CHAPTER 8

INPATIENT AND CRISIS SERVICES

> One thing I came to understand clearly over these years of dealing with and talking to the crisis teams and the staff of the mental health centres is that the system is so under-resourced that they must deal with the life and death cases first and other cases necessarily come second. This is a brutal reality which should not exist in a civilised society.[1]

8.1   Mental health inpatient and crisis services are under significant strain. Witnesses to the inquiry despaired at the absence of treatment or other interventions in all but the most immediate life-threatening situations. There was a clear call for increased resources to meet current needs, to improve service availability and standards of care.

8.2   The committee received many harrowing personal stories from consumers, carers and others about inpatient treatment experiences and mental health crisis situations, in some instances leading to tragic deaths. Many expressed their frustration and anger. Others expressed despair. Some submitters had seldom told their stories before, feeling alienated and stigmatised because of their circumstances. The committee appreciates the great effort and courage they showed in giving evidence to this inquiry.

8.3   Other contributors had told their stories before, many times. They commented that the same issues have been presented over and again in different forums.[2] The committee appreciates the determination these submitters show by continuing to contribute their experience, knowledge and ideas to help improve mental health services and ultimately the lives of those experiencing mental health problems.

Mental health care in an age of deinstitutionalisation

8.4   Care for people experiencing severe mental illness has undergone a revolutionary transformation over the last few decades. Australia had around 30,000 acute care psychiatric beds in the 1960s. The number of public beds had fallen to around 8,000 at the time of the development of the National Mental Health Strategy (NMHS), and is now around 6,000.[3] This decline was driven by several factors[4]:

---

1   Name withheld, *Submission 375,* p. 8.

2   See for example, Ms Isabell Collins, Director, Victorian Mental Illness Awareness Council (VMIAC), *Committee Hansard*, 5 July 2005, p. 72.

3   Australian Government, *National Mental Health Report 2005*, p. 38.

- Changes in views about human rights, treatment and care for people experiencing mental illness

- Improvements in treatment for mental illness, particularly through new pharmaceuticals

- Effective antibiotic treatment of syphilis, avoiding the need for psychiatric hospitalisation in advanced cases of the disease

- Evolution of specialised aged care facilities that could manage geriatric illnesses, particularly dementia

- Creation of specialised institutions for people with intellectual disabilities, and

- Audits and reviews of stand-alone psychiatric institutions that were highly critical of the care they provided.[5]
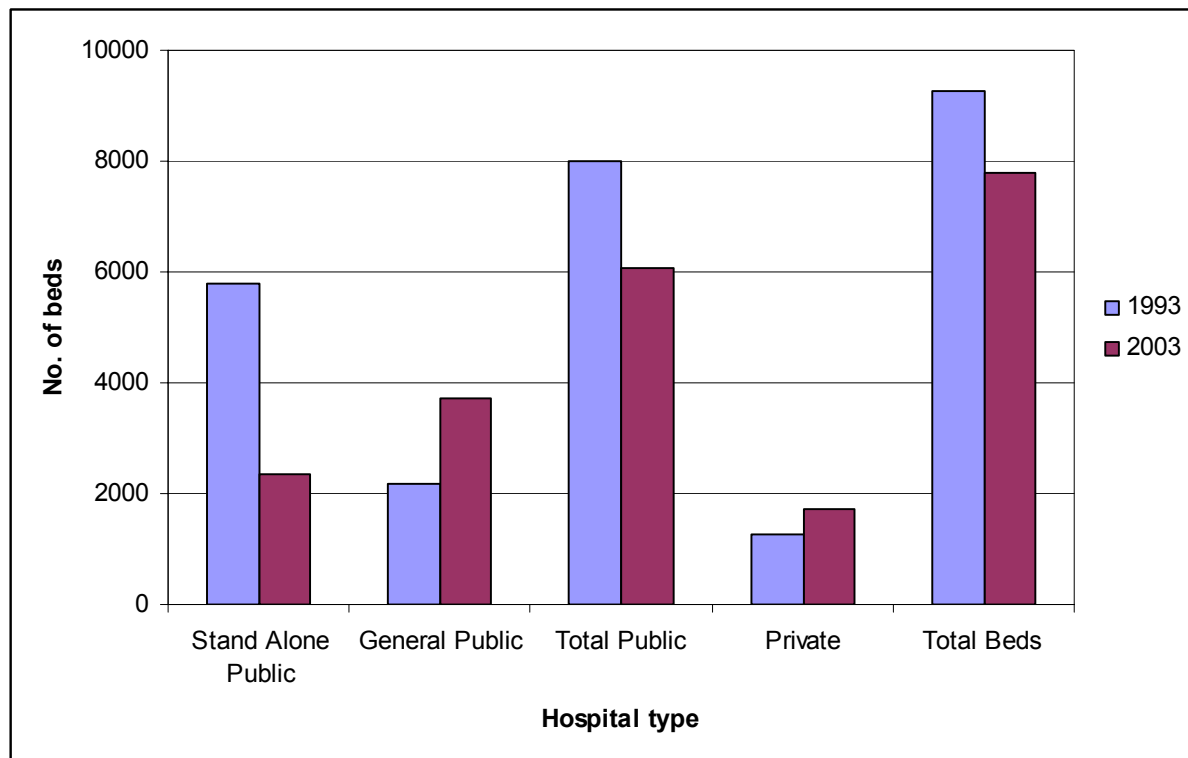
8.5   The closure of stand-alone psychiatric institutions is often referred to as deinstitutionalisation.[6] Figure 1 shows the change in beds over the last decade, and demonstrates two key trends: the shift in beds from stand-alone facilities to general hospitals; and the decline in the total number of beds, as more care takes place in the community.

---

4   Australian Government, *National Mental Health Report 2005*, p. 38; K. Richmond and P. Savy, 'In Sight, In Mind: Mental Health Policy in an Era of Deinstitutionalisation', *Health Sociology Review*, vol. 14, no. 3, 2005, p. 217.

5   See for example, Victoria. Office of Psychiatric Services, *Audit of Standards of Treatment and Care in Psychiatric Hospitals in the State of Victoria*, 1992, Health Department Victoria, Melbourne.

6   The committee recognises that closure of institutions does not occur in isolation, but in conjunction with development of other modes of care.

Figure 1: Number of psychiatric hospital beds[7]

8.6   While deinstitutionalisation has meant closure of many stand-alone psychiatric institutions, this closure has not happened in isolation. It was meant to operate hand-in-hand with two parallel developments: *mainstreaming*, involving the location of acute psychiatric care facilities at general hospital sites; and the *expansion of community care*, ensuring that people no longer in institutions have adequate care in their communities.

8.7   However, there is a general sense that mainstreaming and community care have not kept up with the pace of deinstitutionalisation. There are widespread problems with adequate accommodation, quality of care in the new settings, and perhaps most clearly of all, problems for people in gaining access to care in the new environment.[8] In this environment, it is not surprising that the current policy direction is sometimes called into question. The strong consensus that continues to exist around deinstitutionalisation may be threatened if the policy is not fully and properly implemented and community-based services significantly expanded. Much of the disenchantment with the current system crystallises around experiences of acute care, but as this report shows, the answer lies in improvements in every level of care and a great deal more emphasis on community-based services than is currently the case.

---

7   Australian Government, *National Mental Health Report 2005*, pp. 120, 160.

8   V. Gerrand, 'Can Deinstitutionalisation Work? Mental Health Reform from 1993 to 1998 in Victoria, Australia', *Health Sociology Review*, vol. 14, no. 3, 2005, p. 265.

