Department of Human Services

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10 AUG 2005

OUR REF: ADD-05/24477
YOUR REF:

Mr Ian Holland
Committee Secretary
Senate Select Committee on Mental Health
Department of the Senate
Parliament House
CANBERRA ACT 2600

Dear Mr Holland

During my appearance at the Melbourne public hearing of the Senate Select Committee on Mental Health, I took three questions on notice.

Please find attached written responses to those three questions as requested in the email dated 27 July 2005 from the Committee Chair.

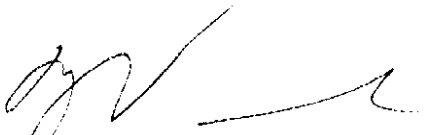
Additionally I would like to provide further information about two items which I responded to at the hearing.

Female forensic beds
During my presentation to the Committee, I was asked about the provision of gender-specific bed-based forensic services and responded that Thomas Embling Hospital had 12 or 15 beds for women. I have now clarified this situation and can report that the Barossa Unit at Thomas Embling Hospital accommodates ten women and is a women-only unit. Women can also be accommodated in the Bass and Daintree units and there are currently fourteen women accommodated at this facility in total.

Relative resource allocation
I also wish to advise that, in addition to the information I provided at the hearing, according to the National Mental Health Report 2004, in 2001/02 Victoria spent approximately 36% of its recurrent services funding on inpatient services, 55% on community-based clinical treatment (community residential and ambulatory clinical services), and 9% on psychiatric disability support services provided by the non-government organisations in the community. The percentage funding that I referred to during the hearing as 'community services' is actually the approximate percentage funding for ambulatory clinical services rather than all community-based services. Since Victoria has well-established community residential services, the two terms are not interchangeable.

I trust the information provided satisfies the requirements of the Committee. Further information can be provided on request.

Yours sincerely



DR RUTH VINE
Director Mental Health

SENATE SELECT COMMITTEE ON MENTAL HEALTH

QUESTIONS ON NOTICE (ex Public Hearing Melbourne, 7 July 2005)

Question1

Following reference to the practices of restraint and seclusion in mental health services, Senator Humphries asked about avenues of complaint relating to the "inappropriate treatment of the mentally ill in public institutions" and the number of such complaints in front of the Chief Psychiatrist at the moment.

During 2004 the Chief Psychiatrist received 556 complaints about mental health services. The major categories of complaint were about involuntary treatment (16%), carers having difficulty gaining access to services (9%) and medication prescribed (14%). Two complaints related to seclusion and there was one complaint about mechanical restraint. In addition, for the same period the Chief Psychiatrist's office also dealt with 436 information requests and 217 general enquiries. Seclusion was the subject matter for 8 information requests and 3 requests for information pertained to mechanical restraint. Currently, the Chief Psychiatrist is investigating two complaints about seclusion practice and one complaint relating to an allegation of sexual assault.

The following provides an overview of the role of the Chief Psychiatrist.

General Clarification of the role of the Chief Psychiatrist

The Victorian Mental Health Act 1986 provides for the appointment of a Chief Psychiatrist by the Secretary to the Department of Human Services. Subject to the general direction and control of the Secretary, the Chief Psychiatrist is responsible for the medical care and welfare of persons receiving treatment or care for a mental illness. The Chief Psychiatrist undertakes a range of statutory and quality monitoring functions in fulfilment of these statutory responsibilities.

In order to facilitate performance of these functions, the Chief Psychiatrist has broad powers of investigation, inspection and enquiry. Following such enquiries, the chief psychiatrist can direct services to discontinue or alter practice, procedure or treatment, direct them to observe or carry out a practice, procedure or treatment specified, or direct provision of treatment to a person. The chief psychiatrist may also direct that a person be admitted to an approved mental health service as an involuntary patient.

The Chief Psychiatrist also receives a range of statutory reports concerning the performance of electroconvulsive therapy (ECT) in licensed premises, seclusion and mechanical restraint in approved mental health services, and annual medical examinations of all involuntary patients under the Act. Deaths of persons in care are also reported to and reviewed by the Chief Psychiatrist. In addition, the Chief Psychiatrist has a range of other functions relating to forensic and security patients pursuant to the *Sentencing Act 1991* (Vic) and the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997.*

COMPLAINTS

The Chief Psychiatrist receives a wide variety of contacts from consumers, carers, relatives, members of the public, health care professionals and other bodies. Contacts are a key source of information about issues of consumer and carer concern, service gaps and matters relating to clinical standards and practice

Patient rights information brochures are required by regulation to be provided to consumers, and include contact details for the Chief Psychiatrist as an avenue of complaint and information. In addition, enquiries and issues may be brought to the Chief Psychiatrist by other agencies such as the Health Services Commissioner, the Office of the Public Advocate, the Ombudsman, the Minister for Health or other areas of the Department of Human Services. Mental health consumers and carers can also complain to the Health Services Commissioner in Victoria.

SECLUSION AND MECHANICAL RESTRAINT

Clearly, seclusion and mechanical restraint impose significant restrictions on an individual's freedom of movement and are only used as an intervention of last resort to protect the person or others when the person is at risk of self harm or harm to others and unable to be treated in a

less restrictive manner. The seriousness of these practices is reflected in the level of observation and review the *Mental Health Act* 1986 imposes. A registered nurse must review the person at not more than 15-minute intervals and a medical practitioner must review them at intervals of not more than four hours. Seclusion can only occur in approved mental health services.

In addition to the legislative requirements, the Chief Psychiatrist has developed and published guidelines for the use of both seclusion and mechanical restraint to establish minimum practice standards, answer some common questions and discuss legal and clinical issues.

