

VICTORIA'S MENTAL HEALTH SERVICES ANNUAL REPORT 2016–17



Department of Health and Human Services

50 Lonsdale Street
Melbourne Victoria 3000
Telephone: 1300 650 172
GPO Box 4057
Melbourne Victoria 3001
www.dhhs.vic.gov.au
DX 210081

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 2016 to 30 June 2017.

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

Kym Peake
Secretary
Department of Health and Human Services



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Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

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ISSN 2206-5989

Available at <www.mentalhealthplan.vic.gov.au>

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SECRETARY'S FOREWORD

I am pleased to present our second *Victoria's mental health services annual report*, reflecting the Victorian Government's commitment to increased accountability and transparency.

It has been two years since *Victoria's 10-year mental health plan* was released. Since then, we have implemented a range of initiatives to improve mental health outcomes for all Victorians, including at-risk groups such as lesbian, gay, bisexual, transgender and intersex (LGBTI) Victorians. Our report provides an update on these initiatives, including work to reduce suicide through Hospital Outreach Post-suicidal Engagement (HOPE) programs and place-based trials of suicide prevention approaches. We are also working to make Victoria's mental health services safer for consumers and staff.

Additional funding in the 2017–18 State Budget means that we will better meet community needs through expanded hospital and community services and better access to allied health clinicians. Specialist services such as forensic mental health have also expanded, enabling earlier intervention when people are at risk of entering the criminal justice system and better support for those with serious mental illness within the prison system. At the same time, the rollout of the National Disability Insurance Scheme is transforming the way many Victorians with a psychosocial disability receive long-term support.

We continue to develop and expand our mental health outcomes framework to understand more about the mental health of all Victorians. The framework also helps us understand the impact of our specialist services for Victorians experiencing serious mental illness. I am pleased that, for the first time, we are reporting the results of the 'Your Experience of Service' (YES) survey. These results enable us to reflect on, and respond to, consumers' service experiences and integrate what we learn into our policy, program and service reform.

These changes are important, but we know there is still much work to do to ensure Victorians who need our specialist mental health services receive them in the right place and at the right time. Rebuilding the mental health system will take time.

I would like to thank the Mental Health Expert Taskforce and its reference groups for their advice and contributions during the year. I especially thank all our contributors for sharing their deeply personal accounts of hope, resilience and recovery. They've highlighted to me the importance of connections to community and having a strong network to rely on, as well as relationships of trust and of feeling safe, respected and included in decisions. I am heartened by the different ways our services are working together to make a positive difference in people's lives.

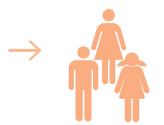
A handwritten signature in black ink that reads "Kym Peake". The signature is fluid and cursive.

Kym Peake
Secretary
Department of Health and Human Services

THE YEAR AT A GLANCE



66,445
registered clients



→ **10,723**
child and adolescent
clients



→ **51,735**
adult clients



→ **7,396**
aged clients



→ **751**
forensic clients



→ **1,817**
specialist
clients



36.6%
new clients



11,337
Mental Health Community
Support Services clients



\$1.26 billion
clinical services



\$125 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, outlines the government's long-term aim to achieve better outcomes for Victorians with mental illness, their families and carers.

Our goal is that all Victorians experience their best possible health, including mental health. We want to create a healthier, fairer and more inclusive society. That means good mental health for everyone, particularly people who are disadvantaged and vulnerable. We want people living with mental illness to receive the same respect and have the same opportunities as everyone else.

The Mental Health Expert Taskforce guides implementation of the *10-year mental health plan* and advises the Minister for Mental Health on reform priorities and effective monitoring of the plan's outcomes. Monitoring progress is important. In 2015–16 we developed and published an outcomes framework to measure our progress and better understand the impact of our programs and services on people's lives (see Table 1).

Our framework brings together information about the mental health of all Victorians from a range of sources including Victorian population health surveys and national mental health-related surveys. It also includes a range of information relating to people who receive treatment, care and support from specialist mental health services.

Over the past year we have expanded the framework based on input from Victorian clinicians, consumers, carers and leading mental health researchers. To help us build a better understanding of what we are doing well and what we need to do differently, we have incorporated results from the statewide 'Your Experience of Service' (YES) survey and information on compulsory treatment duration.