8.8   This chapter sets out the issues in relation to the care people seek when acutely ill. People experiencing acute mental illness now usually seek access to one of three types of service: hospital inpatient services; emergency departments; or crisis assessment teams.

Inpatient services

Pressure on acute care places

8.9   Witnesses reported that unless a person experiencing mental illness is considered to be a threat of immediate harm to themself or others, there is little chance of their being admitted to hospital.[9] Some of the most devastating evidence presented to the committee told the stories of those who knew they had become unwell, had tried to seek hospital admission, been denied and subsequently sought to harm themselves or others.

> There were many instances of death or injury that were easily attributed to not being admitted. A patient in Nepean Hospital was placed on leave, while trying to settle over the weekend, and on returning to the hospital unsettled, to his promised bed found it had been filled. He went home and killed himself and others in the family.[10]

> One parent for example rang in saying her son had gone three times to the local community mental health service and was repeatedly sent away. The parents took him once and the Doctor on duty asked him if he was going to kill himself. When he answered no the doctor said there was nothing wrong with him and sent him away. He then drove his car through the hospital front doors and was subsequently admitted for three days.[11]

8.10   A number of state government submissions to the inquiry acknowledged the pressure on inpatient mental health services. The Victorian Government stated:

> In Victoria, the current operating environment is one of sustained demand pressure. There are a number of inter-related issues that place pressure on the mental health system including growing demand, and increases in complex and involuntary clients. Their impact is most evident in two key aspects of the hospital system: adult acute beds and hospital emergency departments.

> Client growth of more than 7 per cent per annum over five years has led to services operating over capacity, as evidenced by high community caseloads and chronic acute bed blockages, with 9.6 per cent of patients staying more than 35 days. This has resulted in crisis driven services responses, difficulties with service and bed access, 'revolving door' clients

---

9   See for example, Brotherhood of St Laurence, *Submission 97*; Mr Graeme Bond, *Submission 484*.

10   Associate Professor Brian Boettcher, *Submission 1*, p. 4.

11   Mental Health Association of Queensland, *Submission 312*.

(15 per cent each year) and a significant impact on other social policy areas.[12]

8.11   In New South Wales:

> The level of psychiatric distress and disability in the community is rising. Reasons for this change are poorly understood but may include broad social changes, changes in social supports and social capital, increasing inequality, and changes in patterns of drug use. Available resources have not kept up with increased demand. Across Australia there are problems with access to acute care, continuity of care and the availability of coordinated and comprehensive community support. A time lag exists between recognition of increased demand and construction and commissioning of new units and the development and implementation of community based programs.[13]

8.12   This analysis is supported by other reviews of mental health services, such as the *Not for Service* report,[14] the South Australian Legislative Council inquiry,[15] and the Western Australian Legislative Council inquiry.[16]

The impact of acute bed shortages

8.13   Denying admission can result in ongoing hardship for consumers and their carers. Consumers have in some cases been abandoned to a cycle of homelessness and abuse. The costs of not providing treatment and care when sought, both in terms of quality of life and later need for services, is significant.

8.14   Early discharge from hospital places a significant strain on families, which in turn creates a need for services:

> Discharge from hospital is frequently too soon because of the pressure for beds and carers assume responsibility for the consumer in a state of unwellness. Programs are needed to provide support, information and skills development to enable carers to cope in this kind of situation.[17]

8.15   Individual submissions from carers demonstrated ARAFMI's concern:

---

12   Victorian Minister for Health – Victorian Government, *Submission 445*, p. 3.

13   NSW Health – NSW Government, *Submission 470*, p. 23.

14   Mental Health Council of Australia and the Brain and Mind Research Institute, *Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia*, Mental Health Council of Australia, Canberra, 2005, p. 46

15   South Australia, Legislative Council. Select Committee inquiry into Assessment and Treatment Services for People with Mental Health Disorders, Interim Report, 16 February 2006, http://www.parliament.sa.gov.au/committees/committee.asp?doCmd=show&intID=113 accessed February 2006.

16   Western Australia, Legislative Council. Standing Committee on Environment and Public Affairs, 2004, *A Petition on the Provision of Mental Health services in Western Australia - Interim Report*, Tabled Paper No. 2899.

17   ARAFMI National Council Inc, *Submission 23*, p. 1.

> Severe shortage of hospital beds…results in clients not being admitted to hospital when there is a real need, or being sent home too soon, with no other options. I have been called on the day my son is to be discharged, and without prior warning, been told that I am to come and collect him. When I have show reservations because I felt that he was not well enough, and that I couldn't ensure his safety, I have been given the only other option of having him sent to a homeless men's shelter…[18]

8.16   Carers illustrated the significant cost incurred when patients 'recycle' through the hospital system:

> After being put into hospital, my daughter with schizophrenia was given medication for a few weeks and released, despite the family all pleading with the hospital to keep her a bit longer as it was quite clear to us this medication was not reducing her psychosis. In fact she had to be taken back to the hospital within a week. She was put on another medication and stayed in hospital a while. Then, again, despite still having intense psychotic episodes she was let out – despite our huge concern. Off the record hospital staff told me the reason she was let out was due to a shortage of beds! She had to be re-admitted for the third time around August.[19]

> My son was increasingly unwell for three months. When I asked for help because of the case workers heavy work load they said he wasn't ill enough.

> At the end of the three months he was hospitalized six times in two months.

> He was discharged TOO early everytime because there were 25 beds for up to 600 patients. He suffered unnecessarily and stress on the family was enormous.[20]

The causes of acute bed shortages

8.17   The lack of acute beds has several interrelated causes. While insufficient bed numbers was one factor raised, inadequate community-based facilities appeared to be the central issue. Without intervention programs and accessible community treatment, assistance and support, the symptoms of mental illness can escalate, leading to acute episodes and increased demand for inpatient services.

8.18   Following episodes of inpatient care, a lack of 'step down' rehabilitation services and community supports can make discharge difficult, resulting in longer inpatient stays than necessary. Consequently, patients whose needs could be catered for in a less restrictive community environment are retained in hospital, 'blocking' bed availability for new patients. In other cases a combination of insufficient inpatient beds and inadequate community facilities means that patients are discharged too early into inadequate circumstances.

---

18   Name withheld, *Submission 122,* p. 3.

19   Name withheld, *Submission 55,* pp. 2-3.

20   Name withheld, *Submission 49*, p. 1, emphasis in original.

8.19   The NSW Nurses' Association reported that premature discharge was the most common response to pressure for acute beds. A survey of their members in 2004 found that:

> Prematurely discharging patients was the number one way of dealing with the problem, with 29 per cent indicating this method. Next highest scoring method was keeping them in emergency departments (23 per cent) or general wards (6 per cent), refrain from admitting them (13 per cent), manage them in the community (11 per cent), or transfer them around the state (8 per cent). About 8 per cent also indicated they routinely had mental health patients sleeping on couches or on mattresses on the floor.[21]

8.20   Dr Morris, Executive Director of the Gold Coast Institute of Mental Health, expressed the view that state mental health acts were being misapplied in order to deny admissions, due to the shortage of acute psychiatric beds.[22]

8.21   Several states acknowledged that some admitted patients could be better served within the community, if adequate supports existed. In Queensland:

> A recent snapshot of mental health inpatient beds conducted in December 2004 indicated that 30 percent of patients did not need hospitalisation if other options were available. Similar pictures occurred across most jurisdictions which participated in the exercise. Difficulty in accessing suitable support and accommodation was the key factor preventing discharge. This represents substantial numbers of patients accommodated in inpatient care, effectively blocking throughput and being accommodated, often at acute bed day costs, placing further pressure on systems already operating at maximum level and with finite resources.[23]

8.22   In South Australia:

> The Homeless and Housing Taskforce of the Australian Health Ministers' Advisory Council (AHMAC) draft report titled Australian Mental Health Inpatient Snapshot Survey 2004 indicates that there were 505 patients in 10 mental health inpatient units on Census day in SA for whom immediate discharge would have been possible if more intermediate treatment, rehabilitation support and accommodation services were available in SA.[24]

8.23   In Western Australia:

> The key findings from the 2004 national survey are consistent with the earlier two state surveys and include:

---

21   NSW Nurses' Association, *Submission 391*, p. 4.

22   Dr Philip Morris, Executive Director, Gold Coast Institute of Mental Health, *Committee Hansard*, 2 February 2006, pp. 2–3.

