



**OFFICE OF THE
PUBLIC ADVOCATE**

Submission to the Mental Health Reform Strategy

*Because Mental Health Matters – A new focus for mental
health and wellbeing in Victoria*

July 2008

Contact: Janine Bush
Manager, Policy and Education
Office of the Public Advocate
Level 5, 436 Lonsdale St
Melbourne, Vic. 3000
Ph: (03) 9603 9567
Email: Janine.Bush@justice.vic.gov.au

Prepared by: Liz Dearn
Policy & Research Officer
Office of the Public Advocate

Contents

About the Office of the Public Advocate.....	3
Summary of recommendations.....	4
How we have approached this submission.....	9
General comments on the Green Paper.....	11
OPA’s experience of the current mental health system.....	13
Conclusion.....	27

About the Office of the Public Advocate

The Victorian Public Advocate is appointed by the Governor in Council pursuant to the *Guardianship and Administration Act 1986 (Vic)*. It is a statutory office, independent of government and government services and can highlight situations in which people with disabilities are exploited, neglected or abused.

The Office of the Public Advocate (OPA) provides advocacy, guardianship and investigation services to people with a cognitive disability. People with a cognitive disability include people with an intellectual disability, a mental illness, an acquired brain injury, dementia and people who are in a coma or otherwise lack the capacity for cognition or communication.

OPA coordinates the Community Guardianship Program and the Private Guardian Support Program, as well as the Community Visitors Program and the Independent Third Person Program. It also has a role in community education, the provision of advice and information and in undertaking research and policy projects.

OPA has had long standing concerns about the accessibility and responsiveness of the public mental health system in Victoria. The Public Advocate acted as guardian for 1,292 people in 2006-7. People with a mental illness represent around fifteen percent of people for whom advocacy and guardianship was provided by the Office of the Public Advocate in 2007. Many of these were complex clients not receiving adequate and appropriate support and care from the mental health service system.

Community Visitors in the mental health stream made 1251 visits to facilities in 2006-2007. On an annual basis, fifteen to twenty percent of all calls made to OPA's telephone advice service are made in relation to a person with a mental illness. Of these, many are made by people with a mental illness who were involuntary patients and who wished to access the Community Visitors Program.

Summary of recommendations

The mental health reforms offer an opportunity for Victoria to continue to be steps ahead in relation to models of health care for people with a mental illness. An enhanced focus on early intervention and prevention needs to be supplemented with a strong commitment to meeting the needs of people who have fallen between the cracks of the current system - people with complex needs, people in the criminal justice system, people who are homeless or at risk of being homeless.

While not ignoring the significant gaps in bed based care and the need to urgently address acute bed and SECU bed shortages, OPA believes that ultimately a well funded community based system of recovery and care including home-based care is the way of the future. Large injections of funding in the areas of accommodation and support are required, particularly towards the PDRSS service system, which offers an excellent model of home based outreach support, respite, day care, peer support and residential care.

While OPA welcomes models like PARC and the Integrated Rehabilitation and Recovery Service model, they will require additional resourcing for them to have a wide reaching impact. Peer-based models of support and non-clinical step-down models also require further exploration and expansion. Consumer and carer issues are high on the agenda and Victoria would do well to enhance its commitment to this area.

ENTRY POINTS TO THE SYSTEM FOR PEOPLE IN CRISIS

1. Community visitors note that the role of the Dedicated Nurse Practitioner works well in emergency departments, increasing the possibility that consumers will have access to specialist assessment and support. However, these positions need 24/7 funding.
2. Community visitors observe that the bed manager role works well. The use of a centralised system for allocating beds appears to lead to a more efficient and fairer allocation of acute beds.
3. The development of more short stay facilities in general hospitals for the initial assessment of mental health crisis is needed. This would relieve pressure on the emergency department while ensuring a more comprehensive assessment of consumer needs.
4. The development of a community-based entry point to the mental health system is required to facilitate alternatives to crisis-driven entry to the system.
5. OPA would like to see a shift in focus from hospital-based acute care towards well-funded models of individualised acute community-based care and support as recommended in the Mental Health Council of Australia *Time For Service* report, 2006¹.

¹ *Time for Service: Solving Australia's Mental Health Crisis* (2006) Mental Health Council of Australia.

INTEGRATED DISCHARGE PLANNING

6. Improved discharge planning needs to be introduced, including better referrals to Mobile Support Teams and community based mental health services to prevent a cycle of admission and re-admission – in acute as well as in more long-term units. Outcomes need to be monitored.

CULTURE

7. Training for staff is needed to raise awareness about mental illness.

BED BLOCKAGES

8. Urgently increase the number of mental health beds in relation to demand, particularly in expanding population growth areas, such as Barwon-South West Region and in other rural and regional areas where services are severely lacking.
9. Urgently address the shortage of secure extended care beds to help ease the pressure on adult acute beds.

HOUSING

10. Funding of the PDRSS sector needs adjusting proportion of health budget needs to be allocated to PDRSS services to more accurately reflect the vital role PDRSS services play in consumer recovery
11. More adequate funding of PDRSS long-term residential non rehabilitation beds with clinical staffing for higher need CCU and SECU clients is needed.
12. An increase in PDRSS Home Based Outreach Service packages for people in Government-funded housing is needed.
13. Stronger links between the PDRSS sector and clinical setting are required to ensure that patients are able to be discharged into sustainable accommodation and support.
14. A large injection of funding is required to expand the public housing sector.
15. New models of housing are needed to address the cycle of homelessness and disengagement from services experienced by many people with mental illnesses.
16. Further expansion of the PARC model is required to meet shortfalls in discharge options from acute care across the state.
17. Exploration of peer-based models of supported accommodation and care should be trialled as part of Victoria's mental health reforms.

RESTRICTIVE ENVIRONMENTS

18. Take action to reduce the common practice of locking acute units by providing additional high dependency beds where needed.

