VICTORIA'S MENTAL HEALTH SERVICES ANNUAL REPORT 2015–16

Victoria State Government
Health and Human Services

THE HON. MARTIN FOLEY MP
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 2015 to 30 June 2016.

Kym Peake
Secretary
Department of Health and Human Services

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'People, living with or without mental illness, want to be included in the society in which they live without stigma and discrimination.'

Glen Waverley Public Workshop, 12 August 2015

'The mental health service system is confusing and difficult to navigate. There would be value in having a public information platform that outlines the service system and where all the available services are in each region.'

Glen Waverley Public Workshop, 12 August 2015

'The community are not well informed about what services are available and when and how to access them.'

Submission via www.mentalhealthplan.vic.gov.au

SECRETARY'S FOREWORD

I am delighted to present the first *Victoria's mental health services annual report*. I hope that it will contribute to community understanding and dialogue about mental illness and its impacts, how our services work and how they make a difference in people's lives.

This report describes how we are improving and expanding our services to address increasing need and strengthening connections with other parts of the health and human services system as they undergo major reforms. We want these reforms to deliver person-centred services that provide earlier and more connected local support in response to community needs. National Disability Insurance Scheme reforms are also well underway and are described in the report. Once rolled out, these reforms will provide greater choice, control and certainty for people with psychosocial disabilities who currently receive support through Victoria's mental health community support services.

Our annual reports will monitor the implementation of *Victoria's 10-year mental health plan* and our progress towards improving mental health outcomes for Victorians. Change takes time, and this is the first step in consolidating information that helps us better understand the impact of our services.

Many of the stories presented in this report reflect experiences of the people who use our services, their families and carers, and the perspectives of our mental health workforce. I especially want to thank our contributors for their willingness to share their stories and experiences. They are stories of recovery, resilience, innovation and a commitment to providing the best care. They speak to what is possible, but we also acknowledge that these experiences are not universal.

For some people, their experience of our mental health services is far from ideal. We must improve those experiences and ensure our services consistently provide safe, effective and recovery-oriented treatment and support. We know we must also build more effective connections between our mental health services and other parts of our health and human services system that support people with severe mental illness.

We know that more work needs to be done to improve our data systems so that we have an even greater understanding of how people access and experience Victoria's public mental health services. My department will continue to address this over the next 12 months.

This report demonstrates our commitment to increased accountability and improved access to up-to-date information on Victoria's public mental health services. I look forward to hearing community views on the report and the ways in which we can build on it.

Kym Peake
Secretary
Department of Health and Human Services

OVERVIEW

This is the first time the Victorian Government has committed to reporting annually to parliament and the community on our state-funded mental health services. V*ictoria's mental health services annual report 2015–16* reflects the government's commitment to transparency and accountability, and a desire for strong community dialogue about our vision for continuous improvement of public mental health services.

In November 2015 the government released *Victoria's 10-year mental health plan,* a long-term vision to improve the mental health and wellbeing of Victorians. This report provides details of initiatives announced under the plan, together with initiatives underway or funded in 2015–16. It also outlines our approach to monitoring progress in implementing the plan so we know how we are making a difference.

This report focuses on state-funded mental health services and the Victorians who accessed them for treatment, care and support in 2015–16. Mental health services funded by the Victorian Government include a range of hospital and community-based clinical mental health services and non-clinical services provided by mental health community support services.

The report provides data on various aspects of our system. We know that Victoria's public mental health services are under pressure to meet increasing demand. This impacts on the ability of services to consistently deliver contemporary, high-quality mental healthcare. We also know that some regions, including our outer metropolitan growth corridors, have greater challenges regarding access to clinical services than inner city areas.

Our public mental health services have changed, particularly over the past decade. We have created alternatives to hospital care by establishing community-based prevention and recovery care services, and have expanded youth-specific mental health services. Significant steps have been taken to ensure our public mental health services provide person-centred, recovery-oriented and family-inclusive support and care. Peer support workers are playing an increasingly important role in our services, particularly in providing support to consumers following discharge from inpatient care. Consumers and carers are also central to the identification of priority issues and development and implementation of mental health initiatives.

Safeguards around quality, safety and protection of people's rights are also described, including the Mental Health Complaints Commissioner, Mental Health Tribunal, Community Visitors and the Chief Psychiatrist. The report highlights how supported decision making can be facilitated, including through advance statements, nominated persons and the recently established Independent Mental Health Advocacy service.

Victoria has led the way nationally in releasing information about our public mental health system. This report not only strengthens our commitment to transparency, it also provides an opportunity for the Victorian community to gain greater insights into how our public mental health system is working.

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INTRODUCTION

1. INTRODUCTION

Mental illness touches all of our lives at some stage, either directly or indirectly. Many of us have experienced, or have family, friends and colleagues who have experienced, mental illness or mental health issues.

We know that almost one in two people in Australia will experience mental illness at some point in their lives.[1]

Mental illness can be a disruptive and challenging experience. Getting treatment, help and support at the right place and the right time is critically important.

Some of us might need short-term support, while others may need to be admitted to hospital for treatment to manage symptoms, and then receive support and treatment in the community over a longer period of time. Some people with mental illness may require significant ongoing support throughout their lives.

We know more needs to be done to reduce the stigma and discrimination associated with mental illness in our community, and to ensure Victorians know they can seek treatment and support. Stigma and discrimination can impact on people's access to physical healthcare, housing and employment, as well as their sense of connection to the broader community.

**1 in 2
Australians** will experience
mental illness
in their lifetime

**In any 1 year
1 in 5
Australians** experiences
some form of
mental illness
or disorder

**1 in 4
young
Australians**
(aged 16-24) currently
experiences
some form of
mental illness
or disorder

MENTAL HEALTH IN VICTORIA

GOOD MENTAL HEALTH AND WELLBEING FOR ALL VICTORIANS

The critical importance of good mental health is recognised in the *Victorian public health and wellbeing plan 2015–19*, released in late 2015. The plan identifies the close linkages between physical and mental health including mental health's links to alcohol/drug use, sexual health and healthy eating. Local councils are developing plans to address these priority areas, identifying local opportunities and strategies to enhance community health and wellbeing, including mental health.

The Victorian Government supports a range of primary and community-based services to improve the mental health of Victorians. Community health services across the state provide counselling and a range of other services to people who may be experiencing difficulties, and provide specific support for refugees and asylum seekers who may have experienced significant trauma.

Support is also provided for a range of specific Aboriginal health initiatives to help improve mental health in Aboriginal communities. Mental health first aid training helps build community capacity to recognise when people are struggling and to support them to get help. Telephone-based support services such as Lifeline play an important role in supporting people through difficult periods.

Targeted support has also been provided for Victorians in regions affected by drought, recognising the substantial impact such a threat to livelihood can have on wellbeing. Recent initiatives have supported dairy farmers affected by changing industry conditions, including additional counselling, mental health first aid training and community support.

MEN'S SHEDS
AT MELTON AND TAYLORS HILL

Melton City Council was the first Victorian municipality to deliver a men's shed fully as a council service. It opened the Melton Men's Shed in 2009 and the Taylors Hill Men's Shed in 2015. The council strongly advocates for men's sheds, recognising they can play a vital role in improving the health and wellbeing of local men, and ultimately the health and wellbeing of their families too. While sheds aren't just for men experiencing mental health issues, Melton Council has no doubt about the positive impact they are having on all their 'sheddies'.

Steve has been a Taylors Hill sheddie for a year now. He's a regular in the shed and is often the first to say g'day to a new sheddie, to show him around and to welcome him into the fold. In 2008 Steve experienced his first bout with severe depression. 'It was the most traumatic time of my life and I found it very hard to continue,' he said. Asked about what attracted him to the shed, he said, 'It was more than just for something to pass the time; it was the chance to talk with blokes my age, perhaps from a similar background to mine. I wanted some activities to pass the time, instead of sitting at home moping.'

Steve says a men's shed can be a safe place for blokes to open up about their issues, and to share their stories. 'If you want to, you can talk about your issues and realise you're not the only person that feels this way. Men do often open up because we're peers, they know we're interested in their stories, but they don't feel like we're prying. Some of us have been through what they're going through and they do open up.'

Community projects are a big part of what men's sheds do. These projects not only benefit the local community but they can make a real difference to the sheddies too. 'As some blokes get older they don't feel like they're worth anything anymore; it can give them a feeling of accomplishment to give back, and to use their skills again. They give us a sense of worth.'

Steve, Taylors Hill 'sheddie'

Find out more about the Melton and Taylors Hill men's sheds at <www.melton.vic.gov.au/mensshed>.

MENTAL ILLNESS IN OUR COMMUNITY

In any one year, around one in five Victorians (or 19 per cent of our population) will experience some form of mental illness or disorder (see Figure 1).[2]

Of this 19 per cent, most (12 per cent) will experience illnesses such as depression or anxiety ('higher prevalence illnesses') and return to good mental health in time.[3] Around four per cent will experience these and other illnesses or disorders (including substance abuse), which can be unremitting and cause major disruption to their lives.[4] Around three per cent of Victorians will experience more severe impacts through illnesses such as schizophrenia, bipolar disorder, severe depression, severe personality disorders and eating disorders.[5] People who experience these illnesses make up the majority of people who use our public mental health services.

Prevalence of mental illness varies by age. Around 14 per cent of children and young people have mental disorders – most commonly attention deficit hyperactivity disorder and anxiety disorders.[6] The prevalence of mental illness is highest among 16–24 year olds (at around 26 per cent) and lowest among people over 65 years old (less than 10 per cent).[7]

People with psychotic illnesses, such as schizophrenia, frequently experience poor physical health, with much higher rates of diseases such as diabetes compared with the broader population.[8] Severe mental illness can also impact on people's ability to participate in the community, their employment opportunities and their workforce participation. More than 30 per cent of people receiving a disability support pension have a primary condition involving mental illness.[9]

Figure 1: Victorians experiencing some form of mental illness in any one year

- Each year, about 19% of Victorians experience some degree of mental illness
- 12% experience mild disability
- 4% experience moderate disability
- 3% experience severe disability
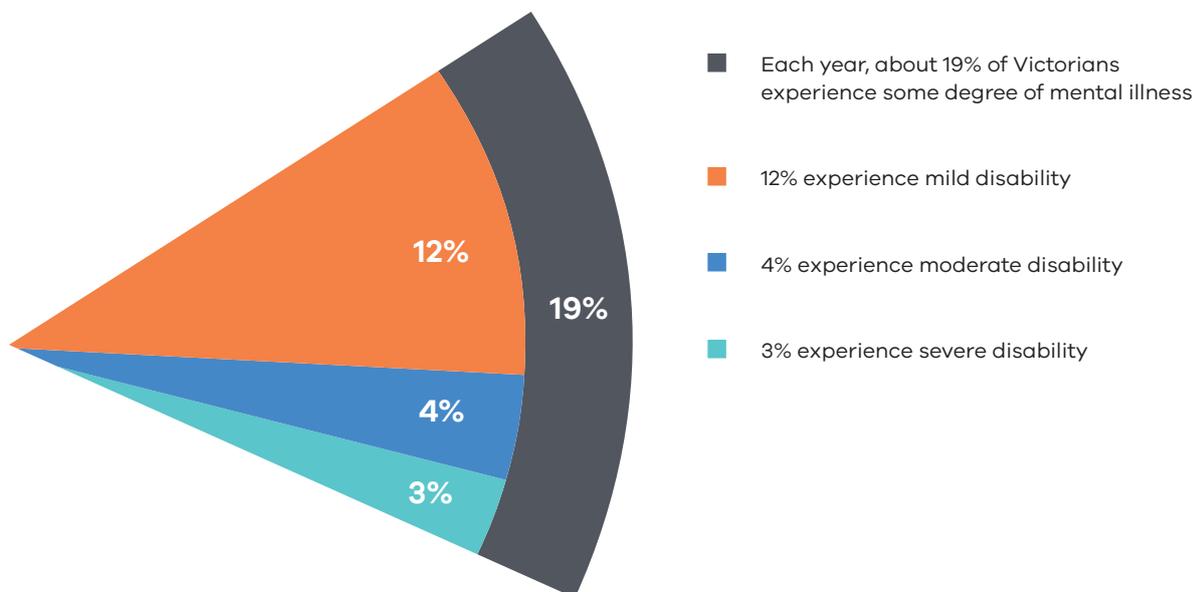
KLASSROOM KALEIDOSCOPE AT DANDENONG WEST PRIMARY SCHOOL

Over the past two years, the Victorian Foundation for Survivors of Torture (Foundation House) and Dandenong West Primary School have worked in close partnership to support children and families from refugee and asylum seeker backgrounds who have experienced displacement, human rights violations and trauma associated with their experience.

The Klassroom Kaleidoscope program was facilitated in one of Dandenong West's most diverse Grade 5 classes during Term 2 in 2016. Klassroom Kaleidoscope aims to enhance personal wellbeing and foster a sense of trust and belonging within the school community by building connections. The program embraces cultural and linguistic diversity and promotes cross-cultural understanding at the classroom level.

Over nine weeks, students were supported to share aspects of their cultural heritage and journey to Australia with their peers and teachers. Reflecting on the differences and similarities between their lives, the students developed a great appreciation of how their past and present experiences have shaped their identity, personal qualities and future aspirations. This has also helped strengthen the students' connections with each other and foster greater understanding and respect.

The analogy of a kaleidoscope is used throughout the program, highlighting the connection between the differing and similar patterns in a kaleidoscope and the backgrounds, religions, languages, journeys and cultures in the class. When brought together, a kaleidoscope creates something fabulous and colourful that enriches our lives.

This group work program is part of an integrated trauma recovery service model that includes child, adolescent and family work, together with the Refugee Education Support Program that focuses on assisting schools to take a whole-of-school approach to supporting students and families of refugee backgrounds.

Find out more about Klassroom Kaleidoscope, Schools in for Refugees, and other resources at <www.foundationhouse.org.au>.

Teacher Josh Teo shares an ancient lantern, used by his father as a child in Singapore, with the class.

GOVERNMENT ROLES AND RESPONSIBILITIES IN MENTAL HEALTH

Nationally, approximately $8 billion is spent on mental health in Australia every year. Of this, around 60 per cent ($4.8 billion) is spent by state and territory governments, 36 per cent ($2.9 billion) by the Commonwealth and four per cent ($309 million) by private health insurance funds.[10]

COMMONWEALTH GOVERNMENT

The Commonwealth Government funds a range of mental health services through the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme.

Primary health services such as general practitioners (GPs) are often the first point of contact for people experiencing mental illness. GPs provided mental health-related services to approximately 465,000 Victorians in 2014–15.[11] The number of Victorians accessing Medicare-subsidised mental health services increased at a rate of about 5.5 per cent every year between 2010–11 and 2014–15.[12]

The Commonwealth also subsidises private psychiatric and psychological services. Victorians used private mental health services including private psychiatrists and psychologists at a higher rate than other states and territories in 2014–15. A total of 99,208 Victorians saw a private psychiatrist, and 275,779 Victorians saw a clinical or other psychologist during this period.[13]

The Commonwealth funds several specific services that are available nationally. These include headspace (young people's mental health), Partners In Recovery, Personal Helpers and Mentors, and the Mental Health Nurse Incentive Program.

VICTORIAN GOVERNMENT

The Victorian Government funds specialist mental health services for people with severe mental illness. These services are described in chapter 3.

The largest proportion of Victorian mental health funding is spent on clinical mental health services delivered in hospitals and community settings. Victorian funding is also provided for residential services such as prevention and recovery care services (PARCs) provided in the community, in addition to non-government mental health community support services (MHCSS). MHCSS funding and services are changing as a result of National Disability Insurance Scheme (NDIS) reforms, described later in this report.

The Victorian Government invested $1.14 billion in clinical mental health services in 2015–16 and $128 million in MHCSS (see Figure 2).

Figure 2: 2015–16 mental health expenditure by service type

- Community clinical — 35%
- Hospital — 27%
- MHCSS — 10%
- Capital asset charge and depreciation — 9%
- Residential — 7%
- Service system capacity — 5%
- Other — 4%
- PARC — 3%
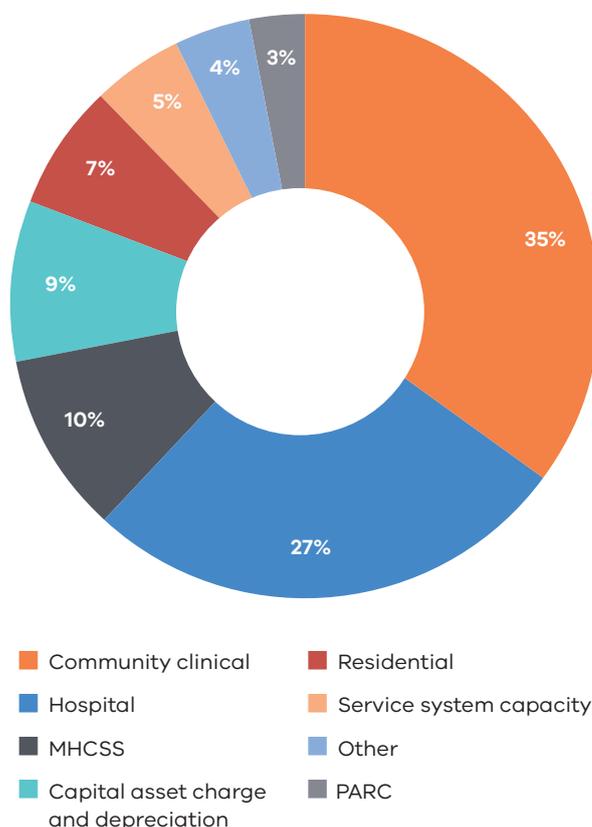
ABOUT THIS REPORT

This report is a new requirement under the *Mental Health Act 2014*. In May 2015 amendments were introduced to the Act requiring an annual report on Victoria's public mental health services to be submitted by the Secretary to the Minister for Mental Health by 31 October each year, and subsequently tabled in parliament.