23   Queensland Government, *Submission 377A,* p.19.

24   Department of Health – South Australia Government, *Submission 506,* p. 6

﹣ 53 per cent of patients could have been discharged if appropriate alternative services were available and, of these patients, 56 per cent required both appropriate intermediate treatment/rehabilitation, support and accommodation services.

﹣ 51 per cent could have been discharged if appropriate support and accommodation services were available.[25]

Responses to acute bed shortages

8.24   There was a strong call from witnesses for additional acute care places, to respond to current shortages. However the Committee's evidence strongly suggested that the key cause of acute bed shortages is the lack of appropriate emergency responses; a rehabilitative focus in acute care; interventions at other levels, particularly step up and step down and respite beds; clinical services in the community; and housing and employment supports. Each of these needs strengthening and expanding to reduce the need for acute care over the longer term. The Australian Mental Health Consumer Network recommended:

> That the call for '*more acute beds*' be understood in relation to the lack of alternative modes of service delivery.[26]

8.25   Dr Freidin, President of the Royal Australian and New Zealand College of Psychiatrists said:

> Increasing the number of hospital beds is not the sole answer either. We need to have an adequate number of outpatient and community services across the public and private sectors and these need to be integrated with all other forms of support. We say that most mental illness is treatable, as demonstrated by the increasing body of evidence. The inability of people with mental illness to get appropriate help is one of the main barriers to the provision of treatment. The treatments are available—it is just that the service system does not deliver them.[27]

8.26   Ms Sheelah Egan said:

> … one hears calls for more beds instead of calls for much better treatment in the community and more appropriate accommodation in the community. Inpatient services are expensive, but could be minimised if sufficient resources were put into the more efficient and cheaper community care. (Unfortunately, in the past, community care has been treated as a cheap option. Good community care is not cheap, but it is cheaper, for obvious reasons, than inpatient care.)[28]

---

25   Department of Health – Government of Western Australia, *Submission 376,* p. 7.

26   Australian Mental Health Consumer Network, *Submission 322*, p. 5.

27   Dr Julian Freidin, President, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard,* 6 July 2005, p. 86.

28   Ms Sheelah Egan, *Submission 113*, p. [4].

8.27   The Mental Health Council of Australia acknowledged recent mental health funding increases announced by the Australian Government, but commented:

> …the next step is the most important: to use this funding to build and strengthen the community based primary and secondary care systems which will then take the pressure off the acute and crisis care services.[29]

8.28   The Council submitted that funding for acute care should be limited to 25 per cent of any new funding.

8.29   All state and territory governments' submissions stated that their budgets included funding to improve inpatient services in coming years. In some jurisdictions this funding related directly to inpatient services, in others it related to increased 'step down' facilities, supported accommodation and intensive community support which would relieve pressure on inpatient services.[30]

8.30   In the short term, one strategy being used to lessen pressure on acute care places is increased collaboration between the public and private sectors. The Victorian Government commented:

> Where public mental health services are operating at capacity, it should be possible to make arrangements to use private mental health services. For example, Victoria has purchased acute inpatient beds from private mental health services to manage periods of bed shortage.[31]

8.31   Healthscope Ltd saw opportunities to increase collaboration between the sectors:

> Although the private sector is primarily committed to providing psychiatric services to privately insured patients, the private sector's ability to increase its capacity could be utilised to improve access during periods of bed block. This could be achieved in a number ways:
>
> • Temporary placement of patients requiring acute admission until a public bed becomes available
>
> • Decanting of more stable patients into the private sector as a mechanism of freeing up more acute beds
>
> • Temporary purchase of beds pending capital works
>
> The basic economics of this solution is compelling. A patient cared for in the Emergency Department for 24 hours by an agency nurse will cost $1500

---

29   Mental Health Council of Australia, *Submission 262*, p. 14.

30   Victorian Minister for Health – Victorian Government, *Submission 445*, p. [7]; NSW Health – NSW Government, *Submission 470*, pp 5-6; Queensland Government, *Submission 377a*, p. 19; Department of Health – South Australia Government, *Submission 506,* p. 6; Department of Health – Government of Western Australia, *Submission 376*, pp. 9 and 19; Tasmanian Government, *Submission 502*, pp 7-8; Northern Territory Government, *Submission 393*, pp. 20 and 30; Minister for Health – ACT Government, *Submission 165*, pp 4-6.

31   Victorian Minister for Health – Victorian Government, *Submission 445*, p. 11.

per day, when a bed could be purchased in the private sector for approximately $500 per day.[32]

8.32   The committee supports innovative practices and collaboration between sectors to respond to the pressure on acute inpatient mental health services. However, investment in community-based care is required to provide earlier interventions and in the longer term reduce the need for acute services. The committee notes that in Trieste, where there is strong community care infrastructure, it is rare for all the psychiatric beds in the general hospital to be occupied (see Appendix 3).

8.33   Expansion of community services is not simply an issue of cost effectiveness. It recognises the need to increase people's experiences of mental health and where possible reduce the severity of illness experiences. Rather than investing only in responses to acute episodes of illness, resources are required to, wherever possible, prevent people's mental health deteriorating to a situation requiring acute care. Following acute phases of illness, adequate rehabilitation and support services are required to help promote stability and wellbeing, and minimise the need for readmission.

Long stay care

8.34   While much of the evidence presented to the committee about inpatient services concerned the pressures on short-term acute beds, submissions also canvassed the issue of long-term care for the relatively small number of people who are severely and chronically disabled by mental illness.[33] Witnesses observed that keeping long-stay patients in hospital, because of a lack of alternative services, only contributed to the strain on acute care places.

8.35   In 1992, the National Mental Health Policy recognised that long-term care would be required for some consumers:

> It is recognised that too much resource emphasis is currently given to separate psychiatric hospitals. In some cases it may be both possible and desirable to close them and replace them with a mix of general hospitals, residential, community treatment and community supported services. However, a small number of people, whose disorder is severe, unremitting and disabling, will continue to require care in separate inpatient psychiatric facilities and these facilities will need to be maintained or upgraded to meet acceptable standards.[34]

---

32   Healthscope Ltd, *Submission 82*, p. 2.

33   See for example, Dr Simon Byrne, *Submission 3;* Mr John Clayer, *Submission 532*; Friends of Callan Park, *Submission 250*.

