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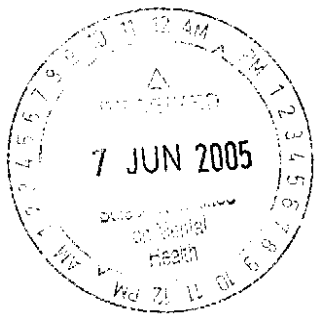


Senator Lyn Allison
Chair
Australian Senate Select Committee on Mental Health
Parliament House
CANBERRA ACT 2600

Dear Senator Allison Lyn

Attached please find Victoria's response to the Senate Select Committee on Mental Health. I welcome the opportunity to provide input into an Inquiry that is looking at issues of national importance.

Mental health continues to be a high priority for the Victorian Government. The social policy action plan *A Fairer Victoria: Creating Opportunity and Addressing Disadvantage* released on 28 April 2005 and the 2005/06 Budget make a substantial commitment of $180 million over the next four years for mental health service growth and improvement.

I look forward to the committee's report, and hope that its findings facilitate the Commonwealth/State partnerships necessary to continue mental health reform in Australia.

Yours sincerely

Hon Bronwyn Pike MP
Minister for Health

Victoria
The Place To Be

VICTORIA'S INPUT TO THE SENATE SELECT COMMITTEE INQUIRY ON MENTAL HEALTH

1. Background

1.1 Victorian Context

There is widespread agreement that Victoria has laid the foundations of a comprehensive age based specialist mental health system, which is now well established and contains most of the elements needed to effectively treat and support people with mental illness. As a specialist system, the bulk of external funding is directed towards the clinical treatment of serious mental illness, supplemented by disability support for consumers to live independently in the community. Victoria, when compared nationally, has proportionally the largest community based system of clinical assessment and treatment and non-clinical support, and the greatest number of people treated in psychiatric wards co-located with general hospitals.

Mental Health System Dimensions
Clinical services treat approximately 56,000 continuing care clients per annum in inpatient and ambulatory settings, with up to 12,000 clients also using disability support services and a clinical workforce of over 5000 staff. These services are resourced from a total mental health budget of $651.8 million in 2004-05.

Table 1: 2004-05 Total Budget Breakdown

Major Output	Output Cost $ million	% of Total Budget
Clinical Inpatient Care	271.4	42
Clinical Community Care	284.2	44
Psychiatric Disability Rehabilitation & Support	60.7	9
Service System Capacity Development	35.5	5
Total	651.8	100

Source: 2004-05 Service Delivery Budget Paper No.3

Mental Health Service Structures
Mental Health Services in Victoria are provided on an area catchment basis. All clinical area services, other than forensic services, have been mainstreamed with general hospitals. Each area provides a range of services.

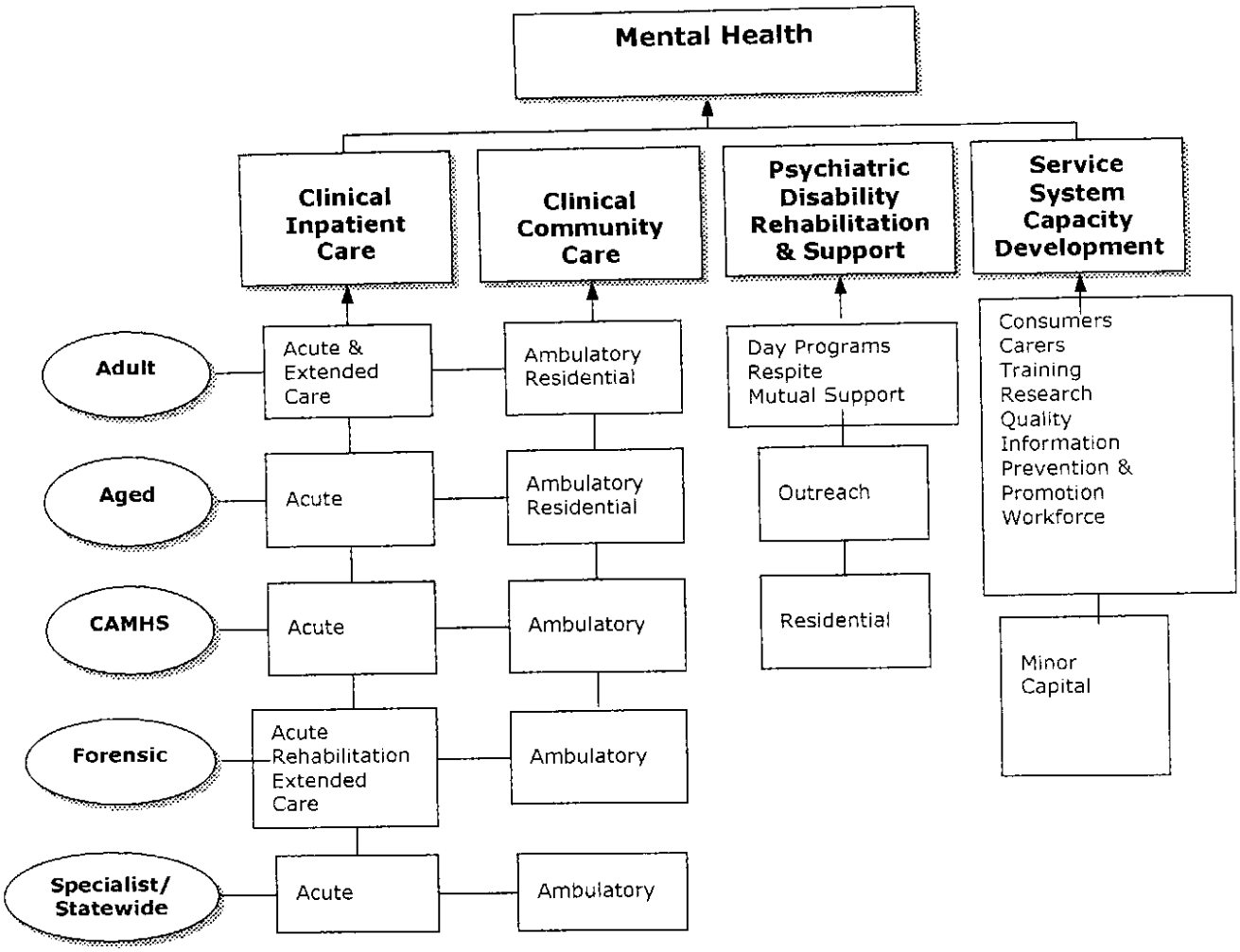
Service delivery within Area Mental Health Services is organised into:

- 21 Adult Mental Health Services, which assess and treat adults (aged 16-64) with serious mental illness.
- 17 Aged Persons Mental Health Services, which assess and treat older people (aged 65 and over).
- 13 Child and Adolescent Mental Health Services, which assess and treat children and adolescents (up to 18 years of age) who have a serious mental disturbance or who are known to be at risk of such disturbance.

All areas have access to a range of inpatient, community residential and ambulatory services. Service providers also have access to a range of Specialist and Statewide services such as mother and baby units, eating disorder units and neuropsychiatry services. In addition, forensic mental health services are provided for people who have both a mental disorder and a history of criminal offending or who present a serious risk of such behavior.

Complementing clinical services are a range of psychiatric disability rehabilitation and support services (PDRSS) delivered by non Government organisations. These services provide support and rehabilitation services to people who have a disability resulting from mental illness.

Diagram 1: Mental Health Service Structure



1.2 Major Service System Issues

The Victorian Operating Environment

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 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% of patients staying more than 35 days. This has resulted in crisis driven service responses, difficulties with service and bed access, 'revolving door' clients (15% each year) and a significant impact on other social policy areas.

There is a disproportionate representation of mental health clients in the justice, homeless and drug and alcohol systems and hospital emergency departments.

- 15% of prisoners have a serious mental illness and more than 50% have a mental disorder
- 30% of homeless people have a mental illness
- More than 50% of new mental health clients have a substance abuse problem
- 4,000 mental health clients in 2003/04 waited 12 hours plus for a bed in emergency departments

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Distribution of Private Psychiatrists and General Practitioners

A major issue for Victoria is the mal-distribution of private psychiatrists and general practitioners, with a concentration of both groups in major cities, particularly Melbourne. This severely restricts the throughput capacity of specialist mental health services, especially in rural areas. One of the solutions to managing the burgeoning demand for specialist services is building capacity beyond the specialist system to enable shared care and supported discharge arrangements with private psychiatrists and general practitioners (GPs). This would enable a proportion of clients to move fully or partially out of the system and free up capacity to admit new clients. The two tables below highlight the distribution issues.

Table 2: Private Psychiatrist by Remoteness Area 2003-04

Area	Victoria	Australia
Major cities	332.1	
Inner regional	11.9	
Outer regional	1.2	
Remote	0	
Very remote	0	
Total all regions	**345.2**	
Per 100,000 population		
Major cities	9.2	7.1
Inner regional	1.1	1.8
Outer regional	0.5	0.1
Remote	0	0
Very remote	0	0
All regions	**7**	**5.9**

Source: Australian Institute of Health and Welfare Report, Mental Health Services in Australia 2002-03

Table 3: General Practitioners by Remoteness Area 2001-03

Australia - Area	Number
Capital city	16007
Other metro	1712
Large rural	1449
Small rural	1571
Other rural	2747
Remote centre	310
Other remote	511
Total of 5,887 GPs in Victoria	

Source: Department of Health and Ageing, GP Statistics and Classification Unit website

The 3 per cent of the Victorian population with a serious mental illness[1], is estimated to comprise:

- 1.2 per cent (58,000 people) are clients of the Victorian specialist mental health service system (includes clients in shared care arrangements).
- 0.95 per cent (46,800 people) are supported by private psychiatrists and other services such as GPs.
- 0.85 per cent (37,500 people) do not receive a response.

Of the 1.2 per cent who are clients of specialist mental health services, it is estimated that:

- 30 per cent have intermittent support needs and move between specialist mental health services and other service providers.
- 16 per cent of the medium and low support clients are already in shared care arrangements with private psychiatrists or GPs.
- a further 32 per cent of these clients could be discharged to shared care or cared for solely by private psychiatrists or GPs if private psychiatrists and GPs are accessible and able to take on these responsibilities, and support is provided by specialist mental health services.

