

VICTORIA'S MENTAL HEALTH SERVICES ANNUAL REPORT 2017–18

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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 2017 to 30 June 2018.

Kym Peake
Secretary
Department of Health and Human Services

CONTENTS

Secretary's foreword	1
The year at a glance	2
1. Progressing Victoria's 10-year mental health plan	4
Preventing suicide	5
Supporting and strengthening our mental health workforce	10
Aboriginal social and emotional wellbeing	15
Meeting the mental health needs of children and families	17
Supporting diversity and increasing access	19
Listening to consumers, families and carers	23
Transitioning to the National Disability Insurance Scheme	26
Forensic mental health reforms	30
2. Reform of Victoria's clinical mental health services 2018–2023	34
Victoria's 2018–19 State Budget	34
What we will do	35
How we will do it	36
3. Year in review – public mental health services in 2017–18	42
Overview	42
Child and adolescent mental health services	49
Adult mental health services	50
Aged persons mental health services	52
Specialist mental health services	53
Forensic mental health services	53
Seclusion and restraint	54
Appendix 1: Outcomes framework	58
Appendix 2: Public mental health service data	64
Appendix 3: Victoria's public mental health system	74



SECRETARY'S FOREWORD

This is our third *Victoria's mental health services annual report* to the Victorian Parliament and the community about mental health service delivery. This report focuses on Victoria's state-funded mental health services and the people who accessed them for treatment, care and support in 2017–18.

I am pleased to highlight progress over the past year in implementing key initiatives focused on improving mental health outcomes under *Victoria's 10-year mental health plan*. I am particularly encouraged by our progress towards halving the rate of suicide in Victoria by 2025. Major suicide prevention initiatives, including place-based trials in local communities and our Hospital Outreach Post-suicidal Engagement (HOPE) programs, are saving lives. I take great heart that more than 500 Victorians have been supported via HOPE, and that communities across the state are coming together to discuss suicide and identify local prevention solutions. HOPE initiatives will start in a further six sites in 2018–19.

During 2017–18 there has been sustained focus on improving system reporting compliance, and I would like to thank mental health services for their support and commitment in this area. We have observed substantial increases in overall client numbers and reported contacts across all mental health service types. Our data and systems continue to develop and improve, and this helped inform extensive work undertaken throughout 2017–18 to further reform our clinical mental health services.

I really value hearing from those who experience our service system – our consumers, carers, clinicians and peer workers. Thank you to everyone who generously shared their thoughts, reflections and personal experiences this year. I believe that sharing stories is a powerful way of connecting with others, breaking down barriers and building understanding.

A handwritten signature in black ink that reads "Kym Peake".

Kym Peake
Secretary
Department of Health and Human Services

THE YEAR AT A GLANCE



72,859
registered clients



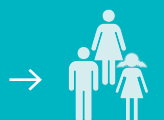
50.3%
women or girls

9.6%

increase since 2016–17



32.9%
live in rural areas



→ **11,945**
child and adolescent clients



→ **57,501**
adult clients



→ **8,279**
aged clients



→ **873**
forensic clients



→ **2,184**
specialist clients



\$1.38 billion
clinical services



\$120 million
Mental Health Community
Support Services

1

PROGRESSING VICTORIA'S 10-YEAR MENTAL HEALTH PLAN

1. PROGRESSING VICTORIA'S 10-YEAR MENTAL HEALTH PLAN

Victoria's 10-year mental health plan, released in November 2015, sets the government's long-term vision to improve the mental health and wellbeing of all Victorians and provides the foundation for our mental health reforms. The plan focuses our efforts on providing people with better access to services, care and support, intervening earlier, creating and supporting local solutions, and developing our mental health workforce.

In the three years since releasing our 10-year mental health plan, we have delivered more investment in suicide prevention and forensic mental health services, and expanded our mental health workforce. Major strategies developed under the plan include the *Victorian suicide prevention framework 2016–25*, the *Mental health workforce strategy*, and *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027*. Work is underway across the state to implement a wide range of initiatives under each of these strategies.

Monitoring progress and reporting on outcomes under our 10-year mental health plan helps us understand the impact of our programs and services on people's lives over time. We use a range of indicators to help us track whether our initiatives and programs are contributing to better outcomes for people with mental illness, and continue to develop more indicators at the local, state and national levels.

Building evidence around what works allows us to assess whether services and programs are effective, and to identify what needs improving. This knowledge underpins the substantial investment in the 2018–19 State Budget to reform Victoria's clinical mental health services and keep pace with growing demand. Initiatives funded through this investment are described in more detail in Chapter 2.

MENTAL HEALTH EXPERT TASKFORCE

The Mental Health Expert Taskforce, established in March 2016 to guide the initial implementation of *Victoria's 10-year mental health plan*, concluded its term in February 2018.

Taskforce members provided expert advice on:

- the development of the *Victoria's 10-year mental health plan* outcomes framework, including the initial indicator suite
- *Victorian suicide prevention framework 2016–25*
- *Mental health workforce strategy*
- *Victoria's mental health services annual report 2015–16* (inaugural)
- housing and homelessness, including the Towards Home and rough sleeping initiatives
- child and youth mental health services
- National Disability Insurance Scheme (NDIS) implementation
- support for lesbian, gay, bisexual, transgender, gender diverse, intersex and queer (LGBTIQ+) communities.

Other key taskforce contributions included advice on the Aboriginal social and emotional wellbeing strategy (led by the Aboriginal Social and Emotional Wellbeing Reference Group and launched in October 2017), the Centre for Mental Health Learning (led by the Workforce Reference Group) and on mental health research and translation (led by the Innovation Reference Group).

The *Lived experience engagement framework* (led by the Lived Experience Reference Group) will be released during 2018–19.

PREVENTING SUICIDE

OUTCOME 4: The rate of suicide is reduced.

Suicide is a significant public health issue and has a profound and lasting impact on families, friends and communities. The Victorian Government remains committed to working with our public hospitals and local communities to halve the number of suicides in the state by 2025.

We have observed small reductions in both suicides and deaths due to intentional self-harm since releasing the *Victorian suicide prevention framework 2016–25*. During 2017 we lost 621 Victorians to suicide, down from 624 in 2016 and 654 in 2015. Victoria now has the lowest suicide rate of all Australian states and territories, with a rate of 9.6 deaths (per 100,000) compared with 9.9 (per 100,000) in 2016.

In contrast, Australia's national suicide rate has increased to 12.6 (per 100,000) in 2017, up from 11.7 (per 100,000) in 2016. Suicide remains the leading cause of death for Australians aged 15–44 years and the second leading cause of death among Australians aged 45–54. During 2017–18 Victoria began leading development of a national suicide prevention implementation strategy on behalf of all Australian governments.

TARGETED, PERSON-CENTRED SUPPORT FOLLOWING SELF-HARM AND SUICIDE ATTEMPTS



HOPE
has helped 500+ people
at risk of suicide

The Hospital Outreach Post-suicidal Engagement (HOPE) program provides dedicated and practical outreach support for people leaving hospital following a suicide attempt or intentional self-harm.

The HOPE trials continue in six hospitals across Victoria:

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

More than 500 people have now been supported through HOPE, each receiving outreach support for up to three months after their discharge from hospital. Each hospital has developed its own service model to provide intensive support during vulnerable periods, with the aim to reduce people's individual risk of future suicide attempts.

Building on HOPE's early success, we are now expanding this initiative to a further six hospitals. During 2018–19, HOPE trials will be rolled out at:

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

DELIVERING HOPE AT ST VINCENT'S HOSPITAL

As a team, we know that the HOPE program has been invaluable to both clients and their loved ones following a suicide attempt or engagement in suicidal or risky behaviours.

It's a privilege to work alongside those who have come so close to suicide and to see clients and their families make positive changes and talk openly about how to keep safe in the future. As they move along their recovery journey from suicidality, it can be tough and challenging, but we know there is real strength in making and developing human connections. We aim to become a supportive and reliable contact who can be called upon in a suicidal crisis and who can hold and foster hope for a life beyond suicidality.

Here are some of the things we really appreciate and value about the HOPE initiative:

- helping empower clients to manage their personal safety through safety planning
- supporting clients to explore and utilise alternative and more adaptive coping strategies to understand and manage their suicidal drivers (for example, psychological pain, stress, agitation, hopelessness, self-hate)
- addressing the psychosocial stressors that may be contributing to a client's suicidality such as housing or financial distress

- involvement and liaison with a client's professional support network to ensure good continuity of care and collaborative decision making and keeping the client as the centre of what we do
- supporting our clients' families and loved ones along their recovery journey post-suicidality and to navigate the complex mental health system.

We relish the opportunity to continue this essential work and to support those in their most vulnerable moments, despite the confronting nature of the work, for as long as suicide remains a significant health and social issue in Australia.

Lilli Haig-Wood, Team Leader

Penny Schleiger, Senior Clinician

Juliet Thornton, Clinician

Hennie Lanting, Family Support Worker



PLACE-BASED SUICIDE PREVENTION TRIALS

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

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

The trials are supporting communities to work together to identify what is needed to prevent suicide, foster individual and community resilience and wellbeing, and strengthen systems to prevent suicide in an ongoing way.

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

This year, strategies collaboratively identified and implemented by the communities included:

- raising awareness of mental health issues and support services so that people know where to go for help (for example, R U OK? Day)
- supporting people with lived experience to talk about suicide in the community
- equipping general practitioners to identify and help people in distress

- school-based programs to help build resilience and help-seeking among young people
- improving mental health in workplaces
- improving the skills and confidence of frontline workers (including ambulance and police staff) to deal with suicidal crisis
- training local volunteers to recognise and respond to people at risk of suicide.

An important part of these trials is developing culturally appropriate and safe suicide prevention approaches. Engagement with Aboriginal communities to explore the particular issues for Aboriginal people is an important part of these trials.

'We have obviously been able to tap into and meet a need in this community.'

Merryl White, Suicide Prevention Coordinator, Murray Primary Health Network (March 2018)

MERBEIN COMMUNITY LEARNS SUICIDE BEREAVEMENT AND SUPPORT SKILLS

The first event of the place-based suicide prevention trial, led by the Murray Primary Health Network, was held in the small community of Merbein in March 2018.

Run by *StandBy Murray*, a 'What do I say? What do I DO?' workshop attracted 65 people, who learnt about suicide bereavement, self-care and what to say and do after a suicide in their town.

Merryl Whyte, suicide prevention coordinator at Murray Primary Health Network, said that the workshop attendance was fantastic and a record for *StandBy Murray*. 'The feedback we have had from *StandBy Murray* facilitator Lucinda Fraser is that they have never had numbers of this type turn up to this workshop before... We are really pleased that our local community embraced this event, the first we have run as part of our Mildura

trial. And that we have obviously been able to tap into and meet a need in this community.'

In the lead up to the event, several Merbein residents were proactive in promoting the workshop in their town. Merryl says that this is partly why so many people came along. 'We had assistance from quite a few Merbein people who were very keen for this training to be held in their town – and it was definitely down to them that we were able to create an event that attracted so many people away from their Monday night commitments.'

The Mildura trial began in August 2017 and is one of the 12 locations across the state where the Victorian Government is partnering with Primary Health Networks to test a new place-based approach to suicide prevention.



Merbein community members attend a 'What do I say? What do I DO?' workshop hosted by *StandBy Murray*

GIPPSLAND DAIRY FARMERS SHARE MENTAL HEALTH JOURNEYS

Gippsland dairy farmers are leading the way in reducing stigma by sharing their personal stories in a calendar promoting help-seeking and suicide prevention.

The Gippsland Dairy Calendar was launched at Farm World 2018 as part of the suicide prevention activities occurring in Gippsland and focuses on stories of 12 brave farmers sharing their mental health journey. Farm World is one of Victoria's largest regional agricultural events, attracting more than 55,000 visitors over four days, and is therefore a great opportunity to directly engage with the local community.

Sallie Jones, project lead for the calendar and co-owner of Gippsland Jersey, said that the calendar 'will serve as a starting point towards breaking down the stigma attached to mental health in our rural communities. Our wish is that this calendar prompts honest and real conversations about a health issue that often we feel ashamed or embarrassed about.' Sallie's dad, Michael Bowen, died by suicide in 2016, and she has dedicated her work on this calendar to his memory.

Distributed free to 1,400 dairy farms throughout the Gippsland region, the calendars serve as a resource for farmers experiencing mental health struggles. The calendar provides relevant assistance numbers for health and welfare support services, encouraging farmers to seek help early. Calendars can also be purchased by the wider community.

The Gippsland Dairy Calendar project has been made possible by place-based suicide prevention trials operating in the Latrobe Valley and Bass Coast areas.



Presenting the Gippsland Dairy Calendar at Farm World 2018

'We are gaining some very valuable and insightful perspectives from the mental health workforce.'

Rosemary Charleston, Director,
Centre for Mental Health Learning (July 2018)

NATIONAL SUICIDE PREVENTION IMPLEMENTATION STRATEGY

The Victorian Government, alongside the Commonwealth and other state and territory governments, endorsed the *Fifth national mental health and suicide prevention plan* in August 2017.

The fifth plan commits governments to developing a national suicide prevention implementation strategy that operationalises the 11 elements of the World Health Organization's initiative *Preventing suicide: a global imperative*. It will take into account existing strategies, plans and activities, with a focus on:

- providing consistent and timely follow-up care for people who have attempted suicide or are at risk of suicide, including agreeing on clear roles and responsibilities for providers across the service system
- ensuring timely follow-up support is available to people affected by suicide
- improving cultural safety across all service settings
- improving relationships between providers, including emergency services
- improving data collection and combined evaluation efforts to build the evidence base on 'what works' in relation to preventing suicide and suicide attempts.

Governments will develop and deliver the strategy for endorsement by Australian health ministers in 2020.

Victoria is leading this work on behalf of all governments.

SUPPORTING AND STRENGTHENING OUR MENTAL HEALTH WORKFORCE

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

CENTRE FOR MENTAL HEALTH LEARNING

Following a competitive process undertaken this year, we were pleased to announce that NorthWestern Mental Health was successful in its bid to establish and operate the highly anticipated Centre for Mental Health Learning. The centre is a key part of Victoria's *Mental health workforce strategy*, released under the 10-year mental health plan.

The centre will become the centrepiece for mental health workforce development in Victoria, creating a platform for learning and development activities, practice support resources, research, increased collaboration and access to expertise.

The centre will act as an umbrella organisation, helping to coordinate and leverage current mental health investments by partnering with statewide trainers, Mental Health Workforce Learning and Development Clusters, health services, clinical and experts-by-experience academics, and other stakeholders.

The centre is expected to begin full operations by the end of 2018.

A new centre for mental health learning

The Centre for Mental Health Learning, auspiced by NorthWestern Mental Health, is an exciting initiative for Victorian public clinical mental health services. Rosemary Charleston was appointed as the centre's first director in early 2018.

Rosemary says, 'Our engagement and consultation processes have now commenced, and we are gaining some very valuable and insightful perspectives from the mental health workforce. There has been great energy and enthusiasm in these discussions about what the centre can contribute to the sector. Another real achievement is our website launch in August 2018.'



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

MENTAL HEALTH WORKFORCE INNOVATION PROGRAM

The Department of Health and Human Services awarded new grants to support consumer-led and carer-led workforce innovation projects during the year. These included four consumer-led projects, four family/carer-led projects and a Forensicare research project on the mental health lived experience workforce within the justice system to be jointly led by a family/carer advocate and consumer consultant.