34   Australian Health Ministers, *National Mental Health Policy*, 1992, p. [3].

8.36   However, the committee was told the NMHS has failed to make appropriate provision for the care of these consumers.[35] Dr Simon Byrne outlined the kinds of services needed for chronically disabled consumers:

> …it is possible to foster and develop long-stay wards with a rehabilitation focus. Such services should be co-located with acute hospital wards, partly because of the economies of scale involved in providing the necessary support services and partly because of the need to rotate staff for training purposes and to maintain morale when working with a very challenging group of patients. The long stay services should have a rehabilitation focus and have continuing active links with a variety of community services including community residential services; thus all patients should be regarded as potential candidates for community living, although the work necessary to achieve this may take very long periods of time and may not always be successful.[36]

8.37   Dr Philip Morris outlined a similar approach:

> We are suggesting that we need a substantial build of supported accommodation. This is not accommodation where someone pops in to see a patient once a day or whatever else. This is accommodation that has 24-hour nursing and an appropriate level of support—medical, nursing, occupational therapy and social worker support for patients. If you start doing that, you are getting back to needing clusters of homes. They can be in the community, but they need to be together. You will need to have them together because you cannot have individual services going out because it is not efficient. We will get to something like having properly based facilities that look different to the old mental hospitals but, nonetheless, the services will be brought back to bear in a sophisticated and specialised way. That will take some time. That is where we need to go and that is the glaring omission at the moment: the longer stay accommodation for people who cannot get back to independent care in the community.[37]

8.38   While some submitters vehemently criticised the implementation of deinstitutionalisation,[38] a return to institutional-based care was not generally considered an appropriate or advisable course for patients requiring long-term care. Witnesses pointed to the stigma, isolation and lack of resources associated with institutional care in the past.[39] Reports have highlighted the abusive practices, discriminatory cultures and lack of accountability which occurred in psychiatric institutions. Rather, witnesses to this inquiry described the need for specialised community-based or co-located services designed specifically for the long-term rehabilitation of people severely disabled by mental illness.

---

35   Dr Simon Byrne, *Submission 3*, p. 1.

36   Dr Simon Byrne, *Submission 3,* p. 2.

37   Dr Philip Morris, *Committee Hansard*, 2 February 2006, p. 6.

38   Name withheld, *Submission 518*.

39   Dr Julian Freidin, *Committee Hansard*, 6 July 2005, pp. 85, 93.

Quality and effectiveness of treatment

8.39   The committee received some graphic and alarming evidence about inpatient treatment experiences. Assault and abuse of people with mental illnesses still occurs within hospital settings. Discriminatory and stigmatising attitudes and procedures remain.

8.40   The committee acknowledges that this inquiry has not systematically reviewed all inpatient experiences and that some positive experiences were also reported.[40] However, the committee is disturbed that after many years of reform, abusive and discriminatory practices remain evident. The following contributions reflect some such experiences:

> Another occasion was when the young man's mother and brother visited him and he asked his brother to look at his room. They reached the room to find a large 6ft male lying on his bed. The patient got a shock and was clearly disoriented and went to another room and kicked some blocks around. A nurse brought him back to his room and he appeared very frightened when the nurse ordered a syringe. His brother asked what it was and was told that it was "**like** liquid valium". A doctor and two security men stood over him either side of his bed. Staff asked the mother and brother to leave the room but they chose to stay and in front of those people the patient's pants were pulled down and he went into a foetal position because it was invasive and he was scared, as he had been a victim of rape. The inhumane treatment raises the question of how and what was being done when no family member was present. The patient was then told he could go and have lunch. He left crying.[41]
>
> ......
>
> Seclusion and restraint are used inappropriately and without proper regard to the person. A client of our service was stripped naked and thrown in seclusion for 12 hours when she had a known history as a victim of sexual abuse. Clients report experiences of seclusion, terrified and left alone for long periods of time with frightening psychotic symptoms. Seclusion is used far more on weekends when no programs are available.[42]
>
> ......
>
> Instead the two security guards who arrived jumped me, threw me to the ground and proceeded to beat the living daylights out of me. I was repeatedly punched to the left eyebrow and as I wear an eyebrow ring, punching the metal onto bone was exceedingly painful. I was repeatedly punched to the right cheek bone. One of the guards twisted my elbow as far as it could be and then brought his fist down onto my elbow with maximum force. This was done several times. Both guards also bent my hands back at

---

40   See for example, Name withheld, *Submission 123*, p. 1.

41   Name withheld, *Submission 54*, p. 2.

42   Mental Health Legal Centre, *Submission 314*, pp. 9–10.

the wrist as far backwards as they would go. I thought they were going to break them. I was kicked in the base of the spine several times…I was kicked in the legs repeatedly. I was punched in the chest and stomach repeatedly. One of the guards grabbed my hair and drove my face forward into the ground, hurting my nose. He then pulled my hair back the other way and repeatedly smashed the back of my head into the hard, vinyl floor.

Throughout the attack I continued to scream and struggle, but this was because I was in extreme agony. One of the guards put his hand around my throat and squeezed to the point no air could enter or leave for at least a minute. I was sure at that moment he was going to kill me. I could barely speak for days afterwards.

The actual nursing and medical care I received … was outstanding so I have no idea why these nurses let the attack go on so long, although one of the guards did lean over me at one point and whispered into my ear, "the nurse can't see what I'm doing from here and you're fucking dead meat". He also laughed and smiled throughout the attack – he was clearly enjoying himself.[43]

……

On arrival [in the 'time out room'] I was ordered to strip all clothes off. The situation was getting more and more bazaar [sic]. I thought I was in hospital because I was sick and needed care. Is this the care that I needed?

I told him "you've got to be joking".

He disappeared for a few minutes and came back with five other nurses. They stripped me naked and put me into pyjamas. I can still see a big guy with tattoos smiling all through the whole thing.

At no point did I abuse anybody or become violent. Why was I getting such heavy-handed treatment when I don't think I deserved it.

After the nurse in charge pushed me into the back of the room they locked the door and turned off the light. There was only a mattress on the floor and the only window was in the locked door. If you have any iota about psychosis you could imagine what was going through my head.[44]

8.41   Ms Isabell Collins, Director of The Victorian Mental Illness Awareness Council asserted that damaging treatment experiences are common:

Having worked in the public mental health care system for some 15 years, I am yet to meet a patient of mental health who has not been damaged by the way he or she was treated and cared for. Indeed, consumers will often say that it takes a good 12 months to recover from hospitalisation just because of the way they were treated.[45]

---

43   Ms Sherry Watson, *Submission 504*, Attachment 1, pp[4–5].

44   Mr Stephen Corry, *Submission 440*, pp 2–3.

45   Victorian Mental Illness Awareness Council, *Submission 267*, p. 6.

Put simply, the current standard of practice is to contain people with medication and then discharge them. That is all we do.[46]

8.42   Consumer researcher Ms Cath Roper said:

I had 13 hospitalisations—all of which were involuntary—yet I cannot look back and say that those were healthy for me. There was extremely traumatic forced treatment involved in each of those hospitalisations.[47]

8.43   The Australian Mental Health Consumer Network recommended:

That government takes seriously the consumer warning that some acute experiences leave people psychologically scarred, sicker and more dependent in the long term.[48]

8.44   There have been some reviews of inpatient services and changes that have been implemented to improve service standards.[49] The committee also heard the reality of the complex situations hospital staff are required to deal with. For example:

When he was again admitted to Maroondah Hospital psych ward my son had a 3 week old untreated fractured leg gained after clinging onto and being thrown from a car; he was taken to William Englis hospital emergency ward after the incident but would not remain stationary for long enough for the cast to be applied. There were several prior attempts seeking admission over preceding months mainly due to violent and abusive behaviour.