The introduction by the Commonwealth Government of new Medicare items through the Better Outcomes in Mental Health (BOMH) initiative together with state funded primary mental health teams have facilitated the current level of shared care arrangements between public mental health services and general practitioners (GPs). Currently, the uptake of BOMH in Victoria is 1095 GPs (19% of all). Nationally, one in four practices has a BOMH trained GP with nearly 40% of rural practices having a BOMH trained GP. Victoria is very interested in furthering these initiatives and, where possible, pooling state and Commonwealth funds to build capacity in primary health services as has already occurred in north east Victoria.

2. Response to the Inquiry

Victoria's response provides:

- A general section with commentary on issues at the Commonwealth/State interface and the direction of effort and resources in Victoria; and
- A commentary on issues that are nationally relevant and a focus of the Inquiry:

Relevant information and views expressed in this response have also been provided in Victoria's response to the draft Human Rights and Mental Health Report prepared by The Mental Health Council of Australia, the Brain and Mind Research Institute and the Human Rights and Equal Opportunity Commission. A copy of Victoria's response is provided at Attachment 1.

2.1 General comments

Victoria has made substantial effort and considerable investment over the past decade in reforming its specialist mental health system consistent with agreed national strategies. These positive achievements have been consistently recognised in national mental health reports since 1993. Victoria has been acknowledged as a national leader in the scope and extent of structural reform. Additionally, Victoria continues to provide exemplar services such as services in the forensic and youth areas and develop innovative service models in response to changing needs and identified service gaps.

[1] Services are prioritised to people most severely affected by mental illness as required by the *Victorian Mental Health Act 1986*. The Government has a legislated responsibility to provide treatment on an involuntary basis to people with a serious mental illness who are at risk to themselves and/or others and are unable or unwilling to consent to

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Although the pace and extent of positive change has been the subject of criticism by a small number of stakeholder groups, it is inappropriate to make generalisations about the national rate of reform and service performance. National mental health reports demonstrate that implementation of national reform has been variable across jurisdictions. This has obviously been determined by the different historical funding arrangements, local needs and service configurations in each state and territory. More weight should also be given to the constraints the states and territories operate under that impact on the rate and extent of change. These constraints include capped budgets and high levels of non-discretionary expenditure related to meeting statutory obligations to involuntary clients.

The strength of mental health reform to date can be significantly attributed to the high and sustained level of cooperation between various governments and political parties. It would be very disappointing to see any diminution in these collaborative arrangements as a result of this Inquiry.

Available data in Victoria indicates that the specialist mental health system operates reasonably well most of the time despite sustained and increasing pressure. It should also be noted that the system contains high levels of accountability with checks and balances that are enshrined in legislation and practice. Service and clinical standards and guidelines are the subject of continued improvement and review. Recent amendments to the Mental Health Act have further embedded good practice into legislation.

On a per capita basis in 2001/02, Victorian public mental health services were well resourced compared with other Australian States and Territories (second only to Western Australia according to the National Mental Health Report 2004).

Whilst much effort has been undertaken by Victoria in relation to reform, this has not been adequately assisted by Commonwealth support and funding. Victoria would argue that Commonwealth health benefits programs are of limited effectiveness and efficiency in meeting the needs of people with the most serious conditions. This is due to the uncapped, unaccountable and mal-distributed nature of funding for private psychiatrist and GP services and the often high cost of medications that treat severe conditions.

The Inquiry's Scope and Methodology

The very broad scope of the terms of reference and significant focus on the adequacy of state funded specialist services such as community, acute, forensic and crisis services, including involuntary treatment, leaves much doubt as to the capacity of such an inquiry to properly and objectively address its task. These terms of reference have been influenced by interest groups with specific agendas without appropriate consideration of Commonwealth/State relationships and responsibilities.

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.

Consequently, the inquiry risks setting unrealistic expectations about what can be delivered by a publicly funded specialist system of care. A number of its 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.

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Recent Victorian Priorities and Achievements

In response to demand pressures and the ongoing need to build on past reforms and improve service access, efficiency and effectiveness, the Victorian Government has systematically invested more than $198 million in service improvement strategies since 1999-00. This funding has been directed to strengthening core services, implementing early intervention and relapse prevention initiatives and creating an environment that enables clinical practice and service models to better align with the changing needs of consumers and their carers. Some major new and innovative initiatives include:

- **Primary Mental Health Teams** that build the capacity of general practitioners and other primary health providers to support people with a mental illness through the provision of specialist consultation.
- **Early Psychosis** programs which provide early intervention for young people with an emerging disorder.
- **Dual Diagnosis** services which provide integrated responses to clients with co-existing mental illness and substance abuse.
- **Sub-acute services** that provide transitional step down support from inpatient care to home.
- **Intensive housing support services** for consumers with complex needs

Mental Health continues to be a high priority in the Victorian Government's 2005-06 budget and further implementation of targeted service growth and new initiatives will occur. A substantial commitment of $180 million has been made over the next four years, including $55.5 million for planned capital developments. Initiatives will focus on early intervention across the age groups by providing:

- **Intervention and prevention during the early stages** of an emerging disorder (in order to prevent the illness progressing and/or avert escalation and the need for a long period of support)
- A **quicker** service response (to prevent a crisis developing or worsening)
- A **more intensive** service response (to ensure treatment is effective)
- **Better follow-up** after discharge (to prevent relapse of the condition).