SECLUSION AND RESTRAINT

19. OPA strongly supports the reduction of and elimination of the use restraint and seclusion in accordance with the National Safety Priorities for mental health services.

CONSUMER AND CARER PARTNERSHIPS

20. Better resourcing of Consumer Advocate positions is needed. At minimum, an increase is required to increase current funding levels from one Consumer Advocate per region which does not reflect population sizes in each region.
21. OPA supports the establishment of a consumer and family worker position in the Department funded as a senior policy position
22. Consumer/carer partnerships need more emphasis. A review of the current Consumer Action Plan and the setting of clear time specific goals and actions would be welcomed.
23. Training for hospital staff is needed on carer and consumer issues.
24. The Centre for Consumer Expertise requires more funding to broaden its education and support role.

ADVANCE DIRECTIVES

25. The Public Advocate supports further exploration of the application of advance directives in mental health by the Mental Health Legal Service.

LEGAL REPRESENTATION

26. Better funding of independent representation for consumers attending Mental Health Review Board meetings.
27. More adequate funding of VMIAC and the Mental Health Legal Service for specialist representation of mental health consumers.

COMMUNITY TREATMENT ORDERS

28. That a committee is established to review cases where the powers of the Mental Health Act should have been used to manage accommodation and treatment issues.
29. Establish a process in mental health facilities for screening any applications for guardianship by the hospital senior social worker.

WOMEN IN MENTAL HEALTH SETTINGS

30. OPA identifies the security of women patients as a critical issue for service development as outlined in the final report from the DHS Mental Health Branch working group *Improving Gender Sensitivity and Safety in Acute Mental Health Inpatient Units* project (June 2008).
31. Priority funding is recommended for the implementation of the recommendations of the DHS Gender Sensitivity and safety in adult acute inpatient units project.

32. Priority establishment of a steering committee to monitor the eight recommendations of the DHS Gender Sensitivity and safety in adult acute inpatient units project is sought.

COORDINATION BETWEEN SERVICES

33. Priority given to the establishment of mechanisms to enhance cross sectoral collaboration.

DUAL DIAGNOSIS AND COMPLEX NEEDS

34. There is a need for consistent definitions for the identification, assessment and treatment of people with recognisable mental health conditions.
35. New approaches are needed for high needs groups (for example clients with multiple needs exiting the corrections system).
36. OPA supports the concept of a 'no wrong door to appropriate services' approach where a person will receive support through whichever door they enter first, whether it is a mental health or alcohol and drug service.
37. Exploration is needed into ways of providing the care and accommodation needs for patients for whom individualised secure accommodation is required which is currently unavailable.
38. OPA notes that the proposed facility for 120 patients at the Heidelberg Repatriation site would be an appropriate place to develop different types of secure care to match the specific needs of individuals.
39. Where evidence of behaviour associated with mental illness is seen (for example the obsessive compulsive nature of consumption in Prada Willi), OPA would like to see barriers to service access removed so that people can access treatment and support they need.
40. That Victoria develop specialist crisis accommodation services for people with a dual diagnosis and complex conditions involving disruptive behaviour.

CRIMINAL JUSTICE SYSTEM

41. The establishment of thorough pre-release planning for individuals and appropriate follow up mechanisms is urgently required.
42. The establishment of step-down facilities for people with mental illness on release from prison would be a welcome development in post release program development.
43. More adequate resourcing of services for the identification and appropriate treatment of mentally ill prisoners is needed.
44. Better training of prison staff around responding to mental illness is required.
45. More adequate resourcing of rehabilitation and treatment programs to people in prisons is needed.

46. Alternatives to incarceration for people with cognitive disabilities awaiting trial is a priority human rights issue.
47. More intensive support for prisoners returning to prison following release from Thomas Embling is needed.

PARTNERSHIPS – WORKFORCE

48. Ongoing training and professional development of the mental health workforce to ensure a cultural shift towards treating patients and their carers with dignity, respect and care is required.
49. Current recruitment initiatives undertaken by government must continue in order to ensure that current and future positions within mental health services are maintained and that optimal mental health service provision is possible.
50. Community Visitors are seeking to expand their visiting to include all mental health facilities including PARCS and those within prison settings.

How we have approached this submission

The Office of the Public Advocate welcomes the opportunity to contribute to the proposed Victorian Government mental health reforms. While OPA has some general comments on the mental health system as a whole, the strength of OPA's understanding of the mental health service system comes from the visiting and reporting role it undertakes through the Community Visitors Program and from the advocacy and guardianship work.

For this reason, OPA's submission is focussed on the experience of service provision for people requiring clinical or community based services. In the introduction, we have provided general comments on the new directions in mental health and contextualised our response. In the body of the submission, we have provided a combined response and recommendations relating to Focus area 3 Access; Focus area 4. Specialist Care and Focus area 5. Complex Clients.

General Comments on the need for Mental Health Reform

OPA congratulates the Victorian Government on the Green Paper. It is a well researched and thorough piece of work which provides an excellent overview of the mental health system in Victoria, covering both the strengths and the pitfalls with a high level of reflective analysis. Doing justice to a review of a system as diffuse and complex as the mental health system takes a strong collaborative approach and significant leadership.

Much critical examination of mental health care, both nationally and state wide has occurred over the past few years as mental health issues have gained centre stage. Commencing with the Mental Health Council of Australia's *Not for Service* report in 2005, which documented the widespread experience of injustice and despair experienced by people with a mental illness, numerous reports have been written about the failure of governments in the process of deinstitutionalisation to provide adequate investment to support people with a mental illness in the community.

In Victoria over the last few years, as in other states, there has been a heightened debate and policy response to this growing crisis in responding to mental health. The Boston Consulting Groups *Improving Mental Health Outcomes in Victoria* (2006) provided an estimate of the economic impact of mental illness, said to be around \$5.2b annually in Victoria, driven in large part by diminished workforce participation and productivity.

