Points from HREOC report draft

Standard no	Issues raised in report	Victoria's issues	Victoria's response
1- Rights	• Fear of retribution if person complains • Information not provided to clients and carers • Unclear who should explain rights to service users • Rights are not explained in an understandable manner	• Unable to quantify extent of the problem from the report. • Report findings appear to contradict Victorian 2003/04 consumer and carer participation survey results that show that 67% of consumers of adult mental health services who responded to the survey thought that Victorian services were good to excellent on consumer rights.	• Consumer consultants are employed in all mental health services and carer consultants in many mental health services to assist clients and to represent consumer and carer views to the organisation. • Independent Third Persons and the Office of the Public Advocate are available to provide assistance and support to individuals who have concerns about their treatment. • Apart from internal complaints mechanisms of individual services, the Office of the Chief Psychiatrist and the Health Services Commissioner can investigate consumer and carer complaints about treatment. • The Mental Health Review Board independently reviews the need for the involuntary treatment of individual clients.
2- Safety	• Use of sedation and restraint during bed waits in Emergency Departments • Concerns about client safety in mixed gender units • Lack of supported accommodation • Poor response to carer safety concerns • Staff safety concerns regarding the behaviour of consumers with co morbid mental health and substance misuse issues.	• Unable to quantify extent of problem from the report. • The report implies that waiting in Emergency Departments for a bed is a form of consumer abuse.	• Initiatives are being introduced to improve bed access and increase staffing to reduce waiting times in Emergency Departments. New subacute services should also help ease the demand for mental health acute inpatient beds. In 2004/05, an extra $8.6 million is being used to reduce the need for acute inpatient beds through diversion, early intervention and relapse prevention services. • The need to maximise acute inpatient bed use preclude the creation of gender specific wards except in some specialist services eg mother-baby/eating disorder services, some forensic services • Additional intensive clinical and rehabilitation resources are being provided to improve service responsiveness and the level of support to clients with complex needs to assist relapse prevention eg in 2004/05, an additional $1.4 million has been provided for housing and support, supported accommodation and residential rehabilitation for young people with dual diagnosis. • Dual diagnosis services are being extended and integrated into adult mental health services eg in 2004/05 an additional $0.75 million was provided for dual diagnosis services.

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3 – Consumer & carer participation	• Poor consumer peak representation nationally • Carers ignored • People with Borderline Personality Disorder (BPD) not considered State or nationally	• The quotes are very general and seem to relate more to consumer and carer participation at the national level. • There is a focus on the availability of diagnosis-specific services rather than services for people with severe mental illness regardless of diagnosis • Responses to the 2003/04 Victorian consumer and carer participation survey showed that carers were usually more dissatisfied with services than consumers.	• Victoria focuses on providing public mental health services to people with serious mental illness regardless of diagnosis, although it does have a statewide specialist borderline personality disorder service that provides consultation to broader mental health services • Carer consultants are employed in many Victorian public mental health services to provide assistance to carers and ensure that the carer views are represented in the organisation • Victoria released a new carer policy, *Caring Together*, in 2004. • Consumers and carers are represented on the Ministerial Advisory Committee on mental health and associated subcommittees.
4 – Community acceptance	• Lack of social supports for consumers • National Mental Health Strategy campaigns to reduce stigma have been unsuccessful • Campaigns focus on psychotic illness & depression and do nothing for other disorders such as Borderline Personality Disorder • Discrimination shown by mental health service providers • Unresponsive, unsympathetic services • Family rejection • Housing discrimination • Later service response means greater acuity seen in community. • Therapy seen as less legitimate than medication	• There appears to be a focus on the lack of diagnosis-specific services and a particular type of treatment. • The Commonwealth is also responsible for universal mental health promotion campaigns aimed at reducing stigma.	• Victoria has extensive psychosocial rehabilitation and support services for consumers with mental illness and their carers (receiving $57.7 million in 2004/05). These supplement the personal support that should be available through generic social services. • Paid consumer and carer consultants in area services often participate in in-house staff training to ensure that consumer and carer perspectives are presented to staff. • Public mental health services provide a variety of treatments that include therapeutic as well as medicinal treatments. Limited counselling is available through generic community health services. The Commonwealth is responsible for improving access to private psychologists and counsellors through Medical Benefits Scheme and private health insurance schemes. • Treatment in the least restrictive environment means that people are not admitted to the more restrictive hospital environment unless they cannot be satisfactorily treated in the community. • Additional funding is being provided to Victorian public mental health services to improve service responsiveness and shift the focus from crisis treatment to earlier intervention and relapse prevention (eg an additional $3.2 million funding was provided for early intervention and relapse prevention in 2004/05). • There is redress under legislation for discrimination by