During this stay in Maroondah hospital my son broke another patients arm.[50]

8.45   Humane and professional responses are needed in what can be complex and difficult situations. The personal experiences shared with the committee show that in some areas inpatient service standards need to improve.

8.46   Mr Graeme Bond submitted that quality standards are required:

When investigating my son's treatment I sought to compare it with any standards I could locate. I was able to locate very few publicly accessible standards published by the Department of Human Services and resorted to statements made by leading academic psychiatrists in a locally published textbook of psychiatry.

There should be a comprehensive set of standards readily accessible to carers and patients so that they can assess the care given against an objective benchmark. Such standards should be the reference against which

---

46   Ms Isabell Collins, VMIAC, *Committee Hansard*, 5 July 2005, p. 73.

47   Ms Cath Roper, *Committee Hansard*, 5 July 2005, p. 29.

48   The Australia Mental Health Consumer Network, *Submission 322,* p. 5.

49   For example, Tasmanian Government, *Submission 502*, pp 7-8.

50   Name withheld, *Submission 195*, p. 3.

actions of clinicians and services are judged, particularly in such forums as the Coroners court.[51]

8.47   Observations by the Victorian Auditor-General are pertinent:

> The current set of mental health measures and key performance indicators (KPIs) do not provide sufficient information to management and the Government to measure the effectiveness of the services being delivered. Most of the current measures and KPIs are not tied to departmental objectives and relate to service delivery (i.e. outputs) rather than consumer outcomes.[52]

8.48   Acute care in hospitals needs to be guided by standards of care that are focused on consumer outcomes, and which take a view beyond the points of admission and discharge. This is important because issues raised with the committee extended beyond acute care to the emergency departments where admission took place and to discharge.

Emergency departments

8.49   While hospital emergency departments are one of the few health services available to people with a mental illness on a 24 hour basis, seven days a week, the environment is not necessarily therapeutic and treatment may not eventuate. The NSW Nurses' Association commented that it was not uncommon for mental health patients to wait in the emergency department for up to five days before a suitable bed became available.[53]

8.50   The ARAFMI National Council Inc described the detrimental impact of waiting in emergency departments:

> The consequence can be that the consumer becomes acutely unwell needing emergency treatment possibly though a hospital emergency service. If it is then accepted that the consumer needs psychiatric care in a psychiatric facility there are frequently no beds available and the consumer is kept in a "holding" situation pending a bed becoming available, This is not only detrimental to the consumer but also causes distress and anxiety to the carer.[54]

8.51   Mrs Jan Kealton described the void in emergency departments services for psychiatric patients:

> Once there you wait and wait and eventually you might get lucky. … They take the person through to the triage area and tell them to sit in one of the

---

51   Mr Graeme Bond, *Submission 484*, p. 6.

52   Auditor-General Victoria, 2002, *Mental Health Services for People in Crisis,* p. 6.

53   NSW Nurses' Association, *Submission 391*, p. 4; also Dr Georgina Phillips, *Submission 255,* p. [2].

54   ARAFMI National Council Inc, *Submission 23*, p. 1.

blue chairs. The chairs are near the reception area, and then there are all the beds with curtains around them and so on. If you are a bit forceful, like me, you say, 'Excuse me, but I am going too,' and then you, the mother, are also allowed to sit on one of the blue chairs.

The blue chair is not in the treatment area and it is not in the triage area, so you just hope that someone notices the person if they are becoming distressed. You can walk straight out the door—if you do not have your mother with you being nice to you and begging you and bribing you to stay—and not get any treatment at all. Nobody would probably even notice. They are too busy handling all the blood and gore, the heart attacks and those sorts of things to go to somebody who looks perfectly normal, sitting there fidgeting …

We have sat there for seven hours on a number of occasions…[55]

8.52   The NSW Nurses' Association described the hectic environment of hospital emergency departments. They noted that it is not possible in this environment to establish rapport with patients and initiate preventative interventions. The Nurses' Association also pointed out that the 'excessive stimulus generated by the chaos and pressured atmosphere in the department' itself can contribute to escalating behaviour. They stated:

Given that security personnel are engaged to provide supervision for such volatile patients, it is clear that restraint and sedation are the likely and foreseeable outcomes… This is an untenable situation for all concerned.[56]

8.53   The committee heard that people with acute mental illnesses are particularly vulnerable to breaches of their privacy and dignity within the emergency department environment. Dr Georgina Phillips said:

Their ED management is usually carried out in a high acuity, highly visible cubicle in the central part of an ED work area (so that medical and nursing staff can closely monitor them). Many in the ED usually overhear their conversations: staff, security officers, other patients and their relatives. Many observe their appearance and behaviour, and if containment and restraint is required then this is usually carried out in full view of the rest of the ED. This affects not only the mentally ill patient, but can cause distress and potential physical harm to other patients or relatives in the ED. These are daily occurrences in EDs, however few would have space or resources to devise appropriate strategies to provide better and safer care.[57]

8.54   A report by the South Australian Ombudsman points to some of the underlying resource issues creating strain on emergency departments:

---

55   Mrs Jan Kealton, *Committee Hansard,* 2 February 2006, p. 77.

56   NSW Nurses' Association, *Submission 391*, p. 5.

57   Dr Georgina Phillips, *Submission 255*, p. [2].

It appears that neither the existing mental health system or supporting resources were sufficient to accommodate the significant changes undertaken in this State, in line with the National Mental Health Strategy… Moreover, there was overwhelming evidence during my inquiry from medical practitioners and others that there has been a significant increase in numbers of mental health patients presenting at emergency departments. This clearly, has placed undue strain on junior medical and nursing staff who are left to manage the increasing numbers of patients in crisis in emergency departments.

A common consumer and staff concern was the need to provide a safe and stable environment for mental health patients in crisis and in the community. It was apparent that in most emergency department environments staff face difficulties in separating highly agitated patients and there is an abundance of evidence that has shown that enormous pressure has been created at times when there has been an acute shortage of available beds in psychiatric wards and on discharge for either the emergency department or an inpatient facility, with a distinct lack of support in the community.[58]

8.55   Several submitters recommended specialised emergency departments for people experiencing mental illness.[59] Dr Philip Morris told the committee:

…patients that have been sent to emergency departments do not get the best of care because the facilities are not providing unique services for patients with mental illness. What we advocate now is a parallel—not a separate but a parallel—program of emergency departments located in the setting of the general health sector for patients with psychiatric illness. Some of these things are now starting to happen in Australia.[60]

8.56   The New South Wales Government described a trial of such services:

Psychiatric Emergency Care Centres (PECCs) have been successfully trialled at Liverpool and Nepean Hospitals. These PECCs have resulted in a reduction of the average length of stay in Emergency Departments for psychiatric patients. The PECCs are dedicated services, situated adjacent to the Emergency Department, staffed 24 hours a day, 7 days a week by mental health specialists for emergency assessment and treatment of people presenting with serious mental illnesses.[61]

---

58   South Australian Ombudsman, *Annual Report 2001/02, Section 26 Reports*, 'Treatment of Mental Health Patients: Shackling and other forms of restraint', p. 60.

59   For example, Dr Philip Morris, *Committee Hansard*, 2 February 2006; Dr Georgina Phillips, *Submission 255*, p. [3].