The report mirrored concerns that have been raised by the advocacy sector for some time and identified three key issues as contributing to the mental health crisis: Insufficient access to clinical services; lack of connectedness between parts of the mental health system and limited investment in prevention and early intervention. This underscores the theme that the paradigm shift from institutional psychiatric care to deinstitutionalisation has had serious pitfalls.

OPA has expressed long standing concerns about the accessibility and responsiveness of the public mental health system in Victoria tabling its Mental Health Community Visitors Report annually in Parliament and making multiple submissions to Victorian and National inquiries and reviews. The inaccessibility of crisis beds and community based accommodation and support paired with high rates of incarceration and homelessness for people with mental health issues are recurring themes in OPA's reports.

OPA welcomed the Federal Government Senate Select Committee Inquiry into mental health in 2005. OPA's submission to the inquiry highlighted critical shortages in accommodation and support options; shortfalls in the number of acute and long stay beds; a lack of accountability mechanisms for measuring mental health outcomes at the state and federal level; shortages in mental health services in rural and regional areas; the need for stronger partnerships between state and federal government and the overrepresentation of people with mental health issues in the criminal justice system.

OPA, like others in the advocacy sector, welcomed the Senate Committee's final report *A National Approach to Mental Health – from crisis to community* and the associated COAG plan *National Action Plan on Mental Health 2006-2011* and state and federal funding commitment.

Despite the renewed commitment to mental health and the injection of additional resources to meet identified need, there is a significant ongoing underinvestment in mental health services nationally and in Victoria. The Mental Health Council of Australia *Time for Service* (2006) also acknowledges the renewed commitment by state and federal governments to mental health funding through the COAG National Action Plan yet highlights the ongoing massive underinvestment in mental health services.

In July this year, the Senate Community Affairs Committee produced an interim review on the progress towards implementation the recommendations of the *National Approach to Mental Health – from crisis to community* (through the COAG plan), concluding that while progress has been made against many of the initiatives outlined in the plan, 'widespread gaps and shortfalls in Australia's mental health care remain.'²

OPA believes that a key step towards achieving an adequate mental health system is a significant increase in funding. Australia spends 7% of its health budget on mental health services compared to 12-15% in other OECD countries³. Although mental health is responsible for 13% of the burden of disease, it attracts only 7% of the health budget.⁴

² Interim Report into the Inquiry into Mental Health Services in Australia, Senate Community Affairs Committee, June 2008.

³ Von Doussa, J (2003) *National Mental Health Strategy – Future Challenges Meeting Broader Community Need*, keynote address at the Mental Health Foundation of Australia Annual Conference, University of Melbourne 27 November.

⁴ Mental Health Council of Australia (2006) *Time for Service: Solving Australia's mental health crisis*.

General Comments on the Green Paper

Despite the shortfalls described above, OPA acknowledges the substantial commitment to the development of mental health service provision in Victoria over the past fifteen years, particularly in what is referred to as the third stage of mental health reform (since 1999). Many of these developments in service provision, although not funded to an optimal degree, address concerns raised by the advocacy sector for some years.

The Green Paper highlights these achievements and sets a positive new direction for the next stage of mental health reform. Some of the achievements welcomed by OPA include the expansion of alternatives to inpatient care through the development of Prevention a Recovery Care (PARC) services, the development of the Integrated Rehabilitation and Recovery Care Services (IRRCS) initiative, the establishment of mental health services in prisons and the expansion of emergency department services to include crisis response to mental health issues.

In terms of new directions, OPA acknowledges the Victorian government's commitment to a whole of government approach in mental health, evidenced by the establishment of an inter-departmental committee consisting of Health, Community Services, Youth, Education, Housing, Police, Justice and Victorian Communities signals a new commitment to cross sectoral collaboration. This is a welcome development, which has the potential to impact both on the commitment to mental health resources as well as broadening the accountability for mental health outcomes.

OPA acknowledges the focus in the Green paper on the development of accountability mechanisms for outcomes in mental health as well as the need for better collaboration between state and federal governments. These are issues OPA has raised for some time and have the potential to ensure stronger coordination and better monitoring of service provision in this next stage of reform.

OPA is supportive of the focus of the Green Paper on preventative care and early intervention and the allocation of funding to expand initiatives in this area. However, it is noted that program development in this area however, while important in the medium and long term, should not be at the expense of initiatives to address the critical shortages in bed based care and community responses to mental illness, particularly for consumers with complex needs.

OPA acknowledges that there are critical blockages in the bed-based system, particularly in acute care and Secure Extended Care settings and these need to be addressed in the short-term. But this not must not be at the expense of higher levels of community based support and accommodation, which in the long term, will alleviate pressure on the acute system. A lack of community based support and accommodation leads to over reliance on crisis clinical care, which becomes a necessity as people are repeatedly propelled into crisis.

OPA has raised the urgent issue of the shortfall in acute care beds for several years now and maintains the position that there will always be a need for acute inpatient beds. However, in principle OPA supports the concept of moving to a community-

based system of mental health care. Ultimately a well funded model of acute community based care would relieve pressure on the emergency care system and be more cost effective as well as, achieve better outcomes for consumers, enabling them to stay connected to their home, their job and the people who support them.

OPA is supportive of the principle of improving pathways into mental health services – creating more accessible and easy to navigate entry points and a stronger triage capacity. OPA supports the concept of a mental health community information and referral service as an alternative entry point to the mental health system.

Strong links between clinical mental health services and the non clinical sector (e.g. community based agencies and primary care services) play a critical aspect of preventative care and recovery and OPA supports the intention to strengthen these links.

Too many consumers are discharged into the community after acute periods of mental illness without adequate support and follow up, leading to further admissions. Consumer and carer involvement in treatment and care is an important principle, which needs further resourcing and commitment in the Victorian mental health system. Consumers need more information about treatment and care options and more involvement in decision-making.

