



VICTORIA'S MENTAL HEALTH SERVICES ANNUAL REPORT 2018–19

Responsible body's declaration

Minister for Mental Health

Dear Minister

In accordance with section 118(2) of the *Mental Health Act 2014*, I am pleased to submit to you *Victoria's mental health services annual report* for the period 1 July 2018 to 30 June 2019.

A handwritten signature in black ink, appearing to read 'Kym Peake', is positioned above the typed name.

Kym Peake
Secretary
Department of Health and Human Services



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Secretary's foreword

I am pleased to present the fourth *Victoria's mental health services annual report*, reflecting the Victorian Government's ongoing commitment to increased accountability and transparency to the community and the Victorian Parliament on mental health service delivery. This report reflects the Victorian Government's key role in stewardship of a complex service system, its role in supporting our public mental health services to deliver treatment across metropolitan, regional and rural Victoria and its role in supporting Victorians with a mental illness and their families and carers to lead lives they value.

Despite unprecedented levels of investment over recent years, Victoria's mental health system continues to face challenges associated with rapidly increasing demand, driven in part by significant population growth and greater awareness of mental illness. During 2018–19 we have observed ongoing increases in overall client numbers and reported contacts. Coupled with increased mental health-related presentations in emergency departments and consistently high occupancy rates in our acute inpatient services, the extent of sustained pressure on Victoria's public mental health services is clear.

It is for this reason that in February 2019 the Victorian Government announced the terms of reference and commissioners for the landmark Royal Commission into Victoria's Mental Health System – the first of its kind in Australia. The Royal Commission will provide a comprehensive set of recommendations on how to best support people in Victoria living with mental illness, including those at risk of suicide.

While the Royal Commission is underway, the department continues with work to improve mental health outcomes through implementation of *Victoria's 10-year mental health plan* and its supporting strategies. The commitment to addressing suicide in Victoria remains a key priority. Our major suicide prevention initiatives include place-based trials in local communities (in partnership with Victoria's Primary Health Networks) and our Hospital Outreach Post-suicidal Engagement (HOPE) programs. These programs are truly saving lives. Just as significantly, they have been developed in consultation with local communities and services, helping to ensure people receive the support they need close to home.

I am humbled to present these stories of recovery, resilience, challenge and hope. They reflect the breadth of knowledge, experience and wisdom within our service system – and come directly from our consumers, carers, peer workers and clinicians. Through them, we can understand the difference our services make in people's lives, and in doing so, help to shape the future of Victoria's mental health services.

Kym Peake
Secretary
Department of Health and Human Services

The year at a glance



74,794
registered clients



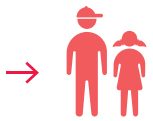
50.4%
women or girls



2.6%
increase overall
since 2017–18



32.7%
live in rural areas



→ **13,403**
child and adolescent clients



2,760
Your Experience
of Service surveys



→ **58,978**
adult clients



\$1.54 billion
clinical services



→ **8,116**
aged clients



\$119 million
mental health community
support services



→ **988**
forensic clients



→ **2,110**
specialist clients

1

Progressing Victoria's 10-year mental health plan



1. Progressing Victoria's 10-year mental health plan

Victoria's 10-year mental health plan was released in November 2015. The plan sets the government's long-term vision to improve the mental health and wellbeing of all Victorians and provides the foundation for our mental health reforms. More than 1,000 Victorians were involved in developing the plan, including people with a mental illness, their families and carers, service providers, clinicians, workers, experts and community members.

Monitoring progress and reporting on outcomes under the plan helps to understand the impact of programs and services on people's lives over time. A range of indicators have been developed to track whether initiatives and programs are contributing to better outcomes for people with mental illness (contained in Appendix 1 to this report). Work to refine and develop additional indicators is ongoing. Building evidence around what works allows us to assess whether services and programs are effective, and to identify what needs improving.

In the four years since releasing the *10-year mental health plan*, investment and delivery has focused on meeting growing demand for clinical services, boosting access to community-based services, expanding and diversifying the mental health workforce, suicide prevention, forensic mental health, and Aboriginal social and emotional wellbeing initiatives.

Major strategies developed under the plan include:

- the *Victorian suicide prevention framework 2016–25*
- the *Mental health workforce strategy*
- *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027*.

As part of the mental health workforce strategy, a range of workforce initiatives have also been implemented that support the learning and development of the workforce. They aim to create better working and learning environments, promote careers in mental health, enhance clinical leadership and develop and expand the lived experience workforce.

Clinical service reforms are focused on helping meet the increasing demand for community-based and inpatient services, development of a new funding model for adult community-based services, and responding more effectively to the needs of people in crisis.

Mental health expert advice and guidance

In early 2016 the Mental Health Expert Taskforce convened to provide expert advice and guidance to the Minister for Mental Health on implementing *Victoria's 10-year mental health plan*. It was supported by four reference groups focusing on lived experience, workforce, innovation and Aboriginal health and wellbeing. The taskforce concluded as planned in February 2018.

In June 2019 the new Mental Health Ministerial Advisory Committee (MHMAC) was established to oversee progress against the plan and related initiatives. The MHMAC is co-chaired by the Parliamentary Secretary for Mental Health, Harriet Shing MP, and Maggie Toko, a consumer leader who is currently the chief executive officer of the Victorian Mental Illness Awareness Council (VMIAC). During its three-year term, the MHMAC will also provide strategic advice on key sector challenges including:

- service access
- workforce planning and distribution
- infrastructure planning
- impacts of, and responses to, the National Disability Insurance Scheme (NDIS) transition and the interface between the NDIS and the clinical service system
- child and youth mental health service design and delivery.

Royal Commission into Victoria's Mental Health System

On 24 February 2019, the Victorian Government announced the terms of reference and commissioners for a Royal Commission into Victoria's Mental Health System.

The first of its kind in Australia, the Royal Commission will provide recommendations on how Victoria's mental health system can most effectively prevent mental illness, and deliver treatment, care and support so that all Victorians can experience their best mental health.

The terms of reference for the Royal Commission were developed following consultation with the Victorian community. In total, more than 8,000 contributions were made via the Engage Victoria website and more than 300 people attended 23 roundtables in metropolitan and regional locations across Victoria. This reflects the importance of mental health to all Victorians.

Feedback came from people with lived experience of mental illness, families and carers, advocacy organisations, service providers, members of the mental health workforce, academics and others. More than 80 per cent of those who contributed said they, or someone close to them, had accessed mental health services in Victoria within the preceding five years.

The Royal Commission will make recommendations appropriate for the short, medium and long term. It will release an interim report in November 2019 and its final report by October 2020. The Victorian Government has committed to implementing all recommendations.

The Royal Commission provides Victorians with the opportunity to shape meaningful, ground-breaking and enduring change in our mental health system. It will identify gaps in prevention, access and support for people with lived experience of mental illness, family members and carers. From this, we will know what needs to be done to improve the system and achieve better outcomes.

Productivity Commission inquiry

At the same time as the Royal Commission into Victoria's Mental Health System, the Productivity Commission is conducting a national inquiry into mental health. This inquiry is considering the role of mental health in supporting economic participation, enhancing productivity and economic growth.

The Productivity Commission will make recommendations about how governments, employers and others can improve population mental health in order to realise economic, social participation and productivity benefits over the long term. The Productivity Commission's final report is due to be provided to the Commonwealth Government in May 2020.

Victorian Auditor-General's Office reports

In 2018–19 there were two separate Victorian Auditor-General's Office reports released regarding mental health: *Access to mental health services* and *Child and youth mental health*.

The *Access to mental health services* audit sought to determine if people with mental illness have timely access to appropriate treatment and support services. The audit recommended that the department complete a system map to project demand and inform investment planning, set relevant access measures and targets, undertake price and funding reform, resolve catchment area issues and improve internal governance and reporting.

The *Child and youth mental health* audit sought to determine whether child and youth mental health services are effectively preventing, supporting and treating child and youth mental illness. The report makes 20 recommendations for the department to improve the design of child and youth mental health services, refine the performance monitoring approach for services, and prioritise access to those most in need.

The department is implementing the recommendations of these reports. Implementation of recommendations about system design and strategic directions will be informed by the outcomes of the Royal Commission.

Victoria's 2019–20 State Budget


The Royal Commission provides an opportunity to build a future mental health system that Victorians deserve. It is critical, however, that work continues to deliver the range of initiatives funded over recent years to ensure that Victorians receive the best possible treatment and care and that more people access the help they need, when they need it.

Building on last year's record mental health investment, the Victorian Government invested a further \$172.8 million in 2019–20 to ensure Victorians with mental illness get better treatment and care, closer to home.

Investments in mental health services in the 2019–20 State Budget include:

 **\$23.3 million** for an **additional 28 inpatient beds** to meet growing demand for mental health bed-based services

 **\$28.7 million** for **more mental health services in the community**, providing earlier care and support

 **\$6.6 million** to **increase capacity at three prevention and recovery care (PARC) units**, supporting Victorians in the early phases of recovery with more treatment options and improved clinical care



\$9 million

to **strengthen and enhance mental health workforce initiatives**, including increased capacity of the nurse transition program, and more support for psychiatrists



\$16.2 million

to **support mental health clinicians at the Victorian Fixed Threat Assessment Centre** and deliver extra specialised public mental health services to meet the needs of people referred by the centre.



\$8.5 million

for **innovative programs supporting Aboriginal Victorians** with severe mental illness

Other key investments include:



\$3 million

for **mental and physical health supports for asylum seekers** awaiting confirmation of their refugee status



\$2.5 million

for targeted **family counselling services over the next four years**, and \$500,000 for additional **mental health support for members of the LGBTIQ+ community**



\$5.7 million

for the **Mental Health Tribunal and the Mental Health Complaints Commissioner** to strengthen their capacity to fulfil their functions in a recovery-focused and rights-oriented way



\$3.5 million

for additional supports and for a campaign to reduce stigma while the **Royal Commission into Victoria's Mental Health System** undertakes its work



\$6 million

to **establish a centre of excellence for emergency workers** to provide timely, evidence-based mental health care

Improving access to specialist mental health services

Outcome 13: The treatment and support that Victorians with mental illness, their families and carers receive is available in the right place, at the right time.

Growth funding for additional community hours



1,370,337
community hours
in 2018–19



6.5%
increase in
community hours
compared with **1,286,789**
in 2017–18

While an estimated 3 per cent of the population has a severe mental illness, by 2016–17, the proportion of the Victorian population registered with public specialist mental health services had declined to 1.07 per cent.

In response to this, the Victorian Government invested \$110.5 million over four years to create capacity to accept new clients into community mental health services.

This investment took into account the need for services to treat more people as the population increases, as well as providing more intensive services to those in greatest need and responding more effectively to people who present in crisis.

In 2018–19, total service hours in the community increased by 6.5 per cent.

Prevention and recovery care services – clinical uplift



3,542
separations from PARC
services during 2018–19

compared with **3,458** in 2017–18

PARCs are an integral part of the clinical mental health service system that provide early intervention or post-hospital support to assist recovery. PARCs predominantly engage with mental health community teams and acute inpatient units for referrals, admissions and discharges, but also work closely with community support agencies and primary care providers.

PARC clinical uplift investment over the last two years enables services to increase the availability of evidence-based clinical interventions as part of a broader recovery-oriented program of support. The clinical uplift investment builds on the existing model of care to deliver more intensive clinical support to consumers.

The aims of this investment are to:

- improve mental health outcomes for consumers experiencing increased symptoms associated with relapse or a post-acute episode, and provide a broader range of evidence-based clinical treatments for consumers and carers
- enable timely and responsive access to clinical review, including reviews of medications and treatment plans
- improve service provision for consumers with multiple and complex needs by improving their access to more clinical input and support
- improve physical health outcomes by increasing access to nurses who can educate and monitor consumers' physical wellbeing
- increase clinical presence to reduce waiting periods for assessment and PARC access
- prevent avoidable admissions to acute inpatient units and/or readmissions following an acute episode.

Funding model reform and intensive community packages

The Victorian Auditor-General's report on access to mental health services in Victoria recommended that the department undertake a price and funding review for mental health services. It further recommended that the department provide detailed advice to the Minister for Mental Health on the results of this review and use this information to inform funding reforms.

While acute health services are predominantly funded based on activity, mental health is funded largely through block funding, which does not take into account changes in the volume and nature of consumer demand.

In 2018–19 the department began work to reform mental health funding, starting with clinical mental health services delivered in the community. Intensive Community Mental Health Packages are designed to target adult consumers whose diagnosis and wellbeing assessments indicate they are at risk of recurring acute episodes and associated hospital admissions without more intensive therapeutic intervention. This targeting reflects development work on an activity-based funding model that can allocate resources for adult community mental health services on the basis of the severity and complexity of consumers' needs and the associated volume and intensity of service responses.

The *Intensive Community Mental Health Packages guidelines* (released in March 2019) have been developed to increase mental health service capacity to deliver evidence-based, intensive supports in the community for consumers with complex needs. Importantly, progressive reforms will be driven by the proposed new funding model and a new performance and accountability framework.

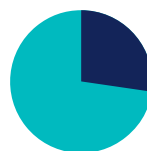
Prehospital Response of Mental Health and Paramedic Team (PROMPT) trial



97,731
mental health-related ED
presentations in 2018–19



5.5%
increase from 2017-18



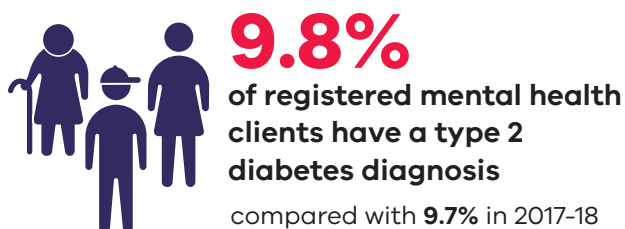
27.5%
of referrals to clinical mental
health services are from EDs
compared with **21.9%** in 2016–17
and **24.4%** in 2017-18

In 2019 Barwon Health, in partnership with Ambulance Victoria, began its 12-week Prehospital Response of Mental Health and Paramedic Team (PROMPT) trial. The trial involved having a specialist mental health nurse work with specialist ambulance paramedics as part of an emergency response. The trial initially ran from May until July 2019.

Approximately 76 per cent of patients seen in the trial were safely diverted from emergency departments. This enabled patients to be referred directly to more appropriate healthcare providers and settings while reducing the demand on emergency departments.

Barwon Health and Ambulance Victoria have agreed to extend the program for a further six-month period.

**Equally well in Victoria:
Physical health framework for
specialist mental health services**



Equally well in Victoria: physical health framework for specialist mental health services was released in March 2019 and is the first policy of its kind in Victoria. It describes partnership initiatives with consumers and carers that promote and facilitate consideration of physical health in a person's recovery. The framework provides information to help mental health services and clinicians tailor treatment strategies to consumers' needs.

The framework emphasises the importance of a recovery approach to physical health and support for consumers that extends beyond biomedical screening, diagnosis and treatment. It also asks clinicians to work inter-professionally to understand each person's recovery journey. It promotes use of recovery plans to enquire about the person's physical health, appreciating the complex interplay with mental illness.

The department will continue working with health services, consumers and carers to implement the framework, providing tools and resources to support services in delivering physical health initiatives.

Personality Disorder Initiative

The Victorian Government is committed to supporting consumers of public clinical mental health services with severe personality disorders to access high-quality, evidence-based assessment and clinical treatment.

The 2018–19 Victorian State Budget committed \$9.16 million over four years (\$2.16 million in 2018–19 and \$2.45 million ongoing) for the Personality Disorder Initiative. This initiative aims to improve outcomes for this consumer group. It will build the expertise and capability of the clinical mental health workforce to assess, treat and support people with severe personality disorders who are at high risk of suicide, high-lethality self-harm and/or violent or aggressive behaviours.

As part of the initiative, six participating health services will employ personality disorder clinical specialists. These clinicians will receive intensive training and active clinical supervision and oversight from Spectrum (Victoria's statewide specialist personality disorder service) that enables them to deliver primary assessment and treatment interventions to a small number of consumers with very complex, high-risk presentations.

The following health services have been funded to deliver the Personality Disorder Initiative:

- Alfred Health
- Monash Health
- Melbourne Health (Northern Area Mental Health Service)
- Barwon Health
- Goulburn Valley Health
- Forensicare.

Specialised treatment and support for adults with complex needs

People with multiple and complex needs require specialised services and care coordination across multiple health, social support and justice agencies.

The Victorian Government funds a range of services and programs targeted to people with mental illness and other complex needs, such as coexisting cognitive impairment or problematic substance use.

Work is underway to explore how current service responses could be further improved using current specialist service delivery models and by building on existing initiatives, sector skills and knowledge to enhance assessment, treatment and support.

The Multiple and Complex Needs Initiative (MACNI) provides interventions to people aged 16 years or older with mental illness, substance dependency, intellectual impairment or acquired brain injury, and who have high support needs. Approximately \$6.2 million in 2018–19 was allocated to fund MACNI, supporting 245 people.

The 2018–19 State Budget provided an additional \$8.9 million over four years to improve access to MACNI. This funding has enabled additional assessment, diversion, consultation and brokerage support to consumers who previously may not have been able to access the initiative.

Preventing suicide

Outcome 4: The rate of suicide is reduced

Suicide has a profound and lasting impact on families, friends and communities. Community support to prevent suicides is strong, especially from people who have a lived experience of suicide. Suicide remains the leading cause of death for Australians aged 15–44 years and the second leading cause of death among Australians aged 45–54.

According to the Australian Bureau of Statistics, 593 Victorians were lost to suicide in 2018. However, care needs to be taken when interpreting this data for 2018. The Victorian Registry of Births, Deaths and Marriages implemented a new registration system in February 2019, with some changed policies and procedures. Coroner-referred registrations to the registry in 2018 are low, and an increase in registrations is expected in 2019.



Targeted, person-centred support following self-harm and suicide attempts

The Hospital Outreach Post-suicidal Engagement (HOPE) initiative is an aftercare program that provides dedicated and practical assertive outreach support for people leaving hospital following a suicide attempt or intentional self-harm. Assertive outreach workers also work with families, friends and carers so they can better support their loved one during this critical time.

So far more than 1,800 service contacts have been provided through HOPE with individuals receiving outreach support for up to three months after their discharge from hospital. Each hospital has developed and implemented its own service model to ensure intensive support is provided during vulnerable periods, aiming to reduce people's risk of future suicide attempts.