60   Dr Philip Morris, *Committee Hansard*, 2 February 2006, p. 4.

61   NSW Health – NSW Government, *Submission 470*, pp. 24–25.

Discharge processes

8.57   Discharge from hospital can be as abrupt as admission can be slow. Submitters told the committee about a lack of discharge planning and continuity of care after discharge from hospital or the emergency department. Poor discharge planning and insufficient community-based services can leave consumers in inadequate environments without appropriate therapeutic care, resulting in increased symptoms and possibly re-admission. Following an acute episode of illness, the risk of suicide is highest in the first weeks after discharge.[62] Where families and carers are contacted and available, early discharge increases their burden in providing care and support.

8.58   Dr Philip Morris said:

> Because of the pressure on bed numbers, patients are being discharged before they are ready to go home. That leads to harm both to them and to their families and the general public. If we had more resources, patients could stay in hospital for longer and be treated to a point where they were much more ready to be discharged. I am not just talking about discharge from acute services. There is no opportunity at the moment to put many patients into longer term facilities where they can be rehabilitated and recover further so they can then go back into the community in a decent state.[63]

8.59   Dr Morris also suggested there is evidence that some practitioners are having patients placed under involuntary treatment orders as the only way to obtain follow up treatment in the community after discharge.[64]

8.60   Mr David Webb shared his discharge experiences with the committee:

> On the strength of that assessment, the psychiatrist judged that I suffered from what he called existential depression and that I did not need to be there. I had attempted suicide just a couple of nights before. He told the social worker and the charge nurse to arrange for my discharge. That was it. The psychiatrist spoke to me about where I would go on discharge and whether I had somewhere to go. I did not have a place to go as I did not have a home in Melbourne at the time. He spoke to the social worker and said, 'Help him find somewhere to go.' I left that hospital with the phone number for the emergency accommodation of the Salvation Army. That was the discharge support that I got a couple of days after a suicide attempt. People tell me that would not happen these days, but I am not sure. I am one of the fortunate ones. There are a lot of people that have been through

---

62   Dr Philip Morris, Gold Coast Institute of Mental Health, *Committee Hansard,* 2 February 2006, p. 2.

63   Dr Philip Morris, *Committee Hansard,* 2 February 2006, p. 2.

64   Dr Philip Morris, *Committee Hansard*, 2 February 2006, p. 3

that experience and they have gone straight to the nearest railway line to jump under the first train.[65]

8.61   Carer's also described the lack of services post discharge:

> Another issue in regard to the post acute-care situation is that in the case of our son's first psychosis, I had to initiate post-hospital case work. No-one offered me access to services. I had to seek these out and despite my best efforts to have a case worker assigned while our son was still in hospital to facilitate a smooth transition on his discharge, it proved a fruitless exercise. I knew nothing about mental health services and no-one offered me any help or information. It concerned me enormously that if our son had not had an active advocate in me, then he would have been discharged, unwell, and having to fend for himself, with no accommodation and with no knowledge or ability to access social welfare let alone any mental health services (as inadequate as these turned out to be).[66]

8.62   Ms Isabell Collins commented on the ethical dilemmas facing staff who make discharge decisions:

> Certainly psychiatrists have said to me that they are constantly in this ethical dilemma where they have somebody who is really sick and needs admission to hospital and they have somebody in hospital who is still sick but not as sick as the one who needs to come in. They have to juggle and take these risks. What happens is that they do take the risk. They send them out into the community where there are no supports for them.[67]

8.63   Reviews of service standards indicate that the personal anecdotes shared with the committee are illustrative of systemic failures. A file audit by the Auditor-General in Victoria in 2002 found that 89 per cent of consumers reported that they were discharged while still acutely unwell, with a high level of need for ongoing support. Yet none of the discharge plans reviewed met all required standards.[68]

8.64   Among the disturbing findings, the Auditor General reported:

- 30 per cent of discharge plans reviewed showed no evidence that consumers had been linked into appropriate community-based services for ongoing treatment following discharge;

- In 80 per cent of cases there was no evidence that consumers were consulted in the formulation of the discharge plan. Family or carers collaborated in discharge planning in only 15 per cent of reviewed cases;

- In only 16 per cent of the reviewed plans was the consumer given emergency contact numbers; and

---

65   Mr David Webb, Chair, VMIAC, *Committee Hansard*, 5 July 2005, p. 81.

66   Name withheld, *Submission 244*, p. 4.

67   Ms Isabell Collins, VMIAC, *Committee Hansard*, 5 July 2005, p. 77.

68   Auditor-General Victoria, 2002, *Mental Health Services for People in Crisis,* p. 65

- In only one per cent of cases reviewed was a copy of the discharge plan actually provided to the consumer.[69]

8.65   Even where services specifically focus on discharge planning with dedicated resources, evidence suggests that actual follow up remains limited. A study of the emergency department of a Sydney hospital, which has a dedicated Mental Health Liaison Nurse, found that 86 per cent of consumers felt that adequate arrangements had been made with them before they left emergency and 71 per cent were referred to a community mental health team on discharge. However, only 63 per cent actually had contact with the community mental health team after leaving emergency.[70]

8.66   The committee suspects that the lack of discharge planning and support, at least in some cases, reflects the fact that acute service providers know there is nowhere for the person to go. The Mental Health Council of Australia submitted:

> Consumers are often discharged without any rehabilitation plan or even reference to appropriate places because the discharging services knows these services have no capacity to accept further referrals.[71]

8.67   This situation reinforces the concern, expressed throughout this report, that the mental health sector in Australia currently lacks a full spectrum of care.

8.68   One possible consequence of inadequate discharge planning, follow up treatment and care is the deterioration of a person's mental health, which results in readmission. This is an unsatisfactory situation for all involved, with consumers carrying an increased burden of illness, carers suffering increased strain, and services sustaining repeated costs. Even in Victoria, a state with above average investment in mental health services and one of the highest per capita investments in community-based care,[72] readmission rates remain high. In 2005 the Victorian Auditor-General reported that although initiatives had been implemented since 2002 to increase community-based care, and more patients were being contacted in the community before and after admission for acute care, an increasing proportion of patients were being readmitted within 28 days of discharge.[73] In the June quarter 2005, 17 per cent of mental health patients were readmitted within 28 days of discharge.

8.69   This level of readmission suggests that community supports remain inadequate to stabilise and support people with a mental illness following acute episodes. However, the data might also suggest that at least hospitals remain an

---

69   Auditor-General Victoria, *Mental Health Services for People in Crisis,* 2002, p. 66

70   T. Wand and P. Schaecken, 'Consumer evaluation of a mental health liaison nurse service in the Emergency Department', *Contemporary Nurse*, 2006, vol 21, Issue 1, p. 18.

71   Mental Health Council of Australia, *Submission 262*, p. 19.

72   Australian Government, *National Mental Health Report 2005*, pp 23 and 34.

73   Auditor-General Victoria, *Follow-up of selected performance audits in 2002 and 2003*, 2005, p. 107.

accessible service for people requiring further care, with people being readmitted rather than turned away.

Crisis services

8.70   Crisis services refer to services designed to respond to mental illness related emergencies in community settings. Such services can save lives and are particularly valued by carers. Crisis assistance needs to be timely to be effective, and achieving prompt crisis response is a challenge facing these services, which appear to be constrained by resources as well as perceived safety issues.