These improvements will be achieved by:

- **Strengthening the capacity of community services** to treat clients in a more effective and timely manner. ($23.4 million over 4 years).
- **Developing more sustainable psychiatric disability rehabilitation and support services** (PDRSS) by a closer matching of funding with costs and actual service provision ($20.9 million over 4 years).
- **Creating capacity in inpatient beds** through the further development of hospital, 'step down' sub acute services and other intensive community based options ($42.8 million over 4 years).
- **Improving responses to dual diagnosis and homeless clients** through better service integration and workforce development ($9 million over 4 years).
- **Continuing to expand early intervention and prevention initiatives** for infants, children and young people ($11.5 million over 4 years).
- **Providing further support to services beyond mental health** such as emergency departments and the range of health services that deal with chronic and complex clients ($11.6 million over 4 years).
- **Investing in the mental health workforce** to attract and retain staff ($5.6 million over 4 years).
- **Building better mental health facilities** through a planned program of capital development ($55.5 million).
- **Implementing practice change and system reform** including reducing inequities in service distribution, improving performance and outcome measurement systems, developing integrated models of care, and improving clinical practice, including triage,

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Commonwealth/State Interface

It is Victoria's view that resolving issues in relation to the Commonwealth/State interface is fundamental to improving services for people with a serious mental illness and the rate of national reform. Structural issues related to this interface actually impede progress and positive change. Substantial action must be taken if national performance at all levels is to be improved.

Both Commonwealth funded and state funded health services have a responsibility for people who have mental health issues, albeit for different target groups. Although the Commonwealth funds more than a third of mental health expenditure, this is not targeted to people with the most serious conditions, nor is it directed to the most effective interventions; for instance, Medicare provides limited access to psychologist provided services and brief psychotherapeutic interventions.

Mental Health expenditure

According to the *National Mental Health Report 2004*, in 2001/02 the Commonwealth Government funded 38% of mental health expenditure in Australia. This expenditure covered Medicare funding to private psychiatrists and General Practitioners, pharmaceuticals, Department of Veterans Affairs and private hospital subsidies, and grants to states and territories under the National Mental Health Strategy. The beneficiaries of these services are predominantly those people with mild to moderate mental disorders, mainly anxiety and depression. Most of the Commonwealth funding was spent on the Medical Benefits Scheme and Pharmaceutical Benefits Scheme, both of which are uncapped.

States and territories funded 58% of the 2001/02 mental health expenditure with the remainder funded through other revenue sources (fees/private insurance). This expenditure was used to provide services to people with serious mental illness such as schizophrenia and severe depression. This group of people is harder to successfully treat, and usually have greater needs, than those accessing mental health services funded by the Commonwealth Government. Under the Australian Health Care Agreement, Victoria receives Commonwealth funding of approximately $18 million for services to people with serious mental illness. This represents a very small proportion (less than 3%) of the $651.8 million spent by Victoria in 2004/05 on services for people with serious mental illness.

Barriers to improved mental health services

The Commonwealth funded health care system also constrains and provides barriers to improving services to people with serious mental illness. For example, newer atypical pharmaceuticals used to treat psychosis are not always funded by the Pharmaceutical Benefits Scheme so the states must find this funding. Additionally, the Medicare Scheme does not impose significant restrictions on the number of visits to private psychiatrists. Neither are there adequate controls over the distribution of private psychiatrists, nor on priority of access for those people most in need. Few incentives exist for psychiatrists to take on new clients or to work in a public sector with capped funding and more complex clients.

Particular issues exist for prisoners who suffer mental illness, one of the most vulnerable client groups. Currently they are not entitled to use the Medicare and Pharmaceutical Benefits schemes. Consequently, all prisoner health services are state funded.

Systems of Detention

The main trigger for this inquiry was the mistaken detention of Cornelia Rau at an immigration detention centre. This event prompted comment from the Commonwealth Government on the capacity of states and territories to adequately provide mental health services. The terms of reference for the inquiry include the practice of detention and seclusion within mental health facilities and the impact of the criminal justice system on prisoners with mental illness.

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While Victoria welcomes close scrutiny of its legislation, clinical practices and services for involuntary mental health clients and prisoners with mental illness, it is very concerned that this same level of scrutiny does not appear to be applied in relation to people with mental illness in Commonwealth immigration detention centres. In Victoria, once a person is identified as needing involuntary treatment, this triggers a statutory response and treatment is prioritised regardless of the setting the person is in or their status.

There is a diversity of views about involuntary mental health treatment including its inherent and complex balancing of rights and protections. Humane treatment and attention to the rights of the individual underpin the treatment of involuntary clients under the Victorian *Mental Health Act 1986.* High levels of accountability are built into the Act. It prescribes specific processes and procedures for assessments and treatment orders, requirements regarding electroconvulsive therapy, seclusion and restraint and regular independent review of treatment orders and plans. Clients can appeal their involuntary status at any time.