The report brings together a range of information about Victoria's publicly funded mental health services for the first time. It aims to be informative and accessible to a broad readership including consumers, carers, service providers and the community.

In 2015–16, at the request of the Minister for Health, the department commissioned a review of whether it has adequate systems for safety and quality assurance in place for hospital care in Victoria, including mental healthcare. As the review was finalised in 2016–17, recommendations resulting from the review will be addressed in next year's annual report.

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VICTORIA'S 10-YEAR MENTAL HEALTH PLAN

2. VICTORIA'S 10-YEAR MENTAL HEALTH PLAN

A LONG-TERM VISION TO IMPROVE SERVICES AND OUTCOMES

Victoria's 10-year mental health plan, **released in November 2015, is a long-term commitment by the Victorian Government to improve the mental health and wellbeing of Victorians, including the services and outcomes for Victorians with a mental illness, their families and carers.**

The plan's goal is that all Victorians experience their best possible health, including mental health. It has four focus areas:

- Victorians have good mental health and wellbeing
- Victorians promote mental health for all ages and stages of life
- Victorians with mental illness live fulfilling lives of their choosing, with or without symptoms of mental illness
- the service system is accessible, flexible and responsive to people of all ages, their families and carers, and the workforce is supported to deliver this.

The plan commits to improving service quality, safety, accessibility and integration with other health and human services. It commits to reducing the number of Victorians who die through suicide. It acknowledges the critical importance of our skilled mental health workforce and their delivery of recovery-oriented, trauma-informed and family-inclusive services. Importantly, the plan recognises that the best outcomes are achieved by involving service users and providers in service design, development and delivery from the outset.

The Mental Health Expert Taskforce provides expert advice and guidance to the government and department on the selection and design of implementation activities. Four reference groups are supporting the taskforce in the following areas: Aboriginal social and emotional wellbeing and mental health; innovation; lived experience leadership; and workforce. The Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Taskforce's Health and Human Services Working Group is providing advice on supporting the social and emotional wellbeing and mental health of LGBTI people.

MONITORING OUR PROGRESS

We want to see improved outcomes for individuals and communities across a range of areas including service experience, health and wellbeing, quality of life, social inclusion, participation and economic security.

We want to know more about the difference our programs and services make in people's lives. This will help us to understand more clearly what works and what doesn't work, what needs improving, and what needs to change. *Victoria's 10-year mental health plan* commits the Victorian Government to monitor and report on outcomes identified in the plan, and to keep strengthening our approach to outcomes and monitoring over time.

As part of whole-of-Victorian-Government reforms, the department has developed a new outcomes framework that focuses on understanding the impact our services have on people's lives. *Victoria's 10-year mental health plan* outcomes have been reframed to ensure clearer alignment with the departmental framework and the whole-of-government reform approach (see Table 1). The aspirations and commitments stated in the *10-year mental health plan* are unchanged.

We have selected an initial suite of indicators to help us monitor our progress. The indicators are measures that describe how well we are achieving our outcomes. These are outlined at Appendix 1.

As at 2016, there are some outcomes for which meaningful indicators are not available. We are working to develop our data to address these gaps, expand our suite of indicators, and improve use of our existing data in the coming years.

This will strengthen our understanding of where we are making an impact and where further work is required.

Achieving change takes time. Regardless, we remain committed to improving mental health outcomes for all Victorians.

Table 1: Victoria's 10-year mental health plan – outcomes

Vision	ALL VICTORIANS EXPERIENCE THEIR BEST POSSIBLE HEALTH, INCLUDING MENTAL HEALTH
Domains	**Outcomes**
Victorians have good mental health and wellbeing	1. Victorians have good mental health and wellbeing at all ages and stages of life 2. The gap in mental health and wellbeing for at-risk groups is reduced 3. The gap in mental health and wellbeing for Aboriginal Victorians is reduced 4. The rate of suicide is reduced
Victorians promote mental health for all ages and stages of life	5. Victorians with mental illness have good physical health and wellbeing 6. Victorians with mental illness are supported to protect and promote health
Victorians with mental illness live fulfilling lives of their choosing, with or without symptoms of mental illness	7. Victorians with mental illness participate in learning and education 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 12. Victorians with mental illness have suitable and stable housing
The service system is accessible, flexible and responsive to people of all ages, their families and carers, and the workforce is supported to deliver this	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 14. Services are recovery-oriented, trauma-informed and family-inclusive 15. Victorians with mental illness, their families and carers are treated with respect by services 16. Services are safe, of high quality, offer choice and provide a positive service experience

MENTAL HEALTH EXPERT TASKFORCE

The Mental Health Expert Taskforce was established in early 2016.

The taskforce guides implementation of *Victoria's 10-year mental health plan* and advises the Minister for Mental Health on reform priorities and effective monitoring of the plan's outcomes.

Its members have significant experience and expertise as clinicians, people with lived experience of mental illness, academics, community service providers, community representatives and health promotion experts.

During 2016 the taskforce provided advice to government on mental health workforce and suicide prevention reforms, and development of an outcomes framework.

Taskforce L–R: Prof. Frank Oberklaid, Lyn Morgain, Prof. Patrick McGorry, Assoc. Prof. Ruth Vine, Jason Trethowan, Julien McDonald, Vrinda Edan, Chris McNamara, Julie Dempsey, Dr Paul Denborough, Steve Dimopoulos MP (Chair), Georgie Harman, Michelle Swann and Brenda Appleton. Absent: Dr Ravi Bhat, Jill Gallagher, Kim Koop and Prof. Dan Lubman.

KEY INITIATIVES DURING 2015–16

Initiatives related to *Victoria's 10-year mental health plan* are being progressively implemented. Initial activities were developed throughout 2015–16 to support reform in 2016–17 and beyond. These included suicide prevention, mental health workforce and child and youth mental health initiatives. New reform initiatives are being developed to guide future work.

Prioritisation of initiatives is guided by the following principles:

- a strong evidence base
- complementing upcoming Commonwealth reforms
- linking with and supporting universal services wherever possible
- aligning with other government strategies and emerging priorities
- supporting ongoing efforts to mainstream clinical mental health services into the broader health system.

Key initiatives are described in this chapter, together with other activities funded, progressed or announced during 2015–16.

SUICIDE PREVENTION FRAMEWORK

During consultations to develop the *10-year mental health plan* in 2015, many people shared stories of loved ones who had taken their own lives. In 2015 there were 654 suicide deaths in Victoria.

The *Victorian suicide prevention framework 2016–25* outlines new initiatives that aim to reduce suicide in Victoria.

We are trialling assertive outreach and personal care for people leaving an emergency department or hospital following treatment for an attempted suicide. Under the trial, mental health professionals will provide one-on-one support to people who have attempted suicide to make sure they get the support they need to recover.

These trials will run in six health services across Victoria – Peninsula Health, Alfred Health, St Vincent's Health, Barwon Health, Eastern Health and Albury Wodonga Health.

Place-based suicide prevention strategies are also being trialled. Six local communities are being supported to develop and implement coordinated suicide prevention strategies. The strategies will include school-based programs, frontline staff training and other initiatives to raise awareness of mental health issues and support services. These trials will run in the Mornington Peninsula and Frankston area, Brimbank and Melton, Whittlesea, Mildura, the Latrobe Valley and Ballarat.

The areas for the trial locations are based on the prevalence of suicide in Victoria, population and community demographics, as well as local capacity.

Evaluation of these initiatives will be undertaken across the trial locations.

ABORIGINAL SOCIAL AND EMOTIONAL WELLBEING FRAMEWORK

Aboriginal people experience significantly poorer mental health outcomes than any other group in Victoria.

The *10-year mental health plan* aims to reduce the gap in mental health and wellbeing for Aboriginal Victorians, and includes a commitment to develop an Aboriginal social and emotional wellbeing framework.

A reference group representing Aboriginal communities and service providers has been established to inform the development of the framework.

> **'We need investment in the mental health workforce to ensure the number of skilled and experienced staff will grow with the population.'**
>
> *Dandenong Public Workshop, 17 August 2015*

BUILDING AND SUPPORTING THE BEST POSSIBLE WORKFORCE

Victoria's mental health workforce is a major strength of our system and has a key role in achieving our *10-year mental health plan* outcomes. Attracting and retaining a skilled and knowledgeable workforce is critically important to delivering safe and high-quality services. Workforce distribution is uneven across Victoria, and services located outside inner city areas have had particular difficulties recruiting and retaining staff.

The new *Mental health workforce strategy* seeks to address current workforce challenges and to continue building our workforce to meet the needs of people with mental illness, their families and carers. It includes initiatives to improve recruitment, retention and development of the specialist mental health workforce and ensure workers have the mix of skills and values that support *10-year mental health plan* outcomes.

A new statewide Centre for Mental Health Workforce Learning and Development will create a platform to harness expertise and share knowledge with mental health workers and organisations.

SERVICES THAT FIT TOGETHER AS A WHOLE

We want people to get the right services at the right time, close to where they live.

Many of our current clinical facilities are ageing. Some inpatient units and community clinics require refurbishment or replacement, or are not meeting population growth and demand. There is an increasing gap between the functionality of older clinical services and those built within the past five years. Older services are expected to cater to a wide range of people in terms of age and diagnosis in mixed-gender environments. This can affect people's experience of care. We also know that our inpatient services for people who are acutely unwell (described in chapter 3) can be particularly challenging and difficult environments.

In response, and as part of a statewide design, service and infrastructure plan for Victoria's health system, the *Design, service and infrastructure plan for Victoria's clinical mental health system* is being developed, and will be completed in June 2017. Its impact on Victoria's clinical mental health services will be described in future annual reports.

MANAGING CLINICAL DEMAND AND INCREASING ACCESS

Our data tells us that Victoria's public mental health services are under pressure to meet increasing demand. The *10-year mental health plan* acknowledges that, over time, these increasing and sustained demands have not been matched with increasing resources and this has affected the capacity of mental health services to provide effective clinical services.

> **Recent initiatives to help manage demand and increase access include:**
>
> - expansion of community clinical mental health treatment and gender dysphoria services
> - new intensive complex care packages for adults with multiple and complex needs associated with drug and alcohol use, homelessness and intellectual disability or acquired brain injury
> - new intensive community treatment services for older people with severe mental illness
> - funding for new beds across the clinical system including a 10-bed residential service for older people with severe mental illness and a new women's PARC service.

Funding has also been allocated to Commonwealth Government-designed programs previously funded under the National Perinatal Depression Initiative so that those services can continue to be delivered.

GENDER DYSPHORIA CLINIC AT MONASH HEALTH

Sex and gender are different: gender is a person's sense that they are male, female or somewhere in between, whereas sex refers to a person's biological appearance. 'Gender dysphoria' is when a person feels a mismatch between their sex and gender identity. Transgender people face many difficulties due to a lack of understanding from family members, from work, educational and residential communities and from peer groups.

Isabelle Duncan, *Fire Fire*, 2005
Courtesy of The Cunningham Dax Collection

Demand for gender dysphoria services has increased dramatically, straining the resources of existing services. The Monash Health Gender Dysphoria Clinic (GDC) is the largest government-funded clinic of its kind in Australia. Since opening for adult clients in 1976, referrals have grown from 47 referrals to more than 250 each year, and the GDC's waiting list is now over 12 months.

Clinicians know there is a danger period for self-harm and suicide between when some transgender people seek healthcare support and when they can start their transition process. In response to this need, the Victorian Government provided a five-fold increase in funding to the GDC in the 2016–17 State Budget. This follows a similar boost for the Royal Children's Hospital child and adolescent service in 2015.

These funding increases allow better access for clients, and the development of a comprehensive, multidisciplinary service. Initiatives include expanding the clinical assessment program beyond two days a week, more counselling services, facilitating support groups, more speech therapy services and support to other services via teleconferencing.

IMPROVING INTEGRATION WITH PRIMARY HEALTH SERVICES

We want to see better integration of services so people can access the support, treatment and healthcare they need. People with severe mental illness often require ongoing treatment for physical health conditions and support from a range of health and community services.

To achieve greater coordination, a significant proportion of Commonwealth mental health program funding is transitioning to Primary Health Networks (PHNs) over the next three years. Six Victorian PHNs commenced in 2015. Each PHN has responsibility for a particular region of Victoria.

Working in partnership with hospitals, community services, Aboriginal organisations, drug and alcohol services and other providers, PHNs will improve coordination by purchasing or commissioning services to meet the local needs of their region. Future annual reports will describe progress on these reforms.

INVESTING IN CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH

We are committed to supporting good mental health for younger Victorians.

Current reforms across government in education, early childhood, child and family services, out-of-home care, Aboriginal social/emotional wellbeing, alcohol/drugs and family violence services seek to promote good mental health and prevent mental illness early in life. These reforms include increasing the focus on prevention and earlier interventions across health, education and social services, promoting resilience and reducing the impact of adverse childhood experiences in children and young people.

Building family capabilities in all services, including family-inclusive practice in adult mental health, is a priority. Supporting children and young people to connect with universal services, including mental health services, through more therapeutic out-of-home care is also a priority. Residential out-of-home care is being transformed to provide a clinical treatment model. The goal of these reforms is to ensure that out-of-home care is a short-term intervention, rather than a destination, helping children transition to family or foster care as quickly as possible.

Prevention, early intervention and specialist treatment services for children aged up to 12 years are being significantly enhanced. All child and adolescent services will have access to expert specialist consultation liaison and advice. The specialist child mental health workforce will have additional resources to support treatment for children with severe disruptive behaviour disorders and to provide support for families and carers.

'The system is confusing. Even for experts and workers in the system.'

Traralgon consumer and carer workshop, 10 August 2015

Services for children aged five to nine with conduct disorders are expanding so they are available across the state. For children with major behavioural disorders, services are also being expanded to provide child-centred and family-focused intensive psychiatric interventions, including first-onset programs.

Additional support is also being provided to expand the Families where a Parent has a Mental Illness (FaPMI) program across Victoria. This program aims to reduce the impact of parental mental illness on family members, particularly dependent children, by ensuring parents with a mental illness are routinely identified and offered early treatment.

Investments have also been made to strengthen service access for young people with mental illness experiencing homelessness.

A range of initiatives aiming to combat transphobia and homophobia and improve the mental health and wellbeing of same-sex-attracted and gender-diverse young people have also been funded, including place-based initiatives in rural Victoria.

An additional $60 million has been allocated to rebuild the Orygen Youth Mental Health clinical and research facility in Parkville.

FORENSIC MENTAL HEALTH SERVICES

Victoria's forensic mental health services provide specialist assessment and treatment for people with mental illness or disorders and a history of 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.

In response to increasing demand for forensic mental health services, a new eight-bed unit is being built at Thomas Embling Hospital and is expected to open in 2017–18.

Victoria's women's prison, the Dame Phyllis Frost Centre, is also expanding. A 44-bed purpose-built mental health unit will support a more integrated response to women requiring voluntary specialist mental health services in the prison system. It is expected to open in 2018.

Ravenhall is the new medium-security men's prison being built in Melbourne's west. It will include a new 75-bed forensic mental health unit, significantly increasing capacity to provide voluntary bed-based forensic mental health services. Ravenhall is expected to open in late 2017.

Over the next year, more forensic mental health specialist capacity will be available across Victoria to build pathways for, and deliver treatment to, people exiting prisons and to improve management of high-risk, violent offenders.

Master planning is also well advanced to assist in determining how we will address longer term forensic bed needs.

CO-PRODUCTION IN MENTAL HEALTH SERVICES

Service users (consumers, their families and carers) and providers should guide government policy and system management, as well as service design and delivery. Co-production shifts approaches to government policymaking from seeking involvement or participation after an agenda has already been set, to seeking it at the outset.

Victoria's 10-year mental health plan outlines a commitment to co-production at every stage in the design, development and delivery of mental health services.

Co-production ensures engagement of users and providers in the initial thinking and priority-setting processes. Co-production creates an equal and reciprocal relationship, recognising the contributions that all partners make to improving services. It values different expertise, experience and knowledge equally. This approach requires longer term engagement by policymakers, system administrators and providers because we are involving people right from the start.

'To truly adopt this model of working we need to change attitudes, culture, priorities and training. We also need to recognise that this will result in a fundamental rebalancing of power by affording equal value to different kinds of skill and expertise.'