OPA welcomes further discussion of the issue of advanced care planning which has the potential to empower consumers and to validate the role of carers in relation to treatment and care planning during acute episodes of illness. Independent advocacy is required in relation to the review of patient legal status. OPA welcomes the proposal to enhance access to independent advocacy for consumers attending the Mental Health Review Board.

The development of mechanisms to achieve a level of coordination between systems for people with complex needs is essential for consumers to be provided with consistent service. However, care coordination will only work if there is adequate funding attached to the case management role. Case managers require brokerage funding as well as realistic case loads so that they can adequately support clients rather than simply act as a referral point to other agencies.

OPA welcomes the stated commitment of the government to improve access to stable and affordable housing. Acquiring and maintaining affordable housing is critical if people with a mental illness are to maintain any level of stability. A significant commitment is required to solve the housing problem of the estimated 30 percent of people who are homeless who have a mental illness.

OPA's experience of the Current Mental Health System

ENTRY POINTS TO THE SYSTEM FOR PEOPLE IN CRISIS

The Office of the Public Advocate, as a result of visits conducted to emergency departments through its Community Visitor Program, is able to provide an overview of some of the issues observed in Emergency Department admissions. The experience of community visitors suggests that there are a range of barriers for patients at this entry point to the mental health system.

Current triage functions are not working adequately, sometimes resulting in consumers and carers being turned away from Emergency Departments (ED) with few options of support available to them in the community.

Patients attending ED report long delays for assessment and referral. There are inconsistencies in the triage capacity of EDs, which impact on the timeliness of patient assessments. The call out of the CAT team for ED attendance creates delays and uses resources that could be better utilised in the community.

EDs in many of the hospitals often have patients awaiting admission to an adult acute inpatient unit for periods of up to 48 hours (e.g. Maroondah and Geelong Hospitals). In Gippsland, patients requiring acute inpatient admission were accommodated in general beds in the hospital due to the acute inpatient unit being full (CV Report 2007).

CASE STUDY – A CASE FOR PROACTIVE INDIVIDUALISED SUPPORT

In Rural Victoria, Multiple admissions in excess of 50 in one year to the Emergency Department, sometimes by ambulance, for one mental health consumer were leading to significant distress for the consumer and were utilising scarce crisis resources. At a meeting between police, ambulance and hospital services, an arrangement was made for home-based support, which resulted in immediate reduction in admissions.

RECOMMENDATIONS

1. Community visitors note that the role of the Dedicated Nurse Practitioner works well in emergency departments, increasing the possibility that consumers will have access to specialist assessment and support. However, these positions need 24/7 funding.
2. Community visitors observe that the bed manager role works well. The use of a centralised system for allocating beds appears to lead to a more efficient and fairer allocation of acute beds.
3. The development of more short stay facilities in general hospitals for the initial assessment of mental health crisis is needed. This would relieve pressure on the emergency department while ensuring a more comprehensive assessment of consumer needs.

4. The development of a community-based entry point to the mental health system is required to facilitate alternatives to crisis-driven entry to the system.
5. OPA would like to see a shift in focus from hospital-based acute care towards well-funded models of individualised acute community-based care and support as recommended in the Mental Health Council of Australia *Time For Service* report, 2006⁵.

INTEGRATED DISCHARGE PLANNING

People are commonly discharged from hospital without receiving the assessment, treatment and support they require (OPA Mental Health Board consultation 2008).

Community visitors report that in one case, the discharge from Maroondah to Dandenong lead to a patient losing her case management support in Maroondah. The discharge of patients outside their geographical area is not appropriate for patients who have carers and support in the region where they live. (CV Report 2007).

CASE STUDY – A CASE FOR IMPROVED ED DISCHARGE PRACTICES

Vera is in her 70's and has an alcohol and drug and mental health problem. She has an OPA guardian who placed her in a high needs aged care residential service. When Vera threatened to harm herself and others in the facility with a knife during an acute mental health episode, Vera was taken by ambulance to an Emergency Department. She was assessed by the CAT Team as not requiring admission and discharged to crisis accommodation as the nursing home would not immediately re accommodate her. Vera shortly absconded from the crisis accommodation. At no point was the guardian contacted by either ED or the nursing home.

A lack in the continuum of care can lead to people being readmitted to hospital on repeated occasions or being vulnerable in the community. There is a need to ensure systems are in place to support clients on discharge. There are examples of this working well in some types of units. e.g. in CCUs, a consumer may be introduced to the Mobile Support Team (MST) worker.

RECOMMENDATIONS

6. Improved discharge planning needs to be introduced, including better referrals to Mobile Support Teams and community based mental health services to prevent a cycle of admission and re-admission – in acute as well as in more long-term units. Outcomes need to be monitored.

⁵ *Time for Service: Solving Australia's Mental Health Crisis* (2006) Mental Health Council of Australia.

CULTURE

Community visitors report that attitudes of hospital staff to people with a mental illness can act a barrier to appropriate care and support. (OPA Mental Health Board consultation).

RECOMMENDATIONS

7. Training for staff is needed to raise awareness about mental illness.

BED SHORTAGES

The shortage of acute beds remains a key finding of the annual Community Visitor reports that has been reported by the Board to the Minister since 2003.

Community Visitor Annual Report for several years has identified the need for urgent increases in secure extended care beds to help ease the pressure on adult acute beds. A small number of high needs patients remain in acute units for up eight months awaiting admission to secure extended care units (CV Report 2007).

There is a shortage of 24-hour care accommodation (e.g. short-term community care units) for patients who require follow-up or permanent care and rehabilitation after discharge, particularly from adult acute inpatient units. Community visitors report that a patient from Maroondah Hospital was placed in the community care unit in Wodonga as there were no beds available in Dandenong.

Shortages in rural and regional mental health services are a significant problem for consumers and carers in regional areas. There are shortages in acute beds, some regions do not have access to SECU unit and others a lack of accommodation and support options on discharge results in discharge delays. There are risks for patients admitted to general wards because no psychiatric acute beds are available.