The HOPE initiative began in 2017–18 at six hospitals across Victoria:

- St Vincent's Hospital (St Vincent's Health)
- The Alfred (Alfred Health)
- Frankston Hospital (Peninsula Health)
- University Hospital Geelong (Barwon Health)
- Maroondah Hospital (Eastern Health)
- Wangaratta Hospital (Albury Wodonga Health).

Building on HOPE's early success, this initiative expanded to a further six hospitals in 2018–19:

- Latrobe Regional Hospital
- Sunshine Hospital (Melbourne Health)
- Casey Hospital (Monash Health)
- Ballarat Health Services (including Horsham)
- Werribee Mercy Hospital
- Bendigo Health Service (including Mildura).

The new sites were selected based on analysis of suicide and intentional self-injury data, population demographics and community profiles. Sites were selected in both metropolitan and regional/rural areas across Victoria. This recognises that mental health needs and supports differ within each community, and that the services and supports available depend on the local setting.

The Victorian Government is working with the Commonwealth to expand the *Beyond Blue Way Back Support Service*, which provides outreach, follow-up care and practical support to people discharged from hospital after a suicide attempt. In June 2019 the Victorian Government entered into a Bilateral Agreement with the Commonwealth Government to deliver its *Aftercare following a suicide attempt measure*. Under the Agreement the Commonwealth will match Victorian investment in HOPE with four *Way Back Support* services, expanding Victorian suicide aftercare to 16 sites across Victoria.

Delivering HOPE at Alfred Health

Under the HOPE program, mental health professionals provide one-on-one support to people who have attempted suicide and make sure they get both the clinical and psychosocial support they need to recover.

At the heart of the HOPE initiative is an understanding that suicide prevention is most effective when integrated with broader efforts to improve social and emotional wellbeing. People who have attempted suicide are supported to address the stressors in their lives depending on their unique circumstances and needs. For example, they may need assistance finding housing or employment, or can be referred to a range of support services, such as education, training, legal support, Centrelink, drug and alcohol services or relationship and family services.

Alfred Health has established an innovative approach to providing aftercare for people discharged from hospital following a suicide attempt. The model was developed with peak consumer and carer bodies and through local and consumer and carer consultations.

Embracing a non-clinical workforce

- Consumers set their goals and work with Alfred Health on what is important to them. This isn't always about their mental health, but the things that affect it, and it means being practical, flexible and focused on the big picture.
- Support workers offer emotional and practical support. This might be meeting for coffee and a chat at a favourite café, help with job hunting, or helping to book specialist appointments and transport to get to those appointments.

- Non-clinical support workers work alongside senior mental health clinicians with flexibility in the level of clinical input. Rapid escalation pathways and continued clinical support are maintained throughout the period of care to ensure a person's needs continue to be met as they evolve.

Respectful persistence

- Flexible use of contemporary channels like email and text are used to encourage continued contact. 'Old-fashioned' postcards and letters help to build a sense of trust and connection.
- When it is time for engagement with a person to end, the opportunity is taken for staff to reflect and write a strengths-based therapeutic letter to the consumer.
- 'Post carding' recognises that the journey after a suicide attempt doesn't end when a person completes their period of care. Alfred Health reaches out with postcards to remind people that help is always available.



Alfred Health HOPE leaflets – Messages of HOPE: locally designed service messaging. Messages and images in the pamphlets were developed by Alfred Health through a participatory design process.

Place-based suicide prevention trials



2,000+
people trained in how
to identify and support
people in mental distress
or suicidal crisis

Place-based suicide prevention trials continue to be delivered through partnerships and co-investment with Primary Health Networks in 12 locations across Victoria:

- Mornington Peninsula/Frankston
- Dandenong
- Latrobe Valley
- Bass Coast
- Brimbank/Melton
- Macedon Ranges
- Whittlesea
- Maroondah
- Mildura
- Benalla
- Ballarat
- the Great South Coast.

The trials support communities to work together to identify what is needed to prevent suicide, foster individual and community resilience and wellbeing, and strengthen approaches to suicide prevention.

This is an innovative way of working together to prevent suicide that requires strong collaborations across many sectors within a community, including people with lived experience of suicide and their families, community agencies, the Aboriginal community-controlled sector, schools, businesses, local councils, transport providers, police, health services, ambulance services and others.

The strategies collaboratively identified and implemented by communities include:

- raising awareness of mental health issues and support services so people know where to go for help (for example, R U OK? Day)
- supporting people with lived experience to talk about suicide in the community
- equipping general practitioners (GPs) to identify and help people in distress
- school-based programs to help build resilience and help-seeking among young people
- improving mental health in workplaces
- improving the skills and confidence of frontline workers (including ambulance and police staff) to deal with suicidal crisis
- training local volunteers to recognise and respond to people at risk of suicide
- developing coordinated responses after a suicide and reducing access to means.

The aim of the trials is to develop culturally appropriate and safe suicide prevention approaches. Engagement with Aboriginal communities to explore the particular issues for Aboriginal people is a central part of these trials.

The trials have established more than 300 local partnerships across the 12 sites, building an improved system to prevent suicide in a diverse range of local communities.

During 2018–19 the place-based suicide prevention trials collectively trained in excess of 2,000 people in how to identify and support people in mental distress or suicidal crisis. Specific training programs to strengthen individual and community resilience have been delivered to people in regional and metropolitan locations including working-age males, young people, and culturally diverse groups.

An evaluation of this initiative is currently underway to inform future suicide prevention activity across Victoria.

Supporting and strengthening the mental health workforce

Outcome 16: Services are safe, of high quality, offer choice and provide a positive service experience

As a key part of *Victoria's 10-year mental health plan*, the *Mental health workforce strategy* was released in 2016. These initiatives strengthen the clinical mental health workforce and are designed to benefit staff development, satisfaction, morale and retention. Despite significant challenges, the mental health workforce continues to grow and diversify.

'Our vision is to be the centrepiece for mental health learning in Victoria; leading and driving innovation that strengthens and sustains a flexible, curious, knowledgeable and recovery-focused workforce.'

Centre for Mental Health Learning



The Centre for Mental Health Learning Victoria (CMHL) was established in 2018 to harness mental health learning and development efforts in Victoria, including expertise, resources, training and research. The CMHL is focusing its work around four pillars: engagement and communication; alignment and coordination; innovation and systems change; and evidence and quality.

Activity in 2018–19 included data collection, model development and engagement and communication, with more than 55 consultation sessions with public mental health services and other key stakeholders.

In 2018–19 the CMHL also engaged with regional health services to understand workforce learning and development priorities. As the CMHL's capacity grows, it will further focus on supporting regional services with local workforce development needs.

The CMHL currently offers frontline workers access to more than 100 training and development events, an online resources hub and dedicated lived experience workforce information. Find out more from the CMHL website <<https://cmhl.org.au>>.

HELLOOPENMINDS

The Hello Open Minds workforce attraction campaign aims to promote careers in mental health. It is designed to grow workforce numbers and support other initiatives in the *Mental health workforce strategy* to further develop and support specific disciplines in mental health. In 2019–20 this campaign will target specific disciplines and areas of need, such as forensic mental health.

Adequate workforce supply to meet current demand in rural and regional Victoria continues to be a key issue. Over the next 12 months, the department will pilot a number of recruitment strategies in specific regional areas to determine the most appropriate methods that can be scaled up across the state.



Workforce Strengthening Project

The Workforce Strengthening Project aims to boost workforce capacity through a number of streams including mental health nursing training positions, community mental health engagement worker positions and clinical nurse consultant positions.

Victoria's 2018–19 State Budget provided additional funding to allow area mental health services to recruit into various new positions. With the support of the department, services received funding for 63 positions across 18 public mental health services in metropolitan and rural/regional Victoria.

The funded positions will enable services to achieve improved outcomes and meet the needs of consumers and their families/carers.



Support for the psychiatry workforce

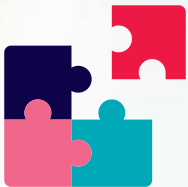
A range of initiatives to support the psychiatry workforce received funding as part of the 2019–20 Budget. These included:

- Funding for a director of training for specialist international medical graduates. Victoria is increasingly relying on international medical graduates to fill selected specialist positions, particularly in rural areas. While there are well-organised support structures for local graduates, this will be further strengthened to provide a greater level of support for graduates from overseas to help them adapt to the local health system and differing cultural contexts.
- Investment to support a director of advanced training in addiction psychiatry. Currently, training and career pathways for addiction psychiatry are limited, with a shortage of psychiatrists with this specialisation.
- A scholarship program to support and promote leadership. This will be established for psychiatrists in 2019, offering development opportunities in priority areas such as clinical governance.
- Funding to promote the uptake of established telehealth infrastructure. This will support workforce development and secondary consultation by psychiatrists.



The **Psychotherapy Essentials in Mental Health Nursing program** is designed to strengthen community mental health nursing practice. The program equips nurses with a comprehensive, coherent and contemporary set of psychotherapy skills to support consumers' personal recovery journeys.

In 2018–19 the program ran two pilot workshops involving staff from Barwon Health, Mercy Health and Goulbourn Valley Health. A mix of online and face-to-face training was delivered. Through this training participants reported gaining significant knowledge that could be applied to their current professional practice.



Lived experience workforce strategies

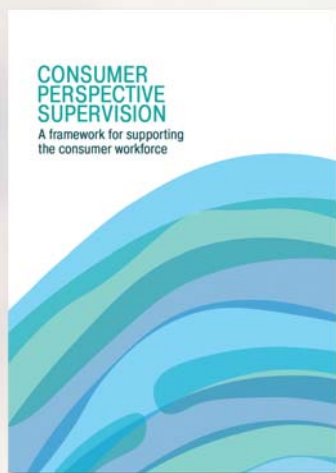
The department has partnered with consumer, family and carer workers through the Consumer and Family Carer Workforce Development groups and alcohol and other drug (AOD) peer workers to co-design strategies and actions to expand the lived experience workforce in Victoria.

Consumer and family carer and AOD lived experience workforce strategies for Victoria were developed throughout 2018–19.



Innovation grants

A Workforce Innovation Grant Program was established in 2017–18 and allocated in 2018–19 to support consumer-led and family/carer-led innovation projects related to workforce development. The department made a pool of \$100,000 available to support a number of projects. Nine projects were awarded grants and are currently underway. These projects range from suicide prevention to examining peer support training.



Consumer-perspective supervision

The *Consumer-perspective supervision framework* was released in November 2018. The framework is part of a wider project that aims to create access to quality, discipline-specific supervision for consumer workers. VMIAC led development of the framework in partnership with the Centre for Psychiatric Nursing and the department. Using the principles of co-production, this consumer-led initiative brings together supervisees, supervisors, health services and thought leaders to create the framework and structures that support consumer-perspective supervision.



The Royal Australian & New Zealand College of Psychiatrists

RANZCP Enabling Supported Decision Making Project

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Enabling Supported Decision Making Project concluded in 2018–19 with the development of an RANZCP-developed position statement on supported decision making, as well as training and practice-change resources that enable psychiatrists to implement supported decision making.

A co-production methodology saw mental health consumers and psychiatrists partnering to plan, develop, deliver and evaluate the project.

The position statement, an online module and other project resources can be found on the RANZCP website <www.ranzcp.org/about-us/australian-branches/victoria>.



Peer workforce expansion

In 2018–19 the department funded six PARCs to each employ one full-time equivalent peer support position. The impact of expanding the peer support workforce to PARCs will be monitored as the positions are embedded during 2019–20.

'We are hopeful that the work we have done does and will make a real difference to those clients discharged from the Acute Assessment Unit and for their families. We are pretty sure it does.'

– Mark Lacey, Lived Experience Coordinator, Ballarat Health Services

Lived experience workforce: Expanding Post Discharge Support Initiative

'One of the things we are proudest about is the commencement of the Expanding Post Discharge Care roles. Two workers – a consumer peer worker and a carer peer worker – commenced work in November 2018. We wanted the roles to be informed by best practice, so we started by visiting a couple of services with those roles working well – Werribee and St Vincent's – and learning from them.

'We then developed a range of resources for the role – we wanted to see that nurses in the adult acute unit knew of, and referred to, the role and that those in the adult community teams did too. We started with the two workers just working in the Acute Assessment Unit (AAU) and running activities so that those clients in the AAU got to know the workers and what they did.

'In 2019, we commenced the roles. The two workers developed a set of notes which allowed them to track their work with a particular client and also to report to the treating clinician when the case was closed. We also wanted staff to know what the two workers do, so we developed an in-service that the workers presented to the AAU and community staff.

'One of the changes since the role was instituted is that there are now more staff delivering more programs in the adult acute unit. When we started, the two workers were working pretty much alone in delivering programs in the AAU. That has now changed. We have again consulted with St Vincent's and have used their program for education and activities for clients in the AAU as a template for the development of a similar program here in Ballarat.

'We still have a way to go. We have been offered the use of the electronic medical records, so work is going into supporting the workers around that capability. We also want to measure what we have done – that is, are there better outcomes for people after discharge than before the program was launched?'

*– Mark Lacey, Lived Experience Coordinator,
Ballarat Health Services*

Workforce Strengthening Project: Clinical nurse consultants

Recruitment into clinical nurse consultant (CNC) positions began in inpatient units across the state in 2018-19. Kaz, one of the newly recruited CNCs, provides an insight into her role and highlights some of the fundamental elements required for the success of this initiative.

'Change is based on authority of philosophy not authority of position. This is my personal perspective regarding the CNC role. It is an opportunity to reframe relationships and treatment delivery approaches, aiming towards optimal consumer outcomes.

'To transform, uphold and in some instances change current practice will require focusing on practices that provoke conflict and often lead to restrictive interventions. This will require change management.

'There is a call on my unit for a cultural shift, buy-in of multidisciplinary teams, role clarification and a determination to withstand the pushback. Mentoring and coaching staff to embrace the Safewards philosophy through deliberate role modelling has proven successful so far.'

– Kaz-Nkathazo Nkomo, Clinical Nurse Consultant – Adolescent Inpatient Unit, Eastern Health

Aboriginal social and emotional wellbeing

Outcome 3: The gap in mental health and wellbeing for Aboriginal Victorians is reduced



2.8%

of all clients in 2018–19 were Aboriginal while Aboriginal people made up 0.8% of Victoria's population

(Source 2016 Census)



25%

of Aboriginal Victorians have high or very high psychological distress

15.4% of Victorian adults have high or very high psychological distress



19%

of Victorian Aboriginal children at school entry are at high risk of clinically significant problems related to behaviour and emotional wellbeing

5.6% of Victorian children at school entry are at high risk of clinically significant problems related to behaviour and emotional wellbeing

'The Aboriginal concept of social and emotional wellbeing is an inclusive term that enables concepts of mental health to be recognised as part of a holistic and interconnected Aboriginal view of health which embraces social, emotional, physical, cultural and spiritual dimensions of wellbeing.'

– *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027*

Balit Murrup

Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027 was launched in October 2017 and is a key initiative under *Victoria's 10-year mental health plan*. *Balit Murrup* was developed with the shared knowledge and wisdom of leaders and experts in Aboriginal social and emotional wellbeing and mental illness.

Balit Murrup focuses on Aboriginal healing, trauma-informed practice and recovery and, most importantly, self-determination. It is underpinned by a holistic understanding of mental health, Aboriginal social and emotional wellbeing and the need for healing and trauma-informed care. Initiatives under *Balit Murrup* focus on self-determination and strengthening leadership and capacity within Aboriginal community-controlled organisations.

Investment in Aboriginal mental health workforce initiatives support the strategic priorities of the framework.

Improving mental health outcomes for Aboriginal and Torres Strait Islander People with moderate to severe mental illness initiative

To improve access to culturally responsive services, the department has funded four demonstration projects to test new service models for Aboriginal Victorians with moderate to severe mental illness.

These projects are funded to deliver integrated, culturally safe mental health services designed to meet the mental health, social and emotional wellbeing needs of their local Aboriginal communities.

Each consortium is led by an Aboriginal community-controlled organisation in partnership with a local public health service.

The four demonstration sites are:

- Ballarat and District Aboriginal Co-operative (in partnership with Ballarat Health)
- Mallee District Aboriginal Services (in partnership with Mildura Base Hospital and Mallee Family Care)
- Victorian Aboriginal Health Service (in partnership with St Vincent's Health, Austin Health and North Western Mental Health)
- Wathaurong Aboriginal Co-operative (in partnership with Barwon Health).

The four sites began operating in 2018–19 and recruited multidisciplinary teams comprising psychologists, dual diagnosis workers, Aboriginal mental health workers, psychiatrists and cultural workers.

All four project sites continue to report positive client outcomes due to strengthened partnerships between services, improved coordination of care and a steady increase in client referrals into services.

Social Compass has been engaged to evaluate this initiative using culturally determined measures and indicators of success. The evaluation is due by June 2021.

Improving outcomes for Aboriginal Victorians with a mental illness: demonstration project

'The program is there to support people that are showing signs of mental ill health. And it's providing a link into our clinical services ... and also into mainstream services. In the past, Aboriginal people haven't linked into mental health services, and our programs provide a bridge for them to do that. We have seen a lot more self and community-based referrals, which has shown that they're more supportive

of the program as well. Our partnership with the mainstream health services is extremely important. This provides an opportunity for us to understand each other's clinical environments ... It is very important for us to work together for the best outcomes for our clients.'

– Paul Hogarth, Team Leader, Mallee District Aboriginal Services



Mallee and District Aboriginal Health Service (Mildura) Demonstration Project team: (L–R) Joshua Symons, Jacinta Tyers, Gloria Spencer, Ross Hensgen and Paul Hogarth.

Aboriginal Mental Health Traineeship program

The Aboriginal Mental Health Traineeship program is a new workforce initiative to help build a mental health workforce that provides culturally safe and inclusive mental health care for Aboriginal Victorians.

In 2018–19 area mental health services recruited 10 Aboriginal mental health trainees. Trainees will receive supervised workplace training and clinical placements over three years while completing a Bachelor of Science (Aboriginal Mental Health) degree through Charles Sturt University, New South Wales.

This specialist course aims to prepare graduates to work within mental health services with all members of the community, with an understanding and appreciation of Aboriginal and Torres Strait Islander clients, their families and communities.

It places mental health workers within a multidisciplinary team working alongside other health professionals, both Aboriginal and non-Aboriginal.

Trainees are full-time employees in the mental health service during the three-year program and will be offered full-time ongoing employment after successfully completing the three-year degree.