We will continue to build the framework as more data becomes available, to provide further information about mental health outcomes for Victorians. We are also developing an evaluation framework to evaluate individual initiatives under the plan.

During 2016–17 the Mental Health Expert Taskforce has provided expert advice on the implementation of suicide prevention initiatives, approaches to child and youth mental health, planning of workforce initiatives including the Centre for Workforce Development, the development of an Aboriginal social and emotional wellbeing framework and the development of additional indicators measuring progress under *Victoria's 10-year mental health plan*.

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

Vision ALL VICTORIANS EXPERIENCE THEIR BEST POSSIBLE HEALTH, INCLUDING MENTAL HEALTH	
Domains	Outcomes
Victorians have good mental health and wellbeing	<ol style="list-style-type: none"> 1. Victorians have good mental health and wellbeing at all ages and stages of life 2. The gap in mental health and wellbeing for at-risk groups is reduced 3. The gap in mental health and wellbeing for Aboriginal Victorians is reduced 4. The rate of suicide is reduced
Victorians promote mental health for all ages and stages of life	<ol style="list-style-type: none"> 5. Victorians with mental illness have good physical health and wellbeing 6. Victorians with mental illness are supported to protect and promote health
Victorians with mental illness live fulfilling lives of their choosing, with or without symptoms of mental illness	<ol style="list-style-type: none"> 7. Victorians with mental illness participate in learning and education 8. Victorians with mental illness participate in and contribute to the economy 9. Victorians with mental illness have financial security 10. Victorians with mental illness are socially engaged and live in inclusive communities 11. Victorians with mental illness live free from abuse or violence, and have reduced contact with the criminal justice system 12. Victorians with mental illness have suitable and stable housing
The service system is accessible, flexible and responsive to people of all ages, their families and carers, and the workforce is supported to deliver this	<ol style="list-style-type: none"> 13. The treatment and support that Victorians with mental illness, their families and carers need is available in the right place at the right time 14. Services are recovery-oriented, trauma-informed and family-inclusive 15. Victorians with mental illness, their families and carers are treated with respect by services 16. Services are safe, of high quality, offer choice and provide a positive service experience

KEY INITIATIVES IN 2016–17

PREVENTING SUICIDE IN LOCAL COMMUNITIES

OUTCOME: The rate of suicide is reduced.

The *Victorian suicide prevention framework 2016–25*, released in July 2016, is a key component of our *10-year mental health plan*. In 2016 we lost 624 Victorians to suicide – more than double the road toll. For every suicide there are many more people – family, friends, carers, colleagues and communities – who are deeply affected. We know that suicide is complex but preventable.

We have seen a reduction in the number of suicides in Victoria (624 in 2016, compared to 654 in 2015), and remain committed to halving Victoria's suicide rate by 2025.

Under two flagship suicide prevention initiatives that began in 2016–17, we are helping vulnerable Victorians who have attempted suicide to get the intensive support they need to recover and supporting 12 Victorian communities to prevent suicide through place-based workforce training, school-based support and mental health literacy.

An important part of these initiatives is developing culturally appropriate and safe suicide prevention approaches.

We will evaluate these initiatives and our learnings will inform future suicide prevention efforts across the state.

PLACE-BASED SUICIDE PREVENTION STRATEGIES

The Victorian Government is partnering with Primary Health Networks (PHNs) to support local communities to develop and implement place-based approaches to suicide prevention. This joint suicide prevention effort between the department and PHNs represents an opportunity to maximise our collective effort and investment.

The purpose is to take a systematic, coordinated approach to suicide prevention, with each site supported to implement proven suicide prevention initiatives.

This approach brings together different parts of the community (including people with lived experience of suicide), schools, businesses, local councils, transport, police, health services, ambulance services, community agencies and the Aboriginal community-controlled sector.

Together, they identify what is needed to prevent suicide and what types of initiatives will best support people in their local communities. This may include initiatives like raising awareness of mental health issues and support services, general practitioner (GP) training, school-based programs, frontline staff training and training people with lived experience to talk about suicide in their communities.

