanagan, K 2010b).

The way forward

What Anglicare's survey suggests is that people affected by mental illness face a very high level of chronic financial hardship. The participants experienced difficulty across all areas of household expenditure, but the cost of telephones, medical treatment and transport posed particular problems. They faced very high levels of deprivation. Anglicare is not suggesting that the findings of this single survey be taken as representative of the experiences of all people with a mental illness in Australia, or even in Tasmania. However, they do provide important evidence that managing a household budget on a day to day basis is extremely difficult for households where someone has a mental illness. The research provides no direct evidence as to why this is the case. The symptoms of people's mental illness may play a role, but equally, so might the adequacy of their incomes. Analysis conducted by the Brotherhood of St Laurence in 2007 found that most income support payments offer incomes that are well below even a conservative measure of poverty such as the Henderson poverty line (Brotherhood of St Laurence 2007). On such low incomes, it is simply not possible to cover the cost of all essential items, let alone the additional costs of a chronic and severe illness.

Income management: Anglicare notes that part of the context for this request for information from the National Advisory Council is the introduction of compulsory income management for certain groups of income support recipients in Australia. Anglicare wishes to place on record that it opposes compulsory income management. While income quarantining on an elective basis may provide a useful budgeting tool for some people, there is not enough evidence that compulsory income management achieves positive outcomes for vulnerable people to warrant supporting a blanket approach. A number of organisations, including Anglicare Australia and the Australian Council of Social Service, emphasised the lack of empirical evidence that this policy works in their submissions to the Senate Community Affairs Legislation Committee inquiry into income management legislation in February 2010 (Anglicare Australia 2010, pp. 4-7; Australian Council of Social Service 2010, pp. 9-16). Anglicare draws the Council's attention to these submissions.

Tasmanians with a mental illness who are deemed to lack the capacity to make reasonable judgements about financial or property matters can already be made subject to a form of 'income management' by the Guardianship and Administration Board. The Board may order the appointment of an Administrator to make legal and financial decisions on behalf of the person with the illness.[1] This order is an option of last resort when no other realistic alternative is available (Cameron & Flanagan, J 2004, p. 76). The Board's decision is guided by legislated principles that focus on protecting the person's freedom of decision and action, their best interests and their wishes (*Guardianship and Administration Act 1995*, s. 6).

[1] Where no suitable person is willing or able to take on this role, the Public Trustee is appointed as administrator. Anglicare's research has raised concerns that the fees the Public Trustee charges for this service are excessive and that people who want to access this service because they believe it will help them choose not to do so because they are aware that they cannot afford it (Cameron & Flanagan, J 2004, pp. 76-7).

In Anglicare's view, it is entirely appropriate that decisions to appoint an administrator be guided by high standards, because taking away an individual's financial autonomy is a serious step and should only be done with great care and consideration and when all other options have failed. While the mandatory 'income management' proposed by Centrelink imposes a lesser degree of control than a guardianship order, it is still an arbitrary and disempowering process and care should be taken not to apply it inappropriately to people who are already made vulnerable by their illness. Just because some people with a mental illness have an impaired ability to manage their own money does not mean that all people with a mental illness do, or that compulsorily quarantining a portion of anyone's income will be effective in improving their health, wellbeing or financial situation.

Nor, and more importantly, should income management be permitted to substitute for genuine action to address income adequacy. Much of the recent Australian Government activity in the emergency relief area has focused on the financial and budgeting side of the spectrum of issues facing clients. Ministerial statements have made this clear:

> We need a service continuum that stretches from basic emergency relief, to financial counselling and money management advice, to innovative approaches that help individuals build a nest egg of their own through structured or matched savings plans. … Crisis assistance will always be an integral part of our support but we need the flexibility to make the most of the enormous front door capacity of emergency relief. Because to break the cycle of emergency relief, the reach of this front door capacity must be extended to build longer term financial capability and resilience (Macklin 2009).