The projects will begin in the second half of 2018. More information about the Mental Health Workforce Innovation Program, including a summary of all grant recipients is available from the department's website <<https://www2.health.vic.gov.au/mental-health/workforce-and-training/consumer-led-and-carer-led-workforce-innovation-grants>>.

Mental Health Workforce Innovation Day was held in September 2017. Eighty-four people attended an event on the day including clinical mental health workers, lived experience workers, statewide training providers, clinical academics and members of the Mental Health Expert Taskforce and its reference groups.

The day provided a forum for the clinical mental health workforce to come together to share ideas about workforce innovation, to share their experiences with innovative workforce models, to discuss factors that support and inhibit innovative practice, and to hear about the experiences of organisations leading the way in implementing innovative workforce models.

ENABLING SUPPORTED DECISION MAKING

The Enabling Supported Decision Making project, established by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) Victorian Branch in 2015, has seen a partnership between consumers, psychiatrists and other stakeholders. This partnership has now produced a position statement for psychiatrists on supported decision making, as well as a pilot workshop.

The workshop was co-designed and co-delivered by consumers and clinicians to 60 psychiatrists and registrars in May 2018. The workshop's interactive format and content was extraordinarily well received and breaks new ground in the way the RANZCP delivers training.

Though principally for Victorian-based psychiatrists working under the *Mental Health Act 2014*, both the position statement and workshop will also support best practice for mental health professionals throughout Australia and New Zealand in all mental health practice settings.

This project was funded by the department as a way to explore and better understand co-production.



Members of the RANZCP Victorian Branch Enabling Supported Decision Making subcommittee at the co-delivered workshop in May 2018

BUILDING CO-DESIGN CAPACITY

OUTCOME 7: Victorians with mental illness participate in learning and education

The department's Workforce branch, together with lived experience workforce partners and their organisations, have embarked on a journey to build and improve skills around co-design. The Australian Centre for Social Innovation (TACSI) worked with consumer academic Cath Roper to create a tailored program run as a pilot series of three co-design workshops from December 2017 to March 2018.

TACSI is supporting several areas of the department to examine and strengthen the conditions required for co-designing with lived experience participants. The department has also funded TACSI to provide planning and coaching support for a number of co-design projects in the sector.

ABORIGINAL MENTAL HEALTH WORKFORCE INITIATIVES

In 2017–18 the Victorian Government announced funding to support two new Aboriginal-specific initiatives:

- a mental health traineeship program for Aboriginal people in mental health services
- Aboriginal clinical and therapeutic positions in Aboriginal community-controlled health services.

ABORIGINAL MENTAL HEALTH TRAINEESHIPS PROGRAM

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

Area mental health services will employ 10 Aboriginal mental health trainees, providing them with supervised workplace training and clinical placements over three years while they complete a Bachelor of Science (Aboriginal Mental Health) through Charles Sturt University in New South Wales.

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

The initiative aims to:

- improve the effectiveness of mental health services in delivering culturally safe and inclusive services to Aboriginal people
- improve mental health promotion, prevention, early detection, intervention and treatment for Aboriginal people and communities
- strengthen Aboriginal-controlled community organisation and area mental health service partnerships and referral pathways.

Trainees will be located at eight area mental health services across metropolitan and rural Victoria. Eastern Health received funding for two trainees, as did Bendigo Health. Alfred Health, Peninsula Health, Latrobe Regional Hospital, Mildura Base Hospital, Monash Health and Forensicare all received funding for one trainee. Recruitment to the positions will be completed in October 2018.

ABORIGINAL CLINICAL AND THERAPEUTIC MENTAL HEALTH POSITIONS

This initiative will support 10 mental health clinical and therapeutic positions in selected Aboriginal community-controlled organisations across rural and metropolitan areas:

- Ramahyuck District Aboriginal Corporation (Morwell)
- Victorian Aboriginal Child Care Agency
- Mallee District Aboriginal Services (Swan Hill)
- Healesville Indigenous Community Services Association
- Gunditjmara Aboriginal Co-operative
- Ballarat and District Aboriginal Co-operative
- Budja Budja Aboriginal Co-operative
- Winda-Mara Aboriginal Corporation
- Dhauwurd-Wurrung Elderly and Community Health Service
- Kirrae Health Services.

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

The clinical and therapeutic mental health positions may be selected from a broad range of disciplines (such as mental health nurses, occupational therapists, psychiatrists, psychologists and social workers), as determined by the selected service provider.

SAFER CARE VICTORIA

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

Across its strategic priorities (partnering with consumers, partnering with clinicians, leadership, review and response, and system improvement and innovation), SCV has progressed a number of activities related to Victoria's mental health clinical services in its first full year of operation. These include:

- partnering with the Office of the Chief Psychiatrist to review sentinel events in mental health services
- working to share consumer feedback and concerns between SCV, the Health Complaints Commissioner, the Mental Health Complaints Commissioner and the department
- funding the trial and evaluation of the 'Safe Haven Cafe' at St Vincent's Hospital through the Better Care Victoria Innovation Fund.

In addition, SCV is establishing the Mental Health Clinical Network. Clinical networks have the primary role of providing clinical leadership, expertise and advice to SCV, with the ultimate aim of improving consumer outcomes and experiences. SCV has engaged with key stakeholders across Victoria, including consumer and carer groups, to begin planning for the Mental Health Clinical Network. In 2018–19 SCV will recruit a clinical lead and establish the Governance and Data/Evidence (INSIGHT) committees.

More information about the Mental Health Clinical Network is available from the Better Safer Care website <<https://bettersafercare.vic.gov.au/>>.



'Balit Murrup means "strong spirit" in the Woi-wurrung language.'

Aboriginal social and emotional wellbeing framework 2017–2027

ABORIGINAL SOCIAL AND EMOTIONAL WELLBEING

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

BALIT MURRUP LAUNCHED

Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027 was launched in October 2017. A key initiative of the 10-year *mental health plan*, *Balit Murrup* was developed through consultation with Aboriginal people about what is needed to improve resilience, social and emotional wellbeing and mental health in the Victorian Aboriginal community.

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

Projects funded in 2016–17 are now underway to test new service models for Aboriginal Victorians with moderate to severe mental illness and other complex health and social support needs. In 2017–18 funding was also allocated to support the Aboriginal-specific mental health training program and clinical and therapeutic mental health positions described earlier in this chapter.

IMPROVING MENTAL HEALTH OUTCOMES FOR ABORIGINAL PEOPLE WITH MODERATE TO SEVERE MENTAL ILLNESS

Four demonstration projects are currently underway to deliver integrated, culturally safe mental health services to meet the mental health and social and emotional wellbeing needs of local Aboriginal communities.

The four demonstration sites are:

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

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

The innovative partnership models encourage coordination of care with other service providers to deliver integrated wraparound care for Aboriginal people with moderate to severe mental illness and other complex health and social support needs.

DOING IT WITH HEART – PREVENTING SUICIDE IN ABORIGINAL COMMUNITIES

A statewide conversation about the difficult and complex issue of suicide prevention in Victorian Aboriginal communities was held in Melbourne in November 2017.

The statewide forum brought together more than 100 people from multiple organisations to focus on preventing suicide in Victorian Aboriginal communities. People from PHNs, Aboriginal community-controlled health organisations, community mental health organisations, health and community health organisations, various government departments, Victoria Police, universities, Aboriginal family violence groups, and Aboriginal social and emotional wellbeing program staff gathered and contributed to the day.

Dynamic Aboriginal actor Tammy Anderson and respected Elder Aunty Nellie Flagg led the forum and set the scene for a heartfelt and honest supported discussion. Counsellors from Yoowinna Wurnalung and Wathaurong Aboriginal Cooperative were on hand for support.

Evidence is growing about what works in suicide prevention. Professor Pat Dudgeon and Leilani Darwin from the Black Dog Institute spoke about the highly regarded Aboriginal Torres Strait Islander Suicide Prevention Evaluation Project and tools. Dr Graham Gee discussed promising results of research conducted through the #HerTribe program in collaboration with the Victorian Aboriginal Health Service. #HerTribe, which combines community connection, culture, physical activity and support, has been shown to reduce the psychological distress of participants and was used to road test the new Aboriginal resilience measure.

Connecting efforts between Aboriginal and non-Aboriginal initiatives was an important theme for the day. Elizabeth Deveny from the South Eastern Melbourne PHN highlighted the broad role of PHNs in mental health reform and alignment with suicide prevention initiatives. Belinda Duarte from Culture is Life and Indi Clarke from the Koori Youth Council also delivered powerful presentations about the work of their respective organisations in building resilience through cultural factors among young Aboriginal people and communities.

It became clear that further conversations and work are needed. Forum outcomes are informing the work of the 12 place-based suicide prevention trials and implementation of *Balit Murrup*.



Indi Clarke, Professor Pat Dudgeon and Dr Graham Gee

MEETING THE MENTAL HEALTH NEEDS OF CHILDREN AND FAMILIES

OUTCOME 1: Victorians have good mental health and wellbeing at all ages and stages of life

PERINATAL MENTAL HEALTH SERVICES

The perinatal period (the weeks before and after birth) can be a particularly vulnerable time for women and their families. Early identification of women who may be at risk of experiencing perinatal depression and anxiety is the key to early recovery.

In Victoria screening is provided as part of routine antenatal care and maternal and child health services. Vulnerable mothers are then referred to appropriate community-based or other specialist services. While routine screening for mental illness during the perinatal period is critical for identifying problems early, we know that to make a difference for women, screening must be supported by timely access to community-based services.

The Victorian Government addressed the withdrawal of Commonwealth funding for perinatal emotional health programs in 2015 by providing additional funding for these health programs in the last three State Budgets. Funding announced in 2017–18 delivers certainty for priority services and projects. It also supports women and their families living in rural and regional Victoria to access specialist perinatal mental health clinical assessment and treatment services.

Mother and baby units have been established in six health services across metropolitan and regional Victoria to provide residential multidisciplinary care for women experiencing serious mental illness in the perinatal period. These are located at Austin Health (Austin Hospital), Monash Medical Centre, Werribee Mercy Hospital, Latrobe Regional Hospital, Ballarat Health Services and Bendigo Health.

Despite new investment, access to perinatal mental health services for some regional and rural communities is still especially challenging. To help improve access to services, the department has increased care coordination services provided by Perinatal Anxiety and Depression Australia (or 'PANDA') to Victorian women.

In 2017–18 Melbourne Health, Monash Health and Eastern Health received grants to establish a sustainable and integrated service model based on partnerships with local service systems and PHNs. This work is designed to inform how sustainable models that improve access to mental health services may be developed across PHNs.

The Victorian Parliamentary Inquiry into Perinatal Services, tabled in Parliament in June 2018, made a number of recommendations about perinatal mental health services. The Victorian Government's response to the inquiry's recommendations will be addressed in next year's annual report.

NEW STEPPING STONES UNIT AND CHILDREN'S NEURODEVELOPMENT UNIT

In February 2018 Monash Health Early in Life Mental Health Service's Stepping Stones Adolescent Inpatient Unit moved from Monash Medical Centre to the new Monash Children's Hospital in Clayton.

The purpose-built facility also hosts a new Children's Neurodevelopment Unit, providing specialist multidisciplinary assessment, treatment and support for children and young people aged up to 25 years, including those with severe and complex psychological, behavioural and psychiatric problems.



Monash Children's Hospital in Clayton



Lighter and brighter rooms in the new facility



SUPPORTING DIVERSITY AND INCREASING ACCESS

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

SUPPORTING CULTURALLY DIVERSE COMMUNITIES TO PROMOTE MENTAL HEALTH

We recognise that culturally diverse communities can sometimes face challenges when accessing services and support in Australia.

We want to ensure that our mental health services identify and overcome language and cultural barriers so they are accessible to all Victorians and can provide effective treatment and support to any Victorian in need, no matter their cultural, religious or linguistic background.

In particular, people from refugee backgrounds almost universally have a history of exposure to highly traumatic events that can significantly impact their mental health. We need to ensure that our services are responsive to these needs.

In 2017–18, 13 organisations received funding through a new small grants program for projects that support culturally diverse Victorians experiencing, or at risk of experiencing, poor mental health, and their families and carers.

Organisations and their funded projects include:

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

These grants have been coordinated by the Victorian Mental Illness Awareness Council (VMIAC) and Tandem, Inc.

MENTAL HEALTH GUIDELINES FOR INTERPRETERS

Research has found that using specialist interpreters can improve mental health outcomes for the most vulnerable. LanguageLoop – formerly known as the Victorian Interpreting and Translating Service – commissioned researchers from Monash University to undertake a study to develop guidelines for interpreters working in mental health settings.

In an Australian first, the study focused on the mental health needs of culturally diverse consumers including newly arrived immigrants and refugees settling in Australia. It studied the outcomes of interpreters and psychologists working together to achieve better outcomes for culturally diverse mental health consumers.

The findings resulted in *Mental health interpreting guidelines for interpreters*, launched in December 2017. LanguageLoop chief executive officer Elizabeth Compton said the study provided a key to overcoming language barriers and will help interpreters become better skilled to help practitioners ensure mental health services are accessible for all.

Through these guidelines, LanguageLoop, in partnership with Monash University, is shedding light on the immediate need for culturally diverse communities to access mental health services without barriers, drawing attention to the importance of interpreters' work in this field.

In the general population, more than three million Australians live with anxiety or depression and approximately 45 per cent of people will experience a mental health condition during their lives. For culturally diverse communities and non-English speakers, this creates a greater challenge to access mental health services.

Dr Jim Hlavac led the Monash University research team that examined the factors at play when an interpreter was involved in a mental health scenario. He described the role as critical in assisting professionals to work effectively with culturally diverse consumers in mental health interactions. Monash University has developed a specialist course for interpreters that will be delivered to LanguageLoop interpreters working across Australia in hospitals, schools, law courts and specialist mental health services.



For more information, visit the LanguageLoop website <<http://www.languageloop.com.au/>>

**'I want to
champion
the youth.'**

*Participant, Seat at the
Table (June 2018)*

EVERYONE DESERVES A SEAT AT THE TABLE

Seat at the Table uses a co-design approach to improve engagement around the mental health of young people from refugee and asylum seeker backgrounds in Melbourne's western suburbs.

Auspiced by HealthWest, Seat at the Table uses a collaborative approach to create ideas that increase engagement and reduce stigma around (the often sensitive issue of) mental health. As one community participant put it, 'Co-design is about everyone having skin in the game'.

The purpose of the project is to actively engage with young people with lived experience and to work together with service providers.

The project continues to:

- pilot innovative strategies to promote mental health
- establish and support a network of young people from refugee and asylum seeker backgrounds with an interest in mental health
- develop an exemplary model of participation and build capacity among service providers for community participation
- improve participation in mental health services.

Ultimately, Seat at the Table seeks to support young people to develop ideas that would improve the mental health outcomes of other young people from refugee and asylum seeker backgrounds.



Bringing young people from refugee and asylum seeker backgrounds together with mental health service providers



Young people and service providers working together to storyboard new co-design ideas

MEETING THE MENTAL HEALTH NEEDS OF NEW ARRIVALS AND REFUGEES

OUTCOME 15: Victorians with mental illness, their families and carers are treated with respect by services

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

The Better Access to Mental Health for Young Syrian and Iraqi Refugees Program supports a range of strategies for improving mental health services in Victoria. This new program aims to improve the capacity of mental health services in the northern metropolitan region to address the mental health and wellbeing issues of newly arrived Syrian and Iraqi refugees early in settlement.