Victoria's 10-year mental health plan, November 2015

Adam Knapper, *Mumbo Jumbo,* 2015
Courtesy of the Mental Health Foundation of Australia (Victoria)

'Nothing about me without me is for me.'

Glen Waverley Public Workshop, 12 August 2015

CONSUMER, FAMILY AND CARER RESPONSIVENESS

Consumers, families and carers continue to tell us that providing treatment and support in recovery-oriented environments and increasing treatment choices are top priorities. Often though, consumers, their families and carers also tell us their voices are not heard when we are setting priorities and planning services.

These concerns are being addressed in a number of ways. Consumer and Carer Partnership Dialogues – co-chaired by the department with the respective consumer and carer peak bodies, the Victorian Mental Illness Awareness Council and Tandem Inc. – were held during 2015–16. This is intended to facilitate greater collaboration across government and the consumer and carer workforces.

During 2016–17 a framework for co-production will be developed in collaboration between the Mental Health Expert Taskforce and the Lived Experience Leadership Reference Group. The framework will outline co-production principles and approaches and provide practical guidance for government, users and providers.

IMPROVING ACCESS TO HOUSING

Additional funding has been allocated to strengthen referral pathways between public and private housing providers and clinical mental health services in order to increase housing access for people with severe mental illness. Funding has also been expanded to help reduce the rate of homelessness among people with severe mental illness.

OUR GOAL–
HALVE THE SUICIDE RATE BY 2025

In 2015 we lost 654 Victorians to suicide – more than double the road toll. Behind these numbers, every single death tells a story, but each has the same underlying message for our community: we need to do more about suicide.

We know that suicide is complex but preventable. We know there is evidence of suicide interventions that work. Better care and follow-up for people and their families and carers saves lives. Action that builds protective factors – strong communities, relationships, contributing lives with purpose and hope and personal resilience – gives people reasons for living.

The *Victorian suicide prevention framework 2016–25* outlines the Victorian Government's commitment to halve the suicide rate over the next ten years.

The framework was backed with a $27 million investment in the 2016–17 Victorian Budget.

Under the plan, people leaving an emergency department or general medical ward following treatment for an attempted suicide will be supported through an assertive outreach program. Mental health professionals will provide one-on-one support to people who have attempted suicide and make sure they get the support they need to recover. The program is being implemented in six health services across the state.

Six local communities are being supported to develop and implement proactive place-based suicide prevention strategies. These strategies include initiatives such as raising awareness of mental health issues and support services, school-based programs and frontline staff training.

Suicide prevention assertive outreach locations

Albury Wodonga Health, Wangaratta
St Vincent's Hospital
Maroondah Hospital
Barwon Health, Geelong
Alfred Health
Peninsula Health

Place-based suicide prevention locations

Mildura
Ballarat
Whittlesea
Brimbank /Melton
Latrobe
Mornington Peninsula / Frankston

3

PUBLIC MENTAL HEALTH SERVICES

3. PUBLIC MENTAL HEALTH SERVICES

OVERVIEW

Our public mental health services have changed significantly over the past three decades.

Victoria led the way in Australia with deinstitutionalisation, replacing stand-alone psychiatric hospitals with mainstreamed inpatient mental health services (collocated with general hospitals or aged care services) and invested in community-based clinical and non-clinical mental health services.

Over the past 10 years we have created alternatives to inpatient care by establishing community-based prevention and recovery care (PARC) services across Victoria. In recognition of the critical importance of prevention and early intervention, particularly in relation to youth mental health, we have also significantly expanded youth-specific mental health services for adolescents and young people.

Our clinical mental health services are part of larger health services that provide a range of hospital and community-based services. Non-clinical mental health community support services (MHCSS) are managed by non-government organisations.

Both clinical and non-clinical mental health services are provided within geographically defined catchment areas. This means that services in each catchment are responsible for providing mental health services to people who live in that area so they have access to local treatment and support.

Victoria also has a number of specialist mental health services provided on a statewide basis (see Figure 3).

These services include specialist mother and baby units, eating disorders services, dual diagnosis services, transcultural mental health and services providing treatment for people with a personality disorder.

The Victorian Institute of Forensic Mental Health (Forensicare) provides clinical services for offenders or people involved in the criminal justice system experiencing severe mental illness. These services are explained in more detail later in this chapter.

People access public mental health services depending on their individual needs. Some people have short periods of treatment in an acute inpatient service, and may no longer need treatment following discharge, or may return to the care of their GP. Others might require specialist services over a longer period of time.

Some people access treatment from a combination of public and private services through shared care arrangements with GPs or private psychiatrists, community mental health services and other support services.

Figure 3: Organisation of our public mental health system

VICTORIA'S PUBLIC MENTAL HEALTH SERVICE SYSTEM

AREA-BASED CLINICAL SERVICES*

CHILD AND ADOLESCENT SERVICES (0–18 YEARS)**

- 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 (16–64 YEARS)**

- Acute community intervention services
- Acute inpatient services
- Psychiatric assessment and planning units
- Secure extended care and inpatient services
- Combined 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

MENTAL HEALTH COMMUNITY SUPPORT SERVICES

Services include individual support packages, youth and adult residential rehabilitation, supported accommodation, planned respite, Aboriginal programs, mutual support, self-help and community support services.

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

** *All child and adolescent and adult services are expected to respond to the needs of youth (16–25 years).*

AREA-BASED CLINICAL SERVICES

Clinical mental health services in Victoria are delivered to three specific age groups:

- children and adolescents (0–18 years)
- adults (16–64 years)
- aged persons (65 years or older).

Youth-specific mental health services have also been developed for adolescents and young people (16–25 years) and are delivered largely through adult mental health services.

Clinical mental health services in Victoria include:

- 13 child and adolescent mental health services, provided in five metropolitan and eight rural catchments
- 21 adult mental health services, provided in 13 metropolitan and eight rural catchments
- 17 aged persons mental health services, provided in nine metropolitan and eight rural catchments.

Acute inpatient unit, Dandenong Hospital

CLINICAL MENTAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS (0–18 YEARS)

Child and adolescent mental health services (CAMHS) provide specialist mental health treatment and care to children and adolescents. These services assess and treat children and adolescents experiencing moderate to severe mental health problems and disorders, and assist those with less severe problems with advice and information about where and how to access help. Vulnerable children and young people, particularly those involved with statutory services such as child protection, are prioritised.

Acute inpatient services provide short-term assessment and inpatient treatment for children and adolescents with severe emotional disturbance that cannot be assessed satisfactorily or treated safely and effectively in the community. There are five acute inpatient units in Victoria – one child and four adolescent units.

Autism assessment: All services have a multidisciplinary team to provide diagnostic assessment of children with serious developmental disorders such as autism. Some services also provide community consultation and liaison, and link patients and their families into appropriate support services in the community including school support.

Consultation and liaison psychiatry services provide consultation, support and assessment to patients and their families in a health service, usually in paediatric inpatient wards. These patients have medical illnesses (for example, cystic fibrosis or leukaemia) with associated psychiatric symptoms. This consultation service ensures a comprehensive holistic approach is taken to assist the patient's treatment.

Continuing care teams undertake assessment and treatment of children and adolescents experiencing significant distress or mental illness. Services include crisis assessment, case management and individual, family and group therapy.

Day programs offer integrated therapeutic and educational support for young people with behavioural difficulties, emotional problems such as severe depression or anxiety, personality difficulties or severe mental illness.

Intensive mobile youth outreach services provide intensive outreach mental health case management and support to adolescents who display substantial and prolonged psychological disturbance, and have complex needs that may include challenging, at-risk and suicidal behaviours.

School-based early intervention programs (conduct disorder programs) offer multilevel early intervention and prevention services designed to reduce the prevalence and impact of conduct disorder.

ADULT MENTAL HEALTH SERVICES (16–64 YEARS)

Adult specialist mental health services are provided for people experiencing severe mental illness such as schizophrenia or bipolar disorder, and may also support and treat people experiencing a severe personality disorder or severe anxiety disorder. People may also present in situational crisis that may lead to self-harm or inappropriate behavior towards others.

Acute community intervention services (ACIS) operate 24 hours a day and provide urgent community-based assessment and short-term treatment interventions to people needing psychiatric treatment. ACIS screen all potential inpatient admissions and assist in deciding the most appropriate treatment option. ACIS provide intensive community treatment and support, often in the person's own home, during the acute phase of illness as an alternative to hospitalisation. ACIS also provide services on site in a number of hospital emergency departments. These services were previously known as crisis assessment and treatment teams (CATT).

Acute inpatient services are provided for people experiencing an acute episode of mental illness who need to be treated in hospital. These services provide both voluntary and compulsory short-term inpatient management and treatment.

Psychiatric assessment and planning units (PAPUs) operate 24 hours a day and provide short-term (up to 72 hours) specialist psychiatric assessment and treatment for people experiencing an acute episode of mental illness. PAPUs provide treatment for drug-induced psychosis, medication overdose, suicidal ideation, comorbid medical conditions or when a person needs to be assessed under the Mental Health Act.

A person admitted to a PAPU may subsequently be referred to an acute mental health inpatient unit, a PARC service, or a community-based public or private mental health service.

Prevention and recovery care (PARC) services are short-term (usually up to 28 days), recovery-focused treatment and support services in residential settings. PARCs provide early intervention for people who are becoming unwell and for people in the early stages of recovery following an acute psychiatric inpatient admission. PARCs aim to assist in preventing acute inpatient admissions and to assist those who are already admitted to be discharged as early as possible.

Secure extended care units (SECUs) are inpatient services for people who need a high level of secure and intensive clinical treatment for severe and unremitting mental illness. SECUs provide compulsory long-term management and treatment services at three metropolitan and three regional hospitals, and there is some non-secure extended care bed capacity at two further hospitals.

Continuing care teams provide assessments, treatment, case management, support and continuing care services in the community. They provide the largest component of adult community-based services. In some health services, continuing care services consist of discrete teams that support people with their specific needs. Other health services have a multiple team structure and operate a more integrated service model.

Continuing care services include (either in discrete teams or as part of an integrated service):

- mobile support and treatment services, which operate seven days a week for extended hours and provide intensive long-term support for people with prolonged and severe mental illness and associated high-level disability

- homeless outreach psychiatric services, which provide specialist clinical and treatment responses tailored to people who may not engage readily with mental health services because of homelessness or insecure accommodation. The services use an assertive outreach approach to provide assessment and secondary consultation to homelessness services and other mental health workers.
- primary mental health teams, which provide advice and consultation for GPs and other primary healthcare providers regarding treatment of mental illness.

Consultation and liaison psychiatry provides mental health services to people admitted to general hospital wards who have a primary medical condition that may be associated with mental illness (for example, a person with cancer or burns may also experience problems with their mental health). Psychiatric consultation-liaison services can assist other practitioners to manage mental health problems in general hospitals and provide direct support to patients. Fourteen health services provide consultation and liaison psychiatry.

Community care units provide residential clinical care and rehabilitation services in home-like environments to support the recovery of people experiencing a severe mental illness.

YOUNG PEOPLE'S MENTAL HEALTH SERVICES (16–25 YEARS)

Youth PARCs are for young people experiencing significant mental health problems who are either leaving an acute hospital inpatient admission or who would benefit from 24-hour support to avoid a hospital admission.

Youth program – early psychosis services are for young people who are experiencing a first episode of psychosis. These services are provided statewide as a subspecialty program in specialist adult mental health services.

Orygen Youth Health provides a specialised youth mental health clinical service for young people 15–25 years old, with a focus on early intervention and youth-specific approaches.

MRS COLLINS' STORY

During admission, Mrs Collins expressed sadness and guilt when reflecting on her relationships with her children and on the distance between them. She lived alone and was estranged from her three sons. In spite of this, her eldest son visited several times while she was in the aged persons mental health unit.

Mrs Collins had been admitted with severe depression compounded by a decline in her memory and physical health at 83 years old. As the depression resolved with treatment, she began thinking about her current living arrangements. She was enjoying the socialisation and support that came with being in hospital and was interested in moving to an aged care facility.

As part of standard practice on the unit, our social worker offered her a family meeting. With her agreement, we contacted all three sons and gave them information about the meeting. The social worker explained the single-session family consultation model that she would implement As part of the model, she encouraged the family to think about what concerns and questions they wanted addressed in the meeting. She assured them that they, along with their mother, would have an opportunity to discuss these in a supported way.

The meeting was facilitated by Mrs Collins' consultant psychiatrist and a social worker, and began by acknowledging the value of each person's attendance. An agenda for the meeting was developed by inviting each family member to identify the issues that what would be most beneficial to discuss at the meeting.

Mrs Collins' sons were able to ask specific questions about their mother's depression and its treatment. Although difficult and emotional at times, family members were also able to gain a better understanding of each other's experiences, including Mrs Collins' feelings of guilt in relation to her sons.

With additional information provided about accommodation options, the sons were able to offer support to their mother in relation to her decision to enter a care facility. Feedback we received from the family indicated that they had all felt heard by the treating team and that the meeting had created an opportunity for family relationships to begin to be restored.

Mrs Collins' story is a case study provided by the Aged Persons Mental Health Team at Bundoora Extended Care Centre.

AGED PERSONS MENTAL HEALTH SERVICES (65 YEARS AND OVER)

These are specialist mental health services for people with long-standing mental illness or for those who have developed a functional illness such as depression, a mood disorder, anxiety or schizophrenia later in life.

Services include inpatient units located in general hospitals or with other aged care facilities, and specialist residential care.

Acute inpatient services provide short-term inpatient management and treatment when a person is acutely unwell. Services may be provided on a voluntary or compulsory basis.

Aged persons mental health residential services are specialist residential nursing homes and hostels providing services to people who cannot be managed in mainstream aged care because of significant and persistent cognitive, emotional or behavioural disturbance.

These services are designed to provide a familiar, home-like atmosphere, and people may remain residents for long periods of time.

Aged persons mental health community teams provide community-based assessment, treatment, rehabilitation and case management services. Services also provide support to other aged care service providers and education for consumers, families and carers.

STATEWIDE SPECIALIST MENTAL HEALTH SERVICES

There are a range of specialist mental health services that are specifically targeted to Victorians with severe and complex illnesses.

Eating disorder services are delivered by the Royal Children's Hospital, Melbourne Health, Austin Health and Monash Health. Services include intensive community-based treatment models for children, young people and adults with eating disorders, and their families, in addition to specialist beds.

Funding is also provided for:

- the Body Image and Eating Disorders Treatment and Recovery Service (BETRS), an intensive community-based program delivered in partnership between St Vincent's Health and Austin Health
- the Centre of Excellence in Eating Disorders, to provide secondary consultation and professional development to Victoria's public mental health services
- Eating Disorders Victoria, to provide support and advocacy for people with eating disorders, their families and carers.

A **personality disorder service (Spectrum)** works with local area-based clinical services to provide treatment for 16–64 year olds with a personality disorder, focusing on people who are at risk from serious self-harm or suicide and who have complex needs. Spectrum receives referrals from area-based clinical services and primary health providers such as GPs or private psychiatrists.

Mother and baby mental health services provide support for women experiencing severe mental illness in the antenatal or postnatal period. Five hospitals have specialist mother and baby units that provide a residential setting for psychiatric treatment, assessment and support for women experiencing severe mental illness and their infants aged up to 12 months.

LAURA'S STORY

I've wanted a baby my whole life, and had been anticipating Sam's arrival for so long – but I found IVF very challenging, and it left me feeling really anxious throughout my pregnancy.

Sam was born prematurely and required special care nursing for the first few weeks of his life – I'd basically prepared for him dying. In those few weeks at home on my own with Sam, I felt like we had no connection and was feeling increasingly helpless and guilty. I wanted to run away from it all and thought about suicide. I felt completely alone and like I couldn't share my struggle with anyone, even my closest family and friends.

I needed urgent treatment for postnatal depression. Sam and I spent three weeks at the Monash Medical Centre Perinatal and Infant Inpatient Unit. He was seven weeks old. I was so upset and overwhelmed. I truly doubted my ability to actually be a mother.

I started medication and received therapeutic support in a daily group program with five other mothers and babies. Almost immediately, I felt like I wasn't alone – I think I now understand the concept of 'it takes a village to raise a child'. They had 24-hour nursing staff helping me continue to care for him, including keeping breastfeeding up, which was really important to me. My family also said they learnt so much through the regular family meetings with my treating team.

After the treatment, I was linked in with the integrated community perinatal and infant community services. I could continue with the same doctors for weekly mother–infant therapy at the clinic. That sort of continuity was invaluable. It was so nice not having to tell my story all over again, and it's validating that the same team that witnessed my darkest days can really appreciate how well I am doing. Sam is doing really well, and I am feeling more and more confident. Seeing him smile back at me for the first time changed everything – that was a day I never thought I would see.

Brain disorder services are for people with acquired brain injury or neurogenerative conditions with associated psychiatric conditions. Services include inpatient, residential and community programs, outreach services and secondary consultation.

A statewide specialist **neuropsychiatry** service specialises in mental illnesses associated with disorders of the nervous system. The service is located at the Royal Melbourne Hospital.