Additionally, *The Crimes Mental Impairment and Unfitness to be Tried Act 1997* (CMIA) provides for detention and treatment of people whose crimes are linked to their mental illness in a high security forensic treatment facility, The Thomas Embling Hospital (TEH). The CMIA contains a transparent and rigorous regime, which satisfies community and judicial concerns about management of risk for these patients when they are in the hospital, on leave or returning to the community.

TEH also provides involuntary treatment of prisoners with mental illness, as under mental health legislation Victorian prisons are not able to undertake such treatment. Victoria is of the view that involuntary treatment in prisons without clear separation of custodial and treatment requirements is contrary to the principles contained in the *Mental Health Act* and in breach of international human rights obligations.

2.2 Comments on Issues of National Relevance

Impact of the National Mental Health Strategy

The National Mental Health Strategy is still undergoing implementation. Its aims and objectives have not been fully achieved, as demonstrated by jurisdictional commitment to a third National Mental Health Plan.

The series of *National Mental Health Reports* show that the public mental health service system in Australia has undergone substantial change since commencement of the first plan in 1992/93. This change was confirmed, and the extent praised, in the international mid-term review of the Second National Mental Health Plan held in 2001.

The *National Mental Health Reports* also show that the rate of mental health reform under the National Mental Health Strategy has varied across jurisdictions. While States and Territories are at different stages of the reform process, all have made changes since the 1992/93 baseline. The 2004 Report highlights key areas of change as being:

- Progress towards community based care (from 29% of specialist mental health funding in 1992/93 to 51% in 2001/02;
- The mainstreaming of mental health inpatient beds (from 55% of acute mental health inpatient beds located in general hospitals in 1992/93 to 82% in 2001/02); and
- The increase in consumer and carer participation in decision-making (from 33% specific mental health consumer representation in 1992/93 to 77% in 2001/02).

Victoria has been at the forefront of mental health reform. Victoria started from the highest per capita funding base in 1992/93 and had the second highest per capita funding in 2001/02, despite the 52% increase in per capita spending by Western Australia. At the start of the National Mental Health Strategy in 1992/93, 83% of Victoria's inpatient beds were in standalone institutions. By June 2002, 89% of Victorian inpatient beds were co-located with general hospitals. Despite a 40% decrease in inpatient beds, this has been more than offset by a 298% increase in community residential beds.

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In 2001/02, Victoria had the highest per capita expenditure on community-based mental health services and Victoria's not-for-profit non-government disability support agencies received the largest share of a state/territory mental health budget (*National Mental Health Report 2004*).

Although specific experiences of some consumers and carers suggest that elements of the mental health service system still require significant change, it would be incorrect to conclude that extensive mental health reform has not occurred, particularly in Victoria.

Resources committed to mental health reform

Although mental health has maintained rather than increased its share of health expenditure (according to the National Mental Health Report 2004), mental health is one of seven National Health Priority Areas and consequently must be considered in the broader context of demands on health funding.

The *National Mental Health Report 2004* (p8) identified that 12% of the net annual increase in spending on mental health reform came from the Australian Government in the form of seed funding, while 47% of the net annual growth was new spending by states and territories on new mental health services.

Under the Australian Health Care Agreement, Victoria receives Commonwealth funding of approximately $18 million for services to people with serious mental illness. This represents a very small proportion (less than 3%) of the $651.8 million spent by Victoria in 2004/05 on services for people with serious mental illness.

Impact on achieving aims and objectives of the National Mental Health Strategy and of the division of responsibility for policy & funding between levels of government

The Australian and State and Territory governments are responsible for funding different elements of mental health services. The Australian government funds private mental health services, such as private psychiatrists and general practitioners, and pharmaceuticals through the Pharmaceutical Benefits Scheme. As mentioned in the general comments section, funding for these services and schemes is uncapped, distribution of services is not related to population need, and there is no prioritisation for those most in need.

States and territories are responsible for funding public specialist mental health services. In Victoria's case, funding is capped, resource allocation and service distribution is informed by estimates of underlying population need, and services are targeted to those most in need. Victoria also funds some of the newer atypical pharmaceuticals in the public system that are now used to treat mental illness but are not covered by the Pharmaceutical Benefits Scheme. Service providers are accountable for providing services to those consumers in their catchment area and are expected to adopt service models that best suit local needs.

Since the users of public mental health services are those most in need, they are usually those with serious mental illness and psychiatric disability, and often have other issues that complicate treatment and rehabilitation, such as substance misuse, low income, social isolation/exclusion, and homelessness. However, the lack of private mental health services in rural areas can result in some people accessing public mental health services who would otherwise access private services.

This is very different to the client profiles of users of private mental health services who usually have mild to moderate mental illness and who can also afford the cost of private health services. Because they are less complex to manage, these clients would appear to be more likely to be accepted for treatment by private psychiatrists.

As all Australian Health Ministers endorsed the National Mental Health Strategy, there is a nationally consistent policy framework. Implementation of the Strategy has to a large extent depended on availability of funding and the base from which reform commenced in each jurisdiction, rather than the separation of Federal and State/Territory responsibilities.

