2019 Submission - Royal Commission into Victoria's Mental Health System

Organisation Name
Wintringham

Name
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What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"While we acknowledge we have had the support of many health services, including mental health, we, at Wintringham also feel that we have had to become 'mental health experts'. Like many families in our community, we have not been able to access much training or resources to help us to do so. Our experience leads us to believe that there are few formal supports for those who are not in or post a mental health crisis, rather we all left to help those who are 'just a bit unwell ' by trialling different things that we think up - a rather hit and miss strategy - that for Wintringham, has resulted in a model of care that appears to work well. It is impossible, though, to imagine the desperation felt by families when they find themselves trying to do this on their own. With this in mind, it seems apparent that those who do not come into contact with a mentally unwell person will be fearful and avoid the encounter - what other tools have they been given in order to do anything else? The primary impetus in establishing Wintringham was anger at seeing older homeless people living and dying on the streets of Melbourne and in night shelters where they were frequently damaged by the brutal conditions they encountered. In 2011, recognising the outstanding success of our approach, United Nation Habitat awarded Wintringham their Scroll of Honour, the world's most prestigious human settlement award. While the antecedents of homelessness may be broad, the older, long-term homeless population is characterised by its high incidence of behaviours of concern often related to underlying psychiatric illnesses. In addition, many have an Acquired Brain Injury (ABI) which is often related to long-term alcohol abuse or asphyxia related to inappropriate drug use or a failed suicide attempt. It is estimated that prevalence rates for co-morbid psychiatric disorders in people living with an ABI may be as high as 44%. For this reason, Wintringham has a strong focus throughout all service streams on effective behaviour management techniques and understand the need to take things slowly to establish trust between the consumer and our services before we can make a meaningful difference and be sure that our assistance will be accepted. Wintringham can demonstrate that often, for the first time ever, we are able to offer our consumers a permanent exit from homelessness. Out of our 1400 clients there is virtually no history of recidivism once they connect with a Wintringham service. While it could be argued that our experience is not in the mental health field, we would counter-argue that people with a psychiatric illness form the bulk of our clients and that the silo nature of services has led to them slipping through the cracks' of the existing system leaving the care of their mental health needs largely in our hands unless a crisis occurs. "

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
"There does not seem to be a clear pathway into mental health services, nor properly resourced support services pre a crisis occurring. There is a desperate need for a properly funded and resourced supported housing solution for many with long term unstable mental health illnesses. We rely on philanthropic funding and contracts with other special needs groups to try to cobble

together enough staff to properly care for those in our SRS and Residential Aged Care Services with ongoing low-grade mental health illness. We are aware that for many who need long term support due to mental health illness, an SRS is the only option. However, SRS's have minimal staff and few have adequate or appropriate training to help a person with a mental health illness. While Residential Aged Care Services have more staff, they are not staffed or funded to provide the one-to-one intervention that can support a client with a low grade mental health illness and stabilise their lifestyle. Staff see the emerging crisis, over and over again, it seems that Mental Health services cannot engage until the crisis hits. Even when engaged, the only options are inpatient treatment, followed by case management, there seems to be no avenues to fund psycho social support despite this now being the treatment of choice. We also have a number of clients living in the community with little to no support and have had similar difficulty getting mental health to engage with them. The case study below is an example of the kinds of problems we find when trying to get help for a distressed person: Case Study Ken (not his real name) was living in his own unit in the community. He started to become paranoid and fearful and realised that he needed help. With the help of his case manager he contacted mental health services on a number of occasions and was eventually admitted to hospital. He was discharged, against his will, asking for help but being told his was a personality disorder and there was nothing that could be done. He was discharged with no future plans in place and no strategies to help him manage his increasing fear and paranoia. He thought that he could burn the problems to make them disappear and so, when his thoughts became too upsetting, he started to light little fires. Two days post discharge, he lit so many little fires that they joined into one huge conflagration which burnt his and another two units in the block to the ground. He was admitted to the local mental health unit and it was agreed he would not be charged for his crime due to his mental health illness. This time on discharge, he was moved into an SRS. Six months on, he is again fearful and paranoid, it is hoped that somehow, with one staff member to every 30 residents during the day, the SRS will be able to keep Ken and his fellow residents safe, however, it is also likely that he will soon be asked to leave and he will have nowhere, appropriate or safe to go to. It must be very frustrating for mental health services and certainly is a frustration of ours, that services seem to be withheld until a real crisis occurs. We have often referred clients when we see a crisis approaching but, like Ken, their mental health illness only seems to be recognised once the crisis has occurred. If Ken could get help now, he might retain his housing and his health and well-being. Further to the above, there seems to be little in the way of practical help we can get to provide group or one-to-one interventions with clients in order to effectively provide a psycho social intervention which will often reduce the need for medical intervention. Most help available is around advice and assessment ? so you get told what to do in order to help each person but not given the resources you need to put these plans in place. Properly resourced and staffed mental health accomodation - dedicated and appropriately staffed to support those with Mental Health illness, could be the solution to this problem as could appropriately funded care packages that could follow the client and enable them to purchase the hands on help they need before the crisis hits, and remain living safely in the community. While the argument here is run from a Provider's point of view, we know that the clients we support would choose the option of appropriately supported housing or a packaged care service to help them to better manage their own health and well-being. It is truly tragic when you work closely with a person who is desperately seeking help but the help they are looking for is not there. "

What is already working well and what can be done better to prevent suicide?