The trainees have access to cultural supervision and support during the program. They also attend the Victorian Aboriginal Social and Emotional Wellbeing Gatherings coordinated by the Victorian Aboriginal Community Controlled Health Organisation (VACCHO). These gatherings are held twice a year. Mental health services must release the trainee to participate in cultural supervision and support activities.

At the end of the traineeship program:

- the health service will create permanent positions for Aboriginal people who successfully complete training
- the number of Aboriginal people working in mental health services will increase
- the capacity of the broader community will increase through training of local people
- Aboriginal employees become cultural awareness ambassadors.

Traineeship positions are funded at eight area mental health services across metropolitan and rural Victoria. Eastern Health received funding for two trainees, as did Bendigo Health. Alfred Health, Peninsula Health, Latrobe Regional Hospital, Mildura Base Hospital, Monash Health and Forensicare all received funding for one trainee.



Michael Thornton, Aboriginal Mental Health Trainee at Mildura Base Hospital

Aboriginal clinical and therapeutic mental health positions in Aboriginal community-controlled health organisations

This initiative aims to increase the workforce available to deliver culturally responsive, trauma-informed services that can address the social and emotional wellbeing and mental health needs of Aboriginal people in Victoria.

During 2018–19, 10 clinical and therapeutic mental health positions were recruited in selected Aboriginal community-controlled organisations across rural and metropolitan areas. All recruited staff are qualified clinicians including mental health nurses, psychiatrists, psychologists, psychiatric nurses, forensic mental health GPs and social workers.

Through these positions, services are delivering trauma-informed social and emotional wellbeing models of care to meet the mental health needs of more than 150 consumers.

Continuous quality improvement tool: Aboriginal health in acute health services and area mental health services

The *Continuous quality improvement tool: Aboriginal health in acute health services and area mental health services (CQI tool)* supports Victorian health services to provide culturally responsive health care to Aboriginal Victorians.

It provides health services with a process to:

- reflect on progress towards becoming a culturally responsive organisation
- identify gaps in organisational and clinical practice
- identify priorities for actions to improve the delivery and outcomes of health care through organisation-wide initiatives and programs to Aboriginal consumers across the organisation
- ensure greater systemic effort and accountability for a whole-of-health-service CQI approach to health care and health outcomes for Aboriginal consumers.

The tool can be used:

- to demonstrate actions for implementing the department's *Aboriginal cultural safety framework* <www.dhhs.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework>
- as evidence within accreditation processes including the *National Safety and Quality Health Service (NSQHS) Standards* and the *National Standards for Mental Health Services* (2010).



Northern Area Mental Health Service (NAMHS) Aboriginal mental health action plan 2019–2020

NAMHS recognises Aboriginal and Torres Strait Islander people as the traditional custodians of Australia and the land on which NAMHS services are based. NAMHS also recognises the long and rich cultural history of Aboriginal people. It acknowledges that colonisation has led to intergenerational trauma, displacement of family and culture, and a significant gap in the health outcomes for the Aboriginal and Torres Strait Islander community.

The Fifth national mental health and suicide prevention plan identifies Aboriginal and Torres Strait Islander adults:

- are almost three times more likely to experience high or very high levels of psychological distress than other Australians
- are hospitalised for mental and behavioural disorders at almost twice the rate of other Australians
- have twice the rate of suicide than that of other Australians.

The NAMHS catchment has one of the highest populations of Aboriginal and Torres Strait Islander people in metropolitan Melbourne. NAMHS is committed to closing the gap on the social and emotional wellbeing of Aboriginal and Torres Strait Islander people living within the Northern catchment and implementing the *Fifth national mental health and suicide prevention plan* and *Balit Murrup* at the local level.



NAMHS has developed its action plan to outline initiatives that will improve the cultural awareness and cultural responsiveness of its services, provide a culturally welcoming environment, grow the Aboriginal and Torres Strait Islander workforce and continue to build on partnerships with local Aboriginal community-controlled organisations.

NAMHS recognises that the Aboriginal community is highly resilient, has a strong sense of cultural identity and pride and that through working together NAMHS can support consumers, carers and the community in their recovery and towards enhancing the overall wellbeing of the community.



Support to drought and bushfire-affected communities

In 2018–19, \$1.89 million was invested in activities to support the mental health and wellbeing of drought-affected communities in Victoria.

Mental health support packages were designed in consultation with farmers and other key stakeholders including Beyond Blue, the Royal Flying Doctor Service, Primary Health Networks, the Victorian Farmer's Federation, the National Centre for Farmer Health and relevant industry partners.

The core components of the community mental health support packages include:

- psychological first aid training (mental health first aid or equivalent training designed to promote awareness of how to recognise the signs of psychological distress and seek help)
- local coordination to ensure information about mental health services and other support options is promoted
- increased capacity of counselling services and outreach workers.

Coordination in the local area helps farming communities better prepare for, respond and adapt to difficult seasonal conditions. Outreach programs and mental health events identify and refer individuals requiring mental health supports to appropriate services.

The 2018–19 funding to support drought-affected communities has led to:

- outreach workers supporting more than 100 people in affected communities
- 57 community events to combat social isolation and promote mental health
- 26 mental health first aid training sessions
- four suicide prevention-specific workshops delivered by Wesley Lifeforce and Standby – Support After Suicide.

A further \$100,000 provided additional counselling services in the Outer Gippsland region to support communities affected by the 2019 bushfires. This funding increased the capacity of community mental health services to provide counselling and support to people in the region experiencing psychological distress associated with the fires.

Safety and quality

Safer Care Victoria



Established in January 2017, Safer Care Victoria (SCV) is the state's lead agency for monitoring and improving quality and safety in Victorian health care. SCV supports health services and clinicians to identify and respond to areas for improvement and works closely with consumers, families and carers.

SCV has established the Mental Health Clinical Network. The primary role of the clinical network is to provide clinical leadership, expertise and advice to SCV, with the ultimate aim of improving consumer outcomes and experiences.

In 2018–19 the Mental Health Clinical Network:

- appointed Associate Professor Sean Jespersen as the network's clinical lead
- established the Governance Committee
- established the Clinical Network Insight Subcommittee, whose function is to interpret clinical data and evidence to identify areas for improvement and set and monitor quality and safety indicators for Victorian emergency care
- initiated work on improving how consumer experience measures are used in Victoria's clinical mental health services.

SCV has also progressed a number of activities related to Victoria's mental health clinical services in 2018–19. These include:

- partnering with the Office of the Chief Psychiatrist to review sentinel events in mental health services
- funding the 'Safe Haven Cafe' at St Vincent's Hospital through the Better Care Victoria Innovation Fund.

Mental health intensive care framework

Mental health intensive care areas (also called high dependency units) are discrete, secure spaces within a mental health acute inpatient unit that are dedicated to safely treating people with increased risk and vulnerability.

Improving safety, consistency and quality in mental health intensive care has arisen as a priority area in a range of reviews including the *Chief Psychiatrist's audit of inpatient deaths 2011–2014* (2017), *Mental Health Complaints Commissioner – The right to be safe* (2018), as well as a 10-year review of restraint practices in Victoria. A new framework and associated training is required to support services to provide contemporary best practice in line with the *Mental Health Act 2014*.

A contemporary mental health intensive care framework is currently being developed. The program of work is about understanding the advanced skill set and clinical uplift required to support people who are highly vulnerable and distressed. It is not about a specific space. It is applicable to all settings through a focus on, and understanding of, a person's needs, human rights and recovery journey.

The work is informed by feedback and the lived experiences of consumers and carers who consistently report that mental health intensive care areas are prison-like, non-therapeutic and unsafe. There is overwhelming evidence to underpin a collaborative, individualised, trauma-informed and recovery-oriented approach. This will support services to provide the best possible care when engaging consumers in need of mental health intensive care.

St Vincent's Safe Haven Café

The Safe Haven Café at St Vincent's Hospital Melbourne is a non-clinical 'café' space that supports customers to maintain their wellbeing. It provides a safe, therapeutic space outside of normal business hours that is intended to support and empower.

Based on a concept trialed in the United Kingdom, the café offers an alternative to attending the emergency department for mental health consumers who may be experiencing difficulties or feeling isolated or lonely.

Better Care Victoria provided original funding of \$446,000 to pilot a café at St Vincent's, with funding to continue operations sourced by the SVHA Inclusive Health Fund. The café is located in the St Vincent's Art Gallery and operates on Friday evenings, Saturdays and Sundays when other support services may be closed.

The café doesn't provide clinical interventions as they are provided by other service providers. The café provides a safe space and enables consumers to access appropriate therapeutic services based on their identified needs. It also supports the lived experience and peer support workforce to improve the consumer-led and recovery-focused culture.

Since its establishment, café survey data indicates that:

- there were more than 1,000 visits in the first 12 months
- 40 per cent of attendees had found out about the space after presenting to the emergency department
- 30 per cent of attendees were seeking a place to feel safe
- 26 per cent of attendees reported attending to maintain their wellbeing.

David's story

David started visiting the café in August 2018. He had wanted to return to the workforce and give back to the community but felt as if this was almost impossible with everything he was going through at the time. As time went by, he visited the café at least once a week, seeking a safe place to receive non-judgmental support and someone to talk to. With the support from café staff, he was able to work on slowly regaining his confidence until he was finally ready to apply for a volunteer position at a local store. The café helped him feel valued, independent and cared for. He is now able to volunteer on a regular basis. He has started to dream again and talk to the café peer support workers about what he wants for his future. He believes he is on the right path to achieving his goals.

Mary's story

Mary was first referred to the café by the café's emergency department peer support worker. At the time, it seemed as though every part of her life was unravelling. In addition to her mental health issues, she was experiencing homelessness, alcohol and substance use, financial issues and poor physical wellbeing.

The café provided what other support systems could not – someone to connect to and listen to her story at a deeper level. The in-depth discussions with the café workers led to encouraging conversations about seeking further support. Through the café's assistance, she was able to seek support autonomously for her finances and housing. She now has stable accommodation, access to healthy food and health services including a GP and allied health services. Since using the café, Mary has a renewed and positive outlook on life.



Safe Haven Café team

'It has turned my whole life around. It's made me more optimistic. It's given me something to look forward to. I'm getting out and about more. I've developed friendships with my NDIS workers.'

– North West Mental Health client and NDIS participant with a psychosocial disability

Transitioning to the National Disability Insurance Scheme

Outcome 6: Victorians with mental illness are supported to protect and promote health

Transition to the National Disability Insurance Scheme

The NDIS is the national approach for providing support to Australians with a disability, their carers and families. This includes people with a severe, enduring psychosocial disability.

Under the NDIS, around 105,000 Victorians will have access to disability services. The NDIS in Victoria is jointly funded by the Victorian and Commonwealth governments, with Victoria investing \$2.5 billion a year.

The NDIS in Victoria began with a trial in the Barwon area in 2013. The Victorian and Commonwealth governments signed a bilateral agreement for transition to the NDIS in 2015. From this agreement the NDIS started a staged rollout in Victoria in 2016.

While there are continuing challenges associated with a substantial reform of this nature, the NDIS represents a significant opportunity for an estimated 15,000 Victorians with a significant, enduring psychosocial disability to receive better and greater levels of support.

Clients of mental health community support services (MHCSS) receiving Individualised Client Support Packages, adult residential rehabilitation services and select supported accommodation services are progressively joining the NDIS. As at June 2019, 9,666 Victorian participants with a primary psychosocial disability had an NDIS-approved plan. Just under 80 per cent of these participants were previously state-funded clients.

The Victorian Government has committed \$10 million over two years to support state-funded community-managed mental health providers to build their organisational capability to operate efficiently as NDIS providers. It is also funding continuity of support for clients of MHCSS-defined programs who are not eligible for the NDIS due to age and residency.



15,000

Victorians with a primary psychosocial disability are expected to be supported by the NDIS



9,666

Victorians with a primary psychosocial disability have an NDIS plan as at 30 June 2019

compared with **4,389** as at 30 June 2018

Early Intervention Psychosocial Support Response

In 2018–19 the Victorian Government committed new funding of \$50 million over two years for the Early Intervention Psychosocial Support Response. This initiative provides psychosocial support to adult clients of clinical mental health services who are not eligible for the NDIS or are waiting for an NDIS access decision and plan commencement.

The Early Intervention Psychosocial Support Response aims to reduce the likelihood clients will develop lifelong disability due to their mental illness. It supports early intervention and contributes to the efficiency of the health system by providing integrated treatment and psychosocial recovery care in the community.

Delivered by health services in partnership with community-managed mental health providers, this investment will support an estimated 2,700 clients at any one time.

'The role of peer facilitators is significant for mental health consumers. The fact that we are able to provide a program which not only trains peer facilitators but then mentors them to educate other consumers is fantastic.'

– Maggie Toko, CEO, VMIAC

Self-advocacy and the NDIS

In August 2018, Independent Mental Health Advocacy (IMHA) was provided a one-off grant of \$450,000 to develop, test and evaluate a peer-facilitated self-advocacy skills development program for people with psychosocial disability.

A series of modules were co-designed with people with lived experience of mental illness. They aim to increase the confidence and capacity of people with psychosocial disability by building their knowledge and skills to self-advocate for their rights.



Peer facilitators with a lived experience of mental illness were trained to test the modules in a variety of settings, and the broader roll out of the program will now be delivered through a train-the-trainer model.

This initiative was delivered through a partnership between IMHA, VMIAC and Tandem, with input from health services and community-managed mental health providers.

'The peer-facilitated self-advocacy program will be invaluable in meeting the needs of consumers with a psychosocial disability who wish to access and make use of the NDIS to reach their life goals. The primary reasons the program will be invaluable are it is ethically sound, engaging, and will be trusted and heard as it comes from fellow consumers that understand how to engage and support self-determination and empowerment.'

– Katherine Crook, Community Mental Health Practitioner, Mind Australia



Transitioning to the NDIS

Jane was successful in gaining access to the NDIS after her third attempt. Understanding and meeting the evidence requirements for NDIS access was very challenging for her. However, with the support of her clinical team, Jane remained engaged, was better informed and aware of her options and able to share the stress of this process with professionals.

Her NDIS plan has now been successfully activated and she is receiving four hours of support per week to access the community, volunteer at a local op shop and attend fortnightly appointments with an occupational therapist. The occupational therapist assessments will be used as further evidence to support funding for a meal delivery service and support coordinator when her plan is reviewed.

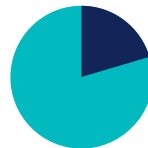
Since the implementation of her NDIS plan, the amount of support Jane needs from clinical mental health services has gradually reduced, and she is now enjoying being able to access the community and looking forward to achieving her goals with her NDIS supports.

Forensic mental health reforms

Outcome 11: Victorians with mental illness live free from abuse or violence, and have reduced contact with the criminal justice system



12.9%
increase in forensic clients in 2018-19 to 988



20.9%
increase in community contacts



34.4%
increase in service hours

The *Forensic mental health implementation plan* (FMHIP) is a cross-portfolio framework aimed at reforming Victoria’s forensic mental health system over 10 years from 2017.

FMHIP was jointly developed by the department and the Department of Justice and Community Safety. It aims to increase community safety by reducing the number of people living with mental illness who have contact with the criminal justice system, as either offenders or victims of crime.

Community Forensic Youth Mental Health Service

An annual survey of young people in Youth Justice custodial settings found that 53 per cent of those surveyed presented with mental health issues. The Community Forensic Youth Mental Health Service seeks to address the particularly high rate of mental illness and mental health problems among young people who come into contact with the justice system. It aims to prevent young people who have a mental illness and behaviours of concern from offending or reoffending by addressing their mental health needs through early intervention.

This service began in the Southern Metropolitan Region through Alfred Health in December 2018 and began in the North-West Metropolitan Region through Orygen Youth Health in October 2019.

The 2017–18 State Budget provided funding of \$2.193 million over four years to support this initiative. The program aims to provide early intervention and support for child and adolescent mental health services (CAMHS) and child and youth mental health services (CYMHS) through forensic mental health assessment, treatment recommendations and conjoint therapy and statewide secondary consultation to CAMHS and CYMHS.

Funding supports approximately 3.6 equivalent full-time positions across both Alfred Health and Orygen Youth Health. This enables primary and secondary consultation for 100 young people in the Southern and North-West metropolitan areas. The service also provides secondary consultation to all CAMHS and CYMHS across Victoria.

The Community Forensic Youth Mental Health Service is supporting young people with mental health needs to get their lives back on track and to reduce their risk of offending. The service is also having an impact on the capability of the CAMHS and CYMHS workforce by enabling them to treat young people with mental health needs and challenging circumstances where they live.

Victorian Fixated Threat Assessment Centre

The Victorian Fixated Threat Assessment Centre (VFTAC) began operating in March 2018. The model comprises an assessment centre (staffed jointly between Victoria Police and Forensicare clinicians) and enhanced specialist mental health and alcohol and other drug (AOD) services. These enhancements increase the ability of both service systems to work effectively with clients. Monash Health and Melbourne Health provide specialist mental health services, with Caraniche providing AOD services.

This model aims to increase the capacity for these providers to work with individuals with complex needs and to support forensic clients within mainstream mental health services.

During 2018–19 the VFTAC has been involved with a number of cases that have resulted in positive outcomes for clients and the community, including:

- re-engaging clients in mental health care and engaging others for the first time
- successfully coordinating and implementing a multi-agency approach to ongoing treatment and management
- stabilising clients' mental health symptoms in response to assertive, ongoing mental health assessment and treatment
- engaging clients in AOD treatment who had previously declined such services
- intervening early with clients at risk of entering the criminal justice system by diverting them to appropriate mental health and other support services
- providing support and intervention relating to clients' psychosocial needs, including accommodation, employment and financial support
- improving outcomes for clients and families, some of whom may be at risk from the client's behaviours and have previously struggled to obtain help
- helping to reunify family members who have become estranged through clients' behaviours.

Custodial Forensic Youth Mental Health Service

A key focus of the Custodial Forensic Youth Mental Health Service is to understand and address the complex interface between mental illness and offending behaviour in young people. With funding of \$4.152 million over four years, the program aims to improve the mental health of young people in custody by providing evidence-based specialist assessment and treatment intervention and reducing any associated risk of reoffending. It also provides services that are integrated with other key custodial and community services. This ensures a holistic approach that supports effective, recovery-oriented treatment outcomes and reintegration into the community.

