mental illness fellowship victoria

CALL TO ACTION

Victoria State Election 2006

"We call upon all political parties and all candidates seeking office at the next Victoria state election to state how they will achieve better outcomes for people with a mental illness, their families and friends, in particular, what new money they will commit to addressing the needs for reform of the mental health system?"

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A member of Mental Illness Fellowship Australia

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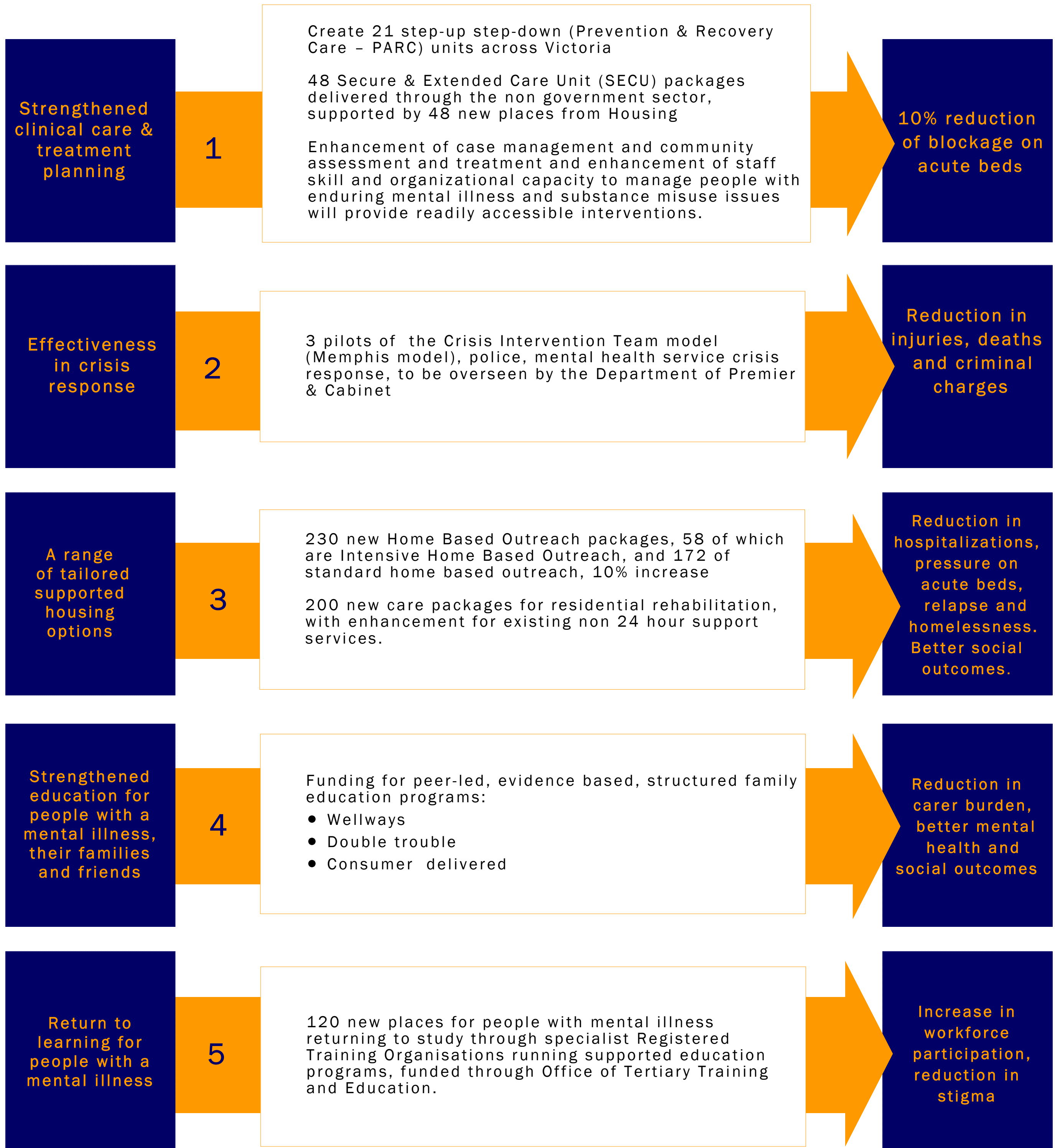
MI Fellowship calls on the next state government to increase spending on mental health to 12% of the total health budget. Victorian spending has traditionally led the nation, but WA now spend $119.00 per person compared with Victoria's $107.00 per person. The new money will help to redress some of the shortcomings of the current system. MI Fellowship calls on commitment to the following sets of measures:



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Strengthen clinical care & treatment planning

1

"More psychiatric beds in hospital, more CAT teams and a place where psychiatric patients can go from hospital before going home" Carlo, MI Fellowship member

This statement is a common solution to an intolerable burden. MI Fellowship believes that creating new acute beds will not fix the problem. Rather, taking the pressure off acute beds through investment in step-up step-down facilities and community based Secure & Extended Care Units (SECU) managed by the non-government sector will ease the blockages to acute beds. MI Fellowship calls on the next state government to address these gaps with the following measures:

Clinical care and treatment planning needs strengthening both by increasing the capacity of clinical services and by ensuring continuity of care in acute treatment. The current pressure on acute beds has resulted in inappropriate early discharge, a lack of continuity of care, a 'revolving door syndrome' and a huge burden on families and the community. All this contributes to greater community stigma and poor outcomes for people with mental illness.

Investment in 21 step-up step-down (Prevention & Recovery Care – PARC) units across Victoria will alleviate blocks in acute units, provide better, timely access for acutely ill people, strengthen continuity of care and reduce community dissatisfaction. It will provide community treatment options in less expensive and restrictive settings. Early access will prevent people from becoming more acutely unwell and using more expensive services for longer, and will provide more acceptable and less stigmatizing treatment.

A small number of secure extended care beds exist to provide treatment to the most disabled, potentially dangerous people with severe and enduring mental illnesses. The Community Care Units (CCU) were created to manage people with severe and enduring mental illnesses not requiring secure facilities. To effectively treat people with this severity of illness and disability, average lengths of stay of 12 to 24 months were planned. These facilities have become blocked because there are inadequate post-discharge highly supported services available, resulting in acute beds being used to house this group, putting more pressure on the system.

The creation of 48 new Secure & Extended Care Unit packages delivered through the non government sector will increase bed capacity in SECU or Community Care Units by 48.

Investment in 48 intensive community treatment and support packages developed across the state will alleviate these bed blocks. This equates to 10% of the current SECU and CCU beds. Investment from Housing in 48 new places is required to support this initiative.

Where clinicians have case loads in excess of 20, the ability to treat and follow-up in an effective timely manner is compromised.

Enhancement of case management and community assessment and treatment and enhancement of staff skill and organizational capacity to manage people with enduring mental illness and substance misuse issues will provide readily accessible interventions.

Effectiveness in crisis response

2

"People with mental health problems are being put into a prison rather than a treatment facility when convicted of an offence. People who are clearly mentally ill are being charged with offences committed whilst affected by their mental illness". John, MI Fellowship member

This statement echoes the many concerns of MI Fellowship members in Victoria (and indeed across Australia) and is documented in multiple reports.

The mental health crisis assessment and treatment (CAT) teams were developed nearly 20 years ago. Their role was to meet the needs of people who had a mental illness when they had a crisis, by assessing and treating the conditions they encountered. They were expected to be available 24 hours per day. The community has come to expect this access and this expectation is not met.

A potentially dangerous situation now exists where families delay calling for assistance when they cannot access a CAT team, which too often results in an escalation of illness symptoms and treatment refusal. Most families are reluctant to call the police as they fear harm will come to their family member. Most police feel untrained and unskilled in dealing with the acutely mentally ill and believe that the CAT teams should be available to them to manage this situation, but this is too often not the case.

The current interface between the mental health service and police services has not been able to address these difficulties.

The Memphis model acknowledges the police's role in maintaining community safety, the treatment and assessment role of the mental health service, and the perspectives of people with a mental illness and their family members. This established intervention has resulted in large reductions in people with mental illness being jailed and injured and has improved timely mental health interventions. It has significantly reduced police injury and has improved community satisfaction.

Investment in three pilots of the Crisis Intervention Team model (CIT Memphis model) with proper evaluation will provide a way forward. It is vital to the success of the model that each of the major stakeholders – police, mental health services and consumers and carers - have ownership of the program and therefore these pilots should be overseen by the Department of Premier & Cabinet.

To facilitate effective police and mental health intervention in a timely way as practiced within the CIT model, additional investment in assessment and management of people with a mental illness will be required in emergency departments.

Investment in physical modifications and augmentation of clinical assessment capacity in the emergency departments of the 3 pilot areas.

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Provide a range of tailored supported accommodation options

3

"The lack of appropriate housing and support options for people with a recognized chronic condition or a dual diagnosis often creates a cycle of homelessness and inappropriate care for people with a mental illness." Catherine, MI Fellowship member

These statements describe the effects of non-tailored accommodation and cost the system heavily. Without appropriate housing options, people with mental illness end up being admitted into the most expensive part of the mental health system – the acute inpatient unit – or end up in jail. Supported accommodation is more than a house. It is a place to live with the supports to stay there and connect meaningfully into the local community.

To ensure that the whole system works, that bed blockages are effectively dealt with, we call for the following investments.

Home based outreach support brings support into a person's home and may be at a standard or intensive level. A unit of intensive support provides five people with high level support to live in the community. Often these people lack skills to live in the community and do not adhere to treatment. Without this support, an individual is likely to relapse and is likely to require more expensive treatment interventions. A unit of standard home based outreach provides less intensive support for ten people.

Investment in 230 new Home Based Outreach packages, 58 Intensive and 172 Standard, a 10% increase on current funded places.

Some people are unable to manage in the community with the level of support provided by home based outreach services. These people experience severe and enduring symptoms. They do not meet the criteria for SECU or CCU. They form a sizeable component of the homeless community or are living with parents who are expressing deep concern about accommodation options as highlighted in the lead- in comments. Because of their lack of skills and treatment adherence, they often have multiple admissions to the acute inpatient unit and regularly disconnect with treatment. An intervention within this setting may be for one to two years and some longer. The creation of such a capacity will lead to a net annual gain of acute beds across the state.

Investment in 200 new care packages for residential rehabilitation, with enhancement for existing non 24 hour support services.

Strengthen education for people with a mental illness, their families and friends

4

"Through Wellways I gained knowledge and understanding especially through interaction with group members ... I have learnt a lot and feel more confident in dealing with my son's illness." Lillian, Wellways participant

This statement underpins the expectations that families and people will illness are experts in dealing with mental illness even though they have no previous knowledge or experience. Frequently the family or individual is blamed for its poor coping behaviour and unsuccessful strategies in managing the mental illness. It is no surprise that people become stressed, depressed, burdened, isolated and unable to continue to work and contribute to the community as they once had. Providing information, structured, evidence-based interventions can change people's perceptions of mental illness.

There is clear evidence to show that when families gain knowledge and their coping strategies improve, there is frequently a positive benefit to the person with a mental illness.

Structured interventions have a demonstrable effect on individual and family stress, improving people's ability to cope with the burden and with depression and anxiety. Further, they provide pathways which enable an understanding of the mental health system that assists appropriate and effective service access.

Professionally supported peer-led programs assist the carer or consumer peer regain control in their lives by acknowledging and validating the lived experience of the mental illness within their family, they augment individual clinical delivered family services (where they exist) and they reduce isolation and build effective community engagement pathways. They are also highly cost-effective interventions.

Investment in the delivery of evidence based, peer-led, structured family and consumer education programs

- *Wellways*
- *Double Trouble*
- *Pathways to Recovery (for consumers)*

Return to learning for people with a mental illness

5

"Certificate in General Education for Adults (CGEA) course run by MI Fellowship helped my communication skills and the teacher made a real effort to understand the difficulties I might be having with my studies." CGEA Participant

Less than 50% of people with severe and enduring mental illness complete their secondary education. The impact of this on a person's life is that employment is unreachable. A proportion of people with these illnesses also try to access skills-based courses through TAFE and do not succeed within this setting.

Currently a small number of places specifically designed for this population are available, most of which are unable to be fully funded within the dollars allocated to the non-affected population. MI Fellowship have had 30 graduates in the past two years. 60% of this group have been able to go on to work, further education or other active community roles.

120 new places for people with mental illness returning to study through specialist Registered Training Organisations running supported education programs, funded through Office of Tertiary Training and Education.