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21 July 2005

OUR REF: ADD/05/20163
YOUR REF:

Mr Ian Holland
Secretary, Senate Select Committee on Mental Health
Parliament House
CANBERRA ACT 2800

Dear Mr Holland

Thank you for your letter of 26 June 2005 and the enclosed submission to the Senate Committee outlining a carer's experience.

I note that the submission provides very detailed comment on concerns relating to the treatment and care provided to the carer's son, whom I understand suffers from schizophrenia, during periods in Queensland, Northern Territory and Victoria between 1999 – 2005.

Some of the submission relates to particular occasions of clinical care and interventions provided by Mental Health Service Providers.

I am not able to comment on those specific instances. However, the submission also covers the concerns in relation to the facilities in which mental health treatment and care is provided, the overall policy of mental health service provision and the legislation which governs such service provision.

It should be noted that the States and Territories of Australia each have their own Mental Health Legislation although these conform to an over arching National Mental Health Policy. It was recognised that at times such discontinuity in Mental Health Service Provision lead to difficulty in continuity of care and in transfer of patients between States. Victoria entered into a cross border agreement with NSW, in relation to Mental Health Services in 2002. This enables improved transfer and continuity of care between the States. In relation to forensic patients this has been further assisted by the development of either legislative provisions or agreements between respective States.

Victoria

The over arching aims of Mental Health Service delivery in Victoria is that treatment should be provided in the community wherever possible and that a person's autonomy and individual freedom should be interfered with as little as possible. Legislation does provide for involuntary treatment both within gazetted Mental Health Services and in the community through provision of a Community Treatment Order. Those subject to a Community Treatment Order are compelled to accept treatment for their mental illness and at times a residential component or other conditions can also be included in the treatment order. I note the concerns raised in the submission that the conditions attached to a community treatment order should be broader and should include psychosocial treatment. The extent to which a person can be compelled to receive such treatment is limited given the need for active engagement and co-operation.

Recognition of the importance of engagement of the person to the maximum extent possible and also engagement of carers wherever possible is contained within recent amendments to the Victorian Mental Health Act which include a requirement that all involuntary patients have a formally constructed treatment plan which includes the roles and responsibility of both the patient and the treatment providers and makes provision for information and engagement of carers.

Legislation relevant to those who have been found to have committed an offence whilst mentally impaired was enacted in 1997. This includes provision for both a custodial supervision order and non-custodial supervision order where a person is found not guilty on the basis of mental impairment at the time of the commission of the offence.

Victoria has in place an area based mental health system, which includes in each area or available to each area a range of bed based and community based services. These include Acute Inpatient Units which are generally open units but which contain a closed high dependency or intensive care area, Secure Extended Care Units for those who require a secure environment for longer periods of time in order to maximumally stabilise their illness and promote rehabilitation and Community Care Units which are open facilities within the community but which are gazetted to enable longer term treatment for those under involuntary treatment care and those who receive such treatment voluntarily. Community Services include Continuing Care Teams, Mobile Support and Treatment Teams and Crisis Assessment and Treatment Teams. In addition, Victorian has a well established non-government sector providing Psychiatric Disability Rehabilitation and Support Services. These include residential rehabilitation units and home based outreach services.

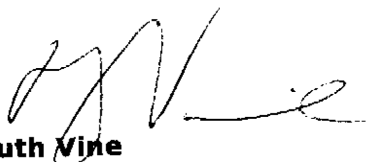
Victoria expends approximately 10 percent of its health budget on mental health services. In 05/06 this represents over $700 million. In recognition of a growing demand for mental health services and for a need to both promote new service initiatives as well as growth of both bed based and community services, the Victorian Government has provided substantial additional funds to mental health services over the past several years. The 05-06 Budget provided an additional $180 million for mental health services over four years. This included $55 million to redevelop and expand bed based and community based services. Of particular relevance to the submission is the inclusion in these funds expansion of the Maroondah Mental Health Service to create an additional 20 beds within that unit.

While Victorian public Mental Health Services are targeted towards those with the most serious illness and the need for most intensive treatment, development of the mental health services has also enabled progressively greater attention to early intervention. Again of relevance to this submission is the progressive development of early-psychosis services to provide more intensive engagement and treatment to those with an emerging psychotic illness.

As noted above, I am not able to comment on specific incidences referred to in the submission. I was greatly concerned by the difficulty in engagement and consistency of treatment detailed in this submission. The Victorian Government is committed to continuing to develop mental health services and to continue to promote a legislative framework that both provides for treatment and care for those who require treatment, including that on an involuntary basis, and does this in a way that best promotes both the mental health of the sufferer, and the engagement and consideration of carer's and the broader community.

Thank you again for your letter.

Yours sincerely



Dr Ruth Vine
Director Mental Health