The program is being rolled out primarily in Melbourne's northern metropolitan region.

It includes the following initiatives:

- Orygen, the Royal Children's Hospital and the Austin Child and Adolescent Mental Health Service are partnering to develop a culturally responsive mental health triage, assessment and referral program for refugee children and young people at risk of mental disorders, including specialised child and youth mental health services outreach to specialised refugee and mainstream services.
- Foundation House is overseeing a community-led mental health promotion and mental health literacy training program to build community resilience and rapid responses.

- Foundation House is partnering with mental health services to establish a Community of Practice in child and youth refugee mental health to support professional/organisational development and capacity building, particularly for primary mental health services.
- Start-up funding is being provided for a HealthWest research partnership on youth refugee mental health.

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

SUPPORTING THE MENTAL HEALTH NEEDS OF LGBTIQ+ YOUNG PEOPLE

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

While most young people with a mental health issue do not exhibit suicidal behaviours, there is a substantial body of research that supports a strong correlation between mental illness and suicidal behaviour.

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

Healthy Equal Youth grants awarded in 2018

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

The 2017–18 HEY Grant recipients were announced in January 2018. They include SYN Media, which will use government support to produce radio programs and podcasts on issues affecting LGBTIQ+ young people, and Knox City Council, which will create a series of short animated films sharing lived experiences and information for local youth.

Other recipients include Maroondah City Council Youth Services, the Victorian and Tasmanian Youth Cancer Service, Mornington Peninsula Shire, Wyndham City Youth Services, Wellington Shire Council, Inclusion Melbourne, Drummond Street Services, Headspace Horsham, Glenroy College and Embittered Swish. The recipients were awarded a total of \$111,000 in grant funding.

Sixty-five organisations have received HEY Grants over the past seven years.



LISTENING TO CONSUMERS, FAMILIES AND CARERS

LIVED EXPERIENCE ENGAGEMENT REGISTERS

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

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

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

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

LIVED EXPERIENCE ENGAGEMENT FRAMEWORK

As we drive mental health reforms across our programs and services, we must engage and partner more effectively with those most affected by the problem to develop real solutions. This means working with our stakeholders, especially consumers, their families and carers who use and need our mental health services. To do this we recognise that our engagement efforts need to shift from traditional methods of 'deliver and inform' to 'involve and collaborate' through co-design and co-production engagement approaches.

Throughout 2017–18 the Lived Experience Reference Group worked to develop a new *Mental health lived experience engagement framework*. This work began in 2016–17 alongside the Mental Health Expert Taskforce and was a key original output of *Victoria's 10-year mental health plan*.

The framework will provide guidance to departmental staff on how to actively engage people with the relevant lived experience of mental illness or caring for someone with mental illness in their work.

YOUR EXPERIENCE OF SERVICE SURVEY

The Your Experience of Service (YES) survey is a national instrument that provides an annual snapshot of consumers' experience using clinical mental health services and psychosocial rehabilitation support services.

There are two questionnaires – one clinical and one for community-managed organisations. The questionnaires were developed with mental health consumers throughout Australia and are based on recovery principles in the *National Standards for Mental Health Services 2010*.

In Victoria the YES survey has been conducted annually since 2016 to better understand consumers' experiences of state-funded specialist mental health services. Areas of consumer experience explored include: dignity and respect; evaluating recovery; uniqueness of the individual; partnership and communication; attitudes and rights; and providing real choices.

In 2016 and 2017 the YES survey was administered in March and April. In 2018 it was administered from March to May to increase uptake.

While the YES survey results for clinical services have been positive overall in many areas during 2017–18, there is some clear variation between service types. In particular, responses from people using acute adult inpatient services have been less positive than clinical services generally, while responses from those accessing acute adult mother and baby units have been more positive. Additional detail on these results is provided in Chapter 3.

Services that have transitioned to the NDIS are no longer required to administer the survey. Once the NDIS is fully implemented, the survey will only be run in clinical services (including residential services).

**'I love to paint.
It makes me feel
alive and well.'**

*Carol Horman, 2017 Winner, Mental Health
Foundation Consumer Art Competition*

IN DEEP THOUGHTFULNESS

Carol Horman was awarded first place in the 2017 Mental Health Foundation Australia (Victoria) Consumer Art Competition. Her winning artwork, *In deep thoughtfulness*, featured on the 2017 Mental Health Week promotional poster, following an exhibition held at Melbourne's Treasury Theatre with the department's support.

I began painting in 2007, a year I can't forget. I spent over 12 weeks in a psychiatric hospital suffering schizophrenia, major depression and post-traumatic stress disorder. I was suicidal.

The hospital helped me immensely, offering an array of activities and learning opportunities including art therapy. I discovered a new passion. I love to paint. It makes me feel alive and well.

When I saw the photograph of my niece's daughter, I knew straight away that I needed to paint her. She has so much depth of character and beauty. Abelia and her mother Kate allowed me the privilege of painting her portrait. I worked regularly on the painting for several months.

Then the opportunity arose to enter a painting in the Mental Health Foundation competition, so I titled her portrait *In deep thoughtfulness* and I hoped then that others would see her the way I did.

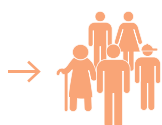


TRANSITIONING TO THE NATIONAL DISABILITY INSURANCE SCHEME

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



42,204
Victorians receiving
NDIS support in June 2018



4,389 have a primary
psychosocial disability

The NDIS is the national approach to providing life-long support to Australians with a disability, their carers and families. This includes people with a psychosocial disability.

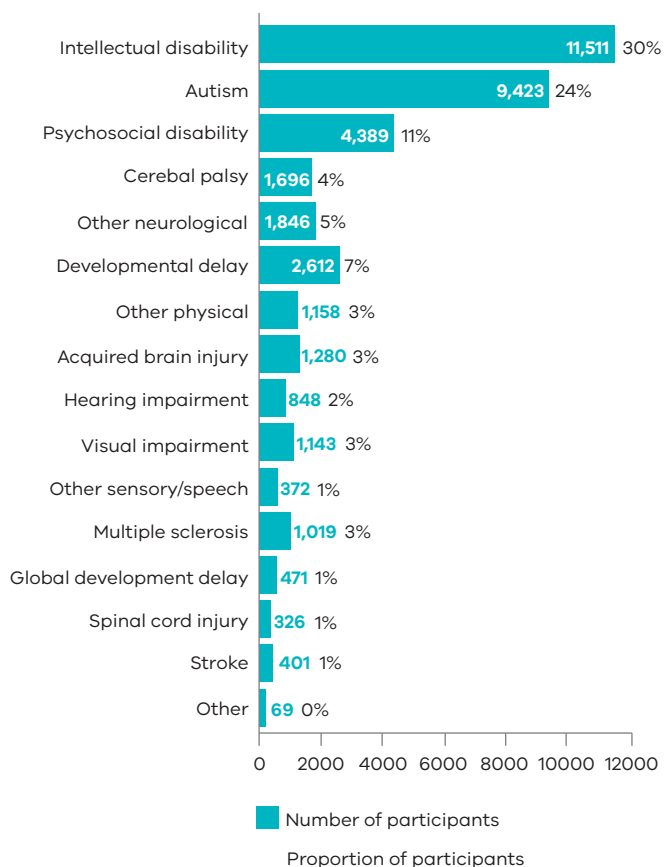
The NDIS is progressively rolling out across Victoria and will be fully underway by 30 June 2019. We are working closely with the National Disability Insurance Agency (NDIA) to ensure the NDIS delivers its intended benefits to eligible Victorians with a severe mental illness and associated psychosocial disability, and to support the smooth transition of consumers to the NDIS.

Throughout 2017–18 clients living in Inner Gippsland, Wimmera South West, Ovens Murray, Inner and Outer Eastern Melbourne, Hume Moreland and Bayside Peninsula transitioned to the NDIS. This process will enter its last year in 2018–19, when the final six areas transition.

While there are a number of challenges associated with substantial reform of this nature, the NDIS represents a significant opportunity for people with a severe, enduring psychosocial disability to receive better and greater levels of support over their lifetime.

As at 30 June 2018, 42,204 Victorians had approved plans and were actively receiving support via the NDIS. This includes 4,389 Victorians with a primary psychosocial disability (see Figure 1).

Figure 1: Primary disability of active participants with an approved plan



When rollout is complete in Victoria, the NDIS will support between 15,000 and 16,000 people with a primary psychosocial disability each year. Not only will a significantly greater number of people with a psychosocial disability receive support, if current trends hold, the value of their funding package is anticipated to be significantly higher than the average level of funding they currently receive as clients of mental health community support services.

INFORMATION, LINKAGES AND CAPACITY BUILDING

During 2017–18 the department received Commonwealth funding to deliver Information, Linkages and Capacity Building initiatives. These initiatives supported 1,520 people with a psychosocial disability and their carers to build their individual capacity for daily living and connectedness, as well as exercise genuine choice and control.

SUPPORT FOR MENTAL HEALTH SERVICES

The department has also been working closely with health services to prepare for the NDIS and optimise opportunities for eligible consumers of clinical mental health services.

The department released a practice guideline to support the interface between the clinical mental health service system and the NDIS. The guideline identifies the key roles and responsibilities of all parties and best practice in supporting consumer access to the NDIS.

The department is working with Austin Health, Melbourne Health and St Vincent's Hospital to develop practical resources for clinical mental health staff who are supporting consumers to access the NDIS. Learnings and resources are being shared with health services across Victoria as they are developed.

The department provided funding to Mental Health Victoria, VMIAC and Tandem to support community-managed mental health organisations, people with a psychosocial disability and their carers as they prepare for, and transition to, the NDIS. The department also funded 10 mental health program leaders in relevant health services to lead NDIS readiness activities within their organisation and to work with the NDIA, Local Area Coordination partners and NDIS providers to resolve local issues and achieve the best outcomes for shared participants.

A MOTHER'S STORY

In July 2016, the Alfred's Child and Youth Mental Health Service (CYMHS) established the Mental Health Intellectual Disability Initiative for Youth (MHIDI-Y), a first-of-its-kind mental health service for young people with an intellectual disability. This unique and essential service has provided much needed support to young people and families whose mental health care has not always been properly understood or treated.

Parenthood is a gift that's mostly joyful, with moments of heartache. Parenting a teenage boy with multiple diagnoses differs somewhat – it can be endless heartache, big to small. Then, peppered with moments of joy.

We live for our family; for family unity. My boy will always belong to our family and be called 'son' and 'brother'.

However, his life will be enriched if he chooses to be physically and emotionally present some of the time, surrounded by the few that truly care. Given the choice and opportunity, would a person prefer to stay alone in a world of pain?

Our son was indeed very sick. His mental health declined considerably in his 12th year, and we crashed along with him. He suffered in all aspects of his daily life across all settings – be it home, school or respite facilities. We didn't know how to help him feel settled and happy. We couldn't manage his behaviours. As a family, we became more and more isolated from the outside world, and even within our home, sometimes taking refuge in separate zones like strangers in a hotel.

Caregivers in other settings felt the strain and struggled to cope – our family unity was in crisis.

It was time to invite other specialised health professionals into our care team. We already had an excellent paediatrician of 10 years on board, who'd gone above and beyond.

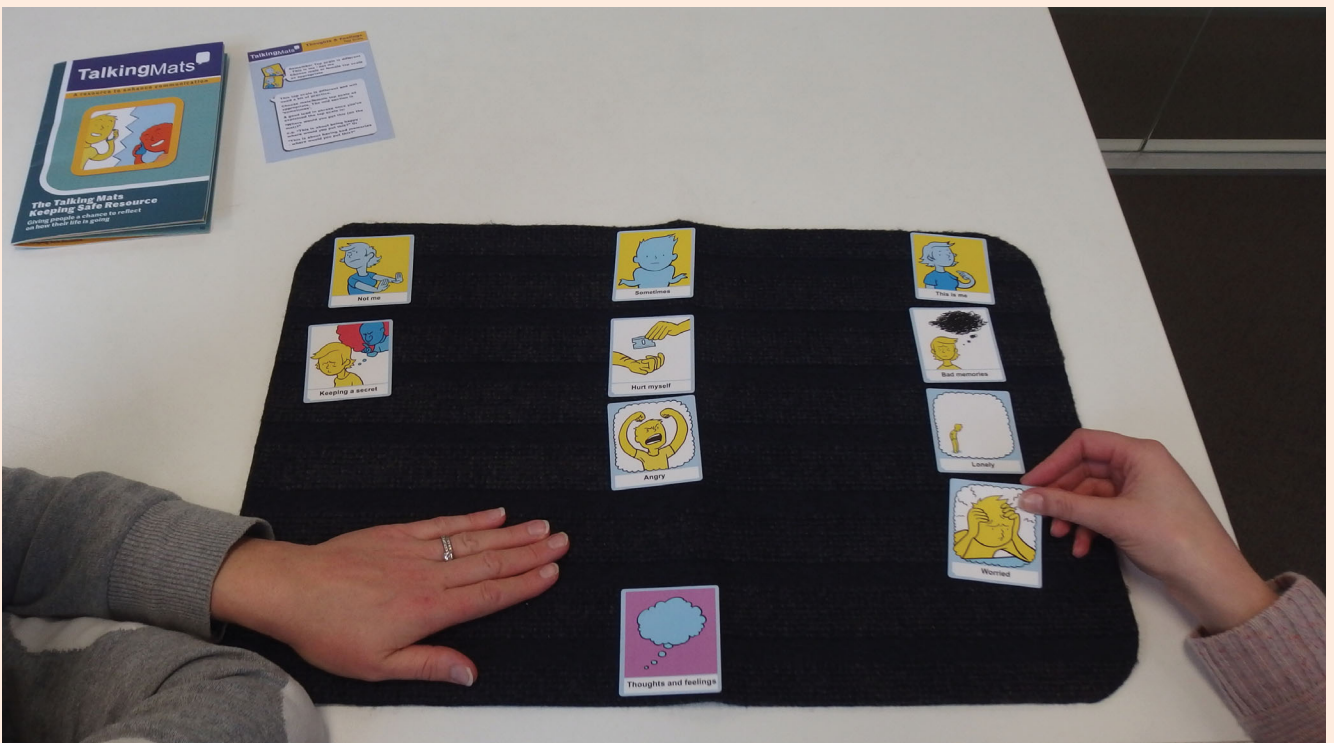
Initially at CYMHS there was much discussion – it became apparent he required urgent medical intervention. He began responding to medications, then Behaviour Support Intervention followed. Throughout, his caregivers, family, school teachers and respite workers needed the knowledge, strategies, support, confidence and motivation from CYMHS to persist.

Very slowly, our son is improving, as is his management of challenging behaviours. He continues to learn, little by little. We have good and bad moments, good and bad days. Overall, more regular, joyful moments – which we celebrate! And less heartache.

His caregivers have a renewed sense of purpose and hope in helping him to succeed. There's greater collaboration between all parties across his environments. So, it is not only our son who is changing for the better – we're all changing as well.

CYMHS is helping our son find happiness. Consequently, we feel happier. His family are remaining strong and united. And he is learning to be a part of it and part of his school and respite families too.

Together, CYMHS and all his families form a wonderful care team.