The **Victorian Dual Disability Service** is located at St Vincent's Hospital Melbourne and works with specialist mental health services across Victoria to assess, treat and support people with a dual disability. A person with a dual disability has an intellectual disability or autism spectrum disorder, as well as a mental illness.

Dual diagnosis services aim to improve treatment outcomes for individuals who have co-existing mental health and substance use issues. Services include education and training for mental health, drug and alcohol and MHCSS staff, support to organisations to develop dual diagnosis capabilities, and clinical consultations in collaboration with primary case managers.

Aboriginal mental health services aim to improve access and the cultural appropriateness of services provided to Aboriginal people. Koori mental health liaison officers are based in rural/ regional mental health services and provide culturally appropriate support and services. St Vincent's Hospital Melbourne has five specialist Aboriginal beds in the mental health acute inpatient unit that are managed with the Victorian Aboriginal Health Service Family Counselling Service.

Victorian Transcultural Mental Health supports area-based clinical services and MHCSS to work with consumers, carers and communities from diverse cultural backgrounds. It is a non-clinical unit administered by St Vincent's Hospital Melbourne and provides education and training, clinician support through an external enquiries service, consultation and service development and research.

Torture and trauma counselling: The Victorian Foundation for Survivors of Torture ('Foundation House') provides torture and trauma counselling for Victorian adults and children who have experienced torture, persecution or war-related trauma prior to arrival in Australia. Foundation House receives direct referrals to its services and also works to improve the skills and competency of healthcare services providing other treatment and support to refugees.

Victorian Institute of Forensic Mental Health ('Forensicare') provides adult forensic mental health services including:

- Thomas Embling Hospital, a 116-bed secure hospital for people from the criminal justice system who need specialist psychiatric assessment and treatment, and patients from the public mental health system who require specialised management
- the Community Forensic Mental Health Service, providing assessment and multidisciplinary treatment to high-risk consumers referred from area mental health services, correctional providers, courts, the Adult Parole Board, Thomas Embling Hospital, prison services, government agencies and private practitioners
- specialist mental health services for men at the Melbourne Assessment Prison
- specialist mental health services for women at the Dame Phyllis Frost Centre
- a mobile forensic mental health service based at the Metropolitan Remand Centre
- psychologists at Barwon Prison and Marngoneet Correctional Centre
- psychiatric registrar clinics, nurse practitioner clinics and visiting consultant psychiatry sessions at other publicly managed prisons.

MENTAL HEALTH COMMUNITY SUPPORT SERVICES

MHCSS support people aged 16–64 with a mental illness and related psychosocial disability to develop life skills, maintain their best possible social and emotional wellbeing, meet their personal recovery goals, and participate in the life of the community.

This is achieved by providing the best rehabilitation and recovery support possible, tailored to each person's individual needs and preferences.

Services include individual support packages, youth and adult residential rehabilitation services, supported accommodation services, planned respite, mutual support and self-help services, Aboriginal mental health programs, catchment-based intake and local catchment area planning functions.

The program's core objectives are to help people manage their own mental health better, be at the centre of decision making related to their support, improve their health and wellbeing, and minimise long-term disability.

The majority of MHCSS funding is delivered in the form of individualised client support packages. MHCSS providers have the flexibility and capacity to 'package' support for individual clients according to the nature of their support needs.

The MHCSS program is designed to complement clinical treatment provided by the specialist clinical mental health service system. The MHCSS program does not provide clinical treatment or mental health counselling. These types of services are provided by Commonwealth-funded primary mental health services, community health services (counselling) and specialist public mental health services.

TRANSITION TO THE NATIONAL DISABILITY INSURANCE SCHEME

In September 2015 the Victorian and Commonwealth governments signed an agreement to roll out the NDIS in Victoria. The scheme is a national approach to providing individualised support for people with a disability, including people with psychosocial disability, their families and carers. The NDIS will provide participants with choice and control over how, when and where their supports are provided. It will also provide certainty that they will receive the support they need, when they need it, over their lifetime. The National Disability Insurance Agency (NDIA) is the national body responsible for the NDIS.

The NDIS will transform the way support is provided for Victorians with psychosocial disability. Individual client support packages, adult residential rehabilitation services and most supported accommodation services currently provided through MHCSS will transition to the NDIS over a three-year period from 2016–17. The NDIA has agreed that the eligibility criteria for these programs align with the eligibility criteria for the NDIS and has designated them as 'defined programs', meaning that existing clients will have automatic eligibility for the NDIS, provided they meet the age and residential eligibility criteria.

Clients who do not meet NDIS age and residency eligibility criteria will receive continuity of support to ensure they are not disadvantaged by the transition to the NDIS.

The NDIA and Victoria have developed an agreed process to streamline access for people on the MHCSS Needs Register. MHCSS intake service providers will actively assist people on the MHCSS Needs Register to prepare for the NDIS access process.

'I hope that we achieve truly coordinated service provision with hospitals and mental health community support services and NDIS services working together.'

Glen Waverley Public Workshop, 12 August 2015

VICTORIA'S MENTAL HEALTH WORKFORCE

Delivering effective mental health services depends on a skilled, sustainable and experienced workforce.

Victoria's clinical mental health workforce comprises psychiatrists, other medical practitioners, nurses, clinical psychologists, social workers, occupational therapists, consumer and carer workers (including peer support workers), managers and administrative staff (see Table 2).

The MHCSS workforce is smaller and draws on a different mix of disciplines. The MHCSS workforce includes direct-care staff, accommodation and residential support staff, outreach staff, and community development staff. The NDIS will be the main vehicle for funding and accessing psychosocial disability support services in Victoria in future, and it is anticipated that this will result in a different workforce profile over time.

Table 2: Victoria's clinical mental health workforce, 2012–13 to 2014–15[14]

Workforce type	2012–13	2013–14	2014–15
Psychiatrists, registrars and medical officers	704	734	771
Nurses	3,727	3,877	4,028
Allied health professionals	1,299	1,381	1,404
Administrative and clerical staff	493	459	546
Consumer workers	19	16	19
Carer workers	19	18	19
Domestic staff	173	161	152
Other personal care staff	233	237	214
Total	**6,667**	**6,882**	**7,153**

Peer support workers at St Vincent's Hospital Melbourne (L–R: Donna Matthews, Liam Buckley and Laura Anstee)

RESEARCH

Victorian researchers are international leaders and collaborators in diverse mental health research including women's mental health, suicide, pathways to care, epidemiology and psychosocial support.

The Victorian Government supports this work through funding a range of mental health research activities including research projects, mental health academic positions and research institutes.

The **Mental Illness Research Fund** is a $10 million fund that currently supports five research collaborations in the following areas:

- a values-based approach to recovery in a catchment area
- e-mental health (two projects)
- co-design for psychosocial recovery
- a recovery model for parents with a severe mental illness.

These are due to conclude in 2018.

Mental health clinical academics are clinicians, consumers or carers who have an academic role within a university and a senior role within specialist mental health services. About 30 positions are fully or partly funded across the state, and these academics are involved in research, practice and quality improvement, and teaching. These roles are also important for the recruitment and retention of leading practitioners in a range of areas.

The Florey Institute of Neuroscience and Mental Health's research focus includes psychiatric conditions such as depression, bipolar disorder and schizophrenia, and neurodegenerative illnesses including Alzheimer's disease and Parkinson's disease.

INFORMATION, ADVICE AND ADVOCACY

The Victorian Government also provides funding to a range of organisations that play an important role in system development, mental health promotion, advice and advocacy.

VICSERV is the peak organisation representing community-managed mental health services in Victoria.

Tandem (previously known as the Victorian Mental Health Carers Network) is the peak organisation for carers of people in Victoria who experience mental illness.

The **Victorian Mental Illness Awareness Council** is the peak organisation for people in Victoria who experience mental illness.

A number of other organisations receive funding to support this vital work, including beyondblue, the Reach Foundation and Eating Disorders Victoria.

4

THE YEAR IN REVIEW – PUBLIC MENTAL HEALTH SERVICES IN 2015–16

4. THE YEAR IN REVIEW – PUBLIC MENTAL HEALTH SERVICES IN 2015–16

OVERVIEW

While some Victorians need assistance with a major crisis or illness just once in their lives, others need ongoing treatment or support.

More than 67,000 people accessed Victoria's clinical mental health services as registered clients during 2015–16. The total number of people accessing MHCSS during 2015–16 was 12,354.

CLINICAL MENTAL HEALTH SERVICES

WHO ACCESSED OUR CLINICAL SERVICES?

In 2015–16, 67,555 people (or 1.1 per cent of the population) accessed Victoria's clinical mental health services as a registered client. New clients (defined as people who have not accessed services in the preceding five years) made up 36 per cent of people accessing services, while approximately 14 per cent of registered clients have accessed the clinical mental health system at least once a year for each of the past five years.

The majority of registered clients were adults, with children, adolescents and older Victorians making up smaller groups. Just over half (50.5 per cent) were women, while nearly 35 per cent lived in rural areas.

A NOTE ON TERMINOLOGY USED IN THIS CHAPTER

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 chapter involves registered clients.

However, a substantial proportion of community mental health services are provided to people who are not registered. In 2015–16 more than 15 per cent of community contact service hours in Victoria were with people who were not registered clients. Circumstances where a client is seen but not registered include the assessment of referred clients when the clinician determines that ongoing specialist public mental healthcare is not required.

This section also refers to 'separations'. The term 'separation' is a way of describing the number of times people require bed-based care.

In order 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.

67,555
registered clients

1.1%
of population

50.5%
women

13.9%
CALD

2.3%
Aboriginal or Torres Strait Islander

34.8%
rural

SUPPORT FOR ALL VICTORIANS

Aboriginal Victorians

Aboriginal people make up 0.9 per cent of the Victorian population[15] but formed just over two per cent of the registered clients who accessed clinical mental health services.

Overall, this data suggests that Aboriginal people are overrepresented in our clinical services when compared with their overall representation within the Victorian population. Nationally, Aboriginal and Torres Strait Islander people have a mental health-related separation rate with specialised psychiatric care that is almost double that of other Australians. This is why the development of an Aboriginal social and emotional wellbeing framework for Victoria is so important.

Victorians with culturally and linguistically diverse backgrounds

Victoria is one of the most culturally diverse societies in the world, with one-quarter of our population born overseas.[16] Victoria settles more refugees than any other Australian state or territory. Our data, however, suggests that people from culturally and linguistically diverse (CALD) backgrounds are underrepresented in Victoria's clinical mental health services. That is, usage of mental health services by CALD Victorians is low when compared with their representation in the Victorian population.

Current data does not provide enough information about CALD Victorians. We know that more than 23 per cent of Victorians speak a language other than English at home.[17] CALD Victorians formed only 14 per cent of the registered clients who accessed clinical mental health services in 2015–16.

ABORIGINAL MENTAL HEALTH PROGRAM AT THE NORTHERN AREA MENTAL HEALTH SERVICE (NAMHS)

We are working on increasing access to culturally sensitive mental healthcare for Aboriginal and Torres Strait Islander people in Melbourne's northern suburbs. Working in collaboration with the Victorian Aboriginal Health Service (VAHS), in particular the Family Counselling Service, has demonstrated very clearly to us that mainstream mental health services can make changes to decrease barriers.

Dr Sabin Fernbacher
Aboriginal Mental Health Coordinator

The creation of an Aboriginal Mental Health Liaison Officer position based at the psychiatric inpatient unit has had a great impact. Michelle assists Aboriginal people to feel more comfortable and welcome. In turn, our staff learn from Michelle about cultural sensitivity and safety.

Over time, we've developed pathways of care, which means that Aboriginal people move smoothly from the psychiatric inpatient unit into other parts of the service such as the subacute PARC or the community care unit.

Aboriginal people who were homeless prior to admission at NAMHS are introduced to Wadamba Wilam ('Renew Shelter', a collaboration and consortium between us, VAHS, Neami National and ReGen). This is a specialised service that supports Aboriginal people with long-term mental illness who are homeless. The staff will begin to work with the person while they are in the inpatient unit and continue with them following discharge, providing a high level of continuity and the opportunity to easily regain access to any of the services, including the inpatient unit.

The number of Aboriginal people accessing all types of services at NAMHS has increased. We've also opened up direct referrals to and from VAHS, which has further increased options and referral pathways for Aboriginal people. NAMHS has been able to do this work with strong and unwavering support by VAHS and the willingness of all collaborating organisations to work together in order to provide better care for Aboriginal people.

> **'We want Aboriginal people and other culturally diverse groups to be supported in our mental health system and when they are navigating our system.'**
>
> *Ballarat Consumer and Carer Workshop, 20 August 2015*

Of the clients born overseas (excluding English-speaking countries), the largest groups included Victorians born in Italy, Vietnam, Greece, India and China. These countries of birth reflect Victoria's largest and more established migrant communities, as well as groups where translators are most commonly available to assist with access to, and understanding of, information and services.

New arrivals and people from Victoria's emerging CALD communities may be especially underrepresented in our services. We know that people from humanitarian and refugee backgrounds experience significant systemic barriers to full community and economic participation and are – for a range of complex reasons – disproportionately disengaged from all mainstream services, including health services.[18]

WHAT CLINICAL SERVICES DID PEOPLE USE?

In 2015–16:

- 10,472 registered clients accessed our CAMHS for children and young people aged 0–18 years
- 52,684 registered clients accessed our adult mental health services for people aged 16–64 years
- 8,112 registered clients accessed our aged mental health services for people aged 65 years or older
- 1,782 registered clients accessed specialist services such as mother and baby units, Aboriginal mental health services and personality disorder services
- 699 registered clients received treatment and support from our forensic mental health services.

Each year, some registered clients access clinical mental health services from multiple age or service streams. For example, a registered client aged 16, 17 or 18 years old might access both CAMHS and adult services. Forensic clients can also be adult or aged clients. As such, the sum of registered clients listed separately here is greater than the total number of registered clients who accessed clinical mental health services during 2015–16.

HOW WERE PEOPLE REFERRED TO OUR CLINICAL SERVICES?

Most people were referred to clinical mental health services by hospitals (including emergency departments) (42 per cent), GPs (13 per cent), or their families (eight per cent) (see Figure 4).

Figure 4: Source of mental health referrals, 2015–16*

- 🟧 Emergency department
- 🟦 Acute health
- ⬛ Other
- 🟩 General practitioner
- 🟥 Family
- ⬛ Community health services
- 🟧 Client/self
- 🟦 Police
- 🟩 Other health practitioners (private)
- 🟥 Accommodation service
- ⬜ Unknown
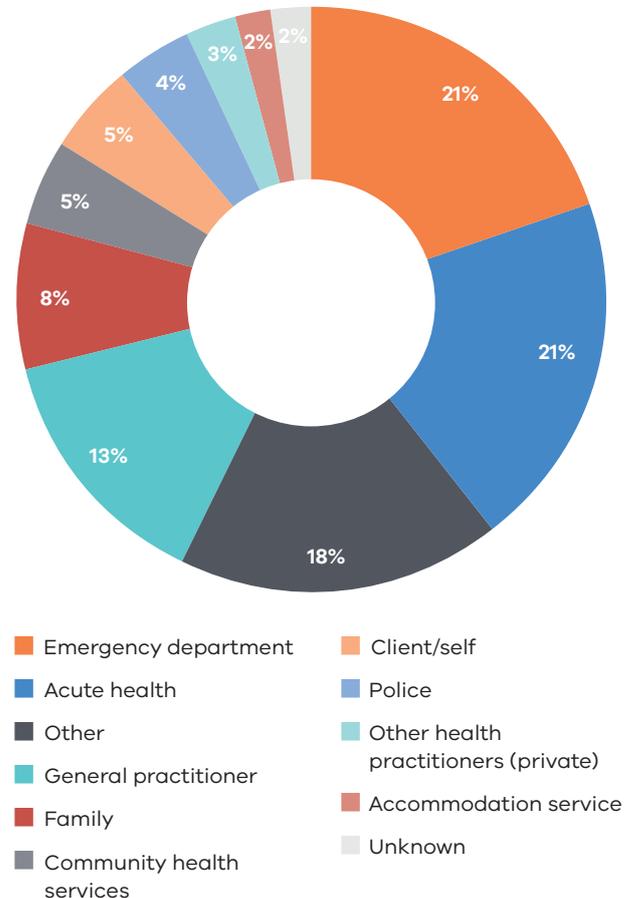
* Figures total more than 100% due to rounding.

There were 51,639 mental-health-related emergency department presentations in 2015–16, an increase of nine per cent from 2014–15. Over the last three years, increases were evident in the number and rate of emergency department presentations for children and adolescents, adults and aged persons.

Across all age groups, there were 23,664 admissions to mental health acute inpatient units in 2015–16, representing two per cent of total hospital admissions during the year. Of these admissions, 52 per cent were compulsory. Compulsory treatment is explained later in this chapter.

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

If at all possible, children and young people (like adults and older people) receive clinical treatment in the community. As such, most are seen in community-based services, but a small proportion of children and young people in Victoria require inpatient treatment for mental illness.