BED BLOCKAGES

Approximately eighty patients have been identified in acute, CCU and SECU units through the Office of the Public Advocate's Long Stay Patient Project, who are not able to be discharged until alternative clinical or community-based accommodation and support options become available.

SECU managers have identified that up to 25% of consumers could be supported in a less intensive environment. i.e. they are ready for discharge but unable to relocate due to a lack of appropriate accommodation and support options (DHS 2007).

RECOMMENDATIONS

8. Urgently increase the number of mental health beds in relation to demand, particularly in expanding population growth areas, such as Barwon-South West Region and in other rural and regional areas where services are severely lacking.
9. Urgently address the shortage of secure extended care beds to help ease the pressure on adult acute beds.

SHORTAGE OF DISCHARGE OPTIONS

Community visitors report an acute shortage of appropriate community-based accommodation available on discharge across all regions. Many patients who have reached their optimum level of rehabilitation may need to remain in the system for periods of two years or more due to the lack of appropriate accommodation and support in the community. (CV Report 2007).

Long-stay patients in CCU and SECU settings who require supervised care with supported access to the community and others who cannot cope with shared accommodation due to their mental illness, are stuck in the system waiting for short-term intensive care and rehabilitation combined with longer-term care options. (CV Report 2007).

CASE STUDY – A CASE FOR MORE DISCHARGE OPTIONS

Two women in their fifties with mental health issues and an intellectual impairment were both considered ready for discharge from a secure extended care mental health unit in 2000 yet in 2008 are still there. They both leave the unit each weekday to participate in day programs then return each afternoon to this locked hospital unit. With 24 hour support and appropriate accommodation, these women could live in a more home like environment in the community where their quality of life and opportunities would be far greater but no place has ever been made available.

HOUSING

Acquiring secure and affordable housing is critical if people with mental health issues are to maintain any level of stability. There are currently serious shortfalls in the system that have been detailed elsewhere. OPA welcomes initiatives like the Integrated Rehabilitation and Recovery Care (IRRC) program that targets long stay consumers in CCU and SECU units but notes that only a small number of clients will be assisted through the last funding round of \$1.26 million.

Victoria's PDRSS models are recognised nationally as an effective low cost accommodation and support option for people with long term mental health. They are seen as effective in supporting people to build lives in their communities and helping to maintain well-being without costly hospital admissions. The sector is currently significantly under funded in proportion to the value of the service it provides (the sector currently only receives around 10% of the mental health budget).

OPA welcomes the expansion of the Prevention and Recovery Care (PARC) program as an alternative to inpatient care. This is a significant development in alternative models patient care and should result in shorter clinical admissions. Further expansion of this model is required to meet shortfalls in discharge options from acute care across the state.

There is a shortage of non-clinical accommodation and support options that provide a social model of support for people recovering from mental illnesses. In the UK, a model like the Surrey County cluster model that provides a step-down home-based environment with 24 hour outreach support in a home like environment provides a cost effective solution to hospital based clinical care that can be utilised by patients in the early days of recovery.

Current responses to homelessness have preconditions that must be met before homeless consumers can attain permanent housing (outreach/drop-in→ shelter→ transitional housing → permanent housing)⁶. Housing First is a new approach to housing for people with a mental illness that believe that housing is not something that people with a mental illness should be forced to work their way towards. In the Housing First model there is no requirement for consumers to accept support and treatment.

Victoria has a history of developing effective models for ensuring housing security of tenure for people with mental illnesses. However, these have not been adequately funded and in many cases not replicated across regions. For example, in the 1990's a model was developed in one region where through collaboration between the Office of Housing and Mental Health facilities, people were able to be discharged into priority public housing. Unfortunately this model is no longer funded.

The HASI model of housing adopted in NSW is also worth noting as it provides a level of security of tenure and choice in housing to tenants. There is strong evidence that the model is successful in averting homelessness and reducing the need for hospitalisation. Evaluations of the program demonstrate success with people maintaining their tenancies, increasing their participation in the community and developing and strengthening social and family networks⁷

RECOMMENDATIONS

10. Funding of the PDRSS sector needs adjusting proportion of health budget needs to be allocated to PDRSS services to more accurately reflect the vital role PDRSS services play in consumer recovery
11. More adequate funding of PDRSS long-term residential non rehabilitation beds with clinical staffing for higher need CCU and SECU clients is needed.
12. An increase in PDRSS Home Based Outreach Service packages for people in Government-funded housing is needed.
13. Stronger links between the PDRSS sector and clinical setting are required to ensure that patients area able to be discharged into sustainable accommodation and support.
14. A large injection of funding is required to expand the public housing sector.

⁶ This feature of community-based housing was described by Sam Tsemberis at the Bruce Woodcock Memorial Lecture in Melbourne this year and applies equally well to Victoria as it does to models of housing provision in the US .

⁷ SPRC Newsletter 2008, No 98, and March 2008.

15. New models of housing are needed to address the cycle of homelessness and disengagement from services experienced by many people with mental illnesses.
16. Further expansion of the PARC model is required to meet shortfalls in discharge options from acute care across the state.
17. Exploration of peer-based models of supported accommodation and care should be trialled as part of Victoria's mental health reforms.

RESTRICTIVE ENVIRONMENTS

OPA continues to raise concerns about the practice of locking acute units due to the lack of high dependency beds. Community visitors in several regions have reported on the routine locking of acute adult units due to concerns about patients at risk of absconding. (CV Report 2007)

RECOMMENDATIONS

18. Take action to reduce the common practice of locking acute units by providing additional high dependency beds where needed.