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Barriers to progress

In Victoria, demand for public mental health services has been growing faster than population. Not everyone who seeks a public mental health service has a serious mental illness, and these people could be treated in the private sector. However, the lack of private psychiatrists in rural and remote areas (eg nationally in 2002/03 1.1 per 100,000 population compared with 6.9 per 100,000 population in metropolitan areas [AIHW 2004]), fewer general practitioners in rural and remote areas (eg in 2001, 74.6% of Victorian GPs who responded to the BEACH survey worked in practices located in capital or metropolitan areas [AIHW 2004]), and issues with after-hours General Practitioner access (Victoria has 40% after-hours GP access compared with 43.4% nationally) mean that people in crisis are more likely to seek assistance from the public system. Also, for those people who are clinically stable and no longer require specialist mental health care, limited access to shared care arrangements with General Practitioners diminishes care options.

People who have a mental illness and are being treated in the community may require access to generic personal care and support services, such as Home and Community Care, vocational and recreational services. Provision of generic services is not the core function of specialist mental health services.

Studies[2] have shown that prisoners have a higher incidence of mental disorder than the general population. Since prisoners do not have access to Medicare, state and territory governments fund prisoner health services.

Psychotherapy (such as Cognitive Behavioural Therapy) has proved to be a cost effective treatment for some mental disorders, especially anxiety and depression[3]. However, under the current Medicare arrangements, Medicare only funds psychotherapy costs where the provider is either a psychiatrist or a general practitioner with some welcome, but limited provision, for psychology services through new initiatives such as Better Outcomes in Mental Health. This effectively restricts longer term psychotherapy access to those people who either have ancillary private health insurance (for a psychologist only) or can afford to pay the costs themselves, or to seek treatment from a psychiatrist or general practitioner, or public mental health services. In addition, few psychiatrists in the private sector provide services in a bulk billing arrangement, reflecting the need to change Medicare items.

Opportunities for improved coordination

Shared care arrangements and integrated care projects involving joint treatment of a client by public and private mental health clinicians demonstrate that partnerships are possible across the public and private health service systems and the continuum of care.

However, the lack of private mental health services in rural areas can result in some people accessing public mental health services who would otherwise access private services (eg people with moderate anxiety or depression). Conversely, the degree of discharge possible from the specialist system is restricted by the availability of private services. In metropolitan and rural areas where there are low levels of private services, this means that the specialist system becomes blocked with reduced ability to take on new clients.

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.

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[2] For example, Mental Illness Among New South Wales Prisoners by Butler, T & Allnutt, S. Corrections Health Service, 2003.

[3] Assessing Cost Effectiveness – Mental Health project. Articles such as Cost-effectiveness of cognitive behavioural therapy and selective serotonin reuptake inhibitors for major depression in children and adolescents – Haby et al. Australian and New Zealand Journal of Psychiatry 2004, 38:579-591, and Cost-effectiveness of psychological and pharmacological interventions fro generalized anxiety disorder and panic disorder – Heuzenroeder et al. Australian and

However, the mal-distribution of private mental health services, particularly those who bulk bill, and lack of incentives (mentioned in previous sections) limits the opportunities for public and private mental health services to work in partnership.

Appropriate role for private and non-government sectors

Limited opportunity exists for transfer of business between public and private mental health services because of different clientele and billing arrangements as outlined previously. This is reinforced in Victoria by only public hospitals being able to admit involuntary clients.

In Victoria, hospitals and non-government providers deliver all public mental health services, The well-established non-government sector in Victoria provides psychosocial rehabilitation and disability support services. Service delivery is in accordance with the same policies as clinical hospital services (ie services are prioritised to those most in need, resource allocation and service distribution is informed by population need and providers are funded to service specific regional areas).

The key issues regarding the role of the non-government and private sectors are about their capabilities rather than the type of organisation. These capabilities include the service functions that can be provided, the skills available, the service cost and agency accountability.

Not-for-profit organisations are well placed to provide life skills training and support to people experiencing mental illness, their families and carers. Their smaller organisational structures and involvement of consumers and carers facilitate peer support and more tailored services for service users. In Victoria, these services complement the more treatment-focussed clinical mental health services.

With demand for public mental health services in Victoria increasing faster than population growth (7% per annum over the past five years compared with 1% per annum), the availability of private mental health services should increase opportunities for shared care arrangements between public and private providers, which in turn frees up public service capacity.

The Role of Primary Health Care

The Bettering the Evaluation And Care of Health (BEACH) report on General Practitioner activity 1998-2003 (AIWH 2004) shows that Victorian GPs managed more psychological problems than the national average (12.4 per 100 encounters compared with 11.3 nationally). The report suggested that the higher management rate might have been influenced by beyondblue, an initiative in which the Commonwealth and Victorian governments are senior partners. As part of beyondblue, Victoria funds the Victorian Centre of Excellence in Depression and Related Disorders. These initiatives foster links between the primary and specialist systems and the capacity of primary carers to manage people with high prevalence mental disorders.

Victoria has also created Primary Mental Health and Early Intervention teams in all areas of the state to strengthen the partnership between specialist mental health services and primary care providers. The teams assist primary care providers such as general practitioners and community health services in the early recognition and management of people with high prevalence disorders, particularly depression and anxiety.

Not all people require specialist mental health services at all times. Therefore there is the potential for shared care between specialist mental health services and primary care services.