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			businesses based on disability.
5 – Privacy & confidentiality	• Lack of carer involvement in consumer treatment	• All the issues raised relate to carers. The report ignores the dichotomy between consumer and carer views	• Privacy and confidentiality provisions regarding client treatment are incorporated in the Mental Health Act. While carer involvement is recommended, it is up to the consumer to decide the extent to which this occurs. • Carer consultants are employed in many services to assist carers and ensure that carer views are presented in the organisation. • Carers are incorporated in treatment plans under Mental Health Act amendments.
6 – Prevention & promotion	• Services only respond to crises • Service providers do not listen to carers • Need increased General Practitioner involvement, less stigma and discrimination, and more promotional strategies	• All the comments in the report about early intervention problems are from carers. Only the community promotion concerns appear to have been raised by consumers.	• Victoria is continuing to expand its early psychosis services for young people (an additional $0.96 million funding provided in 2004/05). • Increased resources are being used to shift service system focus more towards early intervention and relapse prevention and away from crisis intervention (eg an additional $3.2 million funding was provided for early intervention and relapse prevention in 2004/05). • Primary Mental Health Teams (PMHT) continue to build relationships and establish service arrangements with primary care providers through shared care, education and consultation services. • Funding for universal mental health promotion is also the responsibility of the Commonwealth government.
7 – Cultural awareness	• Lack of sensitivity to spiritual beliefs • Lack of understanding about recent immigrants	• It is hard to quantify the extent of this problem since the report presents one case and a general statement that did not indicate whether the service response was an issue.	• Victoria funds the *Victorian Transcultural Psychiatry Unit*, *Victorian Foundation for Survivors of Torture* and *Victorian Aboriginal Health Service* for consultation, staff education and training. • Services employ paid consumer consultants to assist consumers and ensure consumer views are represented in the organisation. • Consumers and carers are represented on the Ministerial Advisory Committee on mental health and associated subcommittees.

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8 – Integration 8.1 Service integration	• Non responsiveness of crisis services • Diminished service access & duration • Lack of bulkbilling General Practitioners & private psychiatrists. • Lack of counselling/psychotherapy services • Staff turnover • Lack of communication across treatment settings	• This standard relates to integration of mental health service components and continuity of client care, not integration with other services nor access to services, which are dealt with under other standards.	• Additional staff have been funded to improve service responsiveness, particularly for clients with complex needs such as homelessness and dual diagnosis (eg in 2004/05, an additional $1.6 million funding has been provided for consumers who are homeless and/or has a dual diagnosis). • General Practitioner & private service access (cost & distribution) is a Commonwealth responsibility. • Workforce is flagged as a national issue under the *National Mental Health Plan 2003-2008*. • Communication across treatment setting is covered in Standard 10 - Documentation
8.2 Integration with health system	• Neglect of physical health • Shared care arrangements	• The quotes about physical health problems are from carers. It is unclear if this was an issue for consumers.	• All services except Forensic are mainstreamed with generic health services. • Primary Mental Health Teams (PMHT) continue to build relationships and establish service arrangements with General Practitioners and primary care providers for shared care, education and consultation services. • Discharge planning guidelines provide protocols for General Practitioner and share care arrangements
8.3 Integration with other services	• Difficulties accessing housing • Financial support • Vocational rehabilitation programs needed • Cross-program linkages • Domestic violence • Children of parent with mental illness • Carer support – social, financial • Early intervention for young people • Support services after suicide • Police involvement in transport & restraint • Medicare rebates – rebate delays, psychologists (no rebates), General Practitioner reimbursement • Lack of employment & support	• Specialist mental health services are not core accommodation providers, although they work in partnership with housing services. • Vocation rehabilitation, employment, Centrelink and Medicare are Commonwealth responsibilities. • Suicide is not the sole responsibility of mental health services and requires a whole-of-government approach.	• Additional funding has been provided for supported accommodation and intensive housing support services to assist people with mental illness maintain stable accommodation (in 04/05 an extra $0.86 million). This is apart from the existing partnership with Office of Housing (Housing & Support program), where public housing properties are provided in conjunction with mental health outreach services. • Victoria is currently expanding its early psychosis services for young people (an additional $0.96 million funding provided in 04/05). • A new protocol was recently released between Victorian mental health services and Victoria Police clarifying the role of police in transport and restraint of mental health clients. • Vocational rehabilitation and employment programs are a Commonwealth responsibility. • Medicare and General Practitioner reimbursement are also a Commonwealth responsibility.