'Talking Mats' is a communication tool that is used to help the young person communicate their thoughts and feelings, and to create a listening space to think about and share how their life is going. It is designed for people with intellectual disability and limited verbal communication skills. Talking Mats Limited is a social enterprise that originated at the University of Stirling in Scotland in 2011. Its vision is to improve the lives of people with communication difficulties by increasing their capacity to communicate effectively about things that matter to them.

NATIONAL PSYCHOSOCIAL SUPPORT MEASURE

In June 2018 Victoria and the Commonwealth signed a bilateral agreement for a national psychosocial support measure.

The measure targets people with a severe mental illness who do not qualify for the NDIS because they do not have a significant, enduring psychosocial disability but require a level of specialist, less intensive and possibly shorter psychosocial support to improve their daily living and connectedness.

The Commonwealth will fund \$20.6 million over four years in non-clinical community mental health services in Victoria as part of the measure. Outside its NDIS contribution, Victoria is continuing to progressively invest in non-clinical mental health supports, with a focus on people experiencing homelessness and social exclusion and vulnerable young people. This funding, which has progressively increased from 2015–16, forms Victoria's co-contribution to the national psychosocial support measure.

Victoria's contribution will fund a range of tailored psychosocial supports. These will build the capacity of people with a severe mental illness and associated psychosocial disability, their carers and families to understand and better self-manage their mental health condition, connect to local health and community services, recover and participate in the life of the community.

Delivered through community-managed mental health support services, these supports will be provided in ways that best suit the consumer and the nature of the supports being provided.

The Commonwealth will allocate its funding contribution to PHNs, which will commission services based on the needs of the local community, taking into account what services and supports are already available. Service delivery is due to begin from early 2019.

The department will actively engage with PHNs to maximise potential synergies between Victoria's psychosocial investment package and supports funded through the Commonwealth contribution.

FORENSIC MENTAL HEALTH REFORMS

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

COMMUNITY SAFETY STATEMENT

In August 2017 the Victorian Government released the *Community safety statement*. The statement focuses on the role of Victoria Police in contributing to the government's long-term community safety outcomes.

The *Community safety statement* includes efforts to:

- increase mental health literacy among Victoria Police staff
- increase diversity and tolerance within the police force
- address cultural barriers and drivers of mental health stigma
- enable appropriate and informed policing responses to vulnerable Victorians, including Victorians with mental illness, in contact with the criminal justice system.

Victoria Police, other government agencies including the department, and the broader justice and correctional system play a fundamental role in achieving and upholding community safety.

Continued progress and investment under *Victoria's 10-year mental health plan* is integral to achieving community safety outcomes outlined in the *Community safety statement*. During 2017–18 we have continued to expand mental health support for those who are in, or at risk of entering, the criminal justice system and to meet increasing demand for mental health services in justice settings.

FORENSIC MENTAL HEALTH IMPLEMENTATION PLAN

A range of forensic mental health reforms funded in Victoria's 2016–17 State Budget comprise the *Forensic mental health implementation plan*. The plan is a cross-portfolio framework aimed at increasing community safety by reducing the number of people living with a mental illness in contact with the criminal justice system, as either offenders or victims of crime.

Under the implementation plan, we are enhancing clinical mental health assessment, treatment and support services delivered to young people in Parkville and Malmsbury Youth Justice Precincts through our Custodial Forensic Mental Health Service.

We are establishing Victoria's first dedicated secure forensic mental health unit for young people who are in custody and require compulsory acute inpatient treatment in hospital.

We are also establishing a Community Forensic Youth Mental Health Service, which will be operational later in 2018. This is an early intervention model for young people with mental health needs exhibiting problem behaviours and focuses on preventing contact with the youth justice system.

We are also expanding and enhancing mental health court advice services in 13 Magistrates' Courts across Victoria through the new Mental Health Advice and Response Service. This service will assist with information about mental illness for the purposes of bail and sentencing decisions. It will also provide a mental health court advice service to the Children's Court, focusing on the mental health of accused young people, with a view to linking them to child and adolescent mental health services in the community.

Clinical mental health services are also being established in community health services across Victoria to deliver mental health support to people on community correction orders or with mental health treatment and rehabilitation conditions on their parole. These services will work with 22 community correctional services sites to provide support to these consumers.

ADDRESSING DEMAND FOR FORENSIC MENTAL HEALTH BEDS

Services at Thomas Embling Hospital remain in high demand. Eighteen additional beds will open during 2018–19 to help meet urgent demand for prisoners requiring compulsory mental health treatment and people subject to orders under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*.

In October 2017 Ravenhall Correctional Centre, the new medium security men's prison, opened in Melbourne's west. The prison includes a specialised unit to provide dedicated forensic mental health treatment for up to 75 prisoners, and a large and varied specialist outpatient program managed by Forensicare.

PUBLIC SAFETY AND PEOPLE WITH COMPLEX NEEDS

We are committed to keeping communities safe from acts of violence and to providing the best possible treatment for people with complex needs who pose a risk to public safety.

In response to the tragic incidents in Melbourne's central business district in early 2017, the Victorian Government established the Victorian Fixated Threat Assessment Centre to help identify high-risk individuals and prevent violence through early intervention.

The assessment centre began operations in March 2018. It brings together police and mental health clinicians to provide a coordinated response to serious threats of grievance-fuelled violence by people with complex needs.

We are also expanding the Multiple and Complex Needs Initiative to provide additional supports to people with complex needs including:

- additional planning and service delivery coordination
- brokerage support and flexible funding packages.

As part of this work, consideration is also being given to how best to strengthen our service capacity to treat and support people with complex needs who pose significant risk of harm to others.

2

REFORM OF VICTORIA'S CLINICAL MENTAL HEALTH SERVICES 2018–2023

2. REFORM OF VICTORIA'S CLINICAL MENTAL HEALTH SERVICES 2018–2023

VICTORIA'S 2018–19 STATE BUDGET

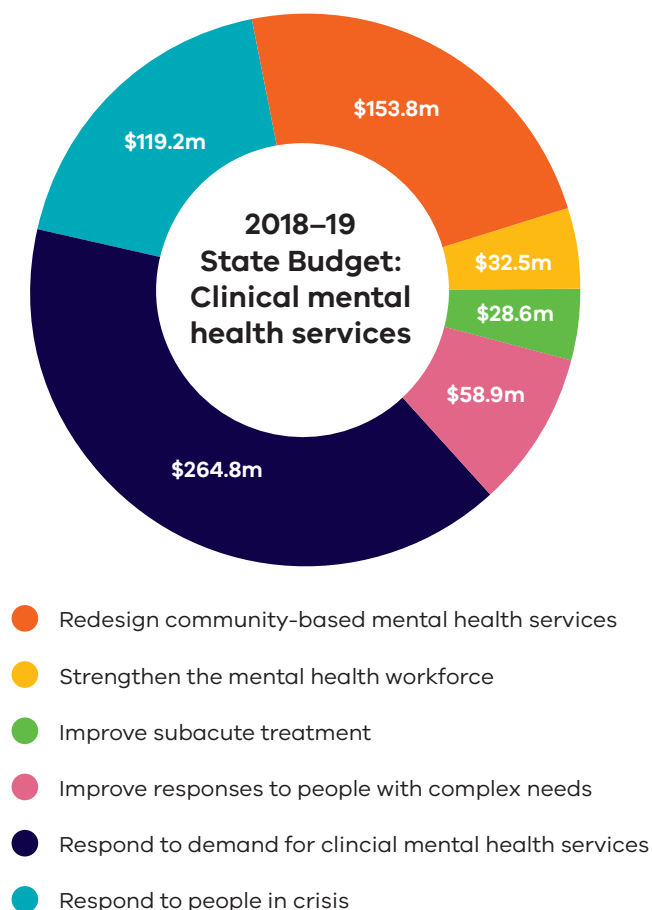
OUTCOME 13: The treatment and support that Victorians with mental illness, their families and carers receive is available in the right place, at the right time

Extensive review work undertaken throughout 2017–18 built a strong case for injecting new resources into the clinical mental health system. This work showed that services are under increasing and sustained demand pressure. As our first two mental health services annual reports highlighted, increasing demand has been driven by multiple factors including population growth, changing patterns of drug use and increasing community awareness of mental illness.

Long-term funding growth has not kept pace with the increased demand for services. As a consequence, mental services are struggling to meet the community's need for high-quality mental health care for people with severe mental illness, their families and carers.

Investment in the 2018–19 Budget will help health services keep pace with growing demand for clinical mental health services, allowing them to open and operate new services, boost the number of treatment hours in community-based mental health services, and improve outcomes for consumers.

Figure 2 demonstrates the spread of investment provided in the budget over the next four years.



Investment to help reform clinical mental health services

Investment announced in the 2018–19 State Budget includes funding, over four years, to:

- operate 89 new and existing acute inpatient beds
- boost the number of treatment hours in community-based clinical mental health services, which will give around 12,800 more Victorians access to these services
- establish six emergency department hubs across the state for people with urgent mental health, alcohol and other drug (AOD) issues
- develop six new HOPE sites
- expand the existing Multiple and Complex Needs Initiative and services for adults with complex needs who pose significant risks to the safety of others
- provide intensive community mental health services and support for current high-needs mental health consumers
- boost clinical support in existing prevention and recovery care units (PARCs)
- establish a new 20-bed residential facility for young people with a mental illness.

Importantly, though, we are investing in system reform. In consultations over the past two years, consumers, their families and carers, mental health clinicians and other professionals have shared their expertise and ideas about how things could be done differently in the clinical mental health sector.

Based on their feedback, we have identified six key priority areas for action and six enablers will shape our reform work over the next five years.

WHAT WE WILL DO

We will:

- reform adult community-based services by
 - increasing service capacity to treat more people and respond at earlier stages of illness
 - supporting clinicians to deliver evidence-based best practice interventions
 - streamlining and improving service entry process so people can get timely assessment of their needs and referral to mental health or other services
- introduce new responses to help people experiencing a mental health crisis
- provide a balanced range of high-quality bed-based services including enhanced subacute and secure extended care services
- build linkages with and support for other services, with AOD services prioritised for immediate action
- respond effectively to people with complex needs who present significant risks to the safety of others
- strengthen services for children and young people.

HOW WE WILL DO IT

We will:

- introduce a new funding model that provides incentives to health services to accept more patients and direct resources to the highest need patient groups
- introduce new performance and accountability frameworks that create greater transparency about service performance and consumer outcomes
- support our mental health workforce to deliver evidence-based and best-practice treatment
- undertake service and infrastructure planning to identify the optimum mix of community-based, subacute and acute inpatient services, taking account of the need for services and infrastructure to reflect demographic changes
- provide effective clinical and policy guidance to the sector
- invest in research and evaluation to support continuous learning about interventions and approaches that improve consumer outcomes.

Proposed reform action area

Key reforms

Action area 1

Reforming adult community mental health services

- ▶ Therapeutic models of care
- ▶ Targeted funding for high-need adult community mental health consumers
- ▶ Introduction of mental health engagement workers to free up clinicians for specialised clinical work

Action area 2

Meeting the needs of people in crisis

- ▶ Mental health/AOD hubs in six emergency departments
- ▶ Expansion of the Hospital Outreach Post-suicidal Engagement (HOPE) initiative
- ▶ Review of triage across different age-based mental health providers

Action area 3

Providing a balanced system of high-quality bed-based services

- ▶ Enhancement of inpatient care and staff wellbeing by introducing 31 senior nurse consultants to major inpatient units
- ▶ Development of new subacute models and pathways

Action area 4

Improving effectiveness of responses to clients with co-existing AOD and mental health issues

- ▶ Support for mental health services to more effectively manage consumers' co-existing AOD problems
- ▶ Support for AOD services to respond to their clients' mental health needs
- ▶ Enhanced dual diagnosis services

Action area 5

Responding to people with complex needs who pose significant risks to others

- ▶ Specialised treatment for adults with complex needs who are at risk of causing harm to others
- ▶ Improved access to the Multiple and Complex Needs Initiative
- ▶ Embed the Victorian Fixated Threat Assessment Centre

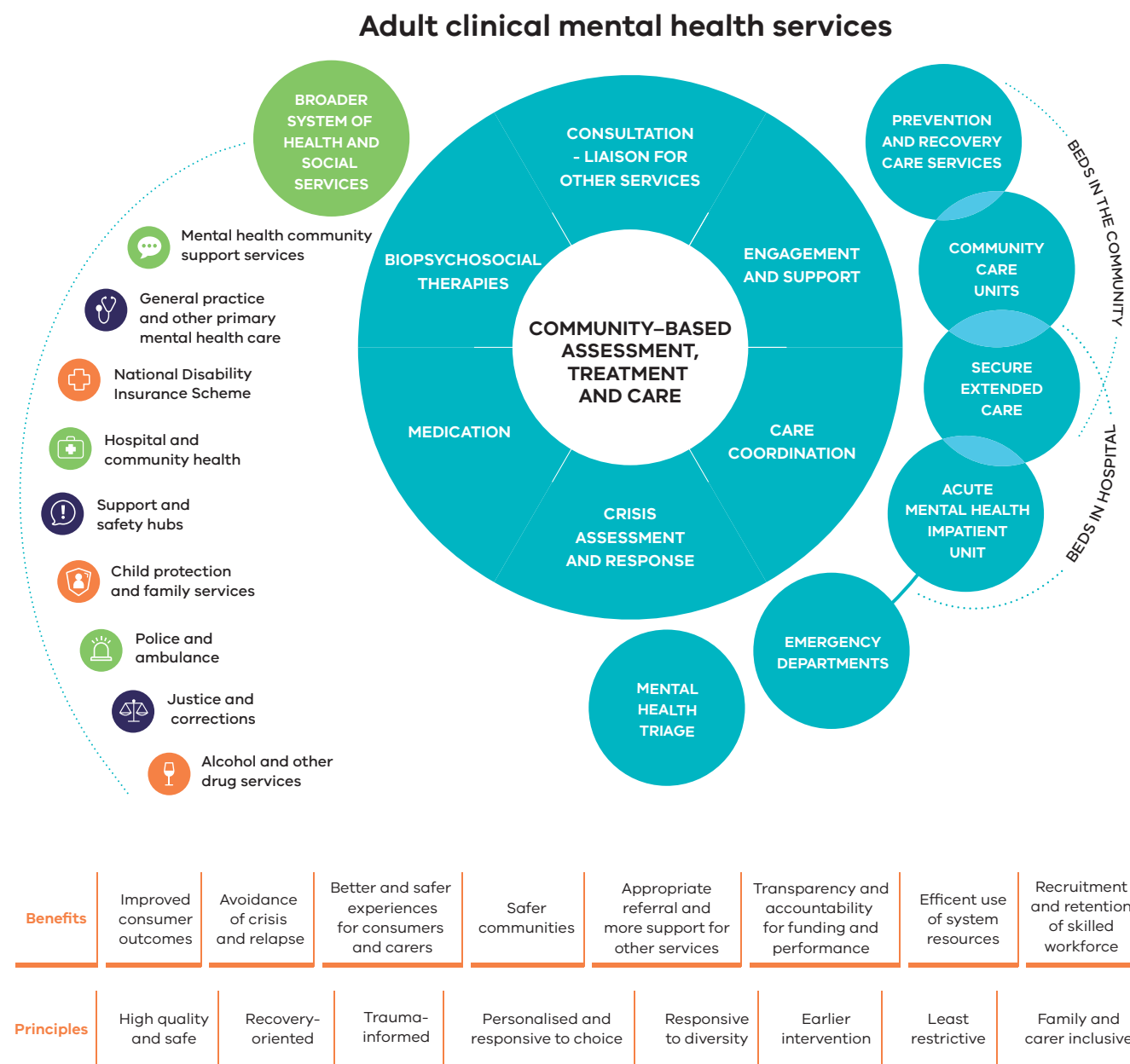
Action area 6

Strengthening services for children and young people

Development of a new strategic framework for the child and youth mental health sector to improve service consistency, access and integration with other services

Figure 3 depicts how these reforms integrate together and link with other health and community services. They aim to strengthen and rebalance our community-based clinical service system while ensuring high-quality, accessible services for people in crisis or those requiring treatment in acute inpatient, subacute or other residential settings.