The National Survey of Mental Health and Wellbeing (1997) showed that, of the people who sought treatment for mental disorders, more people saw General Practitioners than other service providers. This suggests that GP assistance and training are crucial to support people with mental disorders.

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According to the BEACH report, the most common non-pharmacological treatment by Victorian GPs was general advice and education, further emphasising the role of GPs in mental health care.

Overrepresentation in the criminal justice system

Research shows that, in line with other jurisdictions, the prevalence of mental disorders among Victorian prisoners is significantly higher than the prevalence rates in the community - with the prevalence rates for some types of mental illness three to five times that which would be found in the community. About half of the respondents had been assessed by a psychiatrist or a doctor for emotional problems, with more than 15% of those being admitted to hospital for these problems.

Custody giving rise to mental illness

Corrections Victoria acknowledges that prisoners at risk of mental illness are particularly vulnerable in the custodial context. In recognition of this, Corrections Victoria has introduced specific standards of prisoner care that ensure effective early identification, assessment and ongoing management and review of high risk prisoners and prisoners with a mental illness.

Adequacy of legislation and processes

A range of legislative and procedural requirements, together with independent monitoring are in place to safeguard the rights of people with a mental illness in the Victorian correctional system. These safeguards will be augmented with the delivery of a Corrections Disability Framework, which is currently being developed to ensure policy, programs and services are responsive to the rights and needs of prisoners with disabilities, including those with a mental illness.

Diversionary programs

A variety of diversionary programs are in place to divert individuals in the court system from the prison system. They include a range of liaison programs to assist defendants with a mental illness engage effectively with the criminal justice system, as well as programs aimed at maximising eligibility for bail, including referral to relevant accommodation and support services.

Information and Education for Families and Carers

Victoria is a senior partner in beyondblue, which has implemented or funded a number of community awareness programs, designed to increase awareness and understanding of mental illness (especially anxiety and depression) and reduce stigma eg National Workplace program, Lifeline education program. In conjunction with VicHealth, Victoria and beyondblue fund services and activities for children and young people who live with a parent with mental illness.

VicHealth has recently released its second mental health promotion plan since identifying mental health and wellbeing as a priority health issue. Apart from funding projects and programs that directly impact on population attitudes by promoting social inclusion, freedom from discrimination, and economic participation, VicHealth also funds research to ensure that its programs are well targeted and evidence-based.

Victoria also funds psychiatric disability rehabilitation and support services to provide mutual support and self-help to people with mental illness, their families and carers. The Bouverie Centre is funded by Victoria to provide family sensitive training to mental health service providers.

Although much effort has been made in these areas, cultural and attitudinal change takes a long time to take effect. Whilst these efforts should be maintained, they must be balanced with other worthy mental health investments with often greater returns for consumers and their families.

VICTORIA'S INPUT TO THE SENATE SELECT COMMITTEE INQUIRY ON MENTAL HEALTH

Mental Health Research

Mental health research has been identified as a priority theme in the National Mental Health Plan 2003-2008. It needs to be strategically linked to policy priorities, complement broader medical research and focus on the improved dissemination of findings. Coordination of research is well placed at a national level as this minimises duplication of projects and enables maximum information dissemination.

Victoria is developing a mental health research strategy to consolidate and focus future research activity funded by the state. Under the strategy, greater emphasis will be placed on applied research such as evaluation of service delivery models.

Currently, Victoria funds biomedical research through the Victorian Mental Health Research Institute and a range of research projects undertaken by clinical academic positions and beyondblue.

In its suicide prevention action plan, Victoria has identified a need to align data collection and research nationally to properly inform efficacy of interventions.

Data collection, monitoring and evaluation

It is premature to comment on the adequacy of data collection, outcome measures and quality control whilst development is continuing in these areas. There has been ongoing refinement of the national minimum data set for mental health, and reporting on outcome measures is still being implemented. This area has been highlighted for further action in the third National Mental Health Plan.

In Victoria, all public mental health services have been accredited against national health care standards as part of general hospital accreditation or, in the case of the standalone forensic service, in its own right. All the public mental health services have now been scheduled for external review as part of accreditation against the National Standards for Mental Health Services. By June 2005, 77% of services are expected to have completed the external review process, with the rest completed by June 2007.

Victoria is actively participating in the national key performance indicator development process, and in June 2004 implemented the new national key performance indicators in this State. In addition, Victoria also commenced reporting on a number of State-specific indicators. Indicators are reported to services quarterly or annually as applicable, according to the indicator definition and data requirements. In 2005/2006 inclusion of reporting and monitoring against indicators will be incorporated into agency agreements with the Department. Implementation of the indicators enables the State to compare performance between services, identify emerging issues, and ensure that services are operating within appropriate parameters.

VICTORIA'S INPUT TO THE SENATE SELECT COMMITTEE INQUIRY ON MENTAL HEALTH

Attachment 1 - Victorian Response to the Human Rights and Mental Health Report

Victorian Context

There is widespread agreement that Victoria has laid the foundations of a comprehensive age based specialist mental health system, which is now well established and contains most of the elements needed to effectively treat and support people with mental illness. As a specialist system, the bulk of external funding is directed towards the clinical treatment of serious mental illness, supplemented by disability support for consumers to live independently in the community. Victoria, when compared nationally, has proportionally the largest community based system of clinical assessment and treatment and non-clinical support, and the greatest number of people treated in psychiatric wards co-located with general hospitals.