The service began in February 2019 at Parkville and Malmsbury Youth Justice Precincts and will be provided at the new youth justice facility near Cherry Creek when it opens in mid-2021.

This service represents a significant uplift in specialist mental health services for young people in custody, with a team of approximately 10 psychiatry, neuropsychology and mental health clinicians working across Parkville and Malmsbury. The service has seen more than 200 young people as at 30 June 2019.

Forensicare – Apsley unit opening

The Apsley unit at Thomas Embling Hospital opened in March 2019. The eight-bed secure psychiatric intensive care unit for male patients provides compulsory treatment to mentally ill prisoners and was commissioned to address significant growth in the prison population and a corresponding increase in demand for compulsory mental health services.

The 2015–16 State Budget provided \$9.5 million to construct the unit, with the 2017–18 State Budget providing ongoing operational funding.

The Apsley Unit was built in conjunction with the construction of an additional 10 beds and expanded living areas across other units at Thomas Embling Hospital. A further \$7 million was provided for these upgrades.





Forensic Mental Health in Community Health Program

The Forensic Mental Health in Community Health Program (FMHiCH) is a new service. It provides primary mental health services to people on parole or community sentences who are mandated by the court to seek mental health assessment and treatment. The service began in late 2018 and is now fully operational. It is available across approximately half the state, receiving referrals from 23 community correctional services. Its aim is to improve clients' mental health and link them into appropriate health and community-based services, with the goal of supporting personal recovery and reducing contact with the justice system.

The program is offered by five lead community health services:

- Ballarat Community Health Services
- cohealth
- Latrobe Community Health Services
- Monash Health Community
- the Peninsula Health community health program.

Effective service delivery is the result of close collaboration with Corrections Victoria, local Aboriginal organisations, general practice and with links to relevant area mental health services.

Forensic Mental Health in Community Health Program - Jake's story

Jake is a young man charged with serious offences. His case manager at the Community Correctional Services Office referred Jake to the FMHiCH program for an assessment of his mental health condition.

In his assessment Jake spoke of low mood and frequent anger outbursts, regular cannabis use and diagnoses of depression, anxiety and post-traumatic stress disorder, referring to significant childhood trauma. Jake reported a desire to work on his anger outbursts, identifying this as one of his coping strategies when he finds himself feeling anxious.

After discussing his assessment outcome, Jake agreed that he could benefit from sessions with the FMHiCH psychologist. Strategies to assist with lowering anxiety and increasing compliance with medication were explored, with risk to self and others a focus for parts of each session, and elements of various therapies implemented.

Jake took up the option of referral to the program's exercise physiologist, to help him build confidence and manage his anxiety and impulsivity. A GP reviewed his medication and health status, including a sexually transmissible infection check and referral to the dental program for untreated caries.

At discharge, Jake consulted a trauma-informed practitioner, AOD support networks and a GP with experience in addiction medicine and working with forensic clients. Jake was given care provider contacts and the self-management plan he developed with FMHiCH clinicians and met with ReLink staff to continue with his exercise program.

Jake is now better able to monitor and regulate his behaviour and has learnt effective strategies for managing his anxiety but admits 'I've got a way to go'. Jake says that he better understands how his mental health can affect his behaviour, which in the past has led to bad situations, and he hopes this – and feeling better – will help him keep out of trouble. He says he feels good about having his teeth fixed and having an 'all clear' on his health check.

Mental Health Advice and Response Service

The Mental Health Advice and Response Service provides clinical mental health advice within Magistrates' Courts to improve the appropriateness of mental health interventions and referrals for people appearing before a court, and to reduce delays in proceedings and remands.

The program received \$12.248 million in funding over four years through the 2017–18 State Budget. It enables clinical services to intervene early in the criminal justice process by identifying where people charged with an offence and appearing before the court have a mental illness. It provides timely advice and linkage with treatment providers. Where needed, immediate psychiatric intervention is provided and referrals are made to appropriate mental health services.

Specialist clinical mental health advice is provided to magistrates, community correctional services and court users to ensure effective assessment, treatment and management. Priority is given to providing immediate responses to those presenting to the court who are acutely mentally unwell.

In 2018–19 the program expanded to 13 headquarter Magistrates' Courts, the Bail and Remand Court and the Children's Court of Victoria. The headquarter courts are in Melbourne, Sunshine, Ringwood, Broadmeadows, Dandenong, Heidelberg, Frankston, Moorabbin, Ballarat, Bendigo, Geelong, Shepparton and the Latrobe Valley.

'[The program] assists magistrates to make better informed decisions. The advice received from the clinicians provides us with a sounder basis on which to craft conditions attached to community corrections orders. Its particular value to magistrates lies in the information we are able to receive with respect to the mental health and cognitive functioning of those persons coming before us who appear to be unwell, and that in turn assists us to make appropriate decisions with respect to their cases.'

– Jelena Popovic, Deputy Chief Magistrate

2

Engagement with consumers, families and carers



2. Engagement with consumers, families and carers

Families and carers play a major and ongoing role in providing support and care to people with mental illness. An estimated 60,000 Victorians care for an adult with mental illness, and approximately 9,000 are young people under the age of 25. Engaging and working constructively with families and carers is integral to providing high-quality specialist mental health care.

Partnerships between consumers, clinicians and carers should be based on mutual respect and recognition of the specific knowledge, expertise and experience that each brings. Identifying and responding to the needs of families, carers and children improves social, emotional and physical wellbeing and enhances their ability to provide ongoing support and care.

The Mental Health Act principles require services to protect human rights and promote hope, recovery, capacity and autonomy. These principles recognise the importance of carers, promoting and encouraging communication between health practitioners, consumers, their families and carers.

Clinical best practice requires the identification, recognition and involvement of families and carers, including children, across the service continuum. Clinicians need to actively engage with families and carers as an essential part of mental health service delivery and acknowledge that some consumers may not want their families involved and that some families may not want to be involved.

Active participation in mental health services

Lived experience engagement framework

The *Lived experience engagement framework* is a document that was developed during 2018-19 through co-production, reflecting the principle that the people who use services should be empowered to have an equal say in how they are designed and delivered. It is both a demonstration of this approach and a guide to improving the way the department puts this approach into practice.

The consumer and carer members of the Lived Experience Leadership Expert Reference Group prepared the framework. Its aim is to facilitate engagement with consumers and carers and to establish co-production methodologies for policy development and service delivery. It places people with lived experience at the heart of the department's work.

The framework includes information on safe and effective engagement, a history of the consumer and carer movements, how to identify consumer and carer participants, guidance on appropriate remuneration, how to measure successful engagement, and a range of practical tools.

Lived experience engagement framework

Maggie's statement:

'The mental health lived experience engagement framework encapsulates the importance of co-design and co-production. It is a bold statement to imply that a system should change. It is even greater when mental health consumers are brought to the table to speak about what direction to take. This framework allows for the process of change to occur.

'I think it is important that there be an expectation that the framework be embraced by those who use it. It is, after all, about being inclusive and progressive. It sits at the heart of consumers' and carers' human rights.'



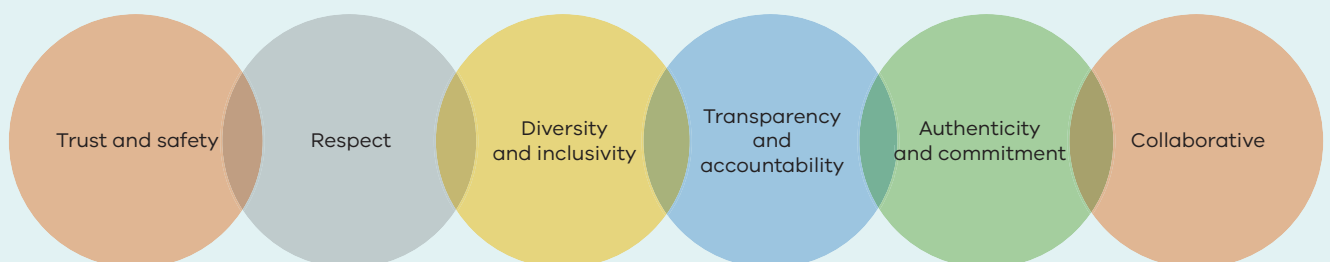
Photos: (L) Maggie Toko, CEO, VMIAC; (R) Marie Piu, CEO, Tandem Inc.

Marie's statement:

'This framework heralds a new beginning. It is an explicit statement by the department recognising that mental health and wellbeing issues impact not only on the person with mental health issues but their family, friends and community. Further, it confirms a commitment to inform all service development and delivery with the experience of those with mental health lived experience. The era of delivering top-down solutions, regardless of how well intentioned, is now over.

'It is now time to bring this tool to life as part of the continual review and refinement required to achieve a safe, funded, inclusive and fair mental health service system for Victoria.

'We are used to having things planned out from start to finish. We pretend it is all certain. I have grown my capacity to be in the grey. Clinicians are very nervous about being in the grey; there is a real desire to solve the problem ASAP. I don't feel that same sense of urgency anymore. I know that as long as you walk together something will emerge – you've just got to be there.'



Lived experience engagement registers

Hearing from those who use mental health services helps to guide, shape and deliver improvements. Victoria's peak mental health consumer and carer organisations were funded to establish lived experience engagement registers in 2017–18. These registers provide a pathway for consumers and carers to contribute their perspectives and experiences directly to the department to inform policies and projects.

VMIAC advocates for the needs of people who experience mental health challenges. The VMIAC Consumer Lived Experience Register has been developed so people with lived experience of mental or emotional distress can provide advice and input as part of policy and service development within the department, within services and, more broadly, across the mental health sector.

Tandem advocates for the needs of family, friends and carers of people with mental health challenges. The Tandem Mental Health Carers' Register is a pool of trained mental health carer representatives from across Victoria who can provide a strong carer voice in the mental health sector.

Register members use their lived experience, knowledge of mental health services and communication skills to influence change by advocating and promoting the issues and concerns of consumers, their families and carers.

Since the participation registers were established, VMIAC and Tandem have recruited more than 90 people to the registers. Both organisations recruit and train participants on an ongoing basis.

In 2018–19 register participants have provided advice and input into a range of projects, including:

- audits conducted by the Chief Psychiatrist
- promoting human rights in mental health services
- resources to support NDIS self-advocacy
- expanding post-discharge support
- developing the Carer Experience Survey
- working with Disability Advocacy Network Australia to create videos aimed at increasing the capacity of workers from the National Disability Insurance Agency to understand and better support people with a diagnosis of schizophrenia.

Lived Experience Advisory Group

The Mental Health Act promotes the principle that people using mental health services are at the centre of their treatment and care and have a key role in ensuring services are safe and effective.

To meet this aim, the department's Mental Health Branch established the Lived Experience Advisory Group in 2018–19. The group is co-chaired by the CEOs of VMIAC and Tandem, and the Director of the Mental Health Branch. Membership comprises a majority of people with lived experience as consumers or carers, as well as senior representation from the department and other agencies.

A key function of the group is to provide lived experience perspectives to the branch. The group will also oversee a wider program of consumer and carer consultation through targeted advisory groups. This includes overseeing implementation of the *Lived experience engagement framework*.

Bringing the consumer voice into mental health services

Consumer consultants have been employed in Victorian services for more than 25 years and have changed the way services, staff and consumers interact and engage with each other. Consumer consultants encourage and support service improvement and seek to ensure services provide high-quality care with compassion, respect and dignity. This role requires careful consideration of the needs of the consumer and their families or carers.



'I never thought I would be a consumer consultant; I never thought my voice would matter. After many, many years of complex mental illness, complex trauma, suicide attempts and intensive therapy I thought the best I could do was to just share my story. Now, after five years of being a consumer consultant with Alfred Mental and Addiction Health, I find that I am highly valued and regarded across the service for more than my story – my courage, my opinions and my insights are all respected.

'Hearing the experiences of consumers using our service and being able to include consumers and their experiences in service improvement, incident reviews and designing new programs and procedures is why I love my job so much. There are times where it is very difficult being the only consumer voice in a room of 40 highly educated clinicians explaining why I disagree – but I am blessed in that my colleagues have always been supportive and respectful because they see me as an equal with a different type of expertise.'

– Catherine Bennett, Consumer Consultant,
Alfred Mental and Addiction Health



VMIAC's Emerging Leadership program

In 2018–19 VMIAC received funding to deliver an Emerging Leadership program based on adaptive leadership and design-thinking principles. The program equips participants with the ability to exercise leadership that depends less on formal authority and more on skill, personal credibility and a holistic understanding of how their thoughts, values and beliefs affect them as leaders.

As well as these key concepts, the program focused on specific themes relevant to access and engagement by people with lived experience of mental illness and psychosocial disability. Participants explored these themes through guided sessions, guest speakers and broader discussions.

The program was supported by NDIS Information, Linkages and Capacity Building funding.

“ I don't think I had a lot of confidence in myself as a leader before this, but I look back on what I've done and can just say “Wow!”

“ For a long time I was walking around without a purpose and I felt a bit lost ... but this program helped me find my purpose.

“ This has been life-changing; I don't know how else to describe it.

Quotes from participants in VMIAC's Emerging Leadership program

VMIAC's Emerging Leadership program

Participants in VMIAC's 2019 Emerging Leadership program exercised their leadership skills by coming up with a project that was near and dear to their hearts – a children's book about mental health, which they have written and designed.



Participants with Vrinda Edan (Chair, VMIAC)

A graduation ceremony for the program was held in June 2019, and some participants from the program have already begun engaging with policy and health service committees to provide a lived experience perspective.



Participants at the graduation ceremony with Maggie Toko (CEO, VMIAC).



Participants at the graduation ceremony



Participants with Frankie Freeman (Program Lead, VMIAC)

Your Experience of Service (YES) survey



2,760
surveys were
collected in 2019



9%
increase from 2018

The YES survey is a national tool that provides an annual snapshot of consumers' experiences using clinical mental health and psychosocial rehabilitation support services.

The YES survey currently consists of two questionnaires, both of which were developed with mental health consumers. The questionnaires are based on the recovery principles in the *National Standards for Mental Health Services*. There are separate questions for users of clinical (hospital and community-based) services and community-managed organisations.

Run annually since 2016, the YES survey covers a number of domains including: dignity and respect; evaluating recovery; uniqueness and the individual; partnership and communication; attitudes and rights; and providing real choices.

For the first time in 2019, six new questions have been included in the clinical questionnaire. These were developed with consumers and refined with feedback from the Chief Psychiatrist and mental health services. The questions explore more specific areas of service experience, including restrictive interventions, advance statements, personal safety and physical health.

Both the 2018 and 2019 surveys ran for three months (compared with two months in the previous years) in an effort to boost responsiveness. In 2019 the number of surveys collected increased to 2,760 compared with 2,532 in 2018.



65.5%
of consumers rated their
experience of care with a
service in the last three months
as very good or excellent



58.1%
of consumers reported the
effect the service had on their
overall wellbeing was very
good or excellent

For the first time in 2019 YES survey results from Victoria, New South Wales and Queensland are being reported nationally through the Australian Institute of Health and Welfare's Mental Health Services in Australia website. Reported data includes overall experience of services in each jurisdiction.

The Department of Health and Human Services continues to host YES forums. The forums provide an opportunity to explore ways to increase the uptake of surveys, review and feedback on reporting and analysis of results, and shared approaches to developing improvement projects based on the survey results.

Mental Health Carer Experience Survey

The Mental Health Carer Experience Survey will be delivered for the first time in 2020. The department engaged Ipsos Public Affairs to scope the optimal methodology for implementing the survey across Victoria. This project included participation by consumers and carers, peak bodies and public mental health services. Delivery will be informed by this scoping work, with the goal of maximising carer survey responses.

Forensicare's Community Advisory Group

The work of Forensicare's Community Advisory Group (CAG) was recognised when it won the Consumer Advisory Group Award at the 2018 VMIAC Consumer Awards. Winners of the award must successfully demonstrate a significant contribution to the experiences of consumers to a service. A small group of staff and consumers attended the event to accept the award.

CAG member Matt* said that winning the award recognises both the consumers and staff. 'It shows consumers don't have to just be consumers – we can help each other as well. It's phenomenal to know we have gotten recognition for the job we do. We never thought we would get an award; we are just doing our best.'

Fellow CAG member Greg* was thankful for the appreciation. 'CAG is a good sounding board for patients, providing comfort and accessibility to patients. It's great to know our work has been acknowledged by peers.'

CAG member Sarah* said the award means that consumers' hard work is being awarded and recognised. 'We are not just a "willy-nilly" group. We do make important change.'



* Names changed

Tandem Lifetime Achievement Award

Peter McDonald has worked tirelessly over 25 years to ensure the carer voice is heard at various levels within Monash Health and beyond. He has advocated for a mental health system that will better support people and their families into the future.

Through his membership on various committees, Peter has accelerated much-needed linkages between carers, management and clinicians regarding current issues and challenges regularly faced by carers.

Peter currently contributes to the Mental Health Consumer & Family/Carer Advisory Committee established five years ago at Monash Health, of which he was a founding member. He has championed the need for different therapeutic approaches for consumers admitted to services for long periods. Peter has worked hard to highlight the need for improved physical health care for consumers in mental health inpatient services.

Peter has also been integral to establishing and continuing to deliver the BBQ Boys project, created to support male carers.



Peter McDonald, Monash Health Mental Health Consumer and Family/Carer Advisory Committee

Promoting Consumer Rights project

One of the four statutory roles of Victoria's Office of the Chief Psychiatrist is to promote the rights of people receiving mental health services.

The Office of the Chief Psychiatrist has focused its consumer rights work on reducing restrictive interventions and on promoting gender and sexual safety. The current objective of the Promoting Consumer Rights project is to reconceptualise this primary role of the office and build a stronger, more strategic and consumer-driven foundation for the Office's work.

This project has led to a mix of co-design, co-production and consumer leadership processes being embedded within project methodologies, including:

- project management by a consumer with relevant expertise
- utilising processes that build the capacity of project teams and advisory group members to work with this type of methodology
- co-creating a shared understanding of issues and what success might look like
- co-creating ideas that take account of complexity and diversity
- co-authoring documentation
- consumer-led processes for broader consultation.

Supporting diversity and increasing access

Outcome 2: The gap in mental health and wellbeing for at-risk groups is reduced

Supporting culturally diverse communities to promote mental health



26%

of the Victorian population speak a language other than English at home



13.7%

of registered mental health clients are from culturally diverse backgrounds

Culturally diverse communities can face challenges when accessing services and support in Australia.