Figure 3: Post-reform adult clinical mental health services



MENTAL HEALTH AND AOD HUBS IN MAJOR EMERGENCY DEPARTMENTS

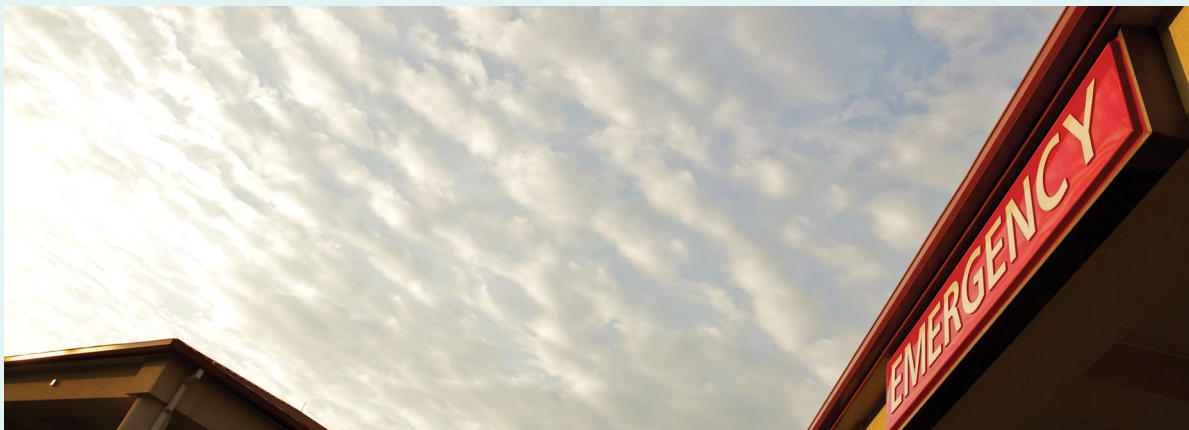
Mental health and AOD hubs will provide a specialised stream of emergency department care for people presenting with high-acuity mental health and AOD issues.

The hubs will be staffed by psychiatrists, psychiatric registrars, social workers, mental health nurses, peer support workers, AOD specialists, nurse practitioners and security personnel. They will work together in a dedicated area of the emergency department to provide assessments and therapeutic interventions. Where people do not require admission to an acute inpatient unit, they will be referred to other more appropriate community-based services once assessed and stabilised. If necessary, mental health clinicians will provide assertive outreach to patients, their families and carers after they leave a mental health and AOD hub.

Six hubs - at the Royal Melbourne Hospital, Barwon Health, Monash Medical Centre, St Vincent's Hospital, Sunshine and Frankston Hospitals - will commence in 2018-19. Short stay beds will be added to the model as they are built. These will provide an option to assess and treat people in the emergency department for up to 24 hours, or longer where clinically appropriate.

This model will provide a timely, recovery-oriented response in an environment that is more suitable for people experiencing mental health or AOD-related crises. Waiting for long periods in high-stimulus environments can exacerbate mental health crises, which can be distressing not only for the person but also for other patients, visitors and staff.

More effective treatment provided through the hubs will reduce re-presentations to the emergency department, with flow-on benefits in terms of reduced need for admission to an inpatient bed and an improved chance of recovery in the community.



Work is underway to establish six mental health and AOD hubs across Victoria, funded in the 2018-19 State Budget

'I am now almost two years into my most recent recovery and working in the field of mental health.'

Belinda (June 2018)

BELINDA'S EXPERIENCE: THE EBB AND FLOW OF RECOVERY

I was 15 and living in South Australia when I was told by a doctor that I was depressed and had an eating disorder.

After that, I spent a lot of time with my psychiatrist and had multiple admissions to an inpatient unit over a three-year period. Sometimes being admitted kept me safe, but other times it brought me into contact with very unwell people. Talk therapy was less of a focus than medication management. My life improved significantly when I left the hospital. I left home and I moved to Melbourne.

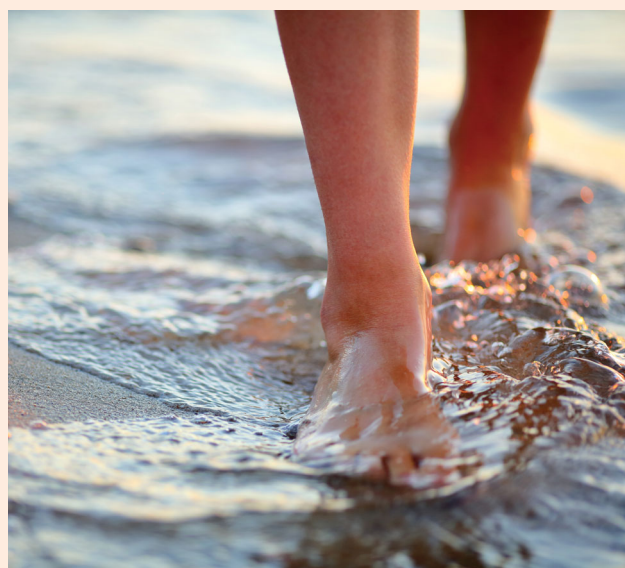
I am 38 years old now, and looking back, it has taken me a long time to learn a couple of important things. Firstly, I know now that I deteriorate rapidly every five years and that this is usually prompted by significant life events. Thankfully, it is possible for me to get back on the road to recovery within a six-month period, but only, I have discovered, if I establish a lifestyle based on daily exercise.

Secondly, I also know now that having someone I can trust to talk to helps my self-awareness of my mental health and means I feel more resilient when things become hard. Finding a trusted professional can be a long and frustrating process, especially for consumers who have been denied the opportunity to make decisions during previous mental health treatment. However, having someone to provide insights from an external perspective is really helpful, especially when they recognise that you ultimately choose your own path.

It is very tempting to look back on my time on an inpatient ward as a misstep. However, my experience has helped me to understand what treatment options work best for me and how this can change over time.

The best kind of mental health system is one that keeps people safe, empowers them to make decisions about their own treatment, and provides a range of different treatment settings that can respond to the 'ebb and flow' of recovery.

I am now almost two years into my most recent recovery and working in the field of mental health. This means my experience can contribute towards building a better mental health system today and in the future.



3

YEAR IN REVIEW – PUBLIC MENTAL HEALTH SERVICES IN 2017–18

3. YEAR IN REVIEW – PUBLIC MENTAL HEALTH SERVICES IN 2017–18

OVERVIEW

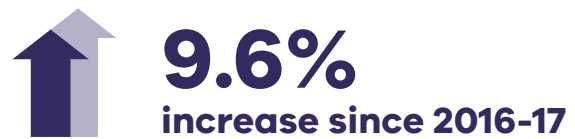
The data in this section of the report helps us to understand who accesses our services and how, the service settings and circumstances in which treatment is provided, and whether that treatment results in better outcomes. It also tells us about demand for, and use of, our services.

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

The data shows a substantial increase in the number of clients across all groups and a substantial increase in the provision of community clinical mental health services. It appears that the increase in community service contacts and service hours is largely the result of improved reporting practices. Although there has been an increase in contacts and hours, it is less than that indicated by the numbers because in the two years before 2017–18 there was incomplete reporting of service activity partly due to industrial action. This will be discussed further later in the chapter.

The majority of our clients are adults, and the data continues to show that adult inpatient services are under pressure to meet demand. Hospitalisations of adults for mental illness are increasing, adult services have very high occupancy levels, and the length of hospital stays is trending down. Forensic services are also under pressure, with very high bed occupancy and a relatively small number of separations.

WHO ACCESSED OUR PUBLIC MENTAL HEALTH SERVICES IN 2017–18?



There was a substantial increase in the number of children, young people, adults and older people accessing public mental health services during 2017–18. The total number of people accessing services was 72,859, up 9.6 per cent from the previous year.

Most clients are adults, but increases of 10–12 per cent in client numbers occurred across all age groups. Although they are a relatively small part of the service system, substantial increases also occurred in the number of clients accessing forensic and specialist services.

Mental illness frequently emerges in late adolescence or early adulthood. Across our bed-based services for adults, more than half our clients are aged 25–44 years. Because many illnesses affect people's functioning in social, family, educational and work roles, the early age of onset can have long-term implications.

Some people need short-term support, while others may need admission to hospital for treatment to manage symptoms, followed by support and treatment in the community over a longer period. Some people with mental illness may require significant ongoing support throughout their lives. Many people with serious mental illness need a range of services over a long period and experience negative social, health and economic outcomes.

During 2017–18 about two-thirds of adult and aged clients, and about half of children and young people, had previously had contact with mental health services during the preceding five years. Across the system, 13.5 per cent of clients (9,809 people) had contact with the system at least once each year for the previous five years.

Just over half our clients are women or girls (50.3 per cent), and a third live in rural areas (32.9 per cent). Only a small proportion of our registered clients (3,716) used both clinical and mental health community support services in 2017–18.

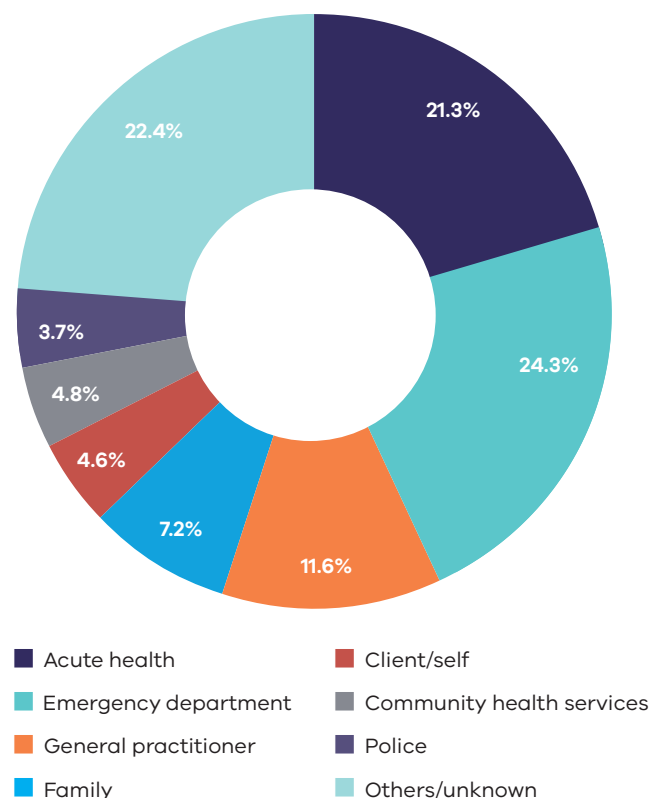
HOW WERE PEOPLE REFERRED TO OUR CLINICAL SERVICES IN 2017–18?

Most people were referred to clinical mental health services by hospitals (see Figure 4). Almost a quarter of referrals came from emergency departments (24.3 per cent) and a further fifth (21.3 per cent) from acute health services. The latter group may include people who are admitted with a physical illness or injury and are subsequently referred for mental health treatment. General practitioners continue to be a key source of referrals (11.6 per cent) as do families (7.2 per cent).

The data tells us that there has been very little proportional change in these main referral pathways and sources over recent years.

There were 92,610 mental health-related presentations in emergency departments during 2017–18, an increase of 6.2 per cent from 2016–17. Across all age groups, there were 26,098 hospitalisations in mental health acute inpatient units in 2017–18, an increase of 7.2 per cent. Half of these admissions (50.3 per cent) were compulsory. There has been a slight downward trend in compulsory admissions over the past three years.

Figure 4: How were people referred to our clinical services in 2017–18?



This year, we changed the definition of ‘mental health emergency department presentation’. In addition to presentations where the person has a primary diagnosis of a mental or behavioural disorder, we now also include presentations:

- where the patient has a general psychiatric examination
- with suicide risk, attempt or ideation
- with intentional self-harm
- where the patient was seen by a mental health practitioner
- where the patient departed to a mental health bed or facility.

This broader definition more accurately reflects the number of emergency department presentations that involve mental illness.

HOW DID PEOPLE EXPERIENCE OUR SERVICES?



2,532
YES survey responses



16.7%
increase since 2016-17

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

The YES survey was carried out for the third time in 2017-18, and this report discusses results for clinical mental health inpatient and community services. A total of 2,532 surveys were completed in 2018 by people aged 16 or older, an increase of 16.7 per cent on the number of responses the previous year. The results show that most clients feel their individuality and values were respected, with 70.7 per cent of people reporting this was always the case and 18 per cent reporting it was usually the case. Just under two-thirds of people reported that their experience of having a care plan developed that considered all their needs was very good (24.9 per cent) or excellent (37.6 per cent).

Consideration and inclusion of families and carers is very important to most Victorians when they receive health care, including people with severe mental illness. Most (83.8 per cent) clients reported that they usually, or always, had opportunities for family and carers to be involved in their treatment or care if they wanted.

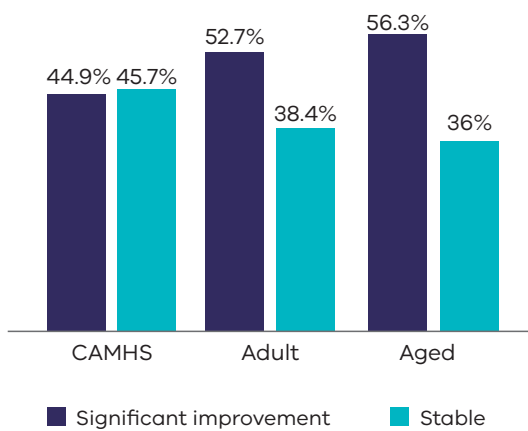
In terms of overall experience of care in the previous three months, 28.7 per cent rated this as very good, and 36.6 per cent as excellent. The effect the service had on the person's ability to manage their day-to-day life was rated as very good by 28.4 per cent of clients and excellent by 29.4 per cent. There is a slight upward trend for this question.

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

The Health of the Nation Outcomes Scales measures are included in our outcomes framework (see Appendix 1), capturing changes that have occurred for clients at the end of a period of treatment in the community. People require assistance for different lengths of time, but on average, people receiving clinical services in the community receive treatment for about six months.

Most child and adolescent mental health services (CAMHS), adult and aged clients in Victoria had stable or improved clinical outcomes in 2017–18 (see Figure 5).

Figure 5: Improvements in mental health outcomes, percentage (2017–18)



For CAMHS clients, there has been a slight downward trend in clients with significant improvement at case closure to 44.9 per cent and a slight increase in clients stable at case closure to 45.7 per cent. The proportion of adults with significant improvement at case closure is stable at 52.7 per cent. For aged persons, there has been a slight increase in people with significant improvement at case closure to 56.3 per cent, and the proportion of people with significant deterioration is stable at 7.6 per cent.