In 2015–16 there were 10,472 registered CAMHS clients and 1,763 CAMHS hospitalisations. Almost 17 per cent of inpatient admissions to hospital were compulsory.

The 28-day readmission rate for CAMHS was 17 per cent in 2015–16 and has been decreasing over the past three years. This is a relatively high rate compared with other age groups and possibly reflects the severity of illness experienced by some young people. Many people with psychotic disorders experience their first episode before they turn 25. It may also reflect health service practice in relation to trialling of discharge for a child or young person.

The trimmed average length of stay (≤ 35 days) for most CAMHS inpatients was 7.5 days in 2015–16. Inpatients who stayed longer than 35 days accounted for eight per cent of all CAMHS bed days.

Bed occupancy was 64 per cent, and there has been an overall downward trend over the past three years. CAMHS services are less widespread than adult services, and the decrease in bed occupancy may reflect geographic factors, treatment in the least restrictive environment and the desire to support and maintain the child or young person's connections to family, school and community.

Community contacts are a key part of CAMHS work. Community contacts may involve activities such as assessment and treatment, adolescent day programs or intensive outreach for young people. CAMHS teams often involve parents and siblings, as well as schools, in supporting a young person. In 2015–16 there were 275,782 community contacts.

CAMHS community contacts reduced in 2015–16 from the previous year but overall have risen significantly in recent years. National data suggests a significant increase in service use by children and young people with mental disorders in Australia between 1998 and 2014, across a wide range of services.

10,472
CAMHS clients

275,782
community contacts

ADULT MENTAL HEALTH SERVICES

52,684
adult clients

Inpatient services

In 2015–16 there were 18,684 hospitalisations of adults for mental illness in a public hospital.

People aged 26–35 accounted for 23 per cent of admissions. Those aged 36–45 had a similar proportion, accounting for 22 per cent of admissions. The most common diagnoses were schizophrenia and mood disorders such as depression or bipolar disorder. Fifty-eight per cent of hospitalisations were compulsory admissions (that is, people were admitted for compulsory treatment).

Our services are under significant pressure to meet demand. Between 2007–08 and 2015–16, the number of clients admitted to adult acute mental health inpatient services increased on average by four per cent per annum. In the past two years (2014–15 and 2015–16), admissions increased by five per cent and nine per cent respectively, with even higher increases above the state average in outer suburban growth corridors.

These sorts of increases are above what we could reasonably expect as a result of population growth. A substantial proportion of this increase is attributable to people with substance abuse issues, such as methamphetamine (ice) use.

On average, adult inpatient services were operating at 95 per cent occupancy throughout the year. The majority of people (58 per cent) had contact with a community service before they were admitted to hospital.

The trimmed average length of stay (≤ 35 days) for most adult inpatients was 9.6 days. This has been decreasing marginally over the past three years. People who stayed longer than 35 days accounted for 10 per cent of all adult inpatient bed days.

Consumers, families and carers can struggle to access treatment early in an episode of illness and say that treatment is often only accessible when a person with a mental illness has become acutely unwell. This is not ideal for the individual, family or community, especially when we know that relapse results in compounding disability.

Our data indicates that people may need better support to safely transition out of hospital and into the community. While the post-discharge follow-up rate is high (at 86 per cent), 15 per cent of people were readmitted to an inpatient service within 28 days of discharge. Readmission within 28 days may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was not adequate to support the person returning home. Pressure on beds may result in shorter-than-optimal hospital stays and a higher risk of relapse and readmission.

Clinical mental health services delivered in the community

1,400,106
community contacts

These clinical services include assessment, treatment, support and other services to consumers in the community. Community contacts for adults have reduced – a total of 1,400,106 community contacts were recorded during the year, down from 1,485,933 community contacts recorded in 2013–14.[19] Fifteen per cent of adult clients receiving treatment in the community were on community treatment orders (CTOs), a decrease from 17 per cent in 2013–14 (CTOs are explained on page 46).

Prevention and recovery care

Although they are a relatively small element of the service system, PARC services are steadily growing, with 3,252 separations in 2015–16. The bed occupancy rate was 77.9 per cent, and occupied bed days increased from 54,348 in 2013–14 to 63,526 in 2015–16. These short-term services in residential settings generally provide 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.

Adult residential services

Residential services provide home-like environments for people with mental illness. There were 672 separations from community care units (CCUs) in 2015–16, and bed occupancy has fluctuated in recent years. There were 96,590 occupied bed days in CCUs in 2015–16, resulting in an average occupancy rate of 74.2 per cent. Some CCUs are now 30 years old and require updating and refurbishment to meet current standards. Consumers also have more choice in relation to complex care packages in the community, which can support people to stay in their own homes.

Other specialist residential services include accommodation for people with borderline personality disorder and brain disorders.

Secure extended care units

Demand for secure extended care is also increasing. There were 200 separations from SECUs in 2015–16, up from 170 separations in 2013–14. In part, this reflects new beds becoming available in the system. Occupied bed days have been stable over the same period, resulting in an average occupancy rate of 76.9 per cent.

AGED PERSONS MENTAL HEALTH SERVICES

8,112
aged clients

Over the past three years, the number of registered clients accessing aged persons mental health services slightly decreased. Despite this downward trend, Victoria's ageing population is likely to increase demand for aged persons mental health services. Our efforts to address the current and future demand challenges faced in CAMHS and adult services also need to be reflected in planning to meet current and future demand for aged services.

In 2015–16 there were 2,280 hospitalisations of Victorians into aged acute inpatient services. Sixty-five per cent had had preadmission contact with the service. On average, aged persons inpatient units were operating at 85 per cent occupancy throughout the year. Seven per cent of registered clients were readmitted to an inpatient service within 28 days of discharge. The post-discharge follow-up rate was 90 per cent.

Some 46 per cent of admissions were compulsory. This reflects a broader downward trend in the number of aged compulsory admissions. The trimmed average length of stay (≤ 35 days) for most people was 16 days, which has been relatively stable over the past three years. People who stayed more than 35 days accounted for 25 per cent of all aged persons bed days.

Aged care residential services (hostels and nursing homes) are provided for people with high levels of persistent cognitive, emotional or behavioural disturbance. For these services, there were 206 separations in 2015–16, and the bed occupancy rate was 89 per cent.

A wider range of community-based care options has contributed to older people delaying entry into public residential aged care services. Occupancy has also been reduced by planned refurbishments of facilities to improve amenity for residents.

There were 219,423 community contacts involving aged persons in 2015–16. Community contacts may involve assessment, treatment and intensive support.[20]

219,423
community contacts

FORENSIC MENTAL HEALTH SERVICES

In 2015–16 there were 699 registered forensic clients. Community contacts increased to 17,863 (from 10,558 in 2013–14), as did service hours to forensic clients in the community at 10,522 (from 8,311 in 2013–14).
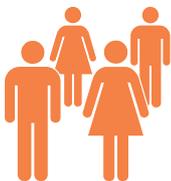
699
forensic clients

SECLUSION AND RESTRAINT

Seclusion involves a person being confined alone in a room or area from which it is not within their control to leave. Reducing or, if possible, eliminating seclusion is a national safety priority. Bodily restraint, including physical and mechanical restraint, involves methods that prevent a person having free movement of his or her limbs. Bodily restraint and seclusion may only be used after all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable.

A number of measures to reduce restrictive practices have been implemented over the past few years and, as a result, inpatient seclusion has reduced. Overall, the rate of seclusion in inpatient units per 1,000 occupied bed days reduced, from 9.8 in 2013–14 to 9.1 in 2015–16.

Definitions and reporting requirements in relation to restraint changed following the introduction of the 2014 Mental Health Act, making it difficult to compare with data prior to 2014. The rate of bodily restraint in inpatient units during 2015–16 was 25.6 per 1,000 bed days.

REPORTABLE DEATHS

The death of any person receiving treatment or support for a mental illness is a tragic event. All publicly funded mental health services are required to notify Victoria's Chief Psychiatrist of a client's reportable death within the meaning of section 4 of the *Coroners Act 2008*. This includes:

- any inpatient death at a designated mental health service, regardless of legal status under the Act, cause or location of death
- the death of any compulsory, security or forensic patients
- the death from any cause of a person in the community on a non-custodial supervision order under the *Crimes (Mental Impairment and Unfitness To Be Tried) Act 1997.*

Services are also required to report the unexpected or unnatural death of a patient in the community or within three months of discharge from an inpatient service.

In 2015–16 publicly funded mental health services reported 376 deaths to the Chief Psychiatrist. The death of a patient in an inpatient unit must also be referred to the department's sentinel events program, to enable review and to identify any systemic factor that might be relevant in each case. More detailed analysis and reporting of deaths in publicly funded mental health services is contained in the *Chief Psychiatrist's annual report 2015–16.*

COMPULSORY ASSESSMENT AND TREATMENT

In 2015–16, 52 per cent of total inpatient admissions were compulsory and 11 per cent of community treatment was on a compulsory basis. The rate of compulsory inpatient admissions has remained relatively stable over the past three years.

Treatment orders are made where a person with a mental illness needs immediate treatment to prevent serious deterioration in their mental or physical health, or to prevent serious harm to the person or any other person. Compulsory treatment is governed under the Mental Health Act.

Compulsory assessment and treatment should only be used where there is no less restrictive means reasonably available to enable the person to receive the immediate treatment they need. The Mental Health Act includes a number of safeguards to ensure assessment and treatment are provided in the least restrictive way possible, with voluntary assessment and treatment preferred.

There are three types of orders:

- **assessment orders** – made by a registered medical practitioner or mental health practitioner that enable an authorised psychiatrist to examine a person
- **temporary treatment orders** – made by an authorised psychiatrist for a maximum of 28 days
- **treatment orders made by the Mental Health Tribunal** – which can only be made if a person is already on a temporary treatment order and requires compulsory treatment beyond 28 days.

Orders can be for inpatient or community assessment/treatment.

In relation to prisoners who require compulsory treatment for mental illness, a secure treatment order can be made by the Secretary of the Department of Justice if satisfied by a report of an authorised psychiatrist that the criteria for compulsory mental health treatment apply.

MENTAL HEALTH COMMUNITY SUPPORT SERVICES

WHO ACCESSED MHCSS?

In 2015–16, 12,354 Victorians accessed MHCSS. The majority were adults, with about two per cent aged under 15 and around five per cent aged 65 or over.

12,354
MHCSS clients

More women than men accessed MHCSS (55.3 per cent). Just over two per cent of people who accessed MHCSS were Aboriginal and 4.4 per cent were from CALD backgrounds.

HOW DID PEOPLE ACCESS MHCSS?

The catchment-based MHCSS intake service provides a single access point to MHCSS for people experiencing a psychiatric disability. This service provides an initial screening assessment for all prospective (new and re-entering) clients to determine eligibility for MHCSS, as well as priority of need, for the following MHCSS program types: individualised client support packages, youth residential rehabilitation services, adult residential rehabilitation services and supported accommodation services.

In 2015–16 the MHCSS intake service screened just over 5,000 people across Victoria.

The rate of allocation to an MHCSS program for people assessed as eligible trended down in 2015–16. Subsequently, the number of people on the Needs Register is trending up. An estimated 1,200 people are currently on the MHCSS Needs Register across the state. People are prioritised on the basis of need.

People with the highest need (priority 1 category) wait four to eight weeks on average for MHCSS. The current waiting time for people in the priority 2 and 3 categories (around 80 per cent of all people on the Needs Register) is a minimum of eight months in all catchments. MHCSS intake providers make at least one contact per week with priority 1 clients and one contact per month with priority 2 and 3 clients to monitor their status and wellbeing.

WHAT SERVICES DID PEOPLE ACCESS?

Individualised client support packages

In 2015–16, 6,026 clients received an individualised client support package (ICSP). ICSPs assist people to learn or re-learn skills and develop confidence for independent living. People are also supported to better cope with and manage their mental illness and to achieve healthy, functional lives. ICSPs are delivered through 14 lead agencies across Victoria. ISCP providers work closely with health services to improve outcomes for their shared clients.

ICSP providers also work with individuals and their families or carers to achieve broader personal goals that are meaningful to them. These include developing social connections and relationships, improving physical health, engaging with education, vocational training and employment, addressing alcohol and drug issues and achieving housing security.

6,026
clients received individualised support packages

Other services

Clients can access more than one service over time; for example, some clients move from an accommodation service with 24-hour support to a non-24-hour service (or vice versa). Hence client counts are listed separately for these services. Residential services with non-24-hour support often provide transitional accommodation with rehabilitation support, as a client moves towards living independently in his or her own accommodation.
In 2015–16:

- 179 clients accessed a youth residential rehabilitation service (non-24-hour service), with total occupied bed days of 45,816
- 72 clients accessed an adult residential service (24-hour support), with total occupied bed days of 19,075
- 66 clients accessed an adult residential service (non-24-hour service), with total occupied bed days of 16,103
- 37 clients accessed a supported accommodation service (24-hour support), with total occupied bed days of 16,539
- 27 clients accessed a supported accommodation service (non-24-hour service), with total occupied bed days of 9,505
- 323 clients accessed in-home planned respite services, which assist in providing short-term respite at home
- 113 clients accessed a residential planned respite service
- 1,279 individuals accessed mutual support and self-help services.

5

HOW DO OUR SERVICES MAKE A DIFFERENCE IN PEOPLE'S LIVES?

5. HOW DO OUR SERVICES MAKE A DIFFERENCE IN PEOPLE'S LIVES?

Under *Victoria's 10-year mental health plan*, we want to ensure that Victoria's public mental health services make a positive difference in people's lives by providing person-centred, recovery-oriented and family-inclusive care.

This chapter describes some of the ways our services are working to improve outcomes and experiences for people with mental illness, their families and carers. It explains supported decision making, including advance statements, nominated persons and the recently established Independent Mental Health Advocacy service.

It also outlines the increasingly important role of peer support workers in our services, and the expansion of post-discharge support.

Importantly, this chapter includes some powerful stories written by people who use our services. These are deeply personal accounts of courage, recovery, resilience and hope.

The principles in Victoria's Mental Health Act place people with mental illness at the centre of decision making about their treatment and care.

The Act also establishes robust safeguards and oversights to protect the rights, dignity and autonomy of people living with mental illness. These include the Mental Health Complaints Commissioner, the Mental Health Tribunal, Community Visitors and the Chief Psychiatrist.

PROMOTING WELLBEING AND RECOVERY

Supporting people to build and maintain a sense of personal identity and to define what a satisfying life means to them, regardless of whether they experience ongoing symptoms of mental illness, is central to recovery-oriented practice in mental health services.

We want to see our mental health services promoting wellbeing and personal recovery for people experiencing mental illness.

Personal recovery does not necessarily mean that a person no longer experiences symptoms of mental illness. It is distinct from clinical recovery, which is generally defined by mental health professionals and refers to a reduction or cessation of symptoms and 'restoring social functioning'.

While recovery is understood as a unique personal journey that belongs to individuals, mental health professionals can practise in ways that encourage and support people's recovery journeys and improve their experiences of mental healthcare.

THE SKY AND THE CLOUDS

For a long time, I've been in recovery. It has been a slow process of taking each day as it comes, being ready for the inevitable setbacks, and, little by little, learning to trust myself. I remind myself that having come this far is in part a testament to my inner strength.

Regardless of where you are along your recovery journey, it has taken strength and courage to come as far as you have.

We carry so many identities. We are mothers, doctors, sons, free spirits, sisters, boyfriends, lawyers, artists and teachers. Some of us are in recovery from an eating disorder or another mental health problem. For a long time, I have defined myself by my recovery. Now, I feel like a butterfly that has just begun to break free of its chrysalis. I am sitting on the branch, wings damp and folded, feeling the air breathing against my skin. I am ready to say that I have recovered.

Recovery has been a process of finding meaning again. All the time, the horizon is shifting. I can see further now than the next meal, the next day, the next year.

Letting go of recovery is scary. It brings up a lot of questions and a lot of uncertainties about the future. I am trying to focus on those parts of myself that haven't gone away. Perhaps they got lost for a little while, but they were always there, beneath the surface, ready for when I needed them. I've been able to rediscover my creativity, my sensitivity and my love for home and family. I'm also trying to think about the things I want to do and who I want to become.

I won't lose sight of my past, but neither will I let it stand in the way of my future.

It can take a long time to accept that recovery may not look the way your life was before you became unwell. For one thing, you're older. You like different things, you have different goals, and perhaps life seems less simple. I had to grieve for the little girl I used to be, because I will never be able to see the world in the uncomplicated way that she could.

For another, you have discovered untapped wells of strength, compassion and deep understanding within yourself. You're more complicated than you were before but also more aware. Shadows are deeper but the sun is brighter. I choose to embrace the woman I am now, and recognise that I can bring about positive change in my own life and hopefully the lives of others.

Imagine yourself as the sky. Your eating disorder, or whatever challenges you face, are the clouds. Sometimes, we have grey days where the sky is blocked out for a little while, but always, always it is there.

The clouds can't exist without the sky, but the sky doesn't need the clouds. You are more than your challenges, and you can remind yourself that they are, and will always be, smaller than you.