Income management is an extreme version of such strategies. The assumption is that the source of people's problems is poor budgeting skills and poor spending decisions. A solution that simply hands over control of expenditure to an outside party seems a simple, attractive solution to a complicated problem. But the focus on financial management and budgeting as the solution is contrary to the arguments of service providers and researchers. Pentland (2005, pp. 2, 4-5), in commenting that financial literacy is 'the flavour of the moment', warns against seeing it as '*the* answer, not part of *an* answer' (emphasis in original). She notes particularly the potential to 'blame the victim for "poor money management"' and calls for the 'excellent money management skills of many low income Australians' to be acknowledged. She argues that many financial counselling clients believe that their problems are their own fault, the result of poor money management strategies, but that financial counsellors often discover other underlying reasons for their difficulties.

As stated above, Anglicare's research was conducted prior to the recent pension increase. The extra money may have alleviated some of the financial pressure facing disability support pensioners, but the increase did not extend to people on other forms of income support or provide any additional assistance to people on very low wages. It is also not yet clear whether the size of the increase was sufficient to adequately protect recipients from poverty.

Income adequacy: The main finding of Anglicare's *Thin ice* report was that there was a critical lack of services to support people with serious mental illness in the community (Cameron & Flanagan, J 2004, p. 108). While there has been considerable investment in mental health services in Tasmania since then, there remain large gaps and people still struggle to gain access to all the support that they need to live independently. Addressing the gaps in the system, ensuring services are adequately funded and recognising that for some people, time-limited support will not be adequate because their illness will be a life-long condition would all help in improving outcomes for people with serious mental illnesses. But Anglicare also believes that urgent attention needs to be paid to addressing the

inadequacies in the income support system, for people with mental illnesses, for their carers, and for all Australians dependent on the social security safety net for food, shelter and warmth.

The recent review of pension rates in Australia defined adequacy as 'a basic acceptable standard of living, accounting for prevailing community standards' (Harmer 2009, p. 8). But as Catholic Social Services Australia (2008, p. 11) points out, there are no benchmarks or standards in place to assess what this basic acceptable standard of living is, or what level of payment would be adequate to support it.

This does not mean that effort has never been put into developing such a benchmark. During the 1990s, the Department of Social Security invested in a major project to develop a set of indicative budget standards for Australia which could then inform decisions relating to the adequacy of income support payments. A budget standard is 'the amount needed by a particular household on average each week to attain and maintain a prescribed standard of living across a range of budget areas, including housing, energy, food, clothing, transport, health care and leisure' (Saunders et al. 1998, p. ii). The project developed two budget standards, one which would provide a 'modest but adequate' standard of living affording 'full opportunity to participate in contemporary Australian society' and one which 'may require frugal and careful management of resources' but would 'still allow social and economic participation consistent with community standards' (Saunders et al. 1998, p. iv). When the 'frugal' budget standard was compared to actual income support payments, the income required to attain this 'frugal' standard of living was shown to lie above the actual incomes provided by the social security system (Saunders et al. 1998, pp. 492-3).[2] The discrepancy for people with a mental illness – or indeed any chronic health condition – would be even greater because the budget standards were designed to 'apply to the cost of meeting a representative range of health care needs by those who are in *generally good health*' (Saunders et al. 1998, p. 310, emphasis in original).[3] The budget standards project was abandoned after the election of the Howard Government (Catholic Social Services Australia 2008, pp. 8-9).

It is Anglicare's view that all income support payments in Australia need to be increased to a level sufficient to provide recipients with a basic, acceptable standard of living and indexed accordingly. What constitutes a basic acceptable standard of living should be defined transparently and made public. Addressing income support inadequacy is one of the most effective strategies available to the Australian Government to promote social inclusion, particularly of vulnerable people.

[2] It must be acknowledged that the budget standards developed were indicative and the authors cautioned that the standards 'need further refinement before they are sufficiently robust to act as a basis for setting payment levels' (Saunders et al. 1998, p. 494).

[3] Focus group discussions conducted to 'test' the budget standards included one focus group with people with disabilities (Saunders et al. 1998, pp. 551-4). However, the focus group did not include anyone with a psychiatric disability.

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