Of Victoria's registered specialist mental health service clients the top five preferred languages other than English in 2018–19 were Vietnamese, Italian, Greek, Arabic and Mandarin.

Preferred language other than English of registered clients (%)



0.5%

0.4%

0.4%

0.3%

0.3%



It is vital that mental health services identify and transcend language and cultural barriers and provide effective treatment, recovery and support to any Victorian in need, no matter their cultural, religious or linguistic background. In particular, people from refugee backgrounds almost universally have a history of exposure to highly traumatic events that can significantly affect their mental health. Services need to be sensitive and responsive to these needs.

In 2018–19, 13 organisations received funding through the small grants program for projects that support culturally diverse Victorians who are experiencing, or are at risk of experiencing, poor mental health, and their families and carers.

Organisations and their funded projects include:

- Diversitat, to support Afghan, Karen, Karenni, Iraqi and Syrian refugees, particularly young people, in the Barwon region
- cohealth, to provide a community-led project supporting women from the Horn of Africa
- Chinese Health Foundation of Australia, to address barriers for Chinese migrants in accessing mental health services
- Ava Iranian Women’s Choir, to create a social support network for Iranian refugee women in the inner northern suburbs of Melbourne.

VMIAC and Tandem coordinated the grants, which the Victorian Transcultural Mental Health Service has evaluated. This 2019 evaluation identified five key outcomes from these grants:



Increased levels of engagement among disadvantaged/underserved groups and communities in strategies to address mental health and social and emotional wellbeing



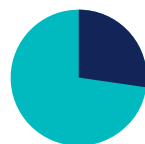
Improved mental health and social and emotional wellbeing of individuals and groups



Increased levels of mental health literacy within communities including more awareness of mental health and the effects of trauma, more understanding of options for help, and a reduction in stigmatising attitudes



Growth in the capacity of health and mental health services to respond to culturally diverse populations



Growth in the capacity of non-health community agencies and groups to respond to mental health issues affecting communities

Mental health needs of new arrivals and refugees

Refugees and asylum seekers are at greater risk of mental illness than the general population and face significant barriers to accessing care. This can be due to pre-migration experiences of trauma and loss, as well as their experiences in Australia, where they face language difficulties, lack of family and social networks, and difficulty finding stable housing and employment.

Refugees and asylum seekers may not seek out mental health support in the immediate settlement period. This can be because they don't know what services are available or because the concept of mental health services is unknown or not culturally appropriate to them.

Other issues such as employment, housing, schooling for their children or serious physical health problems, may seem more pressing in the period after arrival. In some cases, refugees are simply 'not ready' to talk about their experiences and emotions.

Refugees and asylum seekers may only come into contact with specialist services once their symptoms have become severe and are often complicated by other social and medical problems.

Mental health and psychosocial support programs are helping provide newly arrived people from refugee backgrounds access to culturally responsive and trauma-informed mental health and psychosocial support.

The Better Access to Mental Health for Young Syrian and Iraqi Refugees Program aims to improve the capacity of mental health services in the northern metropolitan region to address the mental health and wellbeing issues of newly arrived Syrian and Iraqi refugees early in settlement.

The program has been rolled out primarily in Melbourne's northern metropolitan region. In 2018–19 the program has achieved the following:

- Orygen, the Royal Children's Hospital and the Austin Child and Adolescent Mental Health Service are partnering to develop a culturally responsive mental health triage, assessment and referral program for refugee children and young people at risk of mental disorders. This will include specialised child and youth mental health, specialised refugee and mainstream services.
- Foundation House is overseeing a community-led mental health promotion and mental health literacy training program to build community resilience. The Al Rafahiya Al Sehiya (Healthy Wellbeing) session has been delivered to 174 people across 14 sessions. Twenty-five Advisory Group meetings have informed this work, which included members from affected communities.
- Foundation House also partnered with mental health services to establish a Community of Practice in child and youth refugee mental health. This has now assisted 30 organisations in professional/organisational development and capacity building, particularly for primary mental health services.

Emergency worker initiative

In September 2018 the Victorian Government committed \$14.5 million over five years to provide better mental health care for emergency workers. This included establishing a Centre of Excellence in Emergency Worker Mental Health and developing a Specialist Network of Clinicians with expertise in mental health issues regarding emergency workers.

The network will have access to training and practice guidelines. The Centre of Excellence will lead research, provide secondary consultation and develop practice guidelines.

Outcome 10: Victorians with mental illness are socially engaged and live in inclusive communities

Supporting the mental health needs of LGBTIQ+ people



24.4%
of LGBTIQ+ Victorian adults have high or very high levels of psychological distress

A disproportionate number of Australia's lesbian, gay, bisexual, trans, intersex, queer/questioning and further identities (LGBTIQ+) populations experience mental illness and psychological distress. Evidence shows that the discrimination and marginalisation experienced by LGBTIQ+ people increases the risk of developing mental health issues and creates barriers to accessing supportive services.

LGBTIQ+ young people

Adolescence is a challenging time, not least for a young person who identifies as LGBTIQ+.

LGBTIQ+ young people present with higher levels of depression, anxiety and other mental health problems and are at higher risk of self-harm and suicide due to potential victimisation, harassment and rejection by family, friends and peers.

In 2018–19, \$1.92 million was made available to Healthy Equal Well Youth (HEY) partner services. This funding went towards the following projects:

- The Zoe Belle Gender Collective Youth Project delivered 89 trans and gender diverse inclusive practice training sessions to 297 services and 2,363 staff. All training content was co-designed with young trans and gender diverse people who were also involved in delivering the training.
- Rainbow Health developed a range of professional development opportunities for workers in the youth sector. These opportunities build capacity and increase understanding of the health issues for LGBTIQ+ young people.
- Minus 18 delivered 77 workshops and education sessions to 6,620 people and hosted 18 LGBTIQ+ youth events attended by 3,175 LGBTIQ+ young people.
- The East Gippsland Unique but United HEY Project actively engaged with LGBTIQ+ young people across East Gippsland to develop community-based initiatives and community-awareness activities.

Healthy Equal Youth grants awarded in 2018–19

The HEY project is a partnership of 16 agencies coordinated by the Youth Affairs Council of Victoria. The project delivers programs that support the wellbeing of LGBTIQ+ young people, including the department's annual HEY grants program.

The HEY grants program aims to raise awareness, promote acceptance of diversity, reduce stigma and discrimination and improve the mental health of LGBTIQ+ young people.

Each year specialist LGBTIQ+ and youth organisations are invited to submit proposals for mental health promotion and community engagement activities that focus on LGBTIQ+ young people, aged between 14 and 25 years.

The 2018–19 grant recipients include Maroondah City Council Youth Services, North East Rainbow Collective, Bits and Bods, Hume City Council, Merri Health, Whittlesea Community Connections, Swan Hill District Health, Swan Hill Council, Berry Street, North East Support and Action for Youth and Rainbow Families.

More than 70 organisations have received HEY grant funding over the past eight years.





3

In review – public mental health services in 2018–19

3. In review – public mental health services in 2018–19

Overview

The data in this section helps us to understand who accesses our services and how, the service settings and the circumstances in which treatment is provided, and whether that treatment results in better outcomes. It also tells us about demand for, and use of, our services.

Key aspects of this data are incorporated in our outcomes framework (Appendix 1 to this report), including data about the use of compulsory treatment and restrictive interventions. Our aim is to drive service improvement and increase community understanding about Victoria’s public mental health services.

The data shows a small increase in the overall number of clients in 2018–19, spread unevenly across groups. The increase in our largest client group, adults, is 2.5 per cent, whereas the increases in child and adolescent mental health and forensic services are above 10 per cent. There have been slight reductions in client numbers for aged persons mental health and specialist mental health services.

There is a similar picture in community clinical mental health services. A small increase in service contacts overall can be broken down to larger increases in forensic, specialist and CAMHS services. There is a small increase for adults (3.1 per cent) and a decrease for aged client contacts (down by 4.7 per cent).

Total service hours have increased by 6.5 per cent overall, but the impact varies across different groups. For aged clients there has been a reduction of 0.9 per cent, but for forensic clients, there has been an increase of 34.4 per cent. Following a marked focus by many services on improving data recording and quality in 2017–18, the data is more settled for 2018–19.

The figures reflect recent funding increases to parts of the service system serving children, young people and specialist and forensic clients. Adults form the largest client group, and achieving substantial improvement in service activity levels requires very substantial and sustained investment.

Consistent with previous years, the data continues to show that adult inpatient services are under significant pressure to meet demand. Hospitalisations of adults for mental illness are increasing, adult services have very high occupancy levels, and the average length of hospital stays is under 10 days. Forensic services are also under pressure, with very high bed occupancy and a relatively small number of separations.

Who accessed our public mental health services in 2018–19?



74,794
registered clients



2.6%
increase from 2017–18

There was an increase in the number of children, young people, adults and forensic clients accessing public mental health services during 2018–19. The total number of people accessing services was 74,794, up by 2.6 per cent from the previous year. Most clients are adults and, for this group, there was a modest increase of 2.5 per cent. Increases of 12–13 per cent occurred in CAMHS and forensic services client numbers, although forensic services in particular are a relatively small part of the service system. There was a decrease in the number of clients seen in aged persons mental health services and specialist mental health services. Specialist clients are receiving a higher intensity of service, with more contacts and service hours per person in the past 12 months.

About two-thirds of adult, aged and specialist clients, and more than half of children and young people, had contact with mental health services during the past five years. This has been stable for adult clients over the past several years. For children, young people and aged clients, the proportion of new clients accessing services shows a slight downward trend in the last three years. For forensic and specialist clients, the level of new clients has been broadly stable since 2016–17, with minor fluctuations.

Just over half of registered clients (50.4 per cent) are women or girls, and a third (32.7 per cent) live in rural areas. The proportions of clients by gender and metropolitan/rural location are stable over time. The most common client diagnoses were schizophrenia and mood disorders such as depression and bipolar disorder. Stress and adjustment disorders were the third most common diagnoses. A small proportion of registered clients (2,420 people) used both clinical and mental health community support services. This number is reducing as mental health community support services transition to the NDIS.

A note on the terminology used in this section

The majority of people receiving public clinical mental health services are 'registered clients'. Registration supports continuity of treatment and care and assists services in ensuring that statutory obligations are met. Most of the data reported in this section involves registered clients.

However, a substantial proportion of community mental health services are provided to people who are not registered. In 2018–19, 15.9 per cent of community contact service hours in Victoria involved people who were not registered clients. Circumstances where a person is seen but not registered include assessments where the person is referred when the clinician determines that ongoing specialist public mental health care is not required.

The Victorian registration policy was established many years ago and is not consistent with current administrative and registration processes for people receiving physical health services. The registration approach and discretionary threshold can impede continuity of care for people who may be trying to access mental health services, and accurate recording of service activity. Changing the registration policy and ensuring its consistent application would affect data in future years, for example, client numbers. It may be timely, however, to review approaches to data and registration to improve service delivery, data and access to care.

This section also refers to 'separations'. This term is a way of describing the number of times people receive an episode of bed-based care.

To distinguish between clients requiring very long admissions and other clients, data on length of stay refers to stays under and over a certain number of days. For people requiring acute bed-based care, 'trimmed length of stay' refers to people who are admitted for a period up to and including 35 days.

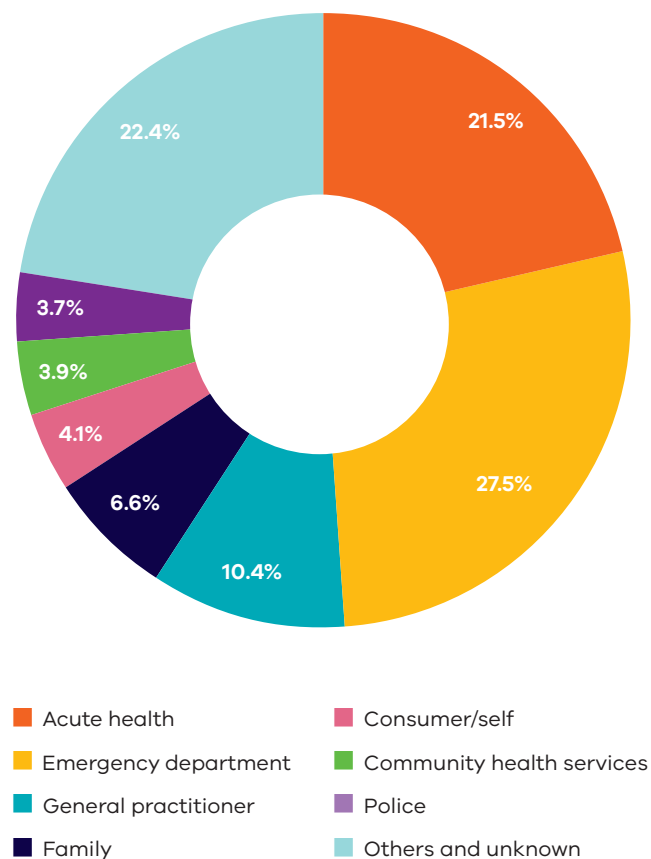
How were people referred to our clinical services in 2018–19?

Most people were referred to clinical mental health services by hospitals. More than a quarter of referrals are from emergency departments (EDs) (27.5 per cent), and the proportion of referrals from EDs is increasing steadily over time – that is, from 21.9 per cent and 24.4 per cent in 2016–17 and 2017–18 respectively (see Figure 1).

A further 21.5 per cent are from acute health. The latter group may include people who are admitted with a physical illness or injury and are subsequently referred for mental health treatment. GPs continue to be a key source of referrals (10.4 per cent), as do families (6.6 per cent). Expanding access to community mental health services is intended to reduce the proportion of referrals from EDs and hospitals and increase the proportion of people who are referred from the community and primary care.

There were 97,731 mental-health related ED presentations in 2018–19, an increase from the prior year of 5.5 per cent. Across all age groups, there were 26,682 hospitalisations in mental health acute inpatient units in 2018–19, an increase of 2.1 per cent. There has been a slight downward trend in compulsory admissions over the past three years. In 2018–19, 49.7 per cent of these admissions were compulsory.

Figure 1: Source of mental health referrals, 2018–19



Consumers' experience of services and outcomes



72.3%

of YES survey respondents feel that their individuality and values were respected



82.5%

of YES survey respondents reported they usually or always had opportunities for families and carers to be involved in their treatment or care

Information about people's experiences of our services, and about their outcomes, is captured in different ways. The Your Experience of Service (YES) survey helps us understand how people experience mental health treatment and care, including whether they feel they were respected, and the impact of the service on their overall wellbeing. Data gathered on outcome measurement by clinicians includes the Health of the Nation Outcomes Scales (HoNOS), which looks at issues like behaviour, symptoms, impairment and social functioning.

The YES survey was carried out in 2018–19 for the fourth time, and this report discusses results for clinical mental health inpatient and community services. In 2019 people aged 16 or older completed 2,760 surveys, an increase of 9.0 per cent on the number of responses the previous year. The results show that most clients feel that their individuality and values were respected, with 72.3 per cent of people reporting this was always the case and 17.8 per cent reporting it was usually the case. Just under two-thirds of people reported that being involved in the development of a care plan that considered all their needs was very good (23.3 per cent) or excellent (40.1 per cent).

In terms of family and carer involvement, 82.5 per cent of clients reported that they usually (20.6 per cent), or always (61.9 per cent), had opportunities for family and carers to be involved in their treatment or care if they wanted. In terms of overall experience of care in the previous three months, 27.7 per cent rated this as very good and 37.8 per cent as excellent. The effect the service had on the person's ability to manage their day-to-day life was rated as very good by 29.4 per cent of clients, and excellent by 26.7 per cent. There is a slight upward trend for this question.

While the results for services are positive in many areas, there is clear variation between service types. For example, responses from people using acute adult inpatient services are much less positive than clinical services generally, while those for clients in mother/baby units are more positive. The YES survey provides important information to services about how they are tracking and assists in identifying areas for improvement.

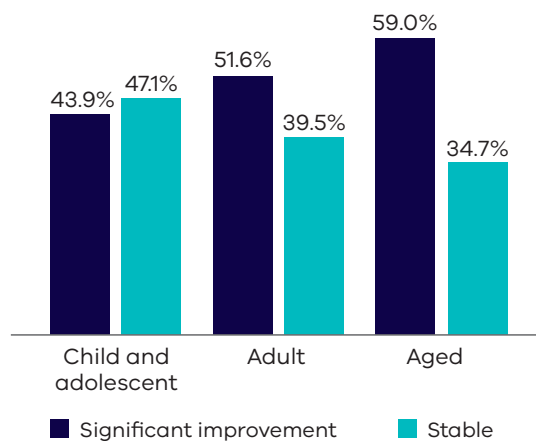
Key HoNOS measures are captured in our outcomes framework, measuring clinically-assessed changes that have occurred for clients at the end of a period of treatment in the community. People require assistance for different lengths of time, and the average length of time that adults received clinical services in the community was just over six months. For metropolitan clients, where demand is higher, the average length of a community case was 5.6 months; for rural Victorians it was 7.9 months.



Most CAMHS, adult and aged clients in Victoria had stable or improved clinical outcomes in 2018–19. For CAMHS clients, there has been a slight downward trend in clients with significant improvement at case closure to 43.9 per cent, from 48.1 per cent two years ago, and a slight increase in clients stable at case closure to 47.1 per cent (43.2 per cent in 2016–17). This appears to relate in part to variation between services, with one service’s results in this area differing from the remainder. This variation is being explored to assess whether it accurately reflects outcomes for children and young people. Case length for children and young people is a little longer than that of adults at 6.1 months (metropolitan) and 8.3 months (rural). It should be noted that inpatient child and adolescent mental health care is provided almost entirely in metropolitan Melbourne.

The proportion of adults with significant improvement at case closure is trending slightly downwards to 51.6 per cent from 53.3 per cent in 2016–17 (see Figure 2). For aged persons there has been a slight increase in people with significant improvement at case closure to 59.0 per cent, from 54.5 per cent in 2016–17, balanced by a reduction in people assessed as being in a stable condition at case closure. Average case length for older clients is 7.8 months in metropolitan Melbourne and 8.1 months in rural Victoria.