SECLUSION AND RESTRAINT

The National Mental Health Seclusion and Restraint Project's forum held in Melbourne in May 2008 identified the need for mental health facilities to adopt contemporary approaches to managing patient behaviour triggered by psychotic episodes⁸. While acknowledging examples of quality improvement in hospitals where seclusion and restraint are on the decline, OPA continues to raise issues about the level of restriction placed on clients in bed based clinical settings. (CV Report 2007) .

CASE STUDY – A CASE FOR REDUCTION ALTERNATIVES TO SECLUSION

Felicity is a young patient whose extreme behaviour posed a risk to others. As part of her treatment plan, she was nursed in a seclusion room of an acute unit. Some furniture and a television were provided to make it more comfortable. As her capacity to interact with others improved, she spent an increasing amount of time out of seclusion until eventually she could move out of seclusion into a room of her own. This consumer's situation highlights the need for a specialist facility that can provide appropriate care without having to resort to extreme measures.

Following a patient's complaint about mistreatment in seclusion, community visitors reported concerns about the use of the hospital's security staff to help manage a patient in seclusion at the Northern Hospital. OPA supports the view that the practice of restraint and seclusion can result in an experience of trauma for patients. (CV Report 2007).

⁷ National Mental Health Seclusion and Restraint Project National Forum 2008
[Hhttp://www.nmhsrp.gov.au/c/mhH](http://www.nmhsrp.gov.au/c/mhH)

RECOMMENDATIONS

19. OPA strongly supports the reduction of and elimination of the use restraint and seclusion in accordance with the National Safety Priorities for mental health services.

CONSUMER AND CARER PARTNERSHIPS

There is a need for consumers to be more involved in treatment and care, modelling the direction of service models in the UK and US. A clear role for consumers in providing peer support and advocacy for other consumers as well as for consumers to be involved in the review and management of their own treatment and care is critical. (Consultation with consumer advocate).

While OPA welcomes the commitment to consumer and care involvement in planning, treatment and care, short falls are evident in the funding of consumer consultant and carer positions.

Carers play a critical role in prevention and recovery of mental illness yet carers report a lack of consultation in relation to patient treatment. Carers report that they are often not consulted about patient discharge even where they are the person's primary carer.

Community visitors note that carer advisory committee meetings in hospitals are not prioritised or well resourced. Many areas do not have a funded carer consultant position. Hospital staff are in many cases not aware of the importance of consumer advocacy, peer support and carer issues.

CASE STUDY – A CASE FOR CARER PARTNERSHIPS

The family of an elderly man suffering from dementia and a mental illness was concerned about the risks associated with him being released from hospital as he had threatened a homicide/suicide on discharge. The family felt the hospital were not taking their concerns seriously as they had determined that he posed no threat. Despite numerous requests from family members, the hospital did not arrange a case management meeting where family members could raise their concerns. When the family member rang OPA's telephone advice service line, the patient's discharge was imminent. They felt they had not been listened to.

RECOMMENDATIONS

20. Better resourcing of Consumer Advocate positions is needed. At minimum, an increase is required to increase current funding levels from one Consumer Advocate per region which does not reflect population sizes in each region.
21. OPA supports the establishment of a consumer and family worker position in the Department funded as a senior policy position
22. Consumer/carer partnerships need more emphasis. A review of the current Consumer Action Plan and the setting of clear time specific goals and actions would be welcomed.

23. Training for hospital staff is needed on carer and consumer issues.
24. The Centre for Consumer Expertise requires more funding to broaden its education and support role.

ADVANCE DIRECTIVES

In the absence of advance directives, consumer involvement in decision making about treatment, support and management of personal matters may be compromised. For example, a consumer may be given medication that has unforeseen effects as they are unable to have their views about treatment given due consideration.

Many patients have serious concerns about how to maintain their rights in relation to treatment choices and practical life management in the event that they become unwell. Advance directives have the potential to achieve and retain independence and self-determination for people living with mental illness⁹.

CASE STUDY – A CASE FOR ADVANCE DIRECTIVES

Madeleine is 48 years old and has a degenerative disease. She became psychotic and was made an involuntary patient. She was subsequently discharged to a nursing home. The discharge occurred prior to the appointment of a guardian. A guardian would have been able to make a decision in Madelaine's best interests. Madeleine was not discharged to the nursing home as part of a residence condition of a CTO. She wished to return home. However, due to her physical condition and care needs was unable to resist the discharge process.

RECOMMENDATIONS

25. The Public Advocate supports further exploration of the application of advance directives in mental health by the Mental Health Legal Service.

LEGAL REPRESENTATION

OPA is concerned that consumers attending Mental Health Review Board hearings have low rates of independent representation. Consumers need independent advocacy for Review Board hearings. The Mental Health Legal Service and VIMIAC have limited funding to meet the demand for independent representation (consultation with consumer advocates).

Mental health consumers have a range of other issues pertaining to their mental health that require representation by specialist legal advice and representation. Currently services are under resourced to meet this demand. (MHLS)

⁹ Mental Health Legal Service Advance Directives Project conference, Hotel Y, June 22 2006.

RECOMMENDATIONS

26. Better funding of independent representation for consumers attending Mental Health Review Board meetings.
27. More adequate funding of VMIAC and the Mental Health Legal Service for specialist representation of mental health consumers.

COMMUNITY TREATMENT ORDERS

Increasingly Community Treatment Orders (CTO) are restrictive to the point where it can obstruct a person from maintaining full-time employment. Clinics are not accessible so that clients can attend for treatment outside working hours.
(Consultation with consumer advocates)

The Public Advocate has been appointed several cases where mental health consumers receiving treatment in clinical mental health settings were referred to VCAT for a guardian to be appointed to make decisions regarding their accommodation. This effectively subjects the consumer to two pieces of legislation (the Mental Health Act and the Guardianship Act)

Where the powers of the Mental Health Act can be used to specify where a person must live if this is necessary for the treatment of the person's mental illness, the recourse to guardianship is unnecessary and an abrogation of the consumers right to the least restrictive outcome.