WILL'S EXPERIENCE WITH ORYGEN YOUTH HEALTH

Will is 26 years old and lives with his mother in a one-bedroom apartment in Melbourne's west. Will has recently returned to his electrician apprenticeship and is making steps to re-engage with his family and friends after a prolonged period of debilitating mental health issues.

Will presented to Orygen two years ago after police found him sitting on the roof of a building site. Will had reportedly contemplated jumping off the building. Will was first supported by Orygen's Mood Clinic before being transferred to the Early Psychosis Prevention and Intervention Centre.

Will described a full range of depressive symptoms dating back many years, which had increased in intensity following his sister's suicide 18 months before. He later reported psychotic symptoms including daily auditory command hallucinations to kill himself and nihilistic delusions that he was 'fated to be dead' and that 'something else is going on that no-one else can see'.

Diagnosed with treatment-resistant schizophrenia and severe major depressive disorder, Will had a prolonged recovery trajectory. This involved seven psychiatric admissions over the first 15 months of his treatment. Will trialled eight different medications and two courses of electroconvulsive therapy before settling on a combination of clozapine, lithium and sertraline, which has ultimately led to good symptomatic and functional recovery.

During his time at Orygen, Will received a comprehensive package of care. He engaged with cognitive behaviour therapy to treat and manage his schizophrenia and depression. The treating team were able to engage with Will around his concerns and attempt to allay some of his fears by providing an alternative model to make sense of his experiences.

Will and his mother had a number of sessions of family therapy with his case manager and the senior family therapist. Will also engaged with the group program, attending the gym group. Orygen liaised closely with Will's employer and school, which assisted his return to his electrician apprenticeship. Will was linked with West Justice for assistance with substantial fines he had accrued and was supported by his case manager to attend court to resolve these matters.

With an improved medication regimen, Will has reported having a far better ability to manage difficulties with his experiences of depression, anxiety and attenuated psychotic symptoms.



How have you found your time with Orygen Youth Health?

I was scared and angry at first. I felt lost and alone. But after a while it became apparent that the people here were on my side and had my best interests at heart – we were working towards the same goals. Orygen helped me feel less isolated, more supported and safe.

What do you like most about Orygen Youth Health?

The staff are genuine and interested. It's not just a job to them – our interactions feel real.

Of all the ways in which the treatment team have tried to help you (medications, inpatient stay, individual support, family support) what have you found most helpful to your recovery?

One-on-one support was really important. It helped me examine and question myself and my experiences and find a new way to understand what was happening to me. It was comfortable, safe and non-judgemental, and allowed true healing.

What difference (if any) did the family sessions make to you, your relationship with your mum, and your recovery?

Initially, this was very daunting. I was scared of what Mum might think and thought it'd be a burden for her to know what was going on for me. But we got it out, and it wasn't as bad as I thought. It helped us talk about our difficulties in a more understanding way. Orygen was a safe space.

What have you found least helpful over the course of your treatment?

Medication side effects are annoying, but not deal breakers. The memory difficulties from the ECT are tough, but I think it really helped at the time, so it was probably worth it. The group stuff didn't have a huge impact for me personally.

What do you like least about Orygen Youth Health?

It was really tough at the start. I didn't get along with my first team – they felt too intrusive. But everyone has their own style and different people get along differently.

If you could change something about Orygen Youth Health, what would it be?

Make the service last longer. It'd be great to have more interaction with staff in hospital. They were all lovely when they did talk to me, but they're always so busy. It would be nice to have more spaces to reflect with staff on the ward – maybe they need some psychologists.

CHANGES IN COMMUNITY CLINICAL MENTAL HEALTH SERVICES REPORTING

Most clients receive public mental health services in the community and use hospital care only when they are acutely unwell. The core functions of community mental health services are to stabilise acute illness, help people prevent or manage relapses, and support their recovery by connecting them to health, community, educational and vocational services.

Service contacts are a key component of community-based mental health activity.

A client service contact must:

- be clinically significant in nature (for example, directly contribute to assessment or treatment)
- be provided by a health professional employed within a specialist public mental health service
- be for a patient/client
- require a dated entry in the health record or triage record of the patient/client.

Service contacts and service hours are two of the few available indicators that monitor the level of community-based mental health service delivery. Victoria, like other states and territories, reports these metrics nationally, and they also form key components of state policy and funding guidelines. Targets for mental health services give the parameters services are expected to work to and within, and inform funding linked to various services to achieve expected outcomes for the community.

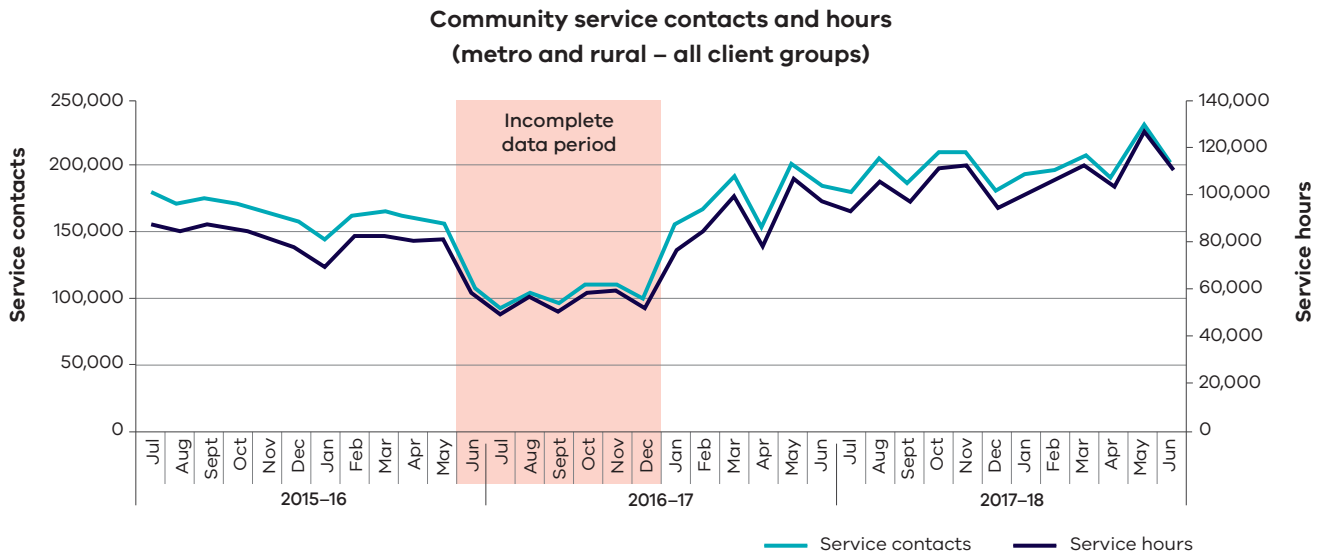
Data and data systems for public mental health services are continuing to develop. During 2017–18 there has been sustained focus by the majority of services on improving their data. This is in part related to strengthened accountability for funding as mental health services begin to move (nationally and at the state level) towards activity-based funding. Other areas of the health system have been funded in this way for many years, and in 2018–19 a new funding model will be implemented in Victoria, initially in adult community-based clinical mental health services.

In preparation for these changes, and following an extended period of incomplete reporting in recent years, particularly in adult and aged persons' services, the improved recording of service contacts and hours is very apparent in 2017–18. In part, the increases in service contacts and hours also reflect increased service provision following growth in funding to community clinical services.

However, increases for adult and aged persons' services can principally be attributed to better reporting of existing services (following the end of industrial activity that affected data reporting in 2015–16 and 2016–17). The definition of service contact was also broadened slightly, complicating the picture further. The data for child and adolescent, forensic and specialist services is more reliable.

Issues with data recording and reporting across the system are demonstrated in Figure 6, showing data over three years.

Figure 6: Community service contacts and hours, 2015–16 to 2017–18



CHILD AND ADOLESCENT MENTAL HEALTH SERVICES



11,945
CAMHS clients



9.8% increase
in hospitalisations
since 2016–17

Inpatient and community clinical mental health service activity increased in 2017–18, in part reflecting increased investment. This includes new beds becoming available at the Monash Children’s Hospital, expansion of services for children aged up to 12 years, and statewide rollout of the Child and Adolescent Schools Early Action program.

Most children and young people receive clinical treatment in the community. A higher proportion of service hours (20.5 per cent) are delivered to unregistered CAMHS clients than to adult and aged people. This may include contacts where a child or young person is referred to a community mental health service and is assessed, but it is found their needs are best met elsewhere. In this instance they may be referred to a more appropriate service and would not be registered as a public mental health services client.

In 2017–18 there were 11,945 registered CAMHS clients, an increase of 11.5 per cent. A relatively small number of children and young people in Victoria require inpatient treatment for mental illness. During the year there were 2,014 hospitalisations of children and young people for mental illness, an increase of 9.8 per cent. Compulsory admissions have risen from 17 per cent to 20.2 per cent, though this remains substantially lower than the level of compulsory treatment for other age groups. The average duration of a period of compulsory treatment remained stable at 23.5 days. The proportion of children and young people on a community treatment order remains low at 1.1 per cent.

The trimmed average length of stay (< 35 days) for CAMHS inpatients is trending downwards and was 6.6 days in 2017–18. Inpatients who stayed longer than 35 days accounted for 8.3 per cent of all CAMHS bed days. The bed occupancy rate increased from 60.9 to 62.6 per cent.

Community contacts are the largest part of CAMHS work. They may involve activities such as assessment and treatment, adolescent day programs, or intensive outreach for young people. CAMHS teams often involve parents and siblings, as well as schools, in supporting a young person. In 2017–18 there were 331,058 reported contacts. This increase of 18.7 per cent reflects an increase in service activity and may reflect improved recording of activities by mental health staff.

ADULT MENTAL HEALTH SERVICES

 **57,501**
adult clients

 **6.7% increase**
in hospitalisations
since 2016–17

INPATIENT SERVICES

During 2017–18 there were 20,536 hospitalisations of adults for mental illness in a public hospital, an increase of 6.7 per cent from last year. The most common diagnoses were schizophrenia and mood disorders such as depression and bipolar disorder. Stress and adjustment disorders were the third most common group of illnesses.

There has been a slight downward trend in compulsory admissions to 55.4 per cent in 2017–18; however, the average duration of a period of compulsory treatment for adults has risen from 64.6 in 2016–17 to 76.8 days. It is not clear why the duration of compulsory treatment is rising, and this will be further reviewed during 2018–19.

Although the number of hospitalisations has increased, the trimmed length of stay for adults is continuing to trend downwards from 9.5 days last year to 9.1 days in 2017–18. People who stayed longer than 35 days accounted for 10 per cent of all adult inpatient bed days. This has been consistent over the past three years. Bed occupancy for adult inpatient services remains high at 95 per cent, a level that has been sustained for several years.

The majority of people (60.2 per cent) who became inpatients had contact with a community service before they were admitted to hospital. The post-discharge follow-up rate was 88.5 per cent, although 14.4 per cent of people were readmitted to hospital within 28 days of discharge. Pressure on beds for adults is evident and may result in shorter-than-optimal hospital stays, with a higher risk of relapse and readmission.

CLINICAL MENTAL HEALTH SERVICES DELIVERED IN THE COMMUNITY

The number of community contacts for 2017–18 is reported to be 1,790,464, an ostensible increase of 50.5 per cent from what was reported last year. Service hours show an apparent increase of 55.5 per cent. As noted earlier in this chapter, these figures largely reflect improved capture of service data, although there has been some increase in service provision.

Consistent with the previous four years, 14.9 per cent of adult clients receiving treatment in the community are on community treatment orders.

OUTCOME 14: Services are recovery-oriented, trauma-informed and family-inclusive

PREVENTION AND RECOVERY CARE

PARC services provide short-term support in residential settings, generally providing care for up to 28 days when a person is either becoming unwell or is in the early stages of recovery from an acute admission.

Service activity is steady by comparison with last year – separations have increased fractionally, as have occupied bed days, and bed occupancy is steady at 77.9 per cent.

Prevention and recovery care units

The Victorian Government is establishing more PARCs across the state as part of *Victoria's 10-year mental health plan* implementation.

A new PARC in Warrnambool opened in late 2017, and planning is underway for new PARCs in Ballarat and Mildura. A further \$11.9 million is being invested to build a new 20-bed PARC for young people with a mental illness, focusing on early intervention and tailored support.

PARCs deliver a unique, home-like setting where people with mental illness can get the support they need to successfully resume their lives in the community. They provide short-term residential treatment programs focussed on early intervention for people who are becoming unwell and for people who are in the early stages of recovery from an episode of acute illness.



Top: Warrnambool PARC.

Bottom: Plans for a new PARC in Mildura.

ADULT RESIDENTIAL SERVICES

Residential services provide homelike environments for people with mental illness. There were 649 separations from community care units in 2017–18, similar to last year. Occupied bed days rose slightly and bed occupancy was steady at 78.9 per cent. Other residential services, including those providing accommodation for people with brain disorders and borderline personality disorder, also showed little change in service activity from the previous year.

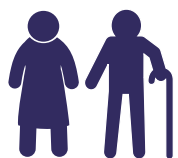
SECURE EXTENDED CARE UNITS

Secure extended care units provide inpatient services for people who need a high level of secure and intensive clinical treatment for severe mental illness. There were 222 separations from these units in 2017–18, similar to the prior year. Occupied bed days increased by 4.1 per cent, and bed occupancy fell a little, remaining high at 89.5 per cent.

AGED PERSONS MENTAL HEALTH SERVICES



8,279
aged clients



2,494
hospitalisations



243,721
community contacts

The number of aged clients using public mental health services grew by 12.3 per cent in 2017–18 to 8,279. Most of this group had previous contact with mental health services, with a minority (37.9 per cent) being new clients.

During the year there were 2,494 hospitalisations of Victorians aged 65 years or older in acute inpatient services. Bed occupancy has slightly increased over the past three years to 86.9 per cent. The trimmed average length of stay is trending downwards slightly to 15.5 days, but this remains much longer than the adult length of stay. People who were inpatients for more than 35 days accounted for more than one in four (26 per cent) of all aged persons' bed days. Some of these figures reflect the need to find safe and appropriate accommodation, or to put in place appropriate discharge supports for elderly unwell people.

The preadmission contact rate for aged persons is the highest of all client groups at 65 per cent. Almost half (46.9 per cent) of admissions were compulsory, and this has been fairly stable over the past four years. The post-discharge follow-up rate was 93.2 per cent, again the highest of all groups.

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 237 separations in 2017–18, similar to last year, and the bed occupancy rate was steady at 84.2 per cent. They provided 150,635 occupied bed days, fractionally down from 2016–17.

There were 243,721 community contacts in 2017–18, an apparent increase of 44.4 per cent. Service hours are reported to have increased by 46.1 per cent. The increase in client numbers suggests there would be some associated increase in contacts and service hours; however, the size of the change indicates that most of this reported increase is due to improved data capture.

SPECIALIST MENTAL HEALTH SERVICES



A range of specialist mental health services provide highly specific treatment and care to Victorians with severe and complex mental illnesses. These services include mother and baby mental health services, a personality disorder service (Spectrum), eating disorder services and a dual disability service (for people with both mental illness and an intellectual disability or autism spectrum disorder). For a full summary of Victoria's mental health service system, including a list of specialist mental health services, please see Appendix 3.