Figure 2: Clinically-assessed mental health outcomes at case closure, 2018–19



Child and adolescent mental health services



13,403

CAMHS clients
an increase of 12.6%



2,127
hospitalisations



6%
increase in reported community contacts



43.9%
of CAMHS clients were assessed by clinicians as significantly improved at case closure
compared with **48.1%** in 2016–17 and **44.8%** in 2017–18



47.1%
of CAMHS clients were assessed by clinicians as stable at case closure
compared with **43.2%** in 2016–17 and **45.9%** in 2017–18

There has been an increase in both inpatient and community clinical mental health service activity in 2018–19, reflecting investment into Victoria’s specialist services from 2016–17 and into 2017–18. This includes new beds becoming fully staffed and operational at the Monash Children’s Hospital, expansion of services for children aged up to 12 years, and statewide rollout of the Child and Adolescent Schools Early Action (CASEA) program. Although CASEA and the child specialist clinical program began in 2016–17, it has taken time for services to be fully operational. In part this reflects limited supply of child mental health clinicians. The opening of the Oasis Unit at Monash means there are now two mental health inpatient units for children under 12 years (the other is at the Austin Hospital).

Most children and young people receive clinical treatment in the community. A higher proportion of service hours (19.7 per cent) are delivered to unregistered children and young people than is the case for adult and aged people. This may include contacts where a child or young person is referred to community mental health services and assessed but it is found their needs are best met elsewhere. In this instance they may be referred to a more appropriate service and would not be registered as a public mental health service client.

In 2018–19 there were 13,403 registered CAMHS clients, an increase of 12.6 per cent, building on a similar increase the previous year (11.1 per cent). The majority of clients were adolescents, aged 14 years or older. Just under 40 per cent of clients were aged 0–13 years, with the largest group seen at the Royal Children’s Hospital, followed by Monash Health and Eastern Health. Overall, more than half of CAMHS clients were female (52.7 per cent). However, in the younger age group, boys predominate (about 60 per cent), and in the adolescent group aged 14 or older, there are more young women (about 62 per cent). The gender and age split has been stable over time, but the number of clients aged 14 or older has grown at a greater pace over the past three years than the group aged 13 or under.

A small number of children and young people in Victoria require inpatient treatment for mental illness. During the year, there were 2,127 hospitalisations of children and young people for mental illness, an increase of 5.6 per cent. Compulsory admissions have risen from 20.2 to 21.9 per cent; however, this remains substantially lower than the level of compulsory treatment for other age groups. The average duration of a period of compulsory treatment, which has been stable at 23–25 days, has risen substantially to 30.6 days. The proportion of children and young people on a community treatment order remains low and stable at 1.1 per cent.

The trimmed average length of stay (≤ 35 days) for CAMHS inpatients is stable and was 6.5 days in 2018–19. The long-term trend for length of stay has been downwards since 2008–09 when it was 10.3 days. Inpatients who stayed longer than 35 days accounted for 7 per cent of all CAMHS bed days, and all these longer admissions occurred at metropolitan services. The bed occupancy rate is steady at 60.5 per cent (see Table 1).

Community contacts are the largest part of CAMHS work. They may involve activities such as assessment and treatment, adolescent day programs or intensive outreach for young people. CAMHS teams often seek to involve families, carers and siblings, as well as schools, in supporting a young person. In 2018–19 there were 350,975 reported contacts, an increase of 6 per cent, which builds further on the increase in service activity in 2017–18.

Table 1: CYMHS bed occupancy rates (including leave, excluding same day), 2016–17 to 2018–19

Population	Setting	2016–17	2017–18	2018–19
CYMHS	Admitted – acute	60.9%	62.6%	60.5%
	Total	60.9%	62.6%	60.5%

Adult mental health services



58,978
adult clients



21,086
hospitalisations in 2018–19



2.6%
increase in hospitalisations



51.6%
of adult clients were assessed
by clinicians as significantly
improved at case closure

compared with **53.3%** in 2016–17
and **52.7%** in 2017–18



39.5%
of adult clients were
assessed by clinicians as
stable at case closure

compared with **37.8%** in 2016–17
and **38.4%** in 2017–18

Inpatient services

In 2018–19 there were 21,086 hospitalisations of adults for mental illness in a public hospital, an increase of 2.6 per cent from 2017–18. There has been a slight downward trend in compulsory admissions to 54.3 per cent in 2018–19, and the average duration of a period of compulsory treatment has dropped slightly to 75.8 days following a substantial increase the year prior.

Although the number of hospitalisations has increased, the trimmed length of stay for adults is similar to last year at 9.2 days in 2018–19. This is the first year since 2010–11 that length of stay for adults has not declined. People who stayed longer than 35 days accounted for 11 per cent of all adult inpatient bed days. Bed occupancy for adult inpatient services remains high at 95 per cent, a level that has been sustained now for several years, and which presents significant ongoing challenges for services.

The majority of people (59.7 per cent) who became inpatients had contact with a community service before they were admitted to hospital. The post-discharge follow-up rate was 89.1 per cent, although 13.7 per cent of people were readmitted to hospital within 28 days of discharge. Pressure on beds for adults is evident and may result in shorter-than-optimal hospital stays, with a higher risk of relapse and readmission.

Clinical mental health services delivered in the community



1,846,052

contacts



975,916

service hours in 2018–19



7.3%

increase in service hours in 2018–19

The number of recorded community contacts for 2018–19 was 1,846,052, an increase of 3.1 per cent over the previous year. Service hours show an increase of 7.3 per cent. Consistent with the previous four years, 14.4 per cent of adult clients receiving treatment in the community are on community treatment orders.

During 2018–19 the department began a review of subacute services – prevention and recovery care (PARC), community care units (CCUs) and secure extended care units (SECUs) to increase opportunities for greater utility, improved service delivery and improved experience of care.

Prevention and recovery care



3,542

separations



61%

women



80.3%

bed occupancy



7.5%

increase in occupied bed days

PARC services provide short-term support in residential settings, generally providing care for up to 28 days when a person is either becoming unwell or is in the early stages of recovery from an acute admission. The majority are for adults, but there are three youth PARCs for young people aged 16–25 years in Bendigo, Frankston and Dandenong. A fourth youth PARC has been funded and is in the planning stage, to be established in the north-west of Melbourne. Young people may also attend an adult PARC; however, it is rare for 16–18-year-olds to do so.

During 2018 new PARCs became fully operational at Mildura and Warrnambool, providing more capacity for their communities. Service activity is up from last year – separations have increased slightly, occupied bed days increased by 7.5 per cent and bed occupancy is at 80.3 per cent, from a level of 76.4 per cent the year before (see Table 2). Occupancy varies between services and tends to be higher in urban areas. Clients are more likely to be female, with women representing 61 per cent of PARC clients over the past three years.

PARCs and CCUs are services delivered to consumers on a voluntary basis, although they can provide care and support to clients on a community treatment order. Some consumers may elect to be discharged before the scheduled discharge date. This can at times affect the ability of services to manage bed-flow and to immediately admit a new client. These factors also contribute to occupancy rates and variance in the number of admissions and separations.

Adult residential services



Community care units

543

separations compared to **650** in 2017–18

Secure extended care units



274

separations compared to **222** in 2017–18

Residential services provide homelike environments for people with mental illnesses, and about 60 per cent of residents are male. There were 543 separations from community care units in 2018–19, a substantial decrease from 2017–18. The acuity of clients and duration of stay in CCU beds has increased, hence bed days and occupancy rates have been largely maintained, but separations have decreased as access has been affected by the increased occupancy and length of stay. It is also possible that limited housing options are a contributing factor, and that clients may also be staying in CCUs longer until suitable supported and affordable housing is found.

SECUs and other admitted non-acute beds

SECUs provide inpatient services for people who need a high level of secure and intensive clinical treatment for severe mental illness. There was an increase in SECUs and other admitted non-acute separations from 222 last year to 274 in 2018–19. Occupied bed days increased 5.0 per cent, and bed occupancy rose slightly, remaining high at 86.9 per cent.

Admitted non-acute beds includes forensic subacute and continuing care beds at Thomas Embling Hospital and a small number of brain disorder transitional beds at the Austin Hospital. The continuing care program at Thomas Embling Hospital assists people to gain and maintain an optimal level of independence over time and involves units that provide a secure environment at different levels of care. Continuing care patients require long-term care for a range of reasons. Patients are generally forensic patients, sentenced prisoners or patients ordered by a court to be detained.

Table 2: Adult bed occupancy rates (including leave, excluding same day), 2016–17 to 2018–19

Population	Setting	2016–17	2017–18	2018–19
Adult	Admitted – acute	95.0%	94.9%	95.0%
	Admitted – non-acute	88.5%	82.7%	83.4%
	Non-admitted – subacute (CCU)	78.6%	80.1%	80.9%
	Non-admitted – subacute (PARC)	80.7%	76.4%	80.3%
	Total	87.9%	87.0%	88.1%

Aged persons mental health services



8,116
aged clients



2,411
hospitalisations in 2018–19



232,101
community contacts
in 2018–19



59.0%
of aged clients were assessed
by clinicians as significantly
improved at case closure

compared with **56.3%** in 2017–18



34.7%
of aged clients were assessed
by clinicians as stable at
case closure

compared with **37.8%** in 2016–17
and **36.2%** in 2017–18

The number of aged clients using public mental health services dropped slightly by 2.0 per cent in 2018–19 to 8,116, following a rise the previous year. Most of this group had previous contact with mental health services, with a minority (35.3 per cent) being new clients. The proportion of new clients in aged persons mental health services is trending slightly downwards. During the year, there were 2,411 hospitalisations of Victorians aged 65 years or older in acute inpatient services. Table 3 shows that bed occupancy has slightly increased over the past three years to 87.7 per cent.

The trimmed average length of stay is trending downwards slightly to 15.1 days, but this remains much longer than the adult length of stay. People who are inpatients for more than 35 days accounted for 28 per cent of all aged persons' bed days. Some of these figures reflect the need to find safe, appropriate accommodation, or to put in place appropriate discharge supports for elderly unwell people. Sometimes a client cannot be discharged to return home, or a nursing home may decline to have them return to that service. It may be necessary to find alternative accommodation and undertake processes such as applications for guardianship and administration orders.

More women than men use these services, reflecting in part the population profile for older Victorians. The pre-admission contact rate is the highest of all groups at 65.7 per cent. In 2018–19, 46.7 per cent of admissions were compulsory, and this has been fairly stable over the past four years. The post-discharge follow-up rate was 94.6 per cent, again the highest of all groups.

Mental health residential aged care services (hostels and nursing homes) are for people with high levels of persistent cognitive, emotional or behavioural disturbance who cannot be managed in general residential aged care services. They have a homelike atmosphere, and residents are encouraged to participate in a range of activities. Where possible, opportunities are sought to discharge clients to less restrictive environments such as general aged care facilities. The number of mental health residential aged care beds has reduced over the past 10 years.

For mental health residential aged care services, there were 200 separations in 2018–19, a marked reduction from last year, although the bed occupancy rate was steady at 87.4 per cent. They provided 150,502 occupied bed days, fractionally down from last year. Some (but not all) of these services have had a steady decline in the demand for aged residential beds, and a wider range of options are available to support older people generally.

There were 232,101 community contacts in 2018–19, a slight decrease of 4.7 per cent. Service hours are steady at 124,655 hours.

Table 3: Aged persons bed occupancy rates (including leave, excluding same day), 2016–17 to 2018–19

Population	Setting	2016–17	2017–18	2018–19
Aged	Admitted – acute	85.2%	87.0%	87.7%
	Admitted – non-acute	86.9%	87.5%	87.4%
	Total	86.4%	87.3%	87.5%

Forensic mental health services



988
clients



12.9%
increase from 2017–18



104
separations



23,745
community contacts
in 2018–19



20.9%
increase from 2017–18



34.4%
increase in service hours

Forensic mental health services provide assessment and treatment for people with mental illness or disorders and involvement with the criminal justice system. Depending on clinical need, treatment may occur within prison, in the community or in a secure inpatient setting at the Thomas Embling Hospital in Fairfield.

The number of clients increased by 12.9 per cent to 988 in 2018–19, building on an increase of 16 per cent the previous year. The increasing number of forensic clients reflects greater investment in these services. There were 104 separations of people from acute forensic mental health inpatient units during the year, an increase of eight from 2017–18. Pressure on forensic inpatient beds remains high, with a bed occupancy rate of 95.5 per cent (see Table 4).

Community contacts have risen by 20.9 per cent and service hours by 34.4 per cent, reflecting the increased investment in these services. In part this reflects the Mental Health Advice and Response Service initiative, which was implemented in September 2018. This initiative expands the Mental Health Court Liaison Service and the Community Correctional Service Mental Health Court Advice Service to provide clinical advice to magistrates on the mental health of people appearing before the court. This reduces delays in proceedings and remands and improves the appropriateness of mental health treatment and rehabilitation conditions applied to community correction orders.

Unregistered client hours are the highest for any group at 59.7 per cent because Mental Health Advice and Response Service clients are not registered. The interventions provided are brief and do not constitute ongoing treatment, but nonetheless other ways of capturing information about these clients are being explored.

Forensic clients have the longest average duration of compulsory treatment, at 91.5 days. This part of the service system has the lowest proportion of new clients at 19.1 per cent – most have had some prior engagement with services in the preceding five years.

Table 4: Forensic bed occupancy rates (including leave, excluding same day), 2016–17 to 2018–19

Population	Setting	2016–17	2017–18	2018–19
Forensic	Admitted – acute	95.0%	96.6%	95.5%
	Admitted – non-acute	94.4%	93.1%	94.5%
	Total	94.6%	94.3%	94.8%

Forensic mental health services for young people

The Custodial Forensic Youth Mental Health Service commenced on 1 February 2019 with a team of specialist mental health clinicians situated in both Parkville and Malmsbury youth justice precincts. The service has seen more than 200 people since it started and is working in close collaboration with the primary health service to achieve more holistic care for young people in custody.

The Community Forensic Youth Mental Health Service began in early 2019 providing primary and secondary consultation to CAMHS and CYMHS.

Specialist mental health services



2,110
clients



954
hospitalisations



25,061
community contacts
in 2018–19



9.6%
increase from 2017–18



15.5%
increase in service hours

A range of specialist mental health services provide highly specific treatment and care to Victorians with severe and complex illnesses. These services include mother and baby mental health services, a personality disorder service (Spectrum), eating disorder services and a dual disability service (for people with both mental illness and an intellectual disability or autism spectrum disorder).

The number of specialist clients has dropped slightly by 3.5 per cent to 2,110. Service contacts increased 9.6 per cent and service hours by 15.5 per cent. There were 954 hospitalisations, similar to last year. The trimmed average length of stay (≤ 35 days) is similar to the past three years at 16.0 days but is substantially longer than the comparable figure for adults. This relates to models of care within these services, which may require a lengthy stay to facilitate assessment and treatment.

People who stayed more than 35 days accounted for 16 per cent of occupied bed days, with the highest rate observed at Austin Health, which hosts a short to medium-term brain disorders unit for people with an acquired brain injury and mental illness. Austin Health also hosts a trauma-related mental health unit largely treating veterans and first responders. Post-discharge follow-up has improved this year at 60.9 per cent but remains low. Readmissions within 28 days are uncommon, with a rate of 1.9 per cent for 2018–19.

Admitted acute occupied bed days grew by 4.3 per cent, and the bed occupancy rate, which is variable, was 68.5 per cent (see Table 5). Demand for beds in some services, such as mother/baby units, can be unpredictable.

There is a small number of specialist residential beds, and bed occupancy for these services dropped substantially to 69.7 per cent from 88.6 per cent. These residential beds are for people with acquired brain injuries and significant comorbid physical issues. The unit is classified as a young person's nursing home and is accredited to Commonwealth aged care standards. There have been few admissions during 2018–19.

Table 5: Specialist services bed occupancy rates (including leave, excluding same day), 2016–17 to 2018–19

Population	Setting	2016–17	2017–18	2018–19
Specialist	Admitted – acute	70.4%	65.7%	68.5%
	Admitted – non-acute	84.6%	58.5%	80.2%
	Non-admitted – residential	89.7%	88.6%	69.7%
	Total	74.2%	69.4%	69.0%

Seclusion and restraint

Mental health services in Victoria continue to work towards eliminating restrictive interventions. Seclusion and restraint are intrusive practices that should only be used after all possible preventative practices have been tried or considered and have been found to be unsuitable. The Office of the Chief Psychiatrist has a statutory function to monitor and review restrictive interventions across Victorian designated mental health services. There is a strong emphasis on services accurately recording restrictive interventions as part of good clinical practice governance.

Data on seclusion is well established, but data on restraint is continuing to develop. Public reporting enables services to review their individual results against state and national rates and those for like services. This reporting, and regular discussion between services and the Office of the Chief Psychiatrist and Office of the Chief Mental Health Nurse about their results, supports service reform and quality improvement. VMIAC, the peak body for mental health consumers in Victoria, released a report on seclusion in Victorian mental health services in April 2019, with a view to making information about seclusion more accessible and encouraging accountability.

The rate of seclusion is trending down and was 8.4 episodes per 1,000 occupied bed days for 2018–19 (see Figure 3). This rate is across all services, which masks the frequency of the intervention with different client groups. It is rare for an aged person or a specialist client to be secluded. Most commonly it is forensic clients who are secluded, and for this group the rate is 26.8 per 1,000 occupied bed days. Children and young people have a similar rate to adults at 12.1 and 9.2 respectively.

Table 6: Seclusion episodes per 1,000 occupied bed days, 2016–17 to 2018–19

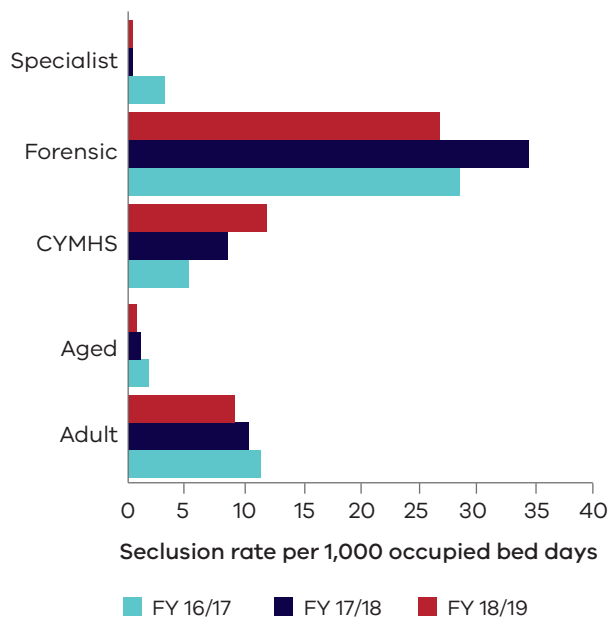
Population	2016–17	2017–18	2018–19
Adult	11.3	10.4	9.2
Aged	1.8	1.2	0.7
CYMHS	5.4	8.8	12.1
Forensic	28.7	34.3	26.8
Specialist	3.1	0.6	0.4
Total	9.9	9.6	8.4

Table 7: Average inpatient seclusion duration (hours)

Population	2016–17	2017–18	2018–19
Adult	9.6	8.9	6.3
Aged	5.0	5.5	4.2
CYMHS	11	1.5	1.0
Forensic	52.2	48.5	81.4
Specialist*	94.6	9.4	2.3
Total	17.4	16.7	20.1

* The number of patients secluded in specialist services is very low and contributes to volatile results.