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			• Suicide services are broader than mental health services. There has been considerable whole of government effort in responding to the issue of suicide in Victoria since the release of the Victorian Suicide Prevention Taskforce Report in 1997.
9 – Service development	• Cuts to inpatient funding over past 10 years • Culture of blame • Disaggregation of system when mainstreaming occurred • Worse than 12 years ago. • Better than 20 years ago • Deinstitutionalised people now homeless or in jail • Not able to deliver best possible service. • Shortage of acute & short-term beds. • Reliance on carers. • Reform stagnated. • No longer consumer focus. Focus is govt protection. • New institutions created, patchy leadership, poor morale and work practices • The Office of the Chief Psychiatrist not independent of government • Minister out of touch. • Workforce review program late • Auditor-General's concerns correct. • Planning without consultation and inflexible resource distribution. • Service for life • Lack of support services eg after hours, counselling, Psychiatric Disability Residential and Support Services • Dual Diagnosis service • Poorer quality services because service diluted. • Variable quality of care	• This section contains a number of personal opinions that do not appear to be supported by facts. • Many of the issues included in this standard relate to other standards. • Rebates for General Practitioners and private medical services and distribution are Commonwealth responsibilities.	• The Victorian government has consistently increased funding for mental health services. Since 1999, the Government has provided additional funding to the mental health system of over $198 million or 30 per cent. • As standalone institutions were closed, funding was redirected to local, community-based services, where most consumers are treated. Long-term inpatient beds in particular were targeted for redevelopment as community-based services. The *National Mental Health Report 2004* shows that there has been minimal change in the numbers of acute inpatient beds over the last 10 years in Victoria. The 2004 Report also shows that there were more non-acute and community residential beds in June 2002 than in June 1993 (a total of 1,217 non-acute and community residential beds in 1993 compared with a total of 1,353 non-acute and community residential beds in 2002). • Investment in ambulatory services enables greater flexibility in meeting client needs rather than tying up large amounts of resources in bed-based facilities. • Victorian planning for public mental health services focuses on addressing areas of greatest need. It is expected that services use the most efficacious treatment model to improve individual client wellness. • Victorian resource allocation is informed by a weighted population formula, which adjusts for area differences in population characteristics such as socioeconomic status, rurality and availability of private mental health services. • Recent funding initiatives have included funding for additional acute inpatient beds (eg in 2004/05 an additional $2.75 million funding). • Workforce has been identified as a national issue. • Distribution of General Practitioners and private psychiatrists, and Medicare funding are Commonwealth responsibilities.

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	• Unsatisfactory levels of service • Need for more intensive inpatient care. • Staff turnover therefore staff continuity problem • Staff shortage • Heavily accented staff • Inadequate funding level & control • Federal funding increased by $1.2 million but State funding decreased by $1million. • New Zealand provides twice the per capita funding • Progressive inpatient budget cuts. • More funding to primary care via Medicare. • No care in rural areas. • In Melbourne, distribution of public mental health services, private psychiatrists and primary care is direct inverse of need. • Because of catchments, if cannot get care in own area, cannot seek care elsewhere. • Under funding of rural areas. • Planning uses medical model only. • Nurse training • Insensitive staff attitudes • Clinician exposed to negative emotions & burn out		• A Ministerial advisory subcommittee is currently examining service catchments with a view to improving service access. • It is unclear how Victoria is alleged to have reduced its funding for mental health services when it has been progressively increasing funding. Since 1999/2000, the Government has provided additional funding to the mental health system of over $198 million or 30 per cent.
10 – Documentation	• Incomplete documentation • Too much paperwork • Limited or no client engagement by staff • Documentation not accessible across service settings	• Some of the examples seem to relate to issues other than documentation and are covered under other standards.	• Clinical reviews highlighted variability in documentation standards across services but have also noticed improvements over time.