The number of specialist clients rose by almost 20 per cent in 2017-18, to 2,184. Service contacts increased by 7.8 per cent and service hours by 5.7 per cent. There were 958 hospitalisations, an increase of 3.9 per cent. The trimmed average length of stay (< 35 days) is trending slightly downwards to 15.3 days but is substantially longer than the comparable figure for adults. People who were inpatients for more than 35 days accounted for 13 per cent of all specialist bed days, with a downward trend in recent years.

Preadmission contacts and post-discharge follow-ups have improved this year, but rates remain low at 38.5 per cent and 53.8 per cent respectively. Readmissions within 28 days are rare, with a rate of 1.2 per cent for 2017-18.

Admitted acute occupied bed days fell by four per cent, and the bed occupancy rate, which is trending slightly downwards, was 64.9 per cent. There are a small number of specialist residential beds, and bed occupancy for these services is substantially higher at 88.6 per cent, consistent with previous years.

FORENSIC MENTAL HEALTH SERVICES



Forensic mental health services provide assessment and treatment for people with mental illness or disorders and a history of involvement with the criminal justice system. The increasing number of forensic clients reflects greater investment in these services, which often provide long-term engagement. Depending on clinical need, treatment may occur within prison, in the community or in a secure inpatient setting at the Thomas Embling Hospital in Fairfield.

The number of clients increased by 16.2 per cent to 873 in 2017-18. There were 96 separations of people from acute forensic mental health inpatient units during the year, which is consistent with the previous year. Pressure on forensic inpatient beds remains high, with a bed occupancy rate of 96.6 per cent. People who were inpatients for more than 35 days accounted for 84.9 per cent of all forensic bed days. Community contacts have risen by 13.8 per cent and service hours by 14.7 per cent.

Forensic clients have the longest average duration of compulsory treatment, at 87.3 days. This part of the service system has the lowest proportion of new clients at 23.3 per cent – most have had some prior interaction with services in the preceding five years.

Unregistered client hours are the highest for any group at 58.6 per cent. Services such as Mental Health Court Liaison, a court-based assessment and advice service, do not register their clients because the interventions provided are brief and do not constitute ongoing treatment. The aims of Mental Health Court Liaison include:

- diverting offenders with a mental illness from the criminal justice system into appropriate mental health treatment
- ensuring timely advice is provided to magistrates regarding the mental health of people appearing before the court
- reducing rates of recidivism in offenders with a mental illness through facilitating access to appropriate mental health treatment services.

The service is available at seven Magistrates' Courts in metropolitan Melbourne and five rural Magistrates' Courts.

SECLUSION AND RESTRAINT

Mental health services in Victoria continue to work towards eliminating restrictive interventions. Data on restraint is continuing to develop, and public reporting enables services to review their individual results against state and national rates and those for like services, supporting service reform and quality improvement agendas. This year, the duration of seclusion and restraint is included in the annual report as it has a strong bearing on consumers' experiences of these practices.

The rate of seclusion has dropped fractionally this year to 9.7 episodes per 1,000 occupied bed days. The average duration has also reduced a little to 16.7 hours. This figure is skewed by the inclusion of forensic patients, for whom the average duration of seclusion is 48.5 hours. The corresponding figure for adults is 8.8 hours, reduced from 9.6 hours the previous year.

The bodily restraint rate has fluctuated over the past three years. After dropping from 25.6 to 19.0 episodes per 1,000 occupied bed days in 2016–17, it has rebounded to 22.6 in 2017–18. The average duration of restraint, however, is trending downwards – in 2017–18 the average duration of restraint was 18 minutes.

LYNDA'S REFLECTION ON CARING FOR HER SON, SELF-CARE AND SPIRITUALITY

As I reflect on the past 14 years of caring for my son, I am often amazed that I have come through the myriad challenges that this role has asked of me. How is it that I have maintained a level of mental health in the face of my adult son's chronic mental illness, which has created such chaos, confusion and distress for him and the entire family?

In darker moments, I wonder: 'Have I truly maintained my mental health?' It could have been so easily lost in the midst of dozens of crisis points in my son's life and a multitude of hospitalisations. There have been times when I skirted depression and burn-out, as the symptoms of his illness and day-to-day needs nearly overwhelmed me.

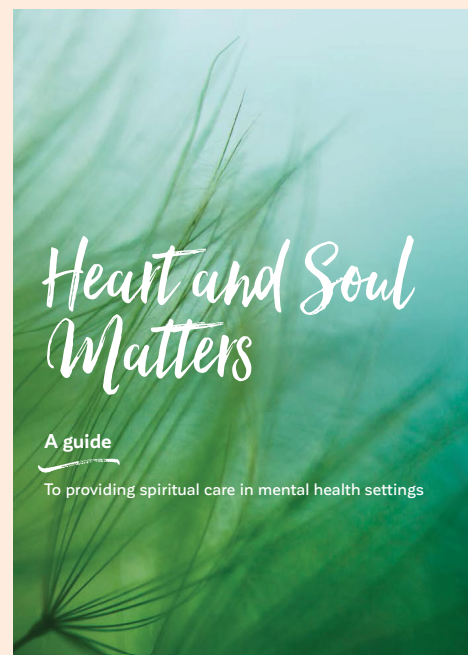
Yet, in my quiet moments late at night, I know where my strength and resilience come from, and from what 'deep well' I seek them. It is in my *spiritual practice* – something I actually cherish 'practising' daily – that strength is restored, patience is mined and gratitude is reclaimed.

I find that as I make time for contemplating and being grateful for *all that life is*, I am drawn into greater hope for *all that life can be*. I retain faith in my son's ability to enjoy his life, to be supported by those who love him, and in turn to express his joy and love to others.

Seldom, if ever, do we hear the words 'love' and 'joy' spoken of within the mental health system. I've never encountered them in a report, a policy, a call to action or a lecture. And yet, they are as fundamental to our mental wellbeing as any

mental health service, program, initiative or reform can be. I've really found *Heart and soul matters: A guide to providing spiritual care in mental health settings* valuable. There are wise words in it that will resonate with many.

As I deepen my spiritual practice, which is my form of self-care, I can more readily experience all that is unique, surprising and gifted about my son. I see the effect of his life experiences on others, and how they are able to access a greater compassion in themselves. Somehow, we are all 'shored up' in this process. It is spirituality in action.



For more information, visit the Spiritual Health Victoria website <<http://www.spiritualhealthvictoria.org.au/>>



APPENDIX 1: OUTCOMES FRAMEWORK

APPENDIX 1: OUTCOMES FRAMEWORK

For the first time this year, the suite of indicators established for the *Victoria's 10-year mental health plan outcomes framework* shows a time series. There are some reporting challenges because data is not always available or comparable for three consecutive years. Nonetheless, it is helpful to see a picture over time.

No new indicators have been added to the outcomes framework in 2017–18, although non-identified data linkage is being undertaken to expand the indicator set. It is hoped that linkage will allow us to look at outcomes such as educational participation and financial security in a meaningful way in future years.

In relation to rates of high or very high psychological distress drawn from the Victorian Population Health Survey 2016, apparent reductions should be interpreted with caution because they are potentially attributable to a different sampling methodology. Trends will be more easily identifiable in future years.

Obtaining current, valid and reliable health data about Victorian Aboriginal people remains challenging. The next national Aboriginal and Torres Strait Islander Health Survey is underway, with interviewers visiting urban, regional and remote communities across Australia. The survey will run until March 2019, with the first survey results available from late 2019. It is expected that the national survey, and the next Victorian Population Health Survey, will provide updated information relating to Aboriginal Victorians and psychological distress.

The Australian Bureau of Statistics released *Causes of death, Australia, 2017* in September 2018, and this report shows a small decrease in the suicide rate for Victoria. This is a heartening trend that has continued for the past three years, though we must note that the suicide rate does tend to fluctuate over time.

Many other indicators have remained stable or fluctuated slightly. This includes clinically reported improved or stable outcomes for child and adolescent, adult and aged clients. The exception is a five per cent increase in the percentage of clinically reported improved or stable outcomes for forensic clients, which may be in part attributable to forensic mental health service expansion over recent years.

There is a small upward trend in the proportion of consumers reporting that the effect the service had on their ability to manage their day-to-day life was very good or excellent. There has also been a slight upward trend in the proportion of consumers reporting both that their individuality and values were usually or always respected and that the service had a very good or excellent effect on their overall wellbeing.

In relation to restrictive practices and compulsory treatment, results are mixed. The proportion of inpatient admissions that are compulsory has slightly declined. However, the duration of compulsory treatment has increased with a very small increase in the number of people receiving compulsory community treatment. The reasons for the increase in duration of compulsory treatment are not yet clear and will be explored over the next 12 months.

1. Victorians have good mental health and wellbeing at all ages and stages of life

Outcome and related indicators	Reference year	Two years prior	One year prior	Most current data
1.1 Proportion of Victorian population with high or very high psychological distress (adults)	2016	n/a*	17.3%	14.8%**
1.2 Proportion of Victorian population receiving clinical mental health care	2017–18	1.12%	1.08%	1.16%
1.3 Proportion of Victorian young people with positive psychological development	2016	70.1%	n/a***	68.8%
1.4 Proportion of Victorian older persons (65 years or older) with high or very high psychological distress	2016	n/a*	10.8%	8.5%
1.5 Proportion of children at school entry at high risk of clinically significant problems related to behaviour and emotional wellbeing ^o	2017	4.6%	4.8%	4.9%

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

Outcome and related indicators	Reference year	Two years prior	One year prior	Most current data
2.1 Proportion of Victorian population who speak a language other than English at home with high or very high psychological distress (adults)	2016	n/a*	18.0%	17.2%
2.2 Proportion of Victorian rural population with high or very high psychological distress (adults)	2016	n/a*	15.9%	14.6%

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

Outcome and related indicators	Reference year	Two years prior	One year prior	Most current data
3.1 Proportion of Victorian Aboriginal population who are receiving clinical mental healthcare	2017–18	2.5%	2.6%	2.6%
3.2 Proportion of Victorian Aboriginal population with high or very high psychological distress****	2012–14	n/a	n/a	22.0%
3.3 Proportion of Victorian Aboriginal children at school entry at high risk of clinically significant problems related to behaviour and emotional wellbeing ^o	2017	14.2%	15.6%	14.4%

4. The rate of suicide is reduced

Outcome and related indicators	Reference year	Two years prior	One year prior	Most current data
4.1 Victoria's rate of deaths from suicide per 100,000	2017	10.6%	9.9%	9.6%

5. Victorians with mental illness have good physical health and wellbeing

Outcome and related indicators	Reference year	Two years prior	One year prior	Most current data
5.1 Proportion of unique admitted clients who were discharged and used tobacco [†]	2016–17	35.9%	37.5%	38.0%
5.2 Proportion of registered mental health clients with a type 2 diabetes diagnosis [†]	2016–17	10.0%	10.1%	9.7%

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 eco

9. Victorians with mental illness have financial security

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

11. The rate of suicide is reduced

Outcome and related indicators	Reference year	Two years prior	One year prior	Most current data
11.1 Proportion of Victorian prison entrants who, at prison reception assessment, are allocated a psychiatric risk rating	2017–18	38%	36.9%	37.2%

12. Victorians with mental illness have suitable and stable housing

Outcome and related indicators	Reference year	Two years prior	One year prior	Most current data
12.1 Proportion of registered clients living in stable housing	2017–18	81%	81%	80%

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

Outcome and related indicators	Reference year	Two years prior	One year prior	Most current data
13.1 Rate of preadmission contact	2017–18	57.2%	51.8%	59.4%
13.2 Rate of readmission within 28 days	2017–18	13.9%	13.4%	13.8%
13.3 Rate of post-discharge follow-up	2017–18	84.2%	77.6%	87.0%
13.4 New registered clients accessing public mental health services (no access in last five years)	2017–18	35.7%	36.6%	36.8%
13.5 Proportion of consumers reporting the effect the service had on their ability to manage their day-to-day life was very good (29.2%) or excellent (26%)	2017–18	51.4%	53.6%	55.2%

14. Services are recovery-oriented, trauma-informed and family-inclusive

Outcome and related indicators	Reference year	Two years prior	One year prior	Most current data
14.1 Proportion of registered clients experiencing stable or improved clinical outcomes (adults)	2017–18	91.1%	91.1%	91.1%
14.2 Proportion of registered clients experiencing stable or improved clinical outcomes (children and adolescents)	2017–18	90.6%	91.3%	90.6%
14.3 Proportion of registered clients experiencing stable or improved clinical outcomes (aged persons)	2017–18	93.9%	92.3%	92.3%
14.4 Proportion of registered clients experiencing stable or improved clinical outcomes (forensic)	2017–18	78.6%	78.6%	83.3%
14.5 Proportion of registered clients experiencing stable or improved clinical outcomes (specialist)	2017–18	94.9%	95.5%	96.5%
14.6 Proportion of consumers who reported they usually (21.5%) or always (62.3%) had opportunities for family and carers to be involved in their treatment or care if they wanted	2017–18	81.5%	82.5%	83.8%

15. Victorians with mental illness, their families and carers are treated with respect by services

Outcome and related indicators	Reference year	Two years prior	One year prior	Most current data
15.1 Proportion of consumers reporting their individuality and values were usually (18%) or always (70.7%) respected	2017–18	87.7%	88.0%	88.7%
15.2 Proportion of people with a mental illness who report a care plan was usually (24.9%) or always (37.6%) developed with them that considered all their needs	2017–18	58.4%	63.0%	62.5%

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

Outcome and related indicators	Reference year	Two years prior	One year prior	Most current data
16.1 Rate of seclusion episodes per 1,000 occupied bed days (inpatient)	2017–18	9.1	9.9	9.7
16.2 Rate of bodily restraint episodes per 1,000 occupied bed days (inpatient)	2017–18	25.6	19.0	22.6
16.3 Proportion of community cases with client on a treatment order	2017–18	11.1%	11.0%	11.3%
16.4 Proportion of inpatient admissions that are compulsory	2017–18	52.2%	51.5%	50.3%
16.5 Average duration of compulsory orders (days)	2017–18	59.3	64.1	76.7
16.6 Proportion of consumers who rated their experience of care with a service in the last three months as very good (28.7%) or excellent (36.6%)	2017–18	62.6%	65.1%	65.3%
16.7 Proportion of consumers reporting the effect the service had on their overall wellbeing was very good (28.4%) or excellent (29.4%)	2017–18	54.4%	56.3%	57.8%

* Owing to a change in sampling methodology to include mobile phone users as well as people with landlines, only two years of data from the Victorian Population Health Survey are available. Direct comparisons of this data with previous years are problematic and should not be made.


** While it appears that rates of high/very high psychological distress have decreased from 2015 to 2016, this is not the case. The 95% confidence intervals overlap between years indicates that the variation between the years is random and not a true decrease. This is also the case for other estimates of psychological distress. Next year, a third data point will be available using the new sampling methodology, and this will support analysis of any trends.

*** This survey is carried out every two years.

**** Sourced from the Victorian Government's *Aboriginal affairs report 2017*, available from the Aboriginal Victoria webpage <<https://www.vic.gov.au/aboriginalvictoria/policy/victorian-aboriginal-affairs-framework/aboriginal-affairs-report-2017.html>>.

∞ Data this year includes all schools in Victoria, not just government schools (as was the case in *Victoria's mental health services annual report 2016–17*).

† It was not possible to duplicate the original methodology used to calculate measures reported in 2016–17. A revised methodology was used that provides broadly comparable results, which can now be duplicated more easily and readily.