The Chief Psychiatrist maintains a number of databases relating to statutory practices, including seclusion and restraint.

Question 2
Senator Forshaw believed that the Australian Health Insurance Association had claimed that 43% of mental health services were provided by the private hospital sector.

The Australian Health Insurance Association (AHIA) and Australian Private Hospitals Association (APHA) have both claimed that 43% of all hospital-based psychiatry services are provided by the private hospital sector. This claim is based on data in *Australian Hospital Statistics 2002-03* (Australian Institute of Health and Welfare, 2004) that showed that 43% of total hospital separations for mental disorders occurred in private hospitals

However, data in *Mental Health Services in Australia 2002-03* (Australian Institute of Health and Welfare, 2005) indicate that only 19% of total hospital separations for mental disorders occurred in private hospitals. The difference in data between the two reports is most likely due to differences in counting rules (ie data definitions) and possibly differences in agencies reporting.

The crucial point is that the National Mental Health Policy espouses treatment in the least restrictive environment. Consequently, public mental health services tend to focus on community-based treatment, with hospital-based treatment used on an episodic basis for acute illness.

For example, in 2002/03, only 20% of clients who received treatment from Victorian public mental health services were treated in Victorian public hospitals. According to the *National Mental Health Report 2004* (Department of Health and Ageing, 2003) In 2001-02, 64% of Victoria's funding was spent on community-based services. Therefore, while the private hospital sector may claim to provide a large proportion of hospital-based mental health services, a comparison of hospital-based treatment does not accurately reflect relative differences in public and private mental health service use because of the public mental health focus on community-based mental health treatment.

It should also be noted that the APHA advised in their submission that there were 25 specialist private psychiatric hospitals (1,463 beds) and 21 other private hospitals with psychiatric wards across Australia. This compares with 19 specialist public psychiatric hospitals (2,358 beds) across Australia and 128 general acute public hospitals with psychiatric units or wards in 2002-03[1].

Senator Forshaw also referred to the AHIA claim that private hospitals treat the full range of mental disorders.

Data[2] indicate that, nationally, although private hospitals treat people with a range of diagnoses, the most common diagnoses treated are depression and stress disorders.

This compares with the public hospitals that, nationally, also treat people with a range of disorders, predominantly people with schizophrenia, depression and bipolar disorders.

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[1] *Mental Health Services in Australia 2002-03* (Australian Institute of Health and Welfare, 2005)
[2] ibid

In mental health, diagnosis is not the best indicator of illness severity, hence the exclusion of mental disorders from the general hospital casemix funding model. Since involuntary treatment is only invoked in the most severe cases of mental illness, this is used as a de facto indicator of illness severity.

Data[3] indicate that nationally involuntary treatment is mostly undertaken in the public mental health sector. Therefore, while private hospitals may claim to treat a full range of mental disorders, they tend not to treat as many people with the level of illness severity and psychiatric disability as treated in public mental health services.

It should be noted that, in Victoria, involuntary mental health treatment as prescribed under the *Mental Health Act (1986)* cannot occur in private hospitals. However, while this may legislatively limit those people with severe illness who can access private hospitals, clients with private health cover, or who desire treatment in the private sector, can be transferred when well enough to accept voluntary treatment, or in the case of community treatment orders, where a private practitioner agrees to work in partnership with the monitoring public psychiatrist.

Question 3
Senator Forshaw sought information about what the Victorian government is doing about mental health literacy in the broader community.

Mental Health Branch
The Victorian Mental Health Branch invests more than $9.4 million per annum in mental health promotion and prevention. This funding includes:

- $0.9 million to fund:
  - VicHealth (to fund programs targeted to both the boarder community and specific population subgroups [eg. refugees, young people, rural, koori, older people]. VicHealth has just finished developing its second Mental Health Promotion Plan;
  - dedicated Mental Health Promotion Officers in all child and adolescent mental health services;
- $3.5 million to beyondblue. Victoria is a senior partner in beyondblue. (This includes $1.3 million is provided for the Centre of Excellence in Depression and Related Disorders.)
- approximately $5 million to psychiatric disability rehabilitation and support agencies to provide mutual support, self-help, information and advocacy.

While not being separately funded, community development around mental illness is also an integral part of the core business for all Victorian public mental health services.

Department of Human Services
More broadly, the Department of Human Services has:

- dedicated Health Promotion Officers in each Primary Care Partnership. Mental health promotion is included in the roles of these positions;
- the Better Health Channel, which provides health information, including mental health information, to the community and professional groups via the Internet;
- same sex attracted youth project to undertake mental illness prevention and build mental health resiliency in same sex attracted young people; and,
- secondary school nurses, who focus on reducing negative health outcomes and risk-taking behaviour in young people.

Whole of Victorian Government
The Victorian Suicide Prevention strategy, coordinated by the Mental Health Branch, is funded $23.9 million per annum to provide primary prevention, early intervention, intervention and postvention programs.

VicHealth (Victorian Health Promotion Foundation) reports to the Victorian Minister for Health and provides health promotion services throughout Victoria. In 2003/04, VicHealth spent 29% of its budget (approximately $7 million) on mental health and wellbeing. Programs focused on

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[3] ibid

improving community collaboration and social inclusion through arts participation, strengthening the health and wellbeing of local communities through cultural festivals, and specific research projects to address identified gaps in mental health promotion such as the engaging and supporting children of parents with mental illness and establishment of a Centre for Research and Practice in the Promotion of Mental Health and Social Wellbeing. Mental health promotion activity was aligned with the new VicHealth Mental Health Promotion Action Plan 2005-2007.