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			• The Office of Chief Psychiatrist is unaware of any complaints from psychiatrists about excessive paperwork associated with Community Treatment Orders and is concerned at the suggestion that a clinician would risk a client's health because of paperwork.
11 – Delivery of Care 11.1 Access	• Cannot access services even if harming • Carers not heard • Telephone triage – messages not passed on, people rejected • Lack of access to private psychiatrists, General Practitioners, counsellors, Psychiatric Disability Residential and Support Services • People absconding and self-medicating • Short case management • Crisis management means treatment more intrusive & restrictive than if undertaken earlier • Need 24hr clinics • Crisis only service responses • Non-responsive services • Crisis in the community perpetuates stigma • Carers cannot initiate treatment	• Victoria is unable to quantify the extent of the problem from the report. • This section highlights the consumer/carer dichotomy relating to treatment.	• Demand for services has grown faster than growth funding. Additional funding has been earmarked to improve service access and shift service focus more to early intervention and relapse prevention (in 2004/05 an additional $3.2 million was provided for early intervention and relapse prevention). • Victoria has recently released the outcomes of a triage project to standardise access across mental health services.
11.2 Entry	• Entering the system via Emergency Departments – the environment & the wait • Mixed reports about triage	• All the comments reported are from carers. It is unclear if consumers have similar views about Emergency Departments.	• Victoria is aware of increasing wait times in Emergency Departments for mental health treatment and is providing additional resources for more intensive services to people with complex needs who frequently attend Emergency Departments, as well as expanding services to become more responsive earlier in an illness episode (eg in 2004/05 an additional $7.4 million to expand existing service capacity, relapse prevention and early intervention).
11.3 Assessment & review	• telephone assessment • assessments but no obvious treatment	• The comments reported are from carers. It is unclear if consumers have similar views.	• Treatment responses are focused primarily on assessment of consumer needs. There are occasions when consumer and carer views may differ about consumer needs

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11.4 Treatment & support	• lack of youth services & carer support • lack of dual diagnosis services • rural & regional areas under serviced • lack of personality disorder services • lack of carer involvement	• Availability of private services is a Commonwealth responsibility. • Access to public mental health services (voluntary and involuntary) is based on illness acuity not diagnosis. • Multiple quotes from one or two submissions presented as separate quotes create the illusion of multiple submissions from different people on the same issue. • Victoria focuses on providing public mental health services to people with a serious mental illness regardless of diagnosis.	• Victoria has continued expansion of early psychosis services for young people and dual diagnosis services for people with co morbid mental illness and substance misuse (in 2004/05 an additional $2.6 million for additional early psychosis and dual diagnosis services). Dual diagnosis services are seen as a core part of specialist mental health services. • Victoria has a statewide personality disorder service that provides consultation and liaison to other services. • Carer consultants ensure carer views are represented in many services. • The extent of carer involvement in consumer treatment is dependent on the consumer. • Carers are incorporated in treatment plans under Mental Health Act amendments.
11.4A Community living	• lack of community support services • discharge from community services • lack of leisure, recreation & employment programs • need for self-care programs and supported accommodation	• It is not the responsibility of specialist mental health services to provide all types of services to clients. Under mainstreaming, generic services are funded to provide many services, although this may be done in partnership with mental health services initially.	• Victoria has a well developed Psychiatric Disability Rehabilitation and Support service system (funded for $57.7 million in 2004/05). This is complemented by personal support services available from generic community services. • Generic leisure & recreation programs are funded to provide services to people with mental illness. The provision of these programs is not seen as core business for specialist mental health services. • The Commonwealth government is responsible for employment and vocational rehabilitation. • Victoria has increased funding to and monitoring of services to ensure better post-discharge follow-up of clients (eg an additional $3.56 million funding in 2004/05 to support discharge functions)
11.4B Supported accommodation	• lack of support accommodation • step up/step down services, especially for dual diagnosis consumers	• Most of the quotes in this section of the report are from clinicians or carers. It is unclear what views consumers have on this issue.	• Victoria has funded intensive supported accommodation services to increase housing stability for complex clients (an additional $0.86 million funding in 2004/05 to expand housing and support and supported accommodation services). This is apart from existing outreach programs that assist clients in maintaining stable accommodation. • The Housing and Support program is the result of a partnership between the Office of Housing and mental health services where public housing is provided in conjunction with mental health services.