CASE STUDY – A CASE FOR BETTER USE OF THE MENTAL HEALTH ACT PROVISIONS

Guardianship was requested for a woman in her 70s with an obsessive compulsive disorder before discharge from an acute mental health facility. The woman had been living independently but her hoarding and vulnerability made return to her residence untenable and supported accommodation was seen as a preferred option. Guardianship was sought for a decision to be made about the woman's accommodation. However, an order could have been made under the Mental Health Act, a less restrictive option with the same outcome.

RECOMMENDATIONS

28. That a committee is established to review cases where the powers of the Mental Health Act should have been used to manage accommodation and treatment issues.
29. Establish a process in mental health facilities for screening any applications for guardianship by the hospital senior social worker.

WOMEN IN MENTAL HEALTH SETTINGS

The Public Advocate is concerned about reports about incidents of sexual harassment and critical incidents relating to sexual abuse of women in mental health units reported community visitors.

Women in mental health settings are particularly vulnerable to exploitation, sexual assault and abuse as was documented in the *No-where to be safe report: Women's experiences of mixed-sex psychiatric wards* produced by the Victorian Women and Mental Health Network in 2008. The report reveals that nearly two thirds of female inpatients surveyed in psychiatric wards have been sexually abused or harassed by male patients.

CASE STUDY – A CASE FOR GENDER SENSITIVE SETTINGS

Miranda was sexually assaulted at night while an inpatient in the HDU by another patient who came into her room and got into bed with her in the middle of the night. Eventually a nurse checked in and removed the patient from her bed. She was placed back in the general ward from where she absconded due to fear of assault. When later she was returned to the ward, she was placed back in HD with the same man who had assaulted her. (story taken from No Where to be Safe Report)

RECOMMENDATIONS

30. OPA identifies the security of women patients as a critical issue for service development as outlined in the final report from the DHS Mental Health Branch working group *Improving Gender Sensitivity and Safety in Acute Mental Health Inpatient Units* project (June 2008).
31. Priority funding is recommended for the implementation of the recommendations of the DHS Gender Sensitivity and safety in adult acute inpatient units project.
32. Priority establishment of a steering committee to monitor the eight recommendations of the DHS Gender Sensitivity and safety in adult acute inpatient units project is sought.

COORDINATION BETWEEN SERVICES

A lack of coordination between services can result in barriers to accessing services for people with dual diagnoses and complex needs. Too many people with mental health problems fall through the gaps and do not receive adequate services. The lack of cross-sectoral collaboration undermines the focus on consumer focussed mental health provision.

RECOMMENDATIONS

33. Priority given to the establishment of mechanisms to enhance cross sectoral collaboration.

DUAL DIAGNOSIS AND COMPLEX NEEDS

Advocate/Guardian case studies provide evidence of the failure of the system to meet the needs of people with dual disabilities where there is too strong a line being drawn between services around who does and does not have the responsibility for support.

The siloing of people with dual conditions into one type of service is problematic as the person is unlikely to receive the range of treatment responses they need. This is sometimes seen in disability services settings where behaviour associated with an intellectual disability may lead to the oversight of a mental health condition requiring assessment and treatment.

CASE STUDY – A CASE FOR A FOCUS ON NEED RATHER THAN DIAGNOSIS

Cheung is 31 years old. When he became known to the service system, he was manifestly unwell and traumatised. Following an intensive period of assessment there were inconclusive findings about the nature of his disability but the mental health team formulated the view that he did not have a mental illness. Over the following months Cheung's presentation changed significantly and ultimately it was generally agreed he did not have a 'disability' (within meaning of the Disability Act) but clearly he was still unwell and did require treatment for his mental health. It sometimes appears the different components of the disability/health sector are competitive in trying to avoid the burden of the resources required to support a person with complex and intensive needs. Clearly a more person-centred approach is required.

The lack of integration between disability services and mental health services and the lack of a clear entry point and standard framework for assessment of needs means that faulty diagnosis or incorrect treatment may be given.

Community visitors report on delays in gaining access to mental health assessments for clients in disability services. There is a failure in some cases for people with intellectual disabilities to have their mental health condition reviewed. Some people have been diagnosed years earlier but then treatment and diagnosis have not been reviewed.

Staff in intellectual disability services are often left to support clients with dual disabilities without specialist support and funding.

OPA is concerned about the service response for people who present with a dual diagnoses of a substance abuse and mental illness. Where a mental health problem is associated with alcohol and drug use, there are often serious delays in gaining access to services due to boundary disputes about which service is responsible.

CASE STUDY – A CASE FOR MORE COMPLEX NEEDS CASE MANAGEMENT

Jamie is a 20 year old with an acquired brain injury he sustained in an accident when he was 16. He has alcohol and drug issues and a mental health diagnosis and he can be aggressive and violent when he drinks. OPA has been unable to find a specialist case management service that can deal with the complexity of his issues but Jamie does not meet the eligibility criteria for most services. OPA notes that while contact with the CAT Team and the acute mental health support went fairly smoothly and there has been follow up support, the system does not provide the ongoing intensive case management support this client requires.

Case managers working with complex clients are often under resourced or do not have the appropriate skills or adequate brokerage money to manage consumers.

OPA advocates for many consumers whose diagnostic criteria do not fit within the *Mental Health Act 1986* or the *Disability Act 2006*. For example, people with Prada Willi Syndrome with an IQ above 70, people with Huntington's Disease and people with late a diagnosis of Autism with an IQ over 70.

CASE STUDY – CASE FOR A SPECIALISED SECURE FACILITY FOR HUNTINGTONS DISEASE

David is a 39 year old man with Huntington's Disease diagnosed ten years ago. Being unable to sustain his accommodation, he ended up homeless from where he was referred to an aged care hostel. Due to risks associated with his impulsive behaviour and his persistent absconding from the hostel, he was later referred to an acute psychiatric ward. The neuromuscular deterioration associated with his Huntington's Disease combined with his aggression and the lack of insight he has into personal safety make him vulnerable to exploitation and injury so discharge to an insecure environment is not a possibility. David was ultimately placed in a psycho geriatric ward as the acute unit needed to discharge him and there were no alternative accommodation options.