We are sufferers and we are strong. We are both of these things, and we will be so much more. My experience has given me the courage to look beyond it.

Emily

THE PUPIL BECOMES A TEACHER

Recently I was invited to participate in the Mind Recovery College as a facilitator in the Food and Mood program. My whole experience at the Recovery College has been a positive one where I have felt a sense of empowerment that comes with self-directed recovery.

Through participating in the group sessions on offer I have felt comfortable in sharing aspects of my journey to recovery in a non-judgemental environment. I have felt supported and validated in a way that I have not experienced in many years in clinical settings as both an in- and outpatient. There is a totally different feel to the college and a sense of equality in having facilitators with lived experience. Just knowing everyone there is on a recovery journey contributes to the sense of shared experience and growth. It felt very natural to become involved in facilitating, and the kind words of support and encouragement from other students at the college was a big plus.

While it can at times be a little confusing learning how the place runs behind the scenes, the camaraderie and support from the staff and other facilitators keeps me going. In particular, the sense of hope that I can help and teach others what I have learned from my own recovery and conversely learn from those attending the groups is very encouraging. Learning to think on my toes again and overcome past fears and anxieties of talking in front of groups has melted away. My confidence in my abilities and people skills has been boosted by this whole experience.

Self-directed recovery has not always been an easy road. I have achieved a greater sense of self-reliance, self-mastery and self-control by becoming a facilitator, and I feel more positive that more opportunities like this will open up for me in the future. More important than that, my self-belief has returned in a way that four months ago I never could have anticipated, in a role I never could have imagined.

It is with much gratitude that I reflect on my time at the Mind Recovery College. My journey is leading me to help, teach and inspire others to reach within themselves to find their own unique pathway to recovery.

Mind Recovery College participant

> **'A person's self-determined goals and self-defined recovery are of huge importance.'**
>
> *Submission via www.mentalhealthplan.vic.gov.au*

Contemporary mental healthcare emphasises three principles:

- **Recovery-oriented practice** recognises that people with lived experience are experts on their own lives, while mental health professionals are experts on available treatment services. Recovery empowers people to make decisions and to be involved in their own care.
- **Trauma-informed care** is sensitive to and understanding of trauma-related behaviours that serve as coping and survival mechanisms for many people experiencing mental illness.
- **Supported decision making:** people are supported to make decisions about their assessment, treatment and recovery.

Victoria's framework for recovery-oriented practice describes an approach that involves:

- promoting a culture of hope
- promoting autonomy and self-determination
- collaborative partnerships and meaningful engagement
- a focus on strengths
- holistic and personalised care
- family, carers, support people and significant others
- community participation and citizenship
- responsiveness to diversity.

Organisational examples of recovery-oriented practice include:

- documentation of people's preferences
- peer-run programs and services
- integration of peer support workers within the mental health workforce
- working in partnerships with consumer and carer organisations
- models of care compatible with a recovery approach, such as strengths-based approaches and individual recovery planning.

SUPPORTING FAMILIES AND CARERS

Caring for and supporting a loved one experiencing mental illness can be challenging – and at times distressing and stressful – for families and significant others.[21]

We recognise that supporting families and carers is vital to a person's personal recovery, as well as for family and carer wellbeing. We expect mental health services to involve carers in key decisions about assessment, treatment and recovery wherever possible and appropriate.

Having access to information, practical support and the opportunity to share personal experiences with other carers can make a big difference to families and carers. Families and carers need better information from the department and mental health services on how to access practical assistance and support, treatment options, and how to best support someone who is experiencing severe mental illness.

FAMILIES WHERE A PARENT HAS A MENTAL ILLNESS

The FaPMI program, initially launched in 2007, aims to reduce the impact of parental mental illness on all family members through timely, coordinated, preventative and supportive action within adult mental health services. The FaPMI program will be expanded across Victoria in 2016–17.

> **'The Carer Support Fund gives people that lift, that weight off their shoulders, lifts their self-esteem.'**
>
> *Sharon Lavery, Carer Consultant, Ramsay Health*

CARER SUPPORT PROGRAM

The Mental Health Carer Support Program includes a range of services designed to support carers in their caring relationship and provides assistance and information about:

- carer consultants located in mental health services across the state including adult, aged persons and CAMHS services
- mutual support and peer-based self-help programs providing support groups, education, counselling and information to carers
- the Mental Health Carer Support Fund (see box below)
- planned respite support for carers
- carer support workers located in Commonwealth Carelink Centres or Carer Respite Centres.

> **The Mental Health Carer Support Fund (CSF) aims to meet people's needs to perform their caring role, promote and sustain the caring relationship, and improve carer wellbeing.**
>
> During 2015–16 the CSF assisted families and friends of people with mental illness with a range of costs, alleviating some of the emotional and financial impact of their caring roles.
>
> In one recent case, the CSF provided fuel vouchers and accommodation for five nights for a family member to travel and be with a person who required treatment at a regional centre, five hours' drive from their home.
>
> Claims funded by the CSF, however small – perhaps $50 to cover a tank of petrol – can make a huge difference in the lives of people caring for loved ones.

CONSUMER AND CARER INVOLVEMENT IN POLICY AND PRACTICE

Consumers and carers are actively involved in the governance, planning, development and evaluation of public mental health services in Victoria. This hasn't always been the case. Consumers and carers have worked hard to have their voices heard about how services that directly affect their lives can be improved.

The consumer and carer workforce has an increasingly important role in Victorian mental health services. The consumer and carer workforce comprises individuals with lived experience as mental health consumers or carers who are employed in mental health services as consumer or carer advocates, consumer or carer consultants, peer support workers or mentors, academics, educators, managers and leaders.

All Victorian clinical and non-clinical mental health services can nominate consumer and carer workforce members to engage directly with government to influence policy and practice. The department co-chairs Consumer and Carer Partnership Dialogues with the respective consumer and carer peak bodies, the Victorian Mental Illness Awareness Council and Tandem to facilitate collaboration across government and the consumer and carer workforces.

Five meetings were held for each of the Consumer and Carer Partnership Dialogues during 2015–16. These dialogues enable us to collaborate with consumers and carers to identify priority issues, drive change and influence and inform the implementation of mental health initiatives.

GRACE'S STORY

I'm a 27-year-old mum with a mental illness. I am married to a wonderful husband and we have three beautiful children who are 10, eight and three years old. I've had mental health problems since I was a teenager. Over the years, I've been diagnosed with depression, anxiety, eating disorders, borderline personality disorder and bipolar disorder. The biggest challenges for me have been feeling isolated and lonely because people don't always understand, being ashamed of my diagnosis, dealing with stress, money and housing issues, juggling parenthood, side effects from medications (!), finding a good psychiatrist, and dealing with the public hospital system.

For many years I dealt with this on my own until I met an amazing social worker who knew the mental health system and was able to help me. This changed everything. For the first time I felt that I had people to talk to that understood and could help my journey to recovery. Having people on my side made the biggest difference to me and my whole family.

Some services that have supported our family have been the Mental Illness Fellowship, CHAMPS (a program that supports kids who have a family member with a mental illness), support groups where you can meet and have coffee with other people who have mental health problems and understand you, the FaPMI fun day (a free day where our kids play and have awesome activities – we look forward to it each year!), and having a great psychiatrist/psychologist to talk to.

Some things I have found helpful over the years are learning to ask for help when you need it (and accepting help from others), knowing your limitations, learning to say 'no' if you're unwell and you are unable to do it (I'm still working on that one…), not to be ashamed of mental illness (it is not a sign of weakness) and accepting yourself and where you're at. I think, for myself, accepting my diagnosis and learning to live with that is a real struggle for me and I find that it is a daily thing which I am working on.

To everyone reading this and if you're struggling to keep going, just remember it's OK to ask for help! This has been my biggest breakthrough and if you have someone advocating for you and supporting you there is a light at the end of the long tunnel.
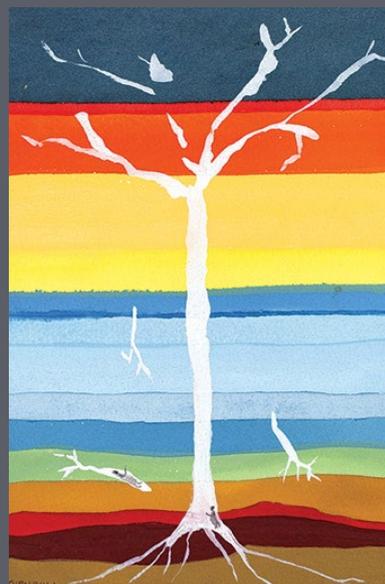
Elizabeth Turnbull, *Tasmania,* 2003
Courtesy of The Cunningham Dax Collection

PEERZONE AT THE INNER WEST AREA MENTAL HEALTH SERVICE

We are the facilitators of PeerZone at Inner West Area Mental Health Service. We are unique, being the only clinical mental health service in Victoria delivering PeerZone.

PeerZone is a series of workshops facilitated by two trained peer support workers who have a lived experience of mental distress. There are group discussions, activities in small groups, art and craft for those so inclined, short videos and music. There is an informal, relaxed feeling to the workshops, and each participant is free to contribute as much or as little as they want. There is also a sense of camaraderie and friendship that develops among the group. In a nutshell, PeerZone helps develop resilience, self-awareness and practical life skills.

PeerZone is growing internationally and was created by mental health leader Mary O'Hagan, who has a lived experience of mental distress.

Our experience facilitating these groups has been profound. Having a dedicated peer space where people can come to connect and learn from each other has been great, and the groups always grow together as we explore each workshop's content. The workshops are straightforward to run, catering for all learning styles and all stages of recovery. We as facilitators are on the journey together as we embark on a parallel process of self-discovery.

Marty Janssen and Donna Matthews
Peer Support Workers
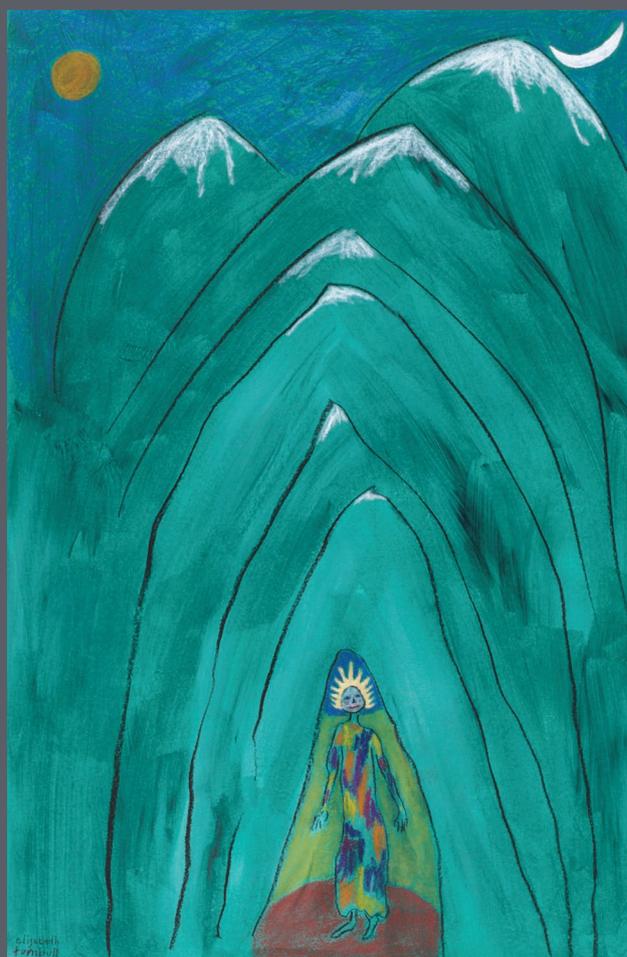
Elizabeth Turnbull, *Untitled*, 2012
Courtesy of The Cunningham Dax Collection

> **'From a service perspective, I don't know how we ever managed without these amazing staff members – it fills a huge gap in our service and I'm eager for further expansion.'**
>
> *Bridget Organ, Manager, St Vincent's Mental Health Melbourne, 12 July 2016*

THE ROLE OF PEER SUPPORT WORKERS

PEER SUPPORT WORKFORCE

Peer support workers are people with lived experience of mental illness or caring for someone with a mental illness who provide support, practical assistance and other guidance or information to people accessing mental health services. Peer support workers operate with, and alongside, other specialists who make up clinical mental health teams (such as psychiatrists, nurses, social workers, psychologists and occupational therapists).

The discipline and specialisation of peer support is not based on traditional diagnostics or medical frameworks – it is based on sharing and using lived experience in support of others with similar experiences, as well as the worker's adept knowledge and skills in peer support practice. Liam Buckley, a senior peer support worker at St Vincent's Hospital Melbourne, says:

… the fact that we have lived experience as consumers of the service, and we've had mental health problems before, can really help the service relationship with the consumer, both in the hospital and in the community, a lot. Once you talk about that – you say 'yes, I have a lived experience, I've been in hospital before, I've been on medication for quite a long time' – it's amazing how many people respond to you in a very positive way. They feel more able to trust you, to have more honesty with you about their current predicament.

Relationship building is at the heart of peer support, though workers perform a range of other functions including advocacy, health promotion, education/training, research, management and leadership.

There is growing evidence that peer support has a positive impact on consumer outcomes, showing that consumer recovery and wellbeing is enhanced by approaches beyond medical treatment.

EXPANDING POST-DISCHARGE SUPPORT

The Expanding Post-Discharge Support initiative is based on the peer support workforce model and follows a successful trial at St Vincent's Hospital Melbourne and Goulburn Valley Health during 2015–16.

Transitioning safely and securely from an acute inpatient setting to a community environment is an important part of recovery. The program provides consumers, their families and carers with targeted peer support immediately after discharge to maximise their recovery and resilience and minimise their risk of readmission.

Funding has been provided to all health services to implement post-discharge support, with initiatives commencing during 2016–17. The initiative will be evaluated by the department and featured in future annual reports.

POST-DISCHARGE SUPPORT LIAM BUCKLEY

Companionship, empathy, empowerment – those three words are really important and sum up what we strive to achieve as peer support workers. I've worked on the post-discharge initiative over the last six months. It's a very recent development in mental health services that's got a lot going for it because it actually helps consumers transition back into the community.

We meet people in the hospital and get referrals from clinical reviews. We have great support from senior management and presence with the nurses, OTs, social workers and other allied health workers. Going to clinical reviews has been a real eye-opener for me. Making clinical notes and going to handovers are not things I did [as a consumer consultant for nearly 20 years]. I'm now getting that opportunity, and really enjoying this aspect of the role.

One person wasn't improving much, and the doctor referred him for peer support. I worked with him during the rest of his admission. He was very anxious, particularly about approaching any organisations for help with his needs. I took him to Centrelink to help him get established. I was able to reassure him and help him understand he wasn't alone – there was meaning in his life; he didn't have to sit alone in a waiting area; he belonged; there were services available to him.

When he left hospital, I gave him vouchers for things like clothes and underwear. We met at a café a couple of times. We'd talk about his housing, his friendships and family – anything relevant for his transition.

He got a lot of benefit from this, and certainly wanted to meet with and be seen by me. We had good rapport. This really helped him focus on things he needed and wanted to do in the community; for example, he moved house to improve his accommodation situation. He appreciated my time for him, and I appreciated his openness about his illness and his life.

With programs like this and increases to the peer support workforce, things can only get better and better in the future. Seeing someone who's really ill when they come in, improve while in hospital, discharged, and then in the community – that opportunity is really rewarding.

Liam Buckley, Senior Peer Support Worker at St Vincent's Hospital Melbourne

DONNA MATTHEWS

I've been preparing to run small peer groups. We'll interact with consumers on the ward, who can self-refer into the sessions, and establish good continuity for post-discharge. Even if people wish not to be supported post-discharge, these groups will help them increase self-awareness of their mental distress and be more informed about the situation they're in. They'll learn how to plan for the future if they become unwell, how to stay well and recognise warning signs that they're becoming unwell.

Donna Matthews, Senior Peer Support Worker at St Vincent's Hospital Melbourne

I left a facility 10 years ago and was told upon discharge, 'Go see your GP, get a script for some medication, and the CATT team will visit you once'. I asked about support groups or anything like that – the chap scribbled some organisations' names on scrap paper and said, 'Try googling those'.

It was so difficult, after such an upsetting and traumatic experience, to just trundle back out into the community. I ended up going back to work – within a month I was readmitted to a psych unit.

So, we're trying to help consumers find their feet again, learn practical skills, and get the support they need, so they're not continually in a cycle of readmission. I've prepared topics covering information on the post-discharge support program, practical tips on 'How do I get out of here?', 'How do I stay out of here?', 'Where to from here?' and the new Mental Health Act to teach people about advance statements and nominated persons. We'll also cover lots of information about community organisations, short courses and other activities. A key focus of the post-discharge support initiative is recognising we need a social connection, to feel useful and do something meaningful. Some people have basic needs – help with housing, food or bills – and other people might be a bit further along their recovery journey; it might be about doing something for fun, learning a new skill, or friendships with people in similar situations.