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			• Subacute services are being piloted as an alternative to hospitalisation, facilitate earlier intervention and support discharge (an additional 10 places were funded in 2004/05).
11.4C Medication & medical technologies	• Clients unable to get a second opinion	• The example used appears to relate more to the service access standard.	• Victoria is not responsible for the funding or distribution of private services. • Victoria is currently examining its catchment areas to facilitate service access.
11.4D Therapies	• Reliance on medicinal treatment, no behavioural change programs	• Multiple quotes from one submission make it difficult to quantify the extent of this problem.	• Victorian public mental health services provide a variety of therapies. Services are expected to provide the most efficacious treatment for clients.
11.4E Inpatient care	• death in inpatient care • lack of beds • police transport • restraint • consumers not involved in treatment plans	• Except for the section on restraint, most quotes are from clinicians or carers. It is difficult to assess consumer issues with this standard. • Consumer involvement in treatment plans is covered under other standards eg Standard 1.	• Victoria has recently released a new protocol between public mental health services and Victoria police that clarifies transport arrangements. • Victoria is currently increasing the number of acute beds in under-bedded areas of the state (an additional 26 adult acute beds were funded in 2004/05). • Victoria has increased funding to and monitoring of services to ensure better post-discharge follow-up of clients (eg an additional $3.56 million funding in 2004/05 to support discharge functions). • Apart from consumer consultants, Independent Third Persons and the Office of the Public Advocate are available to provide independent assistance and support to individuals who have concerns about their treatment. • Apart from internal complaints mechanisms of individual services, the Office of the Chief Psychiatrist and the Health Services Commissioner can investigate consumer and carer complaints about treatment. • The Mental Health Review Board independently reviews the need for the involuntary treatment of individual clients.
11.5 Planning for exit	• exit based on access to beds not wellness of client • exit plans not authorised by medical staff	• All the quotes are from carers, so it is difficult to assess consumer issues with this standard.	• See Standard 10 – documentation • Victoria is currently increasing the number of acute beds in under-bedded areas of the state (an additional 26 adult acute beds were funded in 2004/05). • Victoria has increased funding to and monitoring of services to ensure better post-discharge follow-up of clients.

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11.6 Exit & re-entry	• carers not consulted when consumers discharged from inpatient units • consumers discharged while ill • no follow-up after inpatient discharge • no review of accommodation arrangements prior to exit	• All the quotes are from carers, so it is difficult to assess consumer issues with this standard.	• Victoria has increased funding to and monitoring of services to ensure better post-discharge follow-up of clients (eg an additional $3.56 million funding in 2004/05 to support discharge functions). • Consumer and carer views do not always align. • Carers are incorporated in treatment plans under Mental Health Act amendments.
Homicide & suicide	• Homicide – Victorian client in New South Wales • Suicide – after discharge/on leave, carers not heard • need safe place to stay till OK	• Victoria is not responsible for what occurred in New South Wales. • The report is focused on purported performance of services against national standards. Suicide and homicide do not have a separate standard so should not be reported separately.	• Although a Victorian client was involved, the episode occurred interstate, and the client was treated by the interstate services, which are outside Victoria's jurisdiction. • Victoria has increased funding to and monitoring of services to ensure better post-discharge follow-up of clients. • Carers are incorporated in treatment plans under Mental Health Act amendments.

Further supporting information can be found in:

- Summaries of the 2003/04 surveys of consumer and carer experience of Victorian public mental health services;
- *Victorian strategy for safety and quality in public mental health services*;
- *Annual Report 2003: Office of the Chief Psychiatrist*;
- *Victoria's implementation of the national standards for mental health services; progress report September 2004*; and,
- *Caring Together: an action plan for carer involvement in Victorian public mental health services*.

Copies of these documents were provided to Mr John Mendoza, Chief Executive Officer, Mental Health Council of Australia, on Wednesday 13 April 2005 at his meeting with Dr Ruth Vine, Director, Mental Health, Victorian Department of Human Services.