8.71   A key issue regarding crisis services is the need for services to attend and assist crisis situations out of business hours. Ms Sharon Ponder remarked on this need:

> Apparently acute episodes of schizophrenia occur at the most "inconvenient" times for our system, It needs to be told that an acute schizophrenic episode is rarely "convenient" for the sufferer, never mind the system.[74]

8.72   The lack of after hours mental health services means that hospital emergency departments and emergency services (police and ambulance) are often the only available services out of business hours. These services are not necessarily trained or equipped to deal with mental illness crises, and can create further distress for people experiencing mental illness:

> The response from the mental health services to after hours crisis is that the refuge phone an ambulance to take the young person to accident and emergency or call the police, this of course creates a scene in front of other young people and neighbours, not to mention the trauma for the young person involved.[75]

8.73   In some areas, after hours phone calls to psychiatric units are simply referred to Lifeline.[76] Lifeline commented that its services are over stretched:

> Lifeline…has become a defacto after hours mental health service with volunteers answering call after call from people with a mental illness that have been referred to Lifeline from other mental health services unable to cope with high levels of demand. Lifeline is not adequately equipped, resourced or developed to fulfil this role appropriately. Many of our traditional crisis callers have not been able to access our service because of the dominant usage of some mental health callers. With over half a million calls per annum being answered by Lifeline volunteer telephone counsellors it is clear that this is a significant community problem.[77]

---

74   Ms Sharon Ponder, *Submission 84*, p. [9].

75   Ms Christine Couzens, *Submission 71*, p. [4].

76   Ms Jean Charlton, correspondence 19 September 2005

77   Lifeline Australia, *Submission 329, Attachment 6*, p. 7.

8.74   Lack of services after hours for people experiencing acute mental illness therefore impacts not only on mental health consumers and their carers, but also on wider service providers and their clients.

Crisis assessment and treatment teams

8.75   One service designed specifically to assess and intervene during episodes of mental illness are mobile acute assessment and treatment teams. These teams are 'medical health services which provide home-based assessment, treatment or intervention primarily for people experiencing an acute psychiatric episode and who, in the absence of home-based care, would be at risk of admission to a psychiatric inpatient service'.[78] The services are known by different titles across jurisdictions, including 'psychiatric crisis intervention' services, 'community assessment and treatment' services and 'crisis assessment and treatment' (CAT) services.[79]

8.76   The *National Mental Health Report 2005* describes the essential characteristics of these services as their 24 hour, 7 day per week availability and focus on short-term intervention. However, carers lamented how often they were unable to obtain assistance in crisis situations. Several submissions commented that the poor response record of the Crisis Assessment and Treatment teams had earned them the nicknames 'Can't Attend Today' teams or 'Call Again Tomorrow' teams.[80] If the CAT teams are to be effective and supported by consumers and carers there is a need for better resources and training.

8.77   One submitter described the frustration of the lack of service, as follows:

> …if they are contacted it means that the client or family, or both, needs some help. Instead, you often get this indifferent response, trying to get you to go away as your crisis doesn't fit their criteria. I have even been told that I couldn't be helped because they were too busy with other more urgent matters. This was before I was even listened to…In fact, they have never made a trip for us. The only times I have received help was if my son could be calmed down enough to let me drive him to hospital. If all else failed, I had to call an ambulance.[81]

8.78   Mr Graeme Bond reported his experience with the CAT team:

> Even when I have called reporting the most alarming behaviour which posed a threat to my wife or, on occasions to me, I have been unable to have a CAT Team attend. Indeed, in my area, I believe that after about 7:00pm the CAT Team is one person accessible by a paging service.

---

78   Australian Government, *National Mental Health Report 2005*, p. 94.

79   Australian Government, *National Mental Health Report 2005*, p. 94; Minister for Health – ACT Government, *Submission 165*, p. 2.

80   See for example, Name withheld, *Submission 62*, p. 2; Mr Graeme Bond, *Submission 484*, p. 3.

81   Name withheld, *Submission 122*, p. 3.

> The standard advice offered, in response to a request for a CAT Team, is 'call an ambulance' or 'call the police'.[82]

8.79   The Victorian Mental Illness Awareness Council presented strong criticism of CAT services:

> Crisis Assessment and Treatment teams (CATT) are probably the best example of what happens when governments fail to adequately fund services.
>
> From the consumer perspective CATT would be the most disliked and criticised service in mental health.[83]

8.80   However, the CAT team model is effective when adequately resourced:

> Whilst living in the ACT, we experienced excellence from the local CATT which attended our home when our daughter was in a prodromal state and had locked herself in her room late at night. As a result of the CATT dedication, a humiliating and extremely distressing family situation was brought under control without need for hospitalization or the stigma of well-meaning but untrained police presence in our neighbours' presence.[84]

8.81   Even with well resourced prevention and intervention programs, the severe and episodic nature of some mental illnesses means that crisis situations can occur. Without ready access to personnel adequately trained and experienced in intervention and de-escalation, crisis situations can end in tragedy:

> I have just been involved in a coroner's inquest. A young 23-year-old man had been shot dead by the police. He had an agreement with his parents, before becoming unwell, that should he become unwell they would ring the CAT team. He became very unwell and that was not the case. He had knives and he hurt his father. The location was secured and his mother was terrified her son would be shot. She told the police: 'He is all right. He will be able to talk. Please be careful of him.' The police did everything in their endeavours to get the CAT team. The duty person for the CAT team on the evening of that night, when the police called, did not perceive that they were being asked for assistance. They gave the response: 'Yes, this person has been in this hospital. Yes, this person does have a diagnosis of schizophrenia.' But they did not then go on to say, 'And this person, in fact, has asked before to be killed.' So the police, acting as they believed they should, managed this situation. Something really unfortunate occurred: the young man appeared behind the house and came at a police officer with knives and the consequence was he was shot.
>
> At the coroner's inquest, the CAT team thought that the provision of the information I have just provided to you was enough to give instructions to the police in how to take control of the situation and the young man. The

---

82   Mr Graeme Bond, *Submission 484*, p. 3.

83   Victorian Mental Illness Awareness Council, *Submission 267*, p. 5.

84   Name withheld, *Submission 129*, p. 1.

police do not have effective training in de-escalation; their training is in control, not de-escalation. My submission is that when you have the police ineffectively prepared, and when you have the CAT team not perceiving that they need to attend and, further, saying that they would not attend if their health and safety were in danger, then even if the police could make their health and safety secure we either have to do something about the function of the CAT teams or do something about the education of the police.[85]

8.82   As illustrated it the above example, coordination between crisis teams and the police is essential in responding to crisis situations involving mental health consumers. The role of police in mental health services is discussed further in Chapter 13.

8.83   There is a need to ensure effective responses for people with mental illnesses requiring emergency attention. CAT teams currently have limited availability and are concerned about attending potentially violent situations. Emergency departments, while always open, are stretched and do not necessarily provide an environment or interventions appropriate for acute mental illness. Similarly, while emergency services such as police and ambulance will attend mental illness crisis situations, they are not trained to respond effectively to psychotic episodes and their presence can escalate the situation.

8.84   One of the NSW Government's initiatives is to improve emergency mental health responses is the establishment of a 24-hour 1800 phone number for each NSW Area Health Service.[86] It was not clear from the NSW Government's submission the extent of the services that would be offered via this phone line. However, a single 24 hour access point for mental health emergencies may assist carers and consumers who currently report a desperate need for assistance. The Council of Australian Governments' proposed National Health Call Centre Network[87] may help meet this need, if adequately resourced to include dedicated mental health professionals and backed up by available intervention and treatment services.