Working in the psych ward isn't easy. It's like if someone had cancer, survived and worked in oncology – it's confronting. We still have our illness and our own concerns to deal with, but we want to make it better for other people. I do this line of work because I had a bad experience and I don't want others to have that experience. It's gotten better over the last few years, but we still have a long way to go.

WORKFORCE DEVELOPMENT

THE VICTORIAN MENTAL HEALTH INTERPROFESSIONAL LEADERSHIP PROGRAM

Victoria's 10-year mental health plan acknowledges the vital role of a skilled and committed mental health workforce. We know that as part of this, strong and effective leadership is required to drive change and innovation across the service system.

Leadership needs to be fostered and developed at all levels, not just in formal positions of authority, and should be targeted at team leaders, managers and clinicians.

Recognising this, the department, in partnership with the Western Mental Health Learning and Development Cluster, initiated the Victorian Mental Health Interprofessional Leadership Program in 2015.

The program brings together existing and emerging mental health leaders from across the nursing, allied health, medical and lived-experience workforces, supporting them to lead and coach within interdisciplinary teams.

The program focuses on recovery-oriented practice and supported decision making, and involves 18 multidisciplinary teams from across mental health services.

IMPROVING RESPONSES TO PEOPLE AFFECTED BY METHAMPHETAMINES

In 2015 St Vincent's Hospital Melbourne was funded to make recommendations on the needs of emergency departments, mental health staff and triage nurses managing clients with mental health and methamphetamine (ice) issues.

The project highlighted the need for flexible and contextualised training for all nurses, coupled with mentoring and other forms of practice support that enable staff to embed new skills into their everyday practice and provide effective responses to people affected by ice, their families and carers.

Victoria's *Ice action plan* allocated funding to improve the capability of all frontline workers to respond to people who are affected by ice. Initiatives include:

- an online training package to support self-directed learning for all workforces and assist managers in implementing policies and practices that better protect staff responding to people who are affected by ice
- face-to-face training over the next four years
- a program aimed at building the skills of senior clinicians in mental health and alcohol and drug services to provide clinical supervision and other forms of practice support and ensure that frontline workers can embed the skills learnt through training programs into everyday practice.

These programs are targeted to those parts of our workforce that are likely to come into contact with people affected by ice. This includes staff working in clinical and community mental health settings.

PROTECTING PEOPLE'S RIGHTS AND SAFETY

We want to ensure that public mental health services provide quality treatment and are safe for consumers, their families and carers, and staff. We expect services to make every effort to protect people's physical, sexual and emotional safety.

A number of recent reforms have been introduced to improve the quality and safety of mental health services and protect the rights of people receiving mental health services. These include more effective ways of responding to complaints about public mental health services, and the introduction of greater protections for people who receive compulsory treatment under the Mental Health Act.

Initiatives to address aggression and violence in acute inpatient settings have also been implemented and were evaluated in early 2016. New safety measures to reduce and prevent violence in mental health services for both staff and patients have been supported through the Health Service Violence Prevention Fund.

A review of safety and quality assurance systems in place for Victorian hospitals, including mental healthcare, commenced in 2015–16 and will be finalised in 2016–17. Recommendations resulting from the review will be addressed in next year's annual report.

WOMEN'S SAFETY IN INPATIENT SETTINGS

Creating separate areas for women in adult acute inpatient units has been an important part of improving safety for women accessing treatment and care. Funding was provided in 2013–14 and 2014–15 under the Safety of Women in Mental Health Care initiative. It supported modifications in mental health inpatient services to improve the safety, security and comfort of women. Modifications funded under the initiative included the creation of female-only corridors or wings and lockable bedrooms. A majority of inpatient units now have female-only areas.

SAFEWARDS

A new staff practice model called Safewards has been trialled in Victoria, aimed at creating safer environments for mental health staff and patients and to support reductions in the use of restrictive interventions (including seclusion and restraint). Safewards was developed in the United Kingdom to help reduce conflict within mental health inpatient units and improve people's safety in mental health settings.

Albury Wodonga Health, Alfred Health, Bendigo Health Care Group, Latrobe Regional Hospital, Melbourne Health, Mercy Health and Monash Health participated in the trial, implementing Safewards across 18 inpatient units. Most services applied Safewards in acute adult inpatient units, while a small number applied Safewards in other settings, including secure extended care, aged and youth.

> As an occupational therapist, I am responsible for the coordination of the group program on the ward. As such, I have been involved with the facilitation of the Mutual Help Meetings since they began on the Flynn Unit.
>
> Mutual Help Meetings are the groups with the highest attendance in the week, and once a consumer has been to one, they always return. As one consumer said, 'They get people talking, it feels like a community'.
>
> During our last meeting, we spoke about the impact that Safewards was having on the unit. Participants unanimously praised the program – and as one consumer put it, Safewards is 'making the world of difference'.
>
> **Nik Anderson**
> **Occupational Therapist**
> **Latrobe Regional Hospital**

The University of Melbourne evaluated the trial during 2016, and outcomes reported over the 12 months since implementation are encouraging. The evaluation found that staff and consumers felt Safewards had improved safety and decreased levels of conflict within services. Furthermore, Safewards showed potential for reducing the use of restrictive practices. Surveys also show improvements in interpersonal culture on the participating wards. Strategies to encourage broader uptake and ongoing evaluation of Safewards in services across the state are currently being explored, informed by the outcomes of the trial.

MENTAL HEALTH COMPLAINTS COMMISSIONER

The Mental Health Complaints Commissioner (MHCC) is an independent body established under the Mental Health Act. The MHCC receives, and works to resolve, complaints about public mental health services in Victoria. Through informal and formal resolution processes and investigations, the MHCC works to safeguard people's rights and also makes recommendations for service and system improvements.

The MHCC also works with services to develop effective ways of responding to the concerns and complaints of people accessing their services and receives bi-annual reports from services on the number and outcomes of complaints received by services. Complaints data is analysed to identify quality and safety issues and to inform recommendations for service improvements.

MENTAL HEALTH TRIBUNAL

The tribunal is a key safeguard under the Mental Health Act to protect the rights and dignity of people with mental illness. It is an independent body that decides whether or not a person requires compulsory treatment and makes treatment orders where the criteria in the Mental Health Act are met.

The tribunal determines applications for electroconvulsive therapy for compulsory patients unable to consent to that treatment or where the person is under the age of 18. It also considers applications for performance of neurosurgery for mental illness.

'Advance statements are not yet well understood or utilised – promote them. This has flow-on effects for carers and families.'

Preston Public Workshop, 28 August 2015

COMMUNITY VISITORS

Community visitors are volunteers who monitor the adequacy and appropriateness of public mental health inpatient services and some residential services. The Office of the Public Advocate administers the Community Visitors Program and submits a Community Visitors report annually to government with recommendations on systemic issues requiring action. These recommendations provide valuable opportunities to make positive and sustainable improvements to Victoria's mental health services.

VICTORIA'S CHIEF PSYCHIATRIST

Victoria's Chief Psychiatrist is responsible for overseeing system-wide continuous improvement in the quality and safety of public clinical mental health services, and for promoting the rights of people receiving treatment in public mental health services. The Chief Psychiatrist provides clinical leadership through expert advice, training, education and published guidelines. The Chief Psychiatrist monitors service provision and may conduct investigations, clinical audits or clinical service reviews to improve patient safety and wellbeing.

The role of the Office of the Chief Psychiatrist has recently been independently reviewed to ensure it is effectively tasked and resourced to achieve its statutory obligations under the Mental Health Act. The review identified a range of ways for the office to provide additional clinical leadership and increased monitoring of the quality and safety of mental health services in Victoria. The recommendations will be implemented in 2016–17.

STATEMENTS OF RIGHTS

People receiving compulsory treatment must be given a written statement of rights at key points in their assessment and treatment – for example, when a treatment order is made.

A statement of rights sets out a person's rights when they are receiving services from a mental health service provider. The person must have the information in the statement of rights explained to them and have any questions answered.

REDUCING RESTRICTIVE INTERVENTIONS

Reducing restrictive practices is essential to providing safe mental health services. Restraint and seclusion may only be used after all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable.

Evidence shows that restrictive interventions can re-traumatise people with past experience of trauma, create new traumatic problems and negatively impact on the development of trust between people receiving treatment and clinicians.

The Victorian Government and public mental health services share a continuing commitment to reducing and, where possible, eliminating restrictive interventions and practices, such as restraint and seclusion, in mental health services.

SUPPORTED DECISION MAKING

Under the Mental Health Act a person is presumed to have capacity to make decisions about their own treatment, unless it is established that the person lacks capacity at the time the decision needs to be made.

The Act includes a number of mechanisms to promote supported decision making:

- **Advance statement:** A statement to record a person's treatment preferences in case they become unwell and need compulsory treatment.
- **Nominated person:** A person can nominate someone to support them in the event they become unwell and need compulsory treatment. The role of the nominated person is to provide support and to help represent the person's interests. The nominated person can help the person to exercise their rights and can help represent their views and preferences about treatment to members of the treating team. A nominated person will be given information and be consulted at key points in the person's treatment and recovery.
- **Second psychiatric opinions:** People receiving compulsory treatment under the Mental Health Act can seek a second psychiatric opinion at any time. A second opinion will assist consumers to understand their illness and empower them to participate in decision making about their treatment.

In 2015–16 only two per cent of people receiving compulsory treatment had a nominated person and only two per cent of people had made an advance statement. The current low uptake highlights the need to renew efforts to promote the benefits of these supported decision-making mechanisms to consumers.

Compulsory, security and forensic patients have the right to seek a second psychiatric opinion at any time. Consumers have raised concerns about the lack of independence and choice in seeking a second psychiatric opinion. To date, it has been common practice for another psychiatrist within the person's area mental health service to provide a second opinion. There has also been no commonly established process for responding to requests for a second opinion.

In 2015–16 Melbourne Health and Monash Health received funding to establish a second psychiatric opinion service on a statewide basis. This means that patients under the Mental Health Act will have access to a second opinion provided independently of their treating mental health service. This service will commence in 2016–17.

HOW MY ADVANCE STATEMENT HELPED ME AVOID HOSPITALISATION

Late last year, I became unwell. I was under a new private psychiatrist, who I had previously given my advance statement, including contact details for my nominated person.

He was considering hospital for me, which I said I did not want, and was going to call the crisis assessment and treatment team (CATT).

He referred back to my wishes for at-home treatment with supports from friends and my nominated person, who is a senior psychiatric nurse by trade. And so instead, after being reassured by my nominated person that I could cope at home by putting in place the supports listed in my advance statement, I was allowed to go home that night.

Later, the psychiatrist told me that if he had called CATT he thought they would have certified me and sent me to hospital involuntarily. The whole scenario of forced treatment and a subsequent long recovery was avoided, and within four weeks I was back at work.

Rowena Schroeder, *Cherish Hope*, 2016
Courtesy of the Mental Health Foundation of Australia (Victoria)

WRITING MY ADVANCE STATEMENT

'It's not just about my medical treatment ... I've got things in there about the fact that if I need to go to hospital then I need to be reassured that someone's looking after my dogs, like that has to be in there because that's critical for me. If I'm in hospital but I'm worried about my dogs I'm not going to get well, so I've written quite a lengthy advance statement, but it's quite broad and it covers a lot of things. Probably some of them are a little bit pedantic, but I'd rather have all my bases covered.'

Hear Ann talk about writing her advance statement at <http://research.healthtalkaustralia.org>.

SUPPORTING MY BROTHER

'I think things like the advance statements are really good for my brother, because he has lived with his illness for so long and ... he knows a lot of the medications inside out. And he does have some strong opinions about what works for him and what doesn't. But when he's unwell and you try and get that out of him, it's pretty difficult. So if there's something that they can refer to that shows his preferences, I think that will be helpful. We've spoken about the existence of the advance statements. He said that he wants to write one and he's asked me to help him, you know, so we can have a dialogue about it.'

Hear Lisa talk about supporting her brother at <http://research.healthtalkaustralia.org>.

Options for supported decision making to enhance the recovery of people with severe mental health problems

A new internet resource on supported decision making and personal recovery was launched by Steve Dimopoulos, Member for Oakleigh and Chair of the Mental Health Expert Taskforce, in June 2016.

The resource comprises two websites that present the lived experiences of a diverse group of people with severe mental illness, including those diagnosed with psychosis, schizophrenia and bipolar, and their families and carers, and their perspectives on, and experiences of, supported decision making and personal recovery.

The websites support people with severe mental illness and their families and carers to make informed decisions about their mental health assessment, treatment and recovery. The websites also provide mental health practitioners with an educational resource, and inform policymakers and the wider Australian community about the experiences of people with severe mental illness, their families and carers.

The development of these resources was based on findings from an Australian Research Council-funded interdisciplinary research project entitled Options for Supported Decision-Making to Enhance the Recovery of People with Severe Mental Health Problems led by Monash University in collaboration with the University of Melbourne, the Department of Health and Human Services, a number of mental health community support services, and consumer and carer organisations.

Find out more at <www.healthtalkaustralia.org>.

INDEPENDENT MENTAL HEALTH ADVOCACY SERVICE

The Victorian Government funds the Independent Mental Health Advocacy service for people subject to a compulsory treatment order under the Mental Health Act. The service is provided through Victoria Legal Aid.

Advocates provide information and assist people to understand and exercise their rights. The service supports people who are receiving compulsory psychiatric treatment to have as much say as possible about their assessment, treatment and recovery. Advocates are independent from hospitals and mental health services and are based in Melbourne, Geelong, Bendigo and Dandenong. They provide support to people across Victoria.

Funding is also provided to Victoria Legal Aid to provide assistance to people appearing before the Mental Health Tribunal. This service includes providing Mental Health Tribunal representation and specialist legal advice to people with serious mental illness on a wide range of issues.

LISTENING TO CONSUMERS AND CARERS: SURVEY RESULTS

Understanding the experiences of people who use public mental health services in Victoria helps us to make decisions about what is working well and what needs improvement. In 2015–16 the department commissioned Ipsos Australia, an independent research company, to undertake the Your Experience of Service (YES) survey for the first time. The YES survey will also help our mental health services understand what is working well from the perspective of people who use their services and what needs improvement. It will be conducted annually.

The survey uses two YES questionnaires. One questionnaire is for use in clinical mental health services and the other in MHCSS. The questionnaires have been designed to capture information on the experience of people aged 16–64 who use public clinical mental health services or MHCSS. YES survey results will inform our approach to monitoring people's experience of services, and will be incorporated in the suite of *Victoria's 10-year mental health plan* outcome measures at Appendix 1 following data validation.

In 2015–16 consumers were asked a range of questions about their experience of care at the mental health service, including the effect of the services on their ability to manage their day-to-day lives, and the development of care plans. Early indicative results suggest that consumers were positive about the extent to which they were listened to in all aspects of their care and treatment or support. Further data analysis and validation is underway and a more detailed analysis will be published in future annual reports.

6

CONCLUSION

6. CONCLUSION

We hope this report contributes to community understanding and dialogue about mental illness and its impacts, and how Victoria's publicly funded mental health services are working to improve outcomes and experiences for people with mental illness, their families and carers.

We know more needs to be done to ensure information about our mental health services is up to date, accurate and easily accessible, and that it helps people get assistance when and where they need it. This report is an important step in that direction.

We would particularly welcome feedback and suggestions from consumers, carers, service providers and the community about ways in which future reports can help build understanding of Victoria's public mental health system.

Feedback can be directed to <mhs.annualreport@dhhs.vic.gov.au>

Julie Goodwin, *Immersing Plume*, 2009
Courtesy of The Cunningham Dax Collection

APPENDIX 1:
OUTCOMES FRAMEWORK

APPENDIX 1: OUTCOMES FRAMEWORK

OUR APPROACH TO SELECTING INDICATORS

The *10-year mental health plan* outcomes reflect our long-term goal: that all Victorians experience their best possible health, including mental health. Many of the outcomes are ambitious. Some focus on improved mental health and wellbeing for all Victorians, while others address aspects of our specialist mental health services for people with severe mental illness.

We have established an initial suite of indicators to help monitor progress, but we know we don't have all the information we need to fully understand if we are making a difference. There are some outcomes for which meaningful and reliable Victorian data is not currently available, including data on LGBTI and CALD Victorians, for example, and this affects our capacity to monitor progress.

Victorian and national data sources in mental health are continuing to develop, and forthcoming surveys will provide more information about the experience of people with mental illness, and the experiences of families and carers. In future years, we intend to expand our indicator suite to incorporate measures from the YES survey, Living in the Community Questionnaire and Carer Experience of Care Survey as reliable data becomes available. Where necessary, we may also modify our outcomes to ensure their continued relevance.

We are also considering ways in which we can make more effective use of existing Victorian data sources to increase our understanding of the impacts of severe mental illness on community participation and community issues. One issue on which we lack adequate data is the proportion of people with mental illness among victims of crime. Research supports the view that people with mental illness are more often victims of violence than the general population; however, we lack comprehensive, reliable data in this area. We will also undertake focused work to help us understand whether the physical health needs of our registered clients are being effectively addressed.