RECOMMENDATIONS

34. There is a need for consistent definitions for the identification, assessment and treatment of people with recognisable mental health conditions.
35. New approaches are needed for high needs groups (for example clients with multiple needs exiting the corrections system).

36. OPA supports the concept of a ‘no wrong door to appropriate services’ approach where a person will receive support through whichever door they enter first, whether it is a mental health or alcohol and drug service.
37. Exploration is needed into ways of providing the care and accommodation needs for patients for whom individualised secure accommodation is required which is currently unavailable.
38. OPA notes that the proposed facility for 120 patients at the Heidelberg Repatriation site would be an appropriate place to develop different types of secure care to match the specific needs of individuals.
39. Where evidence of behaviour associated with mental illness is seen (for example the obsessive compulsive nature of consumption in Prada Willi), OPA would like to see barriers to service access removed so that people can access treatment and support they need.
40. That Victoria develop specialist crisis accommodation services for people with a dual diagnosis and complex conditions involving disruptive behaviour.

CRIMINAL JUSTICE SYSTEM

While OPA acknowledges the work being undertaken by Corrections Victoria to improve their assessment processes and in relation progress towards implementing the *Corrections Victoria Disability Framework*.

OPA maintains its concerns about the overrepresentation of people with mental illnesses in the criminal justice system and the lack of assessment and treatment available to people in prisons.

The incarceration of people with non-acute psychiatric illness rarely leads to treatment and rehabilitation. Psychosocial rehabilitation programs in prisons are inadequate and presume cognitive capacity.

Incarceration of people with mental illnesses awaiting trial who require treatment and support is a human rights issue.

CASE STUDY – A CASE FOR PROVIDING ALTERNATIVES TO CUSTODIAL DETAINMENT

In 2008, OPA brought to the media’s attention the case of an 75 year old non-English speaking woman with dementia detained in custody after a threatened suicide/homicide attempt. The woman was placed in the maximum security Dame Phyllis Frost Centre because mental health services were unable to find alternative secure accommodation and support. While the woman was initially detained in a secure psycho-geriatric facility, she was not able to remain there because she no longer required acute psychiatric care. The Public Advocate made the point that a human society does not put an elderly woman in jail simply because she does not neatly fit into the medical or community care system.

Sentencing options for offenders with intellectual disabilities which force people with intellectual disabilities into the prison system are inappropriate.

Lack of post release planning can have serious consequences for prisoners with a mental illness on release from prison. Without adequate income, housing and follow up mental health support, this can be the start of a downward spiral for many.

Thomas Embling is not able to meet the demand for treatment for which it was designed. With half the beds occupied by security patients (people found not fit to plead guilty due to mental impairment - usually long term patients) there are not enough resources to admit and treat acutely unwell prisoners (OPA submission to HREOC enquiry 2004).

Community visitors have reported their concern about delays in transferring prisoners who have been reviewed from Thomas Embling.

RECOMMENDATIONS

41. The establishment of thorough pre-release planning for individuals and appropriate follow up mechanisms is urgently required.
42. The establishment of step-down facilities for people with mental illness on release from prison would be a welcome development in post release program development.
43. More adequate resourcing of services for the identification and appropriate treatment of mentally ill prisoners is needed.
44. Better training of prison staff around responding to mental illness is required.
45. More adequate resourcing of rehabilitation and treatment programs to people in prisons is needed.
46. Alternatives to incarceration for people with cognitive disabilities awaiting trial is a priority human rights issue.
47. More intensive support for prisoners returning to prison following release from Thomas Embling is needed.

PARTNERSHIPS – WORKFORCE

Community visitors have for a number of years raised issues in relation to the training and recruitment of mental health trained staff, particularly psychiatric nurses and allied health staff. There continue to be ongoing staff shortages, which at times result in significant delays in recruitments to critical key staffing positions that provide essential rehabilitation and inpatient services.

The large scale consumer consultation undertaken as part of the Mental Health Council and HREOC *Not for Service*¹⁰ report highlighted deficiencies in the culture of the current mental health system. There was condemnation for the undignified way in which people were treated within the system by service users.

¹⁰ Mental Health Council of Australia (2005) *Not For Service*.

Community visitors also report issues around culture and attitude as having a significant impact on consumers.

RECOMMENDATIONS

48. Ongoing training and professional development of the mental health workforce to ensure a cultural shift towards treating patients and their carers with dignity, respect and care is required.
49. Current recruitment initiatives undertaken by government must continue in order to ensure that current and future positions within mental health services are maintained and that optimal mental health service provision is possible.
50. Community Visitors are seeking to expand their visiting to include all mental health facilities including PARCS and those within prison settings.

CONCLUSION

The mental health reforms offer an opportunity for Victoria to continue to be steps ahead in relation to models of health care for people with a mental illness. An enhanced focus on early intervention and prevention needs to be supplemented with a strong commitment to meeting the needs of people who have fallen between the cracks of the current system - people with complex needs, people in the criminal justice system, people who are homeless or at risk of being homeless.

While not ignoring the significant gaps in bed based care and the need to urgently address acute bed and SECU bed shortages, OPA believes that ultimately a well funded community based system of recovery and care including home-based care is the way of the future. Large injections of funding in the areas of accommodation and support are required, particularly towards the PDRSS service system, which offers an excellent model of home based outreach support, respite, day care, peer support and residential care.

While OPA welcomes models like PARC and the Integrated Rehabilitation and Recovery Service model, they will require additional resourcing for them to have a wide reaching impact. Peer-based models of support and non-clinical step-down models also require further exploration and expansion. Consumer and carer issues are high on the agenda and Victoria would do well to enhance its commitment to this area.