Clinical services treat approximately 56,000 continuing care clients per annum in inpatient and ambulatory settings with up to 12,000 clients also using disability support services with a clinical workforce of over 5000 staff. These services are resourced from a total mental health budget of $652 million in 2004-05.

Victorian Response to the Report

A formal response for inclusion in the final report was requested in relation to sections of the Mental Health and Human Rights Draft Report forwarded to the Victorian Minister for Health on 24 March 2005. Consequently, the following comments are based on an incomplete draft version of the report.

Whilst information about specific consumer and carer experiences of the mental health system provide a critical contribution to the understanding of its performance, these experiences form part of the picture and do not on their own provide evidence of systemic problems in relation to human rights and national standards. However, Victoria accepts that the views expressed are legitimate and reflect the real experiences of particular individuals and wishes to express regret for the negative experiences described in the Victorian section of the report. Victoria also wishes to assure those people who are concerned with services in this state that any feedback received is taken very seriously and that Victoria will continue to improve its services for consumers and their carers.

Notwithstanding the above statements, Victoria has significant concerns with the report's methodology and findings. These concerns are summarised below.

- **The report lacks balance** as it:
  - Draws heavily on the opinions and perspectives of particular individuals and interest groups.
  - Currently excludes publicly available information about service improvement, expansion and reform available at a state and national level.
  - Shows little evidence of any efforts to elicit or report positive views during the consultation process
  - Gives no weight to the constraints the states and territories operate under including capped budgets and high levels of non discretionary expenditure

- **The report has questionable validity** as it:
  - Draws on the results of two surveys with very low response rates, and in Victoria, four meetings and 97 submissions (primarily from individuals), which is hardly representative of Victoria's large consumer, carer and provider base.
  - Generalises the experiences of a limited number of organisations and often aggrieved individuals to the whole system.

- **The report lacks objective data and evidence to support its findings** and therefore makes an unconvincing and uninformed case regarding these findings. For example, it has disregarded the accreditation system for national standards, assessments made by the accreditation agency and level of compliance by services. In Victoria, 82% of area mental health services have completed the accreditation process

VICTORIA'S INPUT TO THE SENATE SELECT COMMITTEE INQUIRY ON MENTAL HEALTH

- **The report draws simplistic conclusions about poor consumer and carer experiences** which cannot always be attributed to specialist mental health system failures but may be:
  - The result of relatively isolated and infrequent events.
  - Linked to the diversity of views about involuntary treatment with its inherent and complex balancing of rights and protections.
  - Related to events which occurred many years previously.

- **The report employs an emotive and adversarial style** that undermines its credibility and is likely to prove unproductive in an area of health where strong collaboration and partnership has underpinned progress to date.

Ultimately, the report is misleading and may undermine the confidence of the community, consumers and carers in the public mental health system. Available data in Victoria indicates that the system operates reasonably well most of the time despite sustained and increasing pressure. It should also be noted that the system contains high levels of accountability with checks and balances that are enshrined in legislation and practice. Service and clinical standards and guidelines are the subject of continued improvement and review. Recent amendments to the Mental Health Act have further embedded good practice into legislation.

The report also risks setting unrealistic expectations about what can be delivered by a publicly funded specialist system of care. A number of issues raised in the report sit well outside the mandate of the specialist mental health system and will require vigorous and sustained effort by the many different areas and levels of government, including the Commonwealth Government, to address.

Victorian Service Developments

In Victoria, the current operating environment is one of sustained demand pressure with an average growth of 7% per annum in clients over the last five years. In response to these pressures and the ongoing need to build on past reforms and improve services access, efficiency and effectiveness the Victorian Government has systematically invested more than $198 million in service improvement strategies since 1999-00. This funding has been directed to strengthening core services, implementing early intervention and relapse prevention initiatives, and creating an environment that enables clinical practice and service models to better align with the changing needs of consumers and their carers. Some major new and innovative initiatives include:

- **Primary Mental Health Teams** that build the capacity of general practitioners and other primary health providers to support people with a mental illness through the provision of specialist consultation.
- **Early Psychosis** programs which provide early intervention for young people with an emerging disorder
- **Dual Diagnosis** services which provide integrated responses to clients with co-existing mental illness and substance abuse
- **Sub-acute services** that provide transitional step down support from inpatient care to home
- **Intensive housing support services** for consumers with complex needs

Mental Health continues to be a high priority for the Victorian Government. Its social policy statement *A Fairer Victoria* released on 28 April 2005 makes a substantial commitment of **$180 million over the next four years** for service growth and improvement, including $55.5 million for planned capital developments. Further improvements will focus on early intervention across the age groups by providing:

- **Intervention and prevention during the early stages** of an emerging disorder (in order to prevent the illness progressing and/or avert escalation and the need for a long period of support)
- A **quicker** service response (to prevent a crisis developing or worsening)
- A **more intensive** service response (to ensure treatment is effective)
- **Better follow-up** after discharge (to prevent relapse of the condition).