8.85   Two points stand out in discussion of crisis services for mental health. First, the very nature of mental health crises often means that it is quite inappropriate for police or ambulance to respond. Mental health crises need a mental health response. Being told to 'call the police' in particular often seems to be inviting the escalation of a situation that need not necessarily deteriorate. Second, better community-based care and support would almost certainly mean less crises in the first place.

---

85   Ms Elizabeth Crowther, Chief Executive, Mental Illness Fellowship Victoria, *Committee Hansard*, 5 July 2005. pp 95-96.

86   NSW Health – NSW Government, *Submission 470*, p. 24.

87   Council of Australian Governments, *Communique 10 February 2006*, www.coag.gov.au/meetings/100206/index.htm, (accessed February 2006).

Contrasting experiences

8.86   Some witnesses expressed a view that evidence presented to the committee may overly represent negative experiences:

> The inquiry will receive a great deal of anecdotal evidence about the inadequacy of services. For various reasons, the inquiry is unlikely to hear from people who are satisfied with the service. For example, stigma is still so great, people who are coping reasonably well will not want to draw attention to themselves.

> Anecdotal evidence can be out of date. Situations can improve or deteriorate quite rapidly. It can come from people who are so shocked, angry or distressed and who wish to find some one or something to blame. Two families can have much the same experience and describe it in quite different ways.[88]

8.87   The Victorian Government commented on the nature of the inquiry:

> The methodology focuses on subjective measures such as submissions and public hearings which will elicit public and expert opinions from those who choose to submit, but will be limited if this information is not balanced by objective evidence of systemic issues regarding state service provision.[89]

8.88   It is difficult to reconcile this view with the Victorian Government's own submission which states that the operating environment in Victoria is one of 'sustained demand pressure', with 'services operating over capacity, as evidenced by high community caseloads and chronic acute bed blockages' and 'crisis driven service responses, difficulties with service and bed access, 'revolving door' clients….and a significant impact on other social policy areas'.[90]

8.89   There is evidence that confirms that systemic issues underlie the personal experience of mental health services. Anecdotal experiences of inpatient and crisis services are consistent with service reviews, such as the Victorian Auditor-General's finding that:

> Increasing service demand and associated levels of unmet demand are resulting in service access difficulties for many consumer, early discharge from hospital, and increased burden on family and carers. These outcomes increase the likelihood of future unplanned re-admissions.[91]

8.90   The NSW Auditor-General similarly remarked:

> The increase in demand for emergency mental health services has offset many (and perhaps all) of the gains from funding increases. The system is

---

88   Ms Sheelah Egan, *Submission 113*, p. [4].

89   Victorian Minister for Health – Victorian Government, *Submission 445*, p. [6].

90   Victorian Minister for Health – Victorian Government, *Submission 445*, p. [3].

91   Auditor-General Victoria, *Mental Health Services for People in Crisis,* 2002, p. 6.

under considerable pressure, and patients can face lengthy delays before being admitted to a bed.

It is important that services work together to share resources at times of peak demand. Yet, there are times when the availability of mental health beds means that some patients face being transferred very long distances to access an acute mental health bed.

There is also evidence that some patients spend inappropriately long periods in emergency departments while awaiting acute mental health beds or are discharged from the emergency department prior to a bed becoming available.[92]

8.91   The dearth of outcome reports in the mental health sector also means there is little ongoing, systematic assessment of the actual health outcomes provided by mental health services. There is generally no data to contradict many of the systemic issues illustrated by personal anecdotes to this committee.

8.92   Hearing personal experiences and reporting individual concerns does not belie the substantial reforms that have occurred, the systemic deficiencies that remain and the concerted and coordinated effort required to continue to improve mental health services. The Victorian Government submitted:

A number of [the inquiry] terms of reference sit well outside the mandate of the specialist mental health system and will require vigorous and sustained effort by many different areas and levels of government, including the Commonwealth Government, to address.[93]

8.93   The committee certainly assumes that all levels of government are committed to making the 'vigorous and sustained effort' required to improve mental health services, and ultimately the mental health of all Australians.

Concluding remarks

8.94   There are serious problems facing people with mental illness who find themselves seeking, or being placed in, acute care. There has been some discussion of whether these problems are a result of the way in which the policy of mainstreaming has been implemented. Mainstreaming was intended to involve the replacement of stand-alone psychiatric facilities with a pattern of brief admissions to acute psychiatric wards within general hospitals backed up by community-based care of varying types. However, for many consumers this has not been the reality.

8.95   A key criticism has been the apparent inability of mainstream services to meet the specific needs of mental health consumers. Submitters pointed to the need for tailored treatment and for the treatment environment to be conducive to recovery:

---

92   New South Wales, Audit Office, *Performance Audit: Emergency Mental Health Services*, NSW Department of Health, May 2005, p. 2.

93   Victorian Minister for Health – Victorian Government, *Submission 445*, p. [6].

> The other point I would like to make in the broad sense is that mainstreaming has failed. Mainstreaming was the idea that you bring all mental health services under the one umbrella of general health and somehow this means that all discrimination goes away. But that is not the case. There is some reduction in stigma. One of the good things about mainstreaming is that it recognised the role of general practitioners. But what it has not done is maintain a focus on the unique needs of patients with psychiatric illness. Because of this loss of focus we now have, for example, inpatient units being built with no space. Psychiatric patients need space. When they are very unwell they are agitated, they are sometimes very sensitive to others and they need room.[94]

8.96   Dr Scott-Orr argued for 'co-located' services, in which psychiatric services share medical resources with general hospitals, but retain a separate environment and specialised care:

> It is my view that general hospital architecture and functioning does not lend itself to mental health care. Nor does the recent design of mental health units in general hospitals give me any hope or joy. I consider the place(s) of round the clock mental health care should be readily accessible by walking, to and from the relevant general hospital, and sharing its resources for all sorts of medical reasons and economies.

> It needs to provide a 'homey' environment, with that look and feel, in which people are up and about in street clothes, preferably to have its own street address, while having provision for some secure area and ready observation where needed.[95]

8.97   On the other hand, the Royal Australian and New Zealand College of Psychiatrists strongly supported mainstreaming:

> We should progressively move to integrate mental health into general health. There are enormous advantages in having the majority of psychiatric services in general hospitals as part of the culture of general hospitals with regard to constant review and quality improvement and in the accessibility of general health care to patients with mental illness as well. There is probably going to be a need for small specialist services for people with particular disorders where all they need is psychiatric intensive care, but I would see that as being a very small part of the much larger integrated system.[96]

8.98   The committee accepts the argument that bringing acute psychiatric care into a mainstream hospital setting helps ensure quality treatment for all of a patient's health needs, and can have workforce and management advantages. Effective acute care, however, needs to involve higher standards of care and the provision of facilities that

---

94   Dr Philip Morris, *Proof Committee Hansard*, 2 February 2006, pp. 3–4.

95   Dr Scott-Orr, *Submission 58*, p. 2.

96   Dr Julian Freidin, *Committee Hansard*, 6 July 2005, p. 92.

meet the specific needs (such as open space and a more home-like environment than is typical for a general hospital) of people with mental illness. Above all, these need to be linked in to community-based services, before admission and after discharge.

8.99   There is now a substantial body of evidence before this and other recent inquiries to show that inpatient and crisis mental health services have severe shortcomings. Services have failed to meet the standards Australians should now, after many years of inquiry and reform, be able to expect.