N/A

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

"We have found there to be two major factors which create barriers to mental health treatment, the first, mentioned previously, is the inability to access services prior to a crisis and lack of services for those who have a low grade mental health illness that is long term without going into a crisis period, but the second is the silo nature and variances of the services that currently exist which create many barriers, both geographic, age related and especially make access very difficult to those who have a complicating factor to their presentation (ie alcohol dependency or acquired brain injury). A person receiving mental health support who moves from one side of Melbourne to the other is not able to have ongoing support - they must wait and be reassessed by a new (to them) service in their new area and seem to have to reach another crisis before being accepted for service. Similarly, in one Western municipality, mental health services for people under the age of 65 have refused to provide assistance to a long term mental health patient as he is living in a nursing home. At the same time, the aged care mental health team have refused service due to his age. The fellow is 62 yrs old. Is this type of red tape really necessary? What has resulted is a person in desperate need unable to access services, yet, in another Southern based suburb, mental health services are freely available, from the appropriate service, for those under 65 years living in a residential aged care service. There also appears to be some distinct differences between aged mental health services, with some, in some regions, able to access in patient treatment and other apparently not as well resourced in this way. We continue to receive referrals of those who have a complex presentation most often around a dual diagnosis. In these situations, we are constantly blocked for help and stuck in a rotating hand ball between D&A services and mental health with each saying the client does not fit their service and is the responsibility of the other. In 2002, The Department of Human Services initiated a project titled, Responding to People with High and Complex Needs Project' in response to concerns raised by service providers, clinicians, carers, The Office of Public Advocates, police, magistrates and others on the difficulty of providing services to a group of people with complex needs. Factors considered in defining complex needs' included mental illness, intellectual disability, acquired brain injury, physical disability, behavioural difficulties, social isolation, family dysfunction and drug and alcohol misuse. There was recognition that these people often move between services due to the absence of cross-jurisdictional case management or funding structure or because they failed to meet organisational eligibility criteria resulting in the inability or unwillingness to provide the appropriate level of care. In 2019, these frustrating, siloed and restrictive practices remain a problem. "

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

"Hoarding Hoarding is a mental health condition that encapsulates some of those key inadequacies in our existing system - it is a slow burning condition that rarely reaches a crisis and so, is rarely considered for mental health treatment. Ignorance around hoarding often sees a mandatory clean of the hoarder's possessions, which has, on occasion, resulted in the suicide of the hoarder who sees these things that are of high value to him or her being callously disposed of. This is an example of one type of mental health condition that never seems to cross those invisible barriers that render a person eligible for support. Case Study Len (not his real name) is an elderly, frail man. Len lives alone and has, for many years, had little to no contact with the world in

general. Len is financially destitute and a hoarder. Len's hoarding is so extreme that Len lives in squalor. When we first visited Len, it was extremely difficult to enter his home. Len had accumulated so many things; there was no access or egress in or out of the house unless you made your way precariously over the piles of accumulated goods. Len himself, was sleeping in the only clear area in the house ? the shower cubicle and was in poor health. The risk to Len was huge ? the Melbourne Metropolitan Fire Brigade advise that 24% of those who perish in household fires do so due to the accumulation of goods in their houses which block their exit in the event of a fire. In other words, hoarders represent a disproportionate number of those who die in household fires. The apparently randomly accumulated and stored goods create a huge fireload, meaning that a hoarder's properties will burn much more quickly and more intensely that a normal household fire. Len himself, distrusted the medical profession as a whole and had not visited a doctor for many years. He did not have running water, gas or electricity connected to his property and was not eating properly, able to wash himself or his clothes (which were rarely changed). For us, he presented a huge challenge. Research tells us that a simple industrial clean of the house will not solve the problem. In fact, one big clean up can result in immeasurable personal problems and the accumulated goods nearly always return and often in greater numbers. While to us, his property resembled a tip, with rubbish everywhere, to Len every item he had collected was valuable and provided him with memories and meaning to his life. We were advised to pursue a slow process, working through all the accumulated goods with Len and sorting them into three piles ? those to be disposed of, those to be kept and those about which Len was undecided (should they be kept or disposed of?). Of prime importance was clearing spaces to allow safe exit from the building, fitting smoke detectors throughout the property, provision of an area in which Len could sleep, re-establishing utilities to the property and clearing areas for cooking and washing. We could not find any funding which would support this project ? money from Philanthropy was used to provide the equipment, furniture and goods needed for this purpose ? including items such as smoke detectors, storage containers and appropriate bedding mentioned above. Philanthropy also provided funding for the Psychologist who initially supported Ken to help him engage with the process of making his unit safe and letting go of some of his treasured items. There is no ongoing service available to support Len or provide treatment for him to try to assist him to better manage his mental health. "

What are the needs of family members and carers and what can be done better to support them?
N/A

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
N/A

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?
N/A

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
"The key areas where we would like to see change: 1.) Provision of supported housing for those

with long term mental health illness 2.) Provision of a support package of funding to those with long term mental health illness that would enable them to afford to acquire needed supports including ongoing psychology services and practical, hands on one-to-one or group therapy. 3.) Funding of group services designed to reconnect clients to community alongside appropriate course and qualified staff to run such services and to provide one-to-one support when group work is not appropriate. 4.) Funding to provide appropriate supports for Hoarders 5.) Education and resources to help understand what you should do for someone with a mental health illness, not just those in crisis as per Mental Health First Aid, but those who have an ongoing, low level condition."

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
N/A

Is there anything else you would like to share with the Royal Commission?
N/A