Figure 3: Seclusion episodes per 1,000 occupied bed days, 2016–17 to 2018–19



Work is underway with all services to reduce the use of restrictive interventions, including work with CAMHS. In 2018–19 an expansion of the Safewards program saw eight of the 11 child and youth inpatient units funded to employ a clinical nurse consultant whose responsibilities include implementing Safewards and other activities to reduce restrictive interventions. Orygen Youth Health had already established a similar role. Over the past 10 years the overall trend for each group except forensic clients is for a reduction in the seclusion rate.

The average duration of seclusion has increased to 20.1 hours from last year’s length of 16.7 hours. This figure is affected by the inclusion of forensic patients, for whom the average duration of seclusion is 81.4 hours, up from 48.5 hours last year. The corresponding figure for adults is 6.3 hours, reduced from 8.9 hours the previous year. For children and young people the average duration of seclusion is one hour.

Some forensic clients may have particularly challenging behaviours. Thomas Embling Hospital has made a substantial effort to reduce the use of restrictive interventions during 2018–19. This has involved developing tailored behavioural programs and intensive staffing efforts. The hospital’s data for the last quarter of 2018–19 showed a reduction in seclusion, and both the service and the department continue to actively monitor restrictive interventions.

The bodily restraint rate is trending upwards and was 25.7 per 1,000 occupied bed days in 2018–19. The rate varies from 0.5 for specialist clients to 162.1 per 1,000 occupied bed days for forensic clients. The average duration of restraint, however, is trending downwards and is 12 minutes for 2018–19, down from 18 minutes the previous year. This may reflect greater understanding by staff and more stringent reporting of any type of hands-on restraint across services.

Appendices

Appendix 1: Outcomes framework

The outcomes framework, and its indicators, measure and monitor how our programs and services are contributing to better outcomes for people with mental illness. The framework continues to develop and will require ongoing work across government to continue the development of valid and meaningful indicators. Some of the results this year cast a light on the importance of social inclusion and equity to the mental health of Victorians.

For the first time, indicators relating to educational outcomes and LGBTIQ+ Victorians have been added to the framework. Data linkage has been used for the educational indicators and permits measurement of outcomes for people with mental illness at the population level. The 2017 Victorian Population Health Survey (VPHS) measured responses from Victorians, including LGBTIQ+ Victorians, to a range of health and wellbeing questions. The survey results will add substantially to our knowledge and will inform relevant programs and services. In future years it is hoped that other linkage work will help to understand more about the economic and financial situation of registered clients.

Estimates of high, or very high, levels of psychological distress are from the 2017 VPHS. This survey runs a larger sample size every three years (approximately 34,000 respondents compared with 7,500 usually), enabling data analysis at the local government level and for populations such as LGBTIQ+ and Aboriginal Victorians.

Psychological distress is a proxy measure of the overall mental health and wellbeing of the population. Very high levels of psychological distress may signify a need for professional help.

The data shows that levels of psychological distress vary among different population groups. In 2017 the proportion of the adult population with high or very high levels of psychological distress was significantly lower (10.3 per cent or less) in the older age groups (65 years or older) compared with the proportion in all adults (15.4 per cent). This difference has been consistent over the preceding three years.

In contrast, the proportion of younger adults (18–24 and 25–34 years of age) who had high or very high levels of psychological distress (23.1 per cent and 18.1 per cent) was significantly higher than the proportion in all adults (15.4 per cent).

The proportion of adults with high or very high levels of psychological distress was not significantly different in people who spoke a language other than English at home (17.3 per cent) compared with the proportion in all adults, as was the proportion in rural Victorians (16.3 per cent). However, the proportion of adults with high or very high levels of psychological distress was significantly higher in the LGBTIQ+ and Aboriginal sub-populations compared with the proportion in all adults, at 24.4 per cent and 25.0 per cent respectively.

Although most LGBTIQ+ Australians live healthy, happy lives, a disproportionate number experience worse health outcomes than their non-LGBTIQ+ peers in a range of areas, in particular mental health and suicidality.¹ Discrimination and exclusion are key contributors to the elevated risk of mental ill-health and suicide; this is sometimes referred to as 'minority stress'.

1 Rosenstreich G 2013, *LGBTI people, mental health and suicide. Revised 2nd edition*. National LGBTI Health Alliance, Sydney.

In the 2017 VPHS the proportion of LGBTIQ+ adults who experienced discrimination in the previous year (30.7 per cent) and family violence currently or in the preceding two years (11.2 per cent) was significantly higher than the proportion in non-LGBTIQ+ adults (15.7 per cent and 5.2 per cent respectively). Stereotyping, ostracising, discrimination, harassment and violence harm people, and these experiences can have a profoundly negative impact on individuals and their health. Supporting the wellbeing of LGBTIQ+ Victorians requires ongoing, whole-of-government and community efforts towards social inclusion and equality, as well as targeted interventions.

The larger sample size in the 2017 VPHS showed that the level of high or very high psychological distress among Aboriginal Victorians was 1.6 times that of all Victorian adults. VicHealth research found that 97 per cent of Aboriginal Victorians had experienced racism in the previous 12 months, and more than 70 per cent had experienced eight or more racist incidents.² People mainly experienced racism in shops and public settings, but it was also common in sports, work and educational settings.

The link between poorer physical and mental health and racism is well documented. There is strong evidence that people who are targets of racism are at greater risk of developing a range of mental health problems such as anxiety and depression. Studies that examine racism as a determinant of ill health have concluded that there is a correlation between the experience of racism and poorer mental and physical health outcomes for Aboriginal Australians. Other factors linked to poor social and emotional wellbeing include grief, past and ongoing child removals, unresolved trauma, economic and social disadvantage, substance use and poor physical health.³

Other outcome indicators relating to Aboriginal Victorians show that they continue to be over-represented in clinical mental health services, although the level is stable. Aboriginal people form about 0.8 per cent of Victoria's population and 2.8 per cent of people receiving clinical mental health care. Concerningly, the proportion of Victorian Aboriginal children at school entry at high risk of clinically significant problems related to behaviour and emotional wellbeing rose this year to 19.0 per cent. The proportion for all Victorian children also rose in 2018 but is substantially lower at 5.6 per cent.⁴

These results again emphasise the need for ongoing, whole-of-government and community efforts towards social inclusion and equality, as well as sustained efforts to combat racism and tailored responses to support the mental health and wellbeing of disadvantaged population groups.

2 VicHealth 2007, *Mental health impacts of racial discrimination in Victorian Aboriginal communities* <https://www.vichealth.vic.gov.au/-/media/ResourceCentre/PublicationsandResources/Discrimination/Mental-health-impacts_racial-discrim_Indigenous.pdf?la=en&hash=AE2B376D4497D0D0C8F8B6EFEF03E33763328FA8>

3 Zubrick S, Shepherd C, Dudgeon P, Gee G, Paradies Y, Scrine C et al. 2014, 'Social determinants of social and emotional wellbeing'. In: Dudgeon P, Milroy H, Walker R (eds) *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice*, Department of Prime Minister and Cabinet, Canberra.

4 It should be noted that the small number of Aboriginal children starting school in any one year means that a minor change in the number of children in the high-risk category can affect the proportion. Hence the indicator for Aboriginal children is likely to fluctuate more than the indicator for all children.

People with severe mental illness have poorer physical health yet receive less and lower quality health care than the rest of the population.⁵ Indicators in this area include tobacco use (as a risk factor) and type 2 diabetes (as a preventable illness). Tobacco use remains high among registered clients at 37.0 per cent. The proportion of registered clients recorded as having type 2 diabetes is also high at 9.8 per cent. Both indicators have remained steady over the past three years. Although not directly comparable, the daily smoking rate for Australians in 2016 was 12.2 per cent,⁶ and 5 per cent of Australian adults had type 2 diabetes in 2017–18.⁷ *Equally well in Victoria* aims to improve outcomes for clients and create a consistent approach to physical health care in Victorian public mental health services.

The Australian Bureau of Statistics released *Causes of death, Australia 2018* in September 2019, and this report shows a slight decrease in the suicide rate for Victoria. However, care needs to be taken when interpreting this data for 2018. The Victorian Registry of Births Deaths and Marriages implemented a new registration system in February 2019, with some changed policies and procedures. Coroner-referred registrations to the registry in 2018 are low, and an increase in registrations is expected in 2019.

Mental illness at a young age can affect schooling and other factors that influence opportunities over a person's lifetime. Education and training play an important role in social participation, economic participation and productivity. Education can enable increased workforce participation and higher earnings, as well as other private and social benefits such as improved health.⁸ However, the age of onset of mental illness, often in adolescence and young adulthood, can disrupt education.

It has not been possible to obtain data about educational outcomes for children and young people with mental illness that is directly comparable with national benchmarks. This is because of the way students who are absent for, or withdrawn from, NAPLAN are treated in the national data calculations. Nonetheless, the 2018 data shows that the proportion of children and young people with mental illness who are at or above national minimum reading standards is below what might be expected and reduces from a Year 3 level of 59.5 per cent to 49.1 per cent at Year 9. Numeracy results are similar, varying from 64.8 per cent at or above the national minimum standard for students in Year 3, to 50.3 per cent for Year 9 students.

The indicators for educational outcomes (and other indicators) will continue to be refined over time. Using a different calculation method, the proportion of all Year 9 Victorian students at or above the national minimum standard for reading is 94.1 per cent and for numeracy 95.5 per cent.⁹ Next year we hope to show directly comparable results.

5 Department of Health and Human Services 2019, *Equally well in Victoria: Physical health framework for specialist mental health services* <<https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/equally-well-in-victoria>>.

6 Australian Institute of Health and Welfare 2017, *National Drug Strategy Household Survey 2016: detailed findings* <<https://www.aihw.gov.au/reports/illicit-use-of-drugs/2016-ndshs-detailed/contents/summary>>

7 Australian Institute of Health and Welfare 2019, *Diabetes* <<https://www.aihw.gov.au/reports/diabetes/diabetes-snapshot/contents/how-many-australians-have-diabetes/type-2-diabetes>>

8 Productivity Commission 2019, *The social and economic benefits of improving mental health: issues paper* <<https://www.pc.gov.au/inquiries/current/mental-health/issues>>

9 Australian Curriculum, Assessment and Reporting Authority (ACARA) 2018, *National Assessment Program – Literacy and Numeracy: Achievement in reading, writing, language conventions and numeracy: national report for 2018*, ACARA, Sydney, p. 2015; Table 9.R1: Achievement of Year 9 students in reading, by state and territory, 2018.

Mental illness has a marked impact on students' attendance, connectedness, engagement and performance at school.¹⁰ A national study found the following:

- Students with mental illness have poorer NAPLAN results. Students with mental illness scored lower on average than students with no mental illness in every test domain and year level.
- Gaps in achievement increase from Year 3 to Year 9. On average, students with a mental illness in Year 3 were seven to 11 months behind students with no mental illness, but by Year 9 students with a mental disorder were on average 1.5–2.8 years behind.
- Students accessing services for mental illness benefit, but the gaps do not fully close. On average, students who used services improved over time compared with students with a mental illness who did not receive support services but did not fully overcome the differences in academic performance due to their mental illness compared with students who did not have a mental disorder.
- Students with mental illness have more absences from school.

Many other indicators have remained stable or fluctuated slightly. This includes clinically reported improved or stable outcomes for child and adolescent, adult and aged clients. The exception is a decrease in the percentage of clinically reported improved or stable outcomes for forensic clients, following an increase the previous year. The number of forensic clients is small, and this can create some volatility in results.

There is a small upward trend in the proportion of consumers reporting that:

- the effect the service had on their ability to manage their day-to-day life was very good or excellent
- their individuality and values were usually or always respected
- the service had a very good or excellent effect on their overall wellbeing.

These client-reported experience measures provide a different and valuable lens on Victoria's mental health service system.

In relation to restrictive practices and compulsory treatment, results are mixed. The proportion of inpatient admissions that are compulsory is trending down slightly. The duration of compulsory treatment has also decreased slightly, with a small decrease in the proportion of people receiving compulsory community treatment. Data on the use and duration of compulsory treatment will continue to be monitored.

The mental health outcomes framework will continue to be populated with indicators over time, as new data and systems become available.

The data in Appendix 1 is drawn from a range of sources, including the Victorian Population Health Survey, the School Entrant Health Questionnaire, the Victorian Student Health and Wellbeing Survey, Justice Health and the mental health Client Management Interface (CMI) / Operational Data Store (ODS). Most, but not all, of the data is in the public domain.

¹⁰ Goodsell B, Lawrence D, Ainley J, Sawyer M, Zubrick SR, Maratos J 2017, *Child and adolescent mental health and educational outcomes. An analysis of educational outcomes from Young Minds Matter: the second Australian Child and Adolescent Survey of Mental Health and Wellbeing*, Graduate School of Education, The University of Western Australia, Perth.

Table A1: Victoria's 10-year mental health plan outcomes framework

Outcome and related indicators	Reference year	Two years prior	One year prior	Most current data
1. Victorians have good mental health and wellbeing at all ages and stages of life				
1.1 Proportion of Victorian population with high or very high psychological distress (adults)	2017	17.3%	14.8%	15.4%
1.2 Proportion of Victorian population receiving clinical mental health care	2018–19	1.07%	1.15%	1.16%
1.3 Proportion of Victorian young people with positive psychological development	2018	68.8%	N/A*	67.3%
1.4 Proportion of Victorian older persons (65 years or older) with high or very high psychological distress	2017	10.8%	8.5%	10.0%
1.5 Proportion of children at school entry at high risk of clinically significant problems related to behaviour and emotional wellbeing	2018	4.8%	4.9%	5.6%
2. The gap in mental health and wellbeing for at-risk groups is reduced				
2.1 Proportion of Victorian population who speak a language other than English at home with high or very high psychological distress (adults)	2017	18.0%	17.2%	17.3%
2.2 Proportion of Victorian rural population with high or very high psychological distress (adults)	2017	15.9%	14.6%	16.3%
2.3 Proportion of Victorian population who identify as LGBTIQ+ with high or very high psychological distress (adults)	2017	N/A	N/A	24.4%
3. The gap in mental health and wellbeing for Aboriginal Victorians is reduced				
3.1 Proportion of Victorian Aboriginal population who are receiving clinical mental health care	2018–19	2.7%	2.7%	2.8%
3.2 Proportion of Victorian Aboriginal population with high or very high psychological distress	2017	N/A	N/A	25.0%
3.3 Proportion of Victorian Aboriginal children at school entry at high risk of clinically significant problems related to behaviour and emotional wellbeing	2018	15.6%	14.4%	19.0%
4. The rate of suicide is reduced				
4.1 Victoria's rate of deaths from suicide per 100,000	2018	10.1	9.6	9.1 ¹¹

¹¹ The Australian Bureau of Statistics has noted that care needs to be taken when interpreting this data for 2018. The Victorian Registry of Births Deaths and Marriages implemented a new registration system in February 2019, with some changed policies and procedures. Coroner-referred registrations to the registry in 2018 are low, and an increase in registrations is expected in 2019.

Outcome and related indicators	Reference year	Two years prior	One year prior	Most current data
5. Victorians with mental illness have good physical health and wellbeing				
5.1 Proportion of unique admitted clients who were discharged and used tobacco	2017–18	37.6%	38.1%	37.0%
5.2 Proportion of registered mental health clients with a type 2 diabetes diagnosis	2017–18	10.1%	9.7%	9.8%
6. Victorians with mental illness are supported to protect and promote health				
7. Victorians with mental illness participate in learning and education				
7.1 Proportion of Year 3 students receiving clinical mental health care at or above the national minimum standard for reading	2018	68.1	64.3	59.5
7.2 Proportion of Year 3 students receiving clinical mental health care at or above the national minimum standard for numeracy	2018	67.9	66.0	64.8
7.3 Proportion of Year 9 students receiving clinical mental health care at or above the national minimum standard for reading	2018	59.2	52.5	49.1
7.4 Proportion of Year 9 students receiving clinical mental health care at or above the national minimum standard for numeracy	2018	60.1	56.3	50.3
8. Victorians with mental illness participate in and contribute to the economy				
9. Victorians with mental illness have financial security				
10. Victorians with mental illness are socially engaged and live in inclusive communities				
11. Victorians with mental illness live free from abuse or violence, and have reduced contact with the criminal justice system				
11.1 Proportion of Victorian prison entrants who, at prison reception assessment, are allocated a psychiatric risk rating	2018–19	36.9%	37.2%	36.2%
12. Victorians with mental illness have suitable and stable housing				
12.1 Proportion of registered clients living in stable housing	2018–19	81%	80%	80%

Outcome and related indicators	Reference year	Two years prior	One year prior	Most current data
13. The treatment and support that Victorians with mental illness, their families and carers need is available in the right place at the right time				
13.1 Rate of preadmission contact	2018–19	51.8%	59.4%	58.6%
13.2 Rate of readmission within 28 days	2018–19	13.4%	13.8%	13.3%
13.3 Rate of post-discharge follow-up	2018–19	77.6%	86.9%	88.0%
13.4 New registered clients accessing public mental health services (no access in last five years)	2018–19	36.6%	36.8%	36.0%
13.5 Proportion of consumers reporting the effect the service had on their ability to manage their day-to-day life was very good (29.4%) or excellent (26.7%)	2018–19	53.6%	55.2%	56.1%
14. Services are recovery-oriented, trauma-informed and family-inclusive				
14.1 Proportion of registered clients experiencing stable or improved clinical outcomes (adults)	2018–19	91.1%	91.1%	91.1%
14.2 Proportion of registered clients experiencing stable or improved clinical outcomes (CAMHS)	2018–19	91.3%	90.7%	91.0%
14.3 Proportion of registered clients experiencing stable or improved clinical outcomes (aged persons)	2018–19	92.3%	92.5%	93.7%
14.4 Proportion of registered clients experiencing stable or improved clinical outcomes (forensic) ¹²	2018–19			
14.5 Proportion of registered clients experiencing stable or improved clinical outcomes (specialist)	2018–19	95.5%	96.5%	99.4%
14.6 Proportion of consumers who reported they usually (20.6%) or always (61.9%) had opportunities for family and carers to be involved in their treatment or care if they wanted	2018–19	82.5%	83.8%	82.5%
15. Victorians with mental illness, their families and carers are treated with respect by services				
15.1 Proportion of consumers reporting their individuality and values were usually (17.8%) or always (72.3%) respected	2018–19	88.0%	88.7%	90.1%
15.2 Proportion of people with a mental illness reporting a care plan was developed with them that considered all their needs as very good (23.3%) or excellent (40.1%)	2018–19	63.0%	62.5%	63.4%

¹² Further analysis of clinical outcomes data for forensic clients indicates that the sample size is too low for the data to be considered reliable.