**APPENDIX 2:
PUBLIC MENTAL HEALTH
SERVICE DATA**

APPENDIX 2: PUBLIC MENTAL HEALTH SERVICE DATA

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

Other collections from which this appendix draws include the Mental Health Establishments National Minimum Dataset, 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. The data and information within appendix two has been supplied by the Victorian Agency for Health Information, whose support and assistance is gratefully acknowledged.

Data source: CMI/ODS or as footnoted otherwise
 Date extracted: 10 August 2018, or as footnoted otherwise
 Date generated: 3 October 2018

Whole population			
	2015–16	2016–17	2017–18
Total estimated residential population in Victoria (based on mental health area) ('000)*	6,049	6,158	6,266
People accessing mental health services**			
	2015–16	2016–17	2017–18
Mental health-related emergency department presentations**	83,024	87,197	92,610
Emergency department presentations that were mental health-related** (%)	5.04%	5.14%	5.27%
People accessing clinical mental health services**			
Consumers			
	2015–16	2016–17	2017–18
Consumers accessing clinical mental health services† ‡	67,559	66,487	72,859
Proportion of population receiving clinical care* (%)	1.12 %	1.08%	1.16%
Consumer location			
Consumer residential location (%)	2015–16	2016–17	2017–18
Metro	62.7%	64.4%	64.2%
Rural	34.8%	32.6%	32.9%
Unknown/other	2.5%	2.9%	2.9%

Consumer demographics		2015–16	2016–17	2017–18
Gender (%)	Female	50.4%	50.4%	50.3%
	Male	49.5%	49.5%	49.6%
	Other/unknown	0.1%	0.1%	0.1%
Age group (%)	0–4	0.8%	0.9%	0.9%
	5–14	7.5%	8.2%	8.2%
	15–24	19.0%	19.1%	19.3%
	25–34	17.8%	17.9%	17.6%
	35–44	18.6%	18.2%	18.1%
	45–54	14.5%	14.6%	14.8%
	55–64	8.7%	8.8%	8.7%
	65–74	6.1%	6.1%	6.2%
	75–84	4.6%	4.3%	4.2%
	85–94	2.3%	1.9%	1.9%
	95+	0.2%	0.2%	0.2%
Consumers of culturally diverse backgrounds (%)	CALD	13.9%	13.5%	13.7%
Aboriginal or Torres Strait Islander	Indigenous	2.5%	2.6%	2.6%
Country of birth (top 10 non-English speaking) (%)	Italy	1.1%	1.0%	1.0%
	Vietnam	0.9%	0.8%	0.9%
	Greece	0.8%	0.8%	0.8%
	India	0.6%	0.7%	0.7%
	China (excludes SARs and Taiwan)	0.6%	0.6%	0.7%
	Sri Lanka	0.4%	0.5%	0.5%
	Philippines	0.4%	0.4%	0.5%
	Turkey	0.4%	0.4%	0.4%
	Iran	0.4%	0.4%	0.4%
	Sudan	0.3%	0.3%	0.4%
Preferred language other than English (top 10) (%)	Vietnamese	0.6%	0.5%	0.5%
	Greek	0.5%	0.4%	0.5%
	Italian	0.6%	0.5%	0.4%
	Mandarin	0.3%	0.3%	0.3%
	Arabic	0.3%	0.3%	0.3%
	Persian (excluding Dari)	0.2%	0.2%	0.2%
	Turkish	0.2%	0.2%	0.2%
	Macedonian	0.1%	0.1%	0.1%
	Cantonese	0.2%	0.1%	0.1%
Croatian	0.1%	0.1%	0.1%	

Treatment		2015–16	2016–17	2017–18
Consumers accessing clinical mental health services ^{† *}	Adult	52,724	51,788	57,501
	Aged	8,066	7,374	8,279
	CAMHS	10,456	10,715	11,945
	Forensic	700	751	873
	Specialist	1,783	1,821	2,184
Diagnosis (%)	Schizophrenia, paranoia & acute psychotic disorders	23.9%	24.2%	23.2%
	Mood disorders	20.3%	20.2%	19.6%
	Stress & adjustment disorders	8.0%	8.5%	8.6%
	Personality disorders	5.5%	6.0%	6.3%
	Anxiety disorders	5.2%	5.3%	5.6%
	Substance abuse disorders	3.5%	3.5%	3.5%
	Organic disorders	3.0%	2.7%	2.6%
	Disorders of childhood & adolescence	1.9%	2.0%	1.9%
	Disorders of psychological development	1.6%	1.9%	1.9%
	Eating disorders	1.5%	1.5%	1.5%
	Other	1.1%	1.1%	1.0%
	Obsessive compulsive disorders	0.5%	0.5%	0.5%
	Unknown	23.9%	22.6%	24.0%
	Referral source (newly referred consumers only) (%)	Emergency department	21.1%	21.8%
Acute health		20.6%	21.7%	21.3%
General practitioner		12.6%	11.7%	11.6%
Family		7.9%	7.9%	7.2%
Community health services		4.8%	4.7%	4.8%
Consumer/self		4.6%	4.6%	4.6%
Police		4.0%	3.6%	3.7%
Others and unknown		24.3%	24.0%	22.4%
New consumers accessing services [†] (no access in the prior five years) (%)	Total	35.7%	36.6%	36.8%
	Total	14.3%	14.1%	13.5%

Service activity – bed based	Setting	2015–16	2016–17	2017–18
Total number of separations (excluding same days)	Admitted – acute	23,664	24,334	26,098
	Admitted – non acute	230	219	222
	Non admitted – residential	240	238	244
	Non admitted – sub acute (CCU)	675	682	649
	Non admitted – sub acute (PARC)	3,257	3,404	3,433
	Total		28,066	28,877
Occupied bed days (including leave, excluding same days)	Admitted – acute	356,652	364,683	375,253
	Admitted – non acute	71,105	71,470	74,409
	Non admitted – residential	169,490	157,495	157,103
	Non admitted – sub acute (CCU)	105,371	104,625	105,125
	Non admitted – sub acute (PARC)	63,425	66,345	66,506
	Total		766,044	764,621
Bed occupancy rate (including leave, excluding same days)	Admitted – acute	88.6%	88.7%	88.7%
	Admitted – non acute	92.1%	92.8%	89.5%
	Non admitted – residential	85.5%	84.0%	84.4%
	Non admitted – sub acute (CCU)	79.1%	78.6%	78.9%
	Non admitted – sub acute (PARC)	77.8%	81.2%	77.9%
	Total		85.8%	85.9%
Service activity – community	Population	2015–16	2016–17	2017–18
Total service contacts, by sector*	Adult	1,400,481	1,189,768	1,790,464
	Aged	219,373	168,746	243,721
	CAMHS	275,039	278,801	331,058
	Forensic	17,998	17,265	19,647
	Specialist	22,369	21,190	22,837
	Total		1,935,262	1,675,772
Total service hours, by sector*	Adult	665,759	585,352	910,305
	Aged	103,618	86,138	125,884
	CAMHS	171,288	180,029	218,709
	Forensic	10,597	10,652	12,225
	Specialist	20,701	19,778	20,902
	Total		971,965	881,950
Unregistered consumer service hours*	Total	15.5%	15.7%	15.6%

Service performance	Population	2015–16	2016–17	2017–18
Re-admission to inpatient rate 28 day (lagged one month)	Adult	14.9%	14.3%	14.4%
	Aged	7.0%	6.8%	8.5%
	CAMHS	16.8%	17.6%	19.3%
	Forensic	10.0%	12.3%	7.8%
	Specialist	2.0%	2.0%	1.2%
	Total	13.9%	13.4%	13.8%
Pre-admission contact rate, all consumers*	Adult	58.2%	53.1%	60.2%
	Aged	64.8%	54.0%	65.0%
	CAMHS	53.8%	49.5%	58.1%
	Forensic	18.6%	17.6%	21.6%
	Specialist	34.5%	30.6%	38.5%
	Total	57.2%	51.8%	59.4%
Post-discharge follow-up rate* (lagged seven days)	Adult	85.7%	79.3%	88.5%
	Aged	90.0%	74.6%	93.2%
	CAMHS	85.8%	83.9%	86.2%
	Forensic	36.8%	31.2%	26.4%
	Specialist	44.0%	41.1%	53.8%
	Total	84.2%	77.6%	87.0%
Trimmed average length of stay ≤ 35 days – inpatient	Adult	9.6	9.5	9.1
	Aged	16.0	15.7	15.5
	CAMHS	7.5	6.9	6.6
	Forensic	18.8	20.5	21.7
	Specialist	16.7	15.8	15.3
	Total	10.1	10.0	9.6

Compulsory treatment	Population	2015–16	2016–17	2017–18
Community cases with consumers on treatment order (%)	Adult	15.0%	14.5%	14.9%
	Aged	4.2%	4.5%	5.0%
	CAMHS	0.9%	1.1%	1.1%
	Forensic	15.3%	16.3%	13.3%
	Specialist	1.8%	2.2%	5.4%
	Total	11.1%	11.0%	11.3%
Compulsory admissions – inpatient (%)	Adult	57.8%	56.9%	55.4%
	Aged	46.0%	48.3%	46.9%
	CAMHS	16.7%	17.0%	20.2%
	Forensic	100.0%	100.0%	100.0%
	Specialist	11.3%	8.8%	8.8%
	Total	52.2%	51.5%	50.3%
The average duration (days) of a period of compulsory treatment		59.3	64.1	76.7
Consumers on an order for more than 12 months (%)		11.5%	12.4%	13.0%
Adult (18+) consumers who have an advance statement recorded (%)		2.02%	2.37%	2.59%
Adult (18+) consumers who have a nominated person recorded (%)		1.90%	2.40%	2.44%
Restrictive practice	Population	2015–16	2016–17	2017–18
Seclusion episodes per 1,000 occupied bed days – inpatient	Total	9.1	9.9	9.7
Average inpatient seclusion duration (hours)	Total	16.4	17.4	16.7
Bodily restraint episodes per 1,000 occupied bed days – inpatient	Total	25.6	19.0	22.6
Average inpatient bodily restraint duration (hours)	Total	0.6	0.4	0.3

Clinician-reported outcomes	Population	2015–16	2016–17	2017–18
Community cases with significant improvement at case closure* (%)	Adult	53.0%	53.3%	52.7%
	Aged	54.3%	54.5%	56.3%
	CAMHS	48.3%	48.1%	44.9%
	Forensic	28.6%	42.9%	33.3%
	Specialist	24.3%	21.1%	24.1%
	Total	52.1%	52.2%	51.7%
Community cases stable at case closure* (%)	Adult	38.1%	37.8%	38.4%
	Aged	39.6%	37.8%	36.0%
	CAMHS	42.3%	43.2%	45.7%
	Forensic	50.0%	35.7%	50.0%
	Specialist	70.6%	74.4%	72.4%
	Total	39.4%	39.2%	39.6%
Community cases with significant deterioration at case closure* (%)	Adult	8.9%	8.9%	8.9%
	Aged	6.1%	7.7%	7.6%
	CAMHS	9.4%	8.7%	9.3%
	Forensic	21.4%	21.4%	16.7%
	Specialist	5.1%	4.5%	3.5%
	Total	8.4%	8.6%	8.7%
Funding		2015–16	2016–17	2017–18
Total output cost# (Budget Paper 3) (\$ million)	Clinical mental health	1,142.0	1,258.0	1,376.8
	Mental health community support services	128.1	124.8	120.0
Service inputs		2015–16	2016–17	2017–18
Specialist mental health beds (from policy and funding guidelines)	Admitted – acute	1,098	1,162	1,174
	Admitted – non acute	212	244	244
	Admitted total	1,310	1,406	1,418
	Non admitted – residential	525	525	495
	Non admitted – sub acute (CCU)	358	358	358
	Non admitted – sub acute (PARC)	230	230	250
	Non admitted total	1,113	1,113	1,103
Total	2,423	2,519	2,521	

Service inputs		2015–16	2016–17	2017–18
Full-time equivalent staff by workforce type [§]	Administrative and clerical staff	566	571	n/a
	Allied health and diagnostic professionals	1,420	1,500	n/a
	Carer workers	17	18	n/a
	Consumer workers	18	18	n/a
	Domestic staff	153	174	n/a
	Medical Officers	812	848	n/a
	Nurses	3,999	4,180	n/a
	Other personal care staff	222	239	n/a

People accessing mental health community support services ^{††}				
Consumers		2015–16	2016–17	2017–18
Total consumers accessing mental health community support services [#]		12,354	11,337	9,765
Consumer demographics		2015–16	2016–17	2017–18
Gender (%)	Female	55.4%	56.2%	57.3%
	Male	44.0%	43.2%	41.9%
	Other/unknown	0.6%	0.6%	0.7%
Age group (%)	0–4	0.3%	0.3%	0.3%
	5–14	1.6%	1.7%	2.1%
	15–24	13.3%	13.6%	13.1%
	25–34	19.1%	19.3%	18.8%
	35–44	24.1%	23.3%	22.6%
	45–54	23.0%	23.5%	24.7%
	55–64	13.4%	14.0%	14.9%
	65–74	1.8%	1.9%	1.9%
	75–84	0.3%	0.3%	0.3%
	85–94	0.0%	0.0%	0.0%
	95+	2.5%	1.6%	0.9%
	Unknown	0.6%	0.5%	0.5%
Aboriginal or Torres Strait Islander (%)	Indigenous	2.2%	2.3%	1.9%
CALD status (%)	Yes	4.4%	4.3%	3.9%

Service activity		2015–16	2016–17	2017–18
Community service units (CSUs)		790,213	757,236	635,040
Residential rehabilitation bed days		78,456	81,130	82,329
Service Inputs	Population	2015–16	2016–17	2017–18
Residential rehabilitation beds	Other	101	101	102
	Youth	159	159	159
	Total	260	260	261

Notes and annotations

- * Population estimate is based on Victoria in Future 2016 projections
 - † Sum of rows will not equal total because one consumer can access multiple services
 - * 2015-16 and 2016-17 data were affected by industrial activity, impacting on the recording of community mental health service activity. This began in May 2016 and was resolved by February 2017. Community mental health activity data reported during this period should be interpreted with caution
 - § Sourced from Mental Health Establishments National Minimum Dataset
 - # Data impacted by the transfer of mental health community support services to the National Disability Insurance Scheme. Activity data are extracted from the Mental Health Community Support Services Collection
 - ** A new measurement method has been applied for mental health-related emergency department presentations to yield greater accuracy by encompassing a wider range of mental health presentations. Data extracted from the Victorian Emergency Minimum Dataset
 - ** Service system inputs, outputs and outcomes data exclude the New South Wales catchment area of Albury Wodonga Health
- n/a: No data available for this period
 Note that some data may not sum due to rounding
 CAMHS = child and adolescent mental health services

APPENDIX 3: VICTORIA'S PUBLIC MENTAL HEALTH SYSTEM

APPENDIX 3

VICTORIA'S CLINICAL MENTAL HEALTH SERVICE SYSTEM

Area-based clinical services*

Child and adolescent services / Child and youth services**

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

Adult services**

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

Aged persons services (65+ years)

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

Statewide specialist services

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

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

** Service models for children and young people vary across the state. Some areas have Child and Adolescent Mental Health Services (0–18 years); some have Child and Youth Mental Health Services (0–25 years); and others have specific services for adolescents (12–18 years) or youth (16–24 years).