Consistent with the outcomes, some of the indicators in this initial suite capture information about all Victorians, while some capture information about those Victorians who use our specialist mental health services. Some indicators also capture information on particular groups within our community where we know mental illness can have a disproportionate impact.

Responsibility for improving the outcomes sought in the *10-year mental health plan* does not sit entirely with us, or with any single department. Many factors that influence the outcomes sit outside government, so we need to work collectively with many organisations, all levels of government, the non-government sector and the broader community to achieve our goals.

Indicator		Most current data	Year
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)	12.6%	2014
1.2	Proportion of Victorian population receiving clinical mental healthcare	1.1%	2015–16
1.3	Proportion of Victorian young people with positive psychological development	70.1%	2014
1.4	Proportion of Victorian older persons (65 years or older) with high or very high psychological distress	8.0%	2014
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)	15.9%	2014
2.2	Proportion of Victorian rural population with high or very high psychological distress (adults)	13.1%	2014
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 healthcare	2.3%	2015–16
4.	**The rate of suicide is reduced**		
4.1	Victoria's rate of deaths from suicide per 100,000	10.8	2015
5.	**Victorians with mental illness have good physical health and wellbeing**		
6.	**Victorians with mental illness are supported to protect and promote health**		
7.	**Victorians with mental illness participate in learning and education**		
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	38%	2015–16
12.	**Victorians with mental illness have suitable and stable housing**		
12.1	Proportion of registered clients living in stable housing	81%	2015–16
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	57.1%	2015–16
13.2	Rate of readmission within 28 days	13.9%	2015–16
13.3	Rate of post-discharge follow-up	84.2%	2015–16
13.4	New registered clients accessing public mental health services (no access in last five years)	35.7%	2015–16

Indicator	Most current data	Year
14. Services are recovery-oriented, trauma-informed and family-inclusive		
14.1 Proportion of registered clients experiencing stable or improved clinical outcomes (adults)	91%	2015–16
14.2 Proportion of registered clients experiencing stable or improved clinical outcomes (CAMHS)	91%	2015–16
14.3 Proportion of registered clients experiencing stable or improved clinical outcomes (aged persons)	91%	2015–16
15. Victorians with mental illness, their families and carers are treated with respect by services		
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)	9.1	2015–16
16.2 Rate of bodily restraint episodes per 1,000 occupied bed days (inpatient)	25.6	2015–16
16.3 Proportion of community cases with client on a treatment order	11.1%	2015–16
16.4 Proportion of inpatient admissions that are compulsory	52.0%	2015–16

APPENDIX 2: PUBLIC MENTAL HEALTH SERVICE DATA

APPENDIX 2: PUBLIC MENTAL HEALTH SERVICE DATA

Much of the data in this appendix is drawn from the Mental Health Client Management Information (CMI)/Operational Data Store (ODS). The CMI/ODS is a real-time reporting system that mental health service providers are constantly updating. For this reason, there may be small differences in reported data, and between annual reports for subsequent years, as the system is not static.

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

Data loaded as at 11/9/2016.

Whole population			
	2013–14	2014–15	2015–16
Total estimated residential population in Victoria (based on mental health area) (million)	5.845	5.951	6.059

People accessing mental health services			
	2013–14	2014–15	2015–16
Mental health-related emergency department presentations	43,993	47,231	51,639
Emergency department presentations that were mental health-related (%)	2.86%	2.99%	3.14%

People accessing clinical mental health services				
Clients		2013–14	2014–15	2015–16
Total clients accessing clinical mental health services*		64,982	67,039	67,555
Proportion of population receiving clinical care (%)		1.11%	1.13%	1.11%
Client location		2013–14	2014–15	2015–16
Client residential location (%)	Metro	63.0%	63.0%	62.6%
	Rural	34.9%	34.7%	34.8%
	Unknown/other	2.1%	2.3%	2.6%

Client demographics		2013–14	2014–15	2015–16
Gender (%)	Female	50.7%	50.8%	50.5%
	Male	49.3%	49.1%	49.5%
	Other/unknown	0.1%	0.1%	0.1%
Age group (%)	0–4	0.9%	0.9%	0.8%
	05–14	7.7%	7.4%	7.5%
	15–24	18.2%	18.4%	19.0%
	25–34	17.5%	17.7%	17.7%
	35–44	18.9%	18.6%	18.6%
	45–54	14.0%	14.3%	14.5%
	55–64	8.5%	8.6%	8.7%
	65–74	6.3%	6.4%	6.1%
	75–84	5.2%	4.9%	4.6%
	85–94	2.5%	2.6%	2.3%
	95+	0.2%	0.2%	0.2%
Clients of culturally and linguistically diverse backgrounds (%)	CALD	14.5%	14.3%	13.9%
Aboriginal or Torres Strait Islander status (%)	Indigenous	2.1%	2.2%	2.3%
Country of birth (top 10 non-English speaking) (%)	Italy	1.3%	1.2%	1.1%
	Vietnam	1.0%	1.0%	0.9%
	Greece	0.9%	0.9%	0.8%
	India	0.6%	0.7%	0.6%
	China (excluding SARs and Taiwan)	0.5%	0.5%	0.6%
	Sri Lanka	0.5%	0.4%	0.4%
	Philippines	0.4%	0.4%	0.4%
	Turkey	0.4%	0.4%	0.4%
	Iran	0.0%	0.4%	0.4%
	Germany	0.4%	0.4%	0.4%
Preferred language other than English (top 10) (%)	Vietnamese	0.7%	0.6%	0.6%
	Italian	0.7%	0.7%	0.6%
	Greek	0.6%	0.6%	0.5%
	Arabic	0.4%	0.4%	0.3%
	Mandarin	0.3%	0.3%	0.3%
	Turkish	0.2%	0.2%	0.2%
	Persian (excluding Dari)	0.2%	0.2%	0.2%
	Cantonese	0.2%	0.2%	0.2%
	Macedonian	0.0%	0.0%	0.1%
	Spanish	0.1%	0.1%	0.1%

Treatment		2013–14	2014–15	2015–16
Total clients accessing clinical mental health services*	Adult	49,518	51,973	52,684
	CAMHS	10,225	10,251	10,472
	Aged	8,428	8,495	8,112
	Specialist	1,697	1,593	1,782
	Forensic	702	684	699
Diagnosis (%)	Schizophrenia, paranoia and acute psychotic disorders	22.5%	23.2%	23.5%
	Mood disorders	20.3%	20.7%	20.2%
	Stress and adjustment disorders	7.7%	7.8%	7.9%
	Personality disorders	4.7%	5.1%	5.5%
	Anxiety disorders	4.3%	4.9%	5.1%
	Substance abuse disorders	2.9%	3.1%	3.5%
	Organic disorders	3.3%	3.3%	2.9%
	Disorders of childhood and adolescence	1.9%	1.8%	1.9%
	Disorders of psychological development	1.4%	1.4%	1.6%
	Eating disorders	1.3%	1.4%	1.5%
	Other	0.9%	1.0%	1.1%
	Obsessive compulsive disorders	0.5%	0.5%	0.5%
	Unknown	28.3%	25.8%	24.8%
Referral source (newly referred clients only) (%)	Health services	38.7%	40.7%	41.7%
	General practitioner	14.6%	13.7%	12.7%
	Family	7.9%	8.3%	8.0%
	Client/self	5.0%	4.8%	4.6%
	Community health services	5.1%	4.6%	4.5%
	Police	3.1%	4.0%	4.0%
	Others and unknown	25.7%	23.8%	24.5%
New clients accessing services (no access in prior five years) (%)	Total	36.1%	36.3%	35.7%
Clients accessing services for more than five years (%)	Total	14.9%	14.4%	14.4%

Service activity – bed-based	Setting	2013–14	2014–15	2015–16
Total number of separations (excluding same days)	Admitted - Acute	21,024	21,886	23,664
	Admitted - Non Acute	207	231	230
	Non Admitted - Residential	329	294	224
	Non Admitted - Sub Acute (CCU)	559	557	672
	Non Admitted - Sub Acute (PARC)	2,842	3,141	3,252
	Total	**24,961**	**26,109**	**28,042**
Occupied bed days (including leave, excluding same days)	Admitted - Acute	339,870	348,288	355,609
	Admitted - Non Acute	62,121	63,674	60,501
	Non Admitted - Residential	215,800	191,602	177,997
	Non Admitted - Sub Acute (CCU)	96,754	103,684	96,590
	Non Admitted - Sub Acute (PARC)	54,348	59,821	63,526
	Total	**768,896**	**767,072**	**754,225**
Bed occupancy rate (including leave, excluding same days)	Admitted - Acute	87.3%	88.4%	88.5%
	Admitted - Non Acute	82.0%	82.7%	78.3%
	Non Admitted - Residential	93.8%	90.9%	89.4%
	Non Admitted - Sub Acute (CCU)	75.0%	79.6%	74.2%
	Non Admitted - Sub Acute (PARC)	76.9%	77.2%	77.9%
	Total	**86.0%**	**86.2%**	**84.7%**

Service activity – community	Population	2013–14	2014–15	2015–16
Total service contacts, by sector	Adult	1,485,933	1,483,303	1,400,106
	Aged	246,675	248,324	219,423
	CAMHS	276,773	290,862	275,782
	Forensic	10,558	15,779	17,863
	Specialist	21,763	22,074	22,259
	Total	**2,041,703**	**2,060,345**	**1,935,435**
Total service hours, by sector	Adult	686,494	691,387	665,724
	Aged	106,573	110,053	103,607
	CAMHS	173,279	178,843	171,787
	Forensic	8,311	10,249	10,522
	Specialist	24,489	21,840	20,688
	Total	**999,148**	**1,012,374**	**972,330**
Unregistered clients service hours, by sector (%)	Total	14.6%	15.0%	15.4%

Service performance	Setting	2013–14	2014–15	2015–16
Readmission to inpatient rate 28 day (lagged 1 month)	Total	14.1%	13.8%	13.9%
Preadmission contact rate, all clients	Total	57.9%	59.4%	57.1%
Post-discharge follow up rate (lagged seven days)	Total	84.6%	85.7%	84.2%
Trimmed average length of stay ≤35 days – inpatient	Total	10.3	10.2	10.1

Compulsory treatment	Population	2013–14	2014–15	2015–16
Community cases with client on treatment order (%)	Total	12.5%	10.9%	11.1%
Compulsory admissions – inpatient (%)	Total	51.2%	51.7%	52.0%
Adult (18+) clients who have an advance statement recorded (%)		n/r	1.4%	2.0%
Adult (18+) clients who have a nominated person recorded (%)		n/r	1.4%	1.9%

Restrictive practice	Population	2013–14	2014–15	2015–16
Seclusion episodes per 1,000 occupied bed days – inpatient	Total	9.8	8.0	9.1
Bodily restraint episodes per 1,000 occupied bed days – inpatient	Total	n/r	17.5	25.6

Client outcomes	Population	2013–14	2014–15	2015–16
Community cases stable or with significant improvement at case closure (%)	Adult	91%	91%	91%
	Aged	91%	91%	91%
	CAMHS	93%	92%	91%
	Forensic	81%	80%	79%
	Specialist	90%	91%	95%
	Total	**91%**	**91%**	**91%**

Funding		2013–14	2014–15	2015–16
Total output cost (Budget paper 3) ($ million)	Clinical mental health	1,059.1	1,082.0	1,142.0
	Mental health community support services	116.9	123.4	128.1

Service inputs		2013–14	2014–15	2015–16
Specialist mental health beds (from policy and funding guidelines)	Admitted - Acute	1,067	1,089	1,098
	Admitted - Non Acute	212	212	212
	Admitted Total	1,279	1,301	1,310
	Non Admitted - Residential	630	603	525
	Non Admitted - Sub Acute (CCU)	358	358	358
	Non Admitted - Sub Acute (PARC)	200	230	230
	Non Admitted Total	1,188	1,191	1,113
	Total	**2,467**	**2,492**	**2,423**
Full-time equivalent staff by workforce type**	Administrative and clerical staff	459	546	n/a
	Allied health and diagnostic professionals	1,381	1,404	n/a
	Carer workers	18	19	n/a
	Consumer workers	16	19	n/a
	Domestic staff	161	152	n/a
	Medical officers	734	771	n/a
	Nurses	3,877	4,028	n/a
	Other personal care staff	237	214	n/a
	Total	**6,882*****	**7,153**	**n/a**

People accessing mental health community support services				
Clients		**2013–14**	**2014–15**	**2015–16**
Total clients accessing mental health community support services		12,350	11,918	12,354
Client demographics		**2013–14**	**2014–15**	**2015–16**
Gender (%)	Female	50.9%	52.9%	55.3%
	Male	48.4%	45.6%	44.2%
	Other/ unknown	0.7%	1.5%	0.5%
Age group (%)	0–4	0.4%	0.5%	0.3%
	5–14	1.1%	1.1%	1.7%
	15–24	12.1%	10.3%	13.1%
	25–34	20.5%	18.5%	18.9%
	35–44	25.0%	25.4%	24.0%
	45–54	23.3%	24.4%	23.0%
	55–64	13.2%	14.6%	13.6%
	65–74	3.1%	2.8%	1.9%
	75–84	0.5%	0.5%	0.4%
	85–94	0.1%	0.1%	0.0%
	95+	0.1%	0.9%	2.6%
	Unknown	0.7%	0.9%	0.6%
Aboriginal or Torres Strait Islander (%)	Indigenous	2.9%	4.7%	2.2%
CALD status (%)	Yes	4.3%	4.3%	4.4%
Service activity		**2013–14**	**2014–15**	**2015–16**
Community service units (CSUs)		n/r	661,855	790,213
Residential rehabilitation bed days		86,085	73,672	78,456
Service inputs	**Population**	**2013–14**	**2014–15**	**2015–16**
Residential rehabilitation beds	Other	103	103	101
	Youth	166	159	159
	Total	269	262	260

Key and notes

Note that some data may not sum due to rounding

* Sum of rows will not equal total clients on page 76 as one client can access multiple services

** Full time equivalent staff, by workforce type (2014–15 Mental Health Establishments data is a provisional result)

*** Columns may not sum due to rounding

n/a: No data available for this period (national data process)

n/r: Not reported for this period

2015–16 data collection was affected by industrial activity in the last months of the financial year. The collection of non-clinical and administrative data was affected, with impacts on community mental health service activity and client outcome measures.

ABBREVIATIONS USED IN THIS REPORT

ACIS   acute community intervention services

CAMHS   child and adolescent mental health services

CALD   culturally and linguistically diverse

CATT   crisis assessment and treatment team

CCU   community care unit

CTO   community treatment order

FaPMI   Families where a Parent has a Mental Illness

GP   general practitioner

ICSP   individualised client support package

LGBTI   lesbian, gay, bisexual, transgender and intersex

MHCSS mental health community support services

NDIS   National Disability Insurance Scheme

PARC   prevention and recovery care

PHN   Primary Health Network

PAPU   psychiatric assessment and planning unit

SECU   secure extended care unit

ENDNOTES

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3 ibid.

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6 Lawrence D, Johnson S, Hafekost J, Boterhoven de Haan K, Sawyer M, Ainley J, et al. 2015, *The mental health of children and adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing*, Commonwealth of Australia, Canberra.

7 Australian Bureau of Statistics 2007, *National Survey of Mental Health and Wellbeing*, Cat. No. 4326.0, ABS, Canberra.

8 Morgan V, Waterreus A, Jablensky A, et al. 2011, *National survey of people living with psychotic illness 2010*, Commonwealth of Australia, Canberra.

9 Department of Social Services 2014, *Characteristics of disability support pension recipients*, June 2013. Commonwealth of Australia, Canberra.

10 Australian Institute of Health and Welfare 2015, *Expenditure on mental health services,* viewed 19 August 2016, <https://mhsa.aihw.gov.au/resources/expenditure/>.

11 Australian Institute of Health and Welfare 2016, *Medicare-subsidised mental health-related services*, viewed 19 August 2016, <https://mhsa.aihw.gov.au/services/medicare/>.

12 ibid.

13 ibid.

14 Unpublished data from the National Mental Health Establishments collection, Department of Health and Human Services, Victoria. Note that columns may not sum due to rounding.

15 Australian Bureau of Statistics, 3238.0.55.001 - Estimates of Aboriginal and Torres Strait Islander Australians, June 2011, available at http://www.abs.gov.au/ausstats/abs@.nsf/mf/3238.0.55.001 accessed September 2016

16 Office of Multicultural Affairs and Citizenship 2013, Victoria's diverse population: 2011 Census, State of Victoria, Melbourne.

17 ibid.

18 Office of Multicultural Affairs and Citizenship 2014, *Victoria's multicultural affairs and citizenship policy: Victoria's advantage – unity, diversity, opportunity*, State of Victoria, Melbourne.

19 This data may have been affected by industrial activity in the last months of the financial year. The collection of non-clinical and administrative data was affected, with impacts on community mental health service activity and client outcome measures.

20 ibid.

21 Cummins RA, et al. 2007, *Australian Unity Wellbeing Index, Survey 16.1, Special Report – Groups with the highest and lowest wellbeing in Australia*, Australian Centre on Quality of Life, Melbourne.