Outcome and related indicators	Reference year	Two years prior	One year prior	Most current data
16. Services are safe, of high quality, offer choice and provide a positive service experience				
16.1 Rate of seclusion episodes per 1,000 occupied bed days (inpatient)	2018–19	9.9	9.6	8.4
16.2 Rate of bodily restraint episodes per 1,000 occupied bed days (inpatient)	2018–19	19.0	22.6	25.7
16.3 Proportion of community cases with client on a treatment order	2018–19	11.0%	11.4%	11.0%
16.4 Proportion of inpatient admissions that are compulsory	2018–19	51.4%	50.3%	49.7%
16.5 Average duration of compulsory orders (days)	2018–19	64.1	76.6	75.6
16.6 Proportion of consumers who rated their experience of care with a service in the last three months as very good (27.7%) or excellent (37.8%)	2018–19	65.1%	65.4%	65.5%
16.7 Proportion of consumers reporting the effect the service had on their overall wellbeing was very good (28.2%) or excellent (30.0%)	2018–19	56.3%	57.8%	58.1%

Key

* This survey is carried out every two years.

Appendix 2: Public mental health service data

Most of the data in this appendix is drawn from the mental health Client Management Interface (CMI)/Operational Data Store (ODS). The CMI/ODS is a real-time reporting system that mental health service providers regularly update. For this reason, there may be small differences in reported data between previous and future annual reports, as the system is not static.

Other collections from which this appendix draws include the Mental Health Establishments National Minimum Dataset and the Mental Health Community Support Services Collection. It should be noted that different data collections may use different definitions, varying inclusion and exclusion criteria, and may disaggregate data in different ways.

Data source: Client Management Interface / Operational Data Store (CMI/ODS), or as footnoted otherwise
 Date extracted: 11 August 2019, or as footnoted otherwise
 Date generated: 30 September 2019

Whole population				
	2016–17	2017–18	2018–19	
Total estimated residential population in Victoria (based on mental health area) ('000)*	6,228	6,339	6,452	
People accessing mental health services				
	2016–17	2017–18	2018–19	
Mental health-related emergency department presentations	87,197	92,610	97,731	
Emergency department presentations that were mental health-related	5.14%	5.27%	5.36%	
People accessing clinical mental health services				
Consumers	2016–17	2017–18	2018–19	
Consumers accessing clinical mental health services ^{† ‡}	66,488	72,904	74,794	
Proportion of population receiving clinical care*	1.07%	1.15%	1.16%	
Consumer location	2016–17	2017–18	2018–19	
Consumer residential location	Metro	64.4%	64.2%	64.0%
	Rural	32.6%	32.9%	32.7%
	Unknown/other	2.9%	2.9%	3.3%

Consumer demographics		2016–17	2017–18	2018–19
Gender	Female	50.4%	50.3%	50.4%
	Male	49.5%	49.6%	49.4%
	Other/unknown	0.1%	0.2%	0.2%
Age group	0–4	0.8%	0.8%	0.8%
	5–14	8.2%	8.2%	8.4%
	15–24	19.1%	19.3%	19.6%
	25–34	17.9%	17.6%	18.0%
	35–44	18.2%	18.0%	17.3%
	45–54	14.6%	14.8%	15.1%
	55–64	8.8%	8.7%	8.8%
	65–74	6.1%	6.2%	6.1%
	75–84	4.3%	4.2%	4.0%
	85–94	1.9%	1.9%	1.7%
	95+	0.2%	0.2%	0.2%
Consumers of culturally diverse backgrounds	CALD	13.6%	13.7%	13.7%
Aboriginal or Torres Strait Islander	Indigenous	2.7%	2.7%	2.8%
Country of birth (top 10 non-English speaking)	Italy	1.0%	1.0%	0.9%
	Vietnam	0.8%	0.9%	0.8%
	India	0.7%	0.7%	0.8%
	Greece	0.8%	0.8%	0.7%
	China (excludes SARs and Taiwan)	0.6%	0.7%	0.7%
	Sri Lanka	0.5%	0.5%	0.5%
	Philippines	0.4%	0.5%	0.4%
	Turkey	0.4%	0.4%	0.4%
	Sudan	0.3%	0.4%	0.4%
	Iran	0.4%	0.4%	0.4%
Preferred language other than English (top 10)	Vietnamese	0.5%	0.5%	0.5%
	Italian	0.5%	0.4%	0.4%
	Greek	0.4%	0.5%	0.4%
	Arabic	0.3%	0.3%	0.3%
	Mandarin	0.3%	0.3%	0.3%
	Persian (excluding Dari)	0.2%	0.2%	0.2%
	Turkish	0.2%	0.2%	0.2%
	Macedonian	0.1%	0.1%	0.2%
	Cantonese	0.1%	0.1%	0.1%
Croatian	0.1%	0.1%	0.1%	

Treatment		2016–17	2017–18	2018–19
Consumers accessing clinical mental health services ^{† *}	Adult	51,788	57,539	58,978
	Aged	7,373	8,279	8,116
	CAMHS	10,716	11,907	13,403
	Forensic	752	875	988
	Specialist	1,821	2,187	2,110
Diagnosis	Schizophrenia, paranoia and acute psychotic disorders	24.2%	23.3%	22.6%
	Mood disorders	20.2%	19.7%	18.9%
	Stress and adjustment disorders	8.5%	8.8%	9.0%
	Personality disorders	6.0%	6.3%	6.5%
	Anxiety disorders	5.3%	5.7%	5.7%
	Substance abuse disorders	3.5%	3.5%	3.3%
	Organic disorders	2.7%	2.6%	2.2%
	Disorders of psychological development	1.9%	1.9%	2.1%
	Disorders of childhood and adolescence	2.0%	1.9%	1.9%
	Eating disorders	1.5%	1.5%	1.6%
	Other	1.0%	1.0%	0.9%
	Obsessive compulsive disorders	0.5%	0.5%	0.5%
	Unknown	22.5%	23.3%	24.9%
	Referral source (newly referred consumers only)	Acute health	21.8%	21.3%
Emergency department		21.9%	24.4%	27.5%
General practitioner		11.6%	11.6%	10.4%
Family		7.9%	7.2%	6.6%
Consumer/self		4.6%	4.6%	4.1%
Community health services		4.7%	4.8%	3.9%
Police		3.5%	3.7%	3.7%
Others and unknown		23.9%	22.3%	22.4%
New consumers accessing services (no access in the prior 5 years) [†]	Total	36.6%	36.8%	36.0%
	Consumers accessing services during each of the previous 5 years [†]	Total	14.1%	13.5%

Service activity – bed-based	Setting	2016–17	2017–18	2018–19
Total number of separations (excluding same day)	Admitted – acute	24,333	26,123	26,682
	Admitted – non-acute	219	222	274
	Non-admitted – residential	239	246	203
	Non-admitted – subacute (CCU)	682	650	543
	Non-admitted – subacute (PARC)	3,405	3,458	3,542
	Total	28,878	30,699	31,244
Occupied bed days (including leave, excluding same day)	Admitted – acute	364,654	376,128	389,706
	Admitted – non-acute	71,470	74,409	78,148
	Non-admitted – residential	157,508	157,150	155,593
	Non-admitted – subacute (CCU)	104,625	105,072	104,873
	Non-admitted – subacute (PARC)	65,894	66,300	71,252
	Total	764,153	779,061	799,573
Bed occupancy rate (including leave, excluding same day)	Admitted – acute	88.7%	88.8%	89.2%
	Admitted – non-acute	90.5%	85.7%	86.9%
	Non-admitted – residential	87.1%	87.5%	86.6%
	Non-admitted – subacute (CCU)	78.6%	80.1%	80.9%
	Non-admitted – subacute (PARC)	80.7%	76.4%	80.3%
	Total	86.3%	85.8%	86.5%
Service activity – community	Population	2016–17	2017–18	2018–19
Total service contacts, by sector*	Adult	1,189,768	1,789,951	1,846,052
	Aged	168,747	243,592	232,101
	CAMHS	278,790	330,977	350,975
	Forensic	17,265	19,648	23,745
	Specialist	21,189	22,863	25,061
	Total	1,675,761	2,407,033	2,477,935
Total service hours, by sector*	Adult	585,320	909,586	975,916
	Aged	86,138	125,732	124,655
	CAMHS	180,015	218,365	229,222
	Forensic	10,652	12,189	16,378
	Specialist	19,778	20,915	24,164
	Total	881,904	1,286,789	1,370,337
Unregistered consumer service hours*	Total	15.7%	15.6%	15.9%

Service performance	Population	2016–17	2017–18	2018–19
Readmission to inpatient care within 28 days (lagged 1 month)	Adult	14.3%	14.4%	13.7%
	Aged	6.8%	8.5%	7.6%
	CAMHS	17.6%	19.3%	19.9%
	Forensic	12.3%	7.8%	6.0%
	Specialist	2.0%	1.2%	1.9%
	Total	13.4%	13.8%	13.3%
Pre-admission contact rate, all consumers*	Adult	53.1%	60.2%	59.7%
	Aged	54.0%	65.0%	65.7%
	CAMHS	49.5%	58.1%	56.9%
	Forensic	17.6%	21.6%	26.8%
	Specialist	30.6%	38.5%	30.8%
	Total	51.8%	59.4%	58.6%
Post-discharge follow-up rate (lagged 7 days)*	Adult	79.3%	88.4%	89.1%
	Aged	74.6%	93.2%	94.6%
	CAMHS	83.9%	86.2%	87.2%
	Forensic	31.2%	26.4%	28.4%
	Specialist	41.1%	53.3%	60.9%
	Total	77.6%	86.9%	88.0%
Trimmed average length of stay ≤ 35 days – inpatient	Adult	9.5	9.1	9.2
	Aged	15.7	15.5	15.1
	CAMHS	6.9	6.6	6.5
	Forensic	20.5	21.7	24.0
	Specialist	15.8	15.3	16.0
	Total	10.0	9.6	9.6

Compulsory treatment	Population	2016–17	2017–18	2018–19
Community cases with consumers on treatment order	Adult	14.5%	14.9%	14.4%
	Aged	4.5%	5.1%	5.3%
	CAMHS	1.1%	1.1%	1.1%
	Forensic	16.2%	13.4%	14.1%
	Specialist	2.2%	5.5%	3.6%
	Total	11.0%	11.4%	11.0%
Compulsory admissions – inpatient	Adult	56.9%	55.3%	54.3%
	Aged	48.2%	46.8%	46.7%
	CAMHS	17.0%	20.2%	21.9%
	Forensic	100.0%	100.0%	100.0%
	Specialist	8.8%	8.9%	11.2%
	Total	51.4%	50.3%	49.7%
The average duration (days) of a period of compulsory treatment		64.1	76.6	75.6
Consumers on an order for more than 12 months		12.4%	13.0%	12.9%
Adult (18+) consumers who have an advance statement recorded		2.38%	2.60%	2.83%
Adult (18+) consumers who have a nominated person recorded		2.40%	2.44%	2.60%
Restrictive practice		2016–17	2017–18	2018–19
Seclusion episodes per 1,000 occupied bed days – inpatient		9.9	9.6	8.4
Average Inpatient seclusion duration (hours)		17.4	16.7	20.1
Bodily restraint episodes per 1,000 occupied bed days – Inpatient		19.0	22.6	25.7
Average Inpatient bodily restraint duration (hours)		0.4	0.3	0.2

Clinician-reported outcomes	Population	2016–17	2017–18	2018–19
Community cases with significant improvement at case closure [†]	Adult	53.3%	52.7%	51.6%
	Aged	54.5%	56.3%	59.0%
	CAMHS	48.1%	44.8%	43.9%
	Forensic**			
	Specialist	20.5%	24.1%	31.4%
	Total	52.2%	51.7%	51.2%
Community cases stable at case closure [†]	Adult	37.8%	38.4%	39.5%
	Aged	37.8%	36.2%	34.7%
	CAMHS	43.2%	45.9%	47.1%
	Forensic**			
	Specialist	75.0%	72.4%	68.0%
	Total	39.2%	39.7%	40.4%
Community cases with significant deterioration at case closure [†]	Adult	8.9%	8.8%	8.8%
	Aged	7.7%	7.5%	6.4%
	CAMHS	8.7%	9.3%	9.0%
	Forensic**			
	Specialist	4.5%	3.5%	0.7%
	Total	8.6%	8.6%	8.4%
Funding		2016–17	2017–18	2018–19
Total output cost (Budget Paper 3) (\$ million) [#]	Clinical mental health	1,258.2	1,372.7	1,542.1
	Mental health community support services	124.8	120.0	118.5
Service inputs		2016–17	2017–18	2018–19
Specialist mental health beds (from policy and funding guidelines)	Admitted – acute	1,162	1,174	1,205
	Admitted – non-acute	244	244	250
	Admitted total	1,406	1,418	1,455
	Non-admitted – residential	525	495	495
	Non-admitted – subacute (CCU)	358	358	348
	Non-admitted – subacute (PARC)	230	250	250
	Non-admitted total	1,113	1,103	1,093
	Total	2,519	2,521	2,548

Service inputs		2016–17	2017–18	2018–19
Full-time equivalent staff by workforce type [§]	Administrative and clerical staff	571	656	N/A
	Allied health and diagnostic professionals	1,500	1,659	N/A
	Carer workers	18	35	N/A
	Consumer workers	18	42	N/A
	Domestic staff	174	193	N/A
	Medical officers	848	901	N/A
	Nurses	4,180	4,343	N/A
	Other personal care staff	239	204	N/A

People accessing mental health community support services				
Consumers		2016–17	2017–18	2018–19
Total consumers accessing mental health community support services [#]		10,051	8,605	5,392
Consumer demographics		2016–17	2017–18	2018–19
Gender	Female	56.2%	57.3%	57.4%
	Male	43.2%	41.9%	41.8%
	Other/unknown	0.6%	0.7%	0.8%
Age group	0–4	0.3%	0.3%	0.2%
	5–14	1.7%	2.1%	3.4%
	15–24	13.6%	13.1%	13.9%
	25–34	19.3%	18.8%	17.2%
	35–44	23.3%	22.6%	20.5%
	45–54	23.5%	24.7%	25.4%
	55–64	14.0%	14.9%	16.3%
	65–74	1.9%	1.9%	2.6%
	75–84	0.3%	0.3%	0.4%
	85–94	0.0%	0.0%	0.0%
	95+	1.6%	0.9%	0.0%
	Unknown	0.5%	0.5%	0.0%
Aboriginal or Torres Strait Islander	Indigenous	2.3%	1.9%	2.2%
Cultural diversity status	Yes	4.3%	3.9%	4.8%

Service activity		2016–17	2017–18	2018–19	
Community service units (CSUs)		767,261	635,040	338,835	
Residential rehabilitation bed days		82,322	81,435	62,417	
Service Inputs		Population	2016–17	2017–18	2018–19
Residential rehabilitation beds		Other	101	102	22***
		Youth	159	159	159
		Total	260	261	181

Notes and annotations

* Data was extracted from CMI/ODS on 11 August 2019. At the time, single year of age data was not available for the Victorian in Future 2019 release. Therefore, population estimates have been based on the Victorian in Future 2016 projections.

† Sum of rows will not equal total because one consumer can access multiple services.

* 2016–17 and 2017–18 data were affected by industrial activity, impacting the collection of non-clinical and administrative data and recording of ambulatory mental health service activity and consumer outcome measures. This industrial activity began in May 2016 and was resolved by February 2017. Affected data reported during this period should be interpreted with caution.

§ Sourced from Mental Health Establishments National Minimum Dataset.

Data impacted by the transfer of mental health community support services to the NDIS.

** Further analysis of clinical outcomes data for forensic clients indicates that the sample size is too low for the data to be considered reliable.

*** Note that 80 adult residential rehabilitation beds transitioned to the NDIS during 2018–19, bringing the 'Other' figure down from 102 to 22.

N/A: no data available for this period

SARs: special administrative regions

Note that some data may not sum due to rounding.

Appendix 3: Victoria's public mental health system

Victoria's clinical mental health service system

Area-based clinical services*

Child and adolescent services / child and youth services**

- Acute inpatient services
- Autism assessment
- Consultation and liaison psychiatry
- Continuing care
- Day programs
- Intensive mobile youth outreach services
- School-based early intervention programs

Adult services**

- Acute community intervention services
- Acute inpatient services
- Psychiatric assessment and planning units
- Secure extended care and inpatient services
- Continuing care
- Consultation and liaison psychiatry
- Community care units
- Prevention and recovery care (PARC)
- Early psychosis (16–25 years)
- Youth PARC (16–25 years)

Aged persons services (65+ years)

- Acute inpatient services
- Aged persons mental health residential services
- Aged persons mental health community teams

Statewide specialist services

- Aboriginal services
- Brain disorder services
- Dual diagnosis services
- Dual disability services
- Eating disorder services
- Mother and baby services
- Neuropsychiatry
- Personality disorder services
- Torture and trauma counselling
- Victorian Institute of Forensic Mental Health (Forensicare)
- Victorian Transcultural Mental Health
- Transition support units

* Delivery of activities varies between areas. Some services have separate teams for the various activities; others operate 'integrated teams' performing a number of different functions.

** Service models for children and young people vary across the state. Some areas have child and adolescent mental health services (0–18 years); some have child and youth mental health services (0–25 years); and others have specific services for adolescents (12–18 years) or youth (16–24 years).

