

**FAMILY AND COMMUNITY**

**DEVELOPMENT COMMITTEE**

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**MS M. WOOLDRIDGE, Member**

**INQUIRY INTO SUPPORTED ACCOMMODATION  
FOR VICTORIANS WITH A DISABILITY OR  
MENTAL ILLNESS**

**Witness:**

**MR EUGENE MEEGAN**  
**Continuing Care Team, Mobile Support Team**  
**& Youth Early Psychosis Team**  
**for the**  
**Bendigo Psychiatric Service**

**BENDIGO**

**WEDNESDAY, 19 NOVEMBER 2008**

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THE CHAIR: Thank you very much. Yes. I would like to call up Mr Eugene Meegan

MR MEEGAN: Eugene.

THE CHAIR: Yes – that's you, is it? Sorry. You were here for some time, so I'm not going to go through the introductions, so please introduce yourself for the Hansard.

MR MEEGAN: Yes, my name is Eugene Meegan. I'm the manager of the Continuing Care Team, Mobile Support Team, and Youth Early Psychosis Team for the Bendigo Psychiatric Service. Bendigo Psychiatric Service provides mental health services for people with severe mental illness throughout the Loddon Mallee Southern and Campaspie region, and we cover the towns of Kyneton and Castlemaine, Greater Bendigo and Echuca and Swan Hill and a myriad of other small towns in between. We provide services for all ages, but my position covers the adult community case-managed clients in the greater Bendigo area. People with severe mental illness - and I apologise that I haven't presented you with a submission earlier, but someone just rang me this morning to say this has happened, so for some reason there has been a communication breakdown – people with severe mental illness and associated disabilities have got a range of needs.

In relation to housing, their housing needs are not dissimilar to the needs of the rest of the community. Those with disabilities have a range of support needs. Some have very minor support needs and some have major support needs, and the housing provision needs to be titrated to the individual's particular circumstances and particular manifestation of illness. I'm mindful of a client who once brought to my attention that what he wanted was to live in a flat. In association with others without interference from outsiders. But, because he suffered from mental illness, he knew that he had to have others involved. What the mental health providers wanted him to do was to live in a six-room accommodation. He put it to me that I wouldn't be able to cope with living with five other people with mental illness, and we expected that he could do that, and he's suffering from mental illness, which is a very telling comment.

A high proportion of our clients abuse substances, and that is very common amongst people with mental illness, either to attenuate symptoms or simply to – sometimes, these substances actually cause the mental illness or make the mental illness worse. So in terms of the residential options that people with mental illness suffer – and I said initially we treat people with severe mental illness, that's only about one per cent of the population, but 18 per cent of the population have mental illness, and so the population we're looking at is the low prevalence disorders, that's mostly the psychotic disorders, schizophrenia and various kinds of psychosis including bipolar, affective disorder, and severe personality disorder.

The rest of the population are mostly catered for by the private sector and by GPs and by some of the newer Commonwealth programs, but in the main, the component of the population we're looking at are those people who would have previously been

in institutions and who are now living in the community. The range of services we need for that group of clients goes across the spectrum. At the moment, what we have in Bendigo is two special – two SRSs, one of which, Lansell Lodge, which is going to be closed by Friday, and so we've had a major issue in the relation to the closure of Lansell Lodge in relocating some of our clients, and we've been able to locate some of them into other SRSs, but they've been out of area.

We've had – one client has had to go to Melbourne, had several go to Lansfield, and some have gone to Maryborough, and they generally would prefer not to move out of Bendigo. Some others have gone into rooming houses and for some, we've had to negotiate a variety of HACC services to support them. There have been concerns expressed by the department that these clients are now beyond the purview of the community visitors. It is a concern that this has taken place, but there has been no other option.

In the past, we've had difficulty getting people into accommodation within the catchment area, so we've had to look elsewhere. We've sometimes had to look to Shepparton area, and much to the chagrin of the Mental Health Service there, who seeing us as shifting our responsibilities, but when people need these supported accommodation services, they need them. Then we have – next down the ladder is CCU. We've got 12 beds of a CCU at Vahland House and eight beds in Secure Extended Care which is essentially a locked unit. Then for residential rehabilitation services, we have the MIND service at Solomon Street, which was discussed before.

It caters for people from 15 to 24 years of age, and provides a great service for that group of people, but we don't have that kind of service, that kind of residential rehabilitation service, for people in the older age groups above 25. In Melbourne, there are a range of residential rehabilitation services, but they've got a bigger population, so they do have access to those services. I've approached some of the services in Melbourne which are targeted to specific sub groups, but they preference people who live in their own locality, and then they want people to go for assessments and maybe several visits, and it's an onerous requirement for people with a psychiatric disability to travel to Melbourne for these assessments, and they may well get knocked back, and so it generally doesn't happen.

We then have crisis accommodation, sometimes even discharge from our inpatient unit – we're discharging people to caravan parks, Dower Caravan Park, which is no great accommodation. We are grateful for it, but it's not the sort of place that you'd want to send someone that you were related to or cared about. And we sometimes send people to local hotels and motels for crisis accommodation. Sometimes they're managed by a CAT team in those accommodations. And some of those proprietors are ambivalent about providing accommodation to our clients, because some of them have behaved badly in the past and created a bad reputation for the rest of our clients..

Other accommodations, supported accommodations provided by Loddon Mallee Housing and by St Lukes, which are the two PDRSs in the area, and they can be quite good. They provide an excellent service, but one of the difficulties with the

PDRSs is their philosophy of providing a client-centred service sometimes extends to hearing what the client says and acting on what the client says, and sometimes what the client says is based on an inability to test reality or an inability to understand their circumstances or to have insight, which is a core component of the severe mental illnesses. Often our clients don't have insight, they don't understand they've got an illness, they don't understand the consequences of their action, so they'll say, "I don't need a service," and if they don't – if they say they don't need a service, then the PDRSs feel obliged to withdraw, and the service is withdrawn, and then some time down the track, the client will stop taking medication, they'll deteriorate, then they'll present in a crisis, and then they'll look for admission to the psychiatric inpatient unit, and then we'll pick them up again.

But the problem with that is every relapse is – there is research to support the view that every relapse is toxic. So there is a neurotoxicity associated with a relapse, and so this is something that we've not been very good at working at. In response to this the Mental Health Service has placed a worker one day a week with St Lukes as a liaison and one day a week with Loddon Mallee Housing so that we can improve our dialogue and maybe help staff to be more understanding of those needs, and understand the fact that the natural history of conditions like schizophrenia is that if people don't take the medications, within the year, 80 per cent of them will have a relapse.

If people do take the medications, every medication, within the year, only 20 per cent of them – no, 12 per cent of them – will relapse. So medication is very important, but whether it's aspirin or antibiotics, people generally prefer not to take medication. People who have no insight into the fact that they've got an illness are even less reliable in taking medication. We need to have systems that allow some degree of paternalism in following people up assertively in the community without grossly controlling their lives or interfering with their ability to get on with life.

Clients tend to withdraw from the services. With deinstitutionalisation – I was certainly a big supporter of moving people away from the institutions where they suffered from institutional neurosis and there were various other problems and inefficiencies, but having said that, there were positive benefits in institutions in that staff could pick up early warning signs of deterioration and intervene early. They could monitor risks. They could encourage people to take medications or to engage in activities, which people need to do. They need to engage with others. They need to be involved with a range of activities whether it's occupation or recreation.

Staff could monitor whether clients were attending to their activities of daily living, if they were washing and so forth. Often subtle changes in behaviour are an early warning sign that somebody is deteriorating. The sleep pattern and so forth, they could monitor that, and that is another very sensitive sign. Often families provide these benefits, but many of our clients don't live with families. It's good for the individual to develop as an individual by moving away from family. Many clients have destroyed their relationship with their family, sometimes because of drug and alcohol abuse and sometimes it's because of manifestation of mental illness.

And typically, what you see is people move from families, they usually move into inner city areas. This is a phenomena across the world known as the social drift theory. Clients often have their first psychotic episode when they're living in a rooming house, usually somewhere like Fitzroy or Footscray. It could also be somewhere in Bendigo, because they move from rural areas to Bendigo. Others move from the outer suburbs of Melbourne into inner city areas, and the reason they move in there because of the anonymity, tolerance, public transport and cheap housing which is there. There are services, often there are food parcels and so forth available in the inner city, and there are open spaces and beaches and places where they can sleep, and unfortunately within that environment, there is also a lot of drug taking, and a subculture that is destructive for the individuals. There is a lot of crime and they tend to get drawn into that scenario.

I did mention this earlier, the lack of – limited residential rehabilitation. In central Victoria there is also a lack of places where people can go for drug and alcohol rehabilitation, and in some of the residential rehabilitation places, one of the exclusion criteria is a person is not using drugs and alcohol. It's a catch 22 for that group of people, and as I say, the majority of my clients do use substances. Even if they are saying they don't, there are many, many studies that have been done that have taken blood samples from everybody that has come into an inpatient unit, and they find that there is a big range of substance abuse.

Marijuana being a principal one, it's a very common drug of abuse, partly because it attenuates symptoms, it helps people to calm down, but unfortunately it causes more paranoia and hallucinations. Clients don't have insight into the relationship between substance use and the increasing in their psychotic symptoms. I have to cut my story short, because as I say, I'm not very well prepared. There are a range of other issues in terms of providing social support, structure, vocation, engagement with the community and all of these really help people to stay well. People who are engaged with the community do much better than those who are allowed to sit in a back room and merely hallucinate while looking at the wall.

There is another subgroup of people with intellectual disabilities and mental health problems, and they tend to be extremely complex because of the interaction between the two conditions. We have had some very good successes working collaboratively with the DHS around some particularly difficult clients. We've also had a lot of problems deciding who's got responsibility. Is this behaviour to do with intellectual disability? Is this a manifestation of a psychiatric illness?

And one of the big problems there is finding appropriate accommodation, and the department has sometimes expended large amounts of money in developing one-off responses for particularly difficult clients who were doing outrageous things in the community. And often we see that other areas, other rural areas, will say, "No, they're too complex for us," and the end point is Bendigo. While we've had some good successes, we don't have a ready solution for that sort of complexity. Thank you very much.

THE CHAIR: Thank you very much. That concludes our open public hearing. We have another witness who would like to make an in-camera presentation, so I would ask you to respect her wishes and please vacate the room. If anybody wanted to make a written submission, feel free to do so. Thank you very much for your presence.

**ADJOURNED**

**[1.21 pm]**

**CONTINUED IN TRANSCRIPT-IN-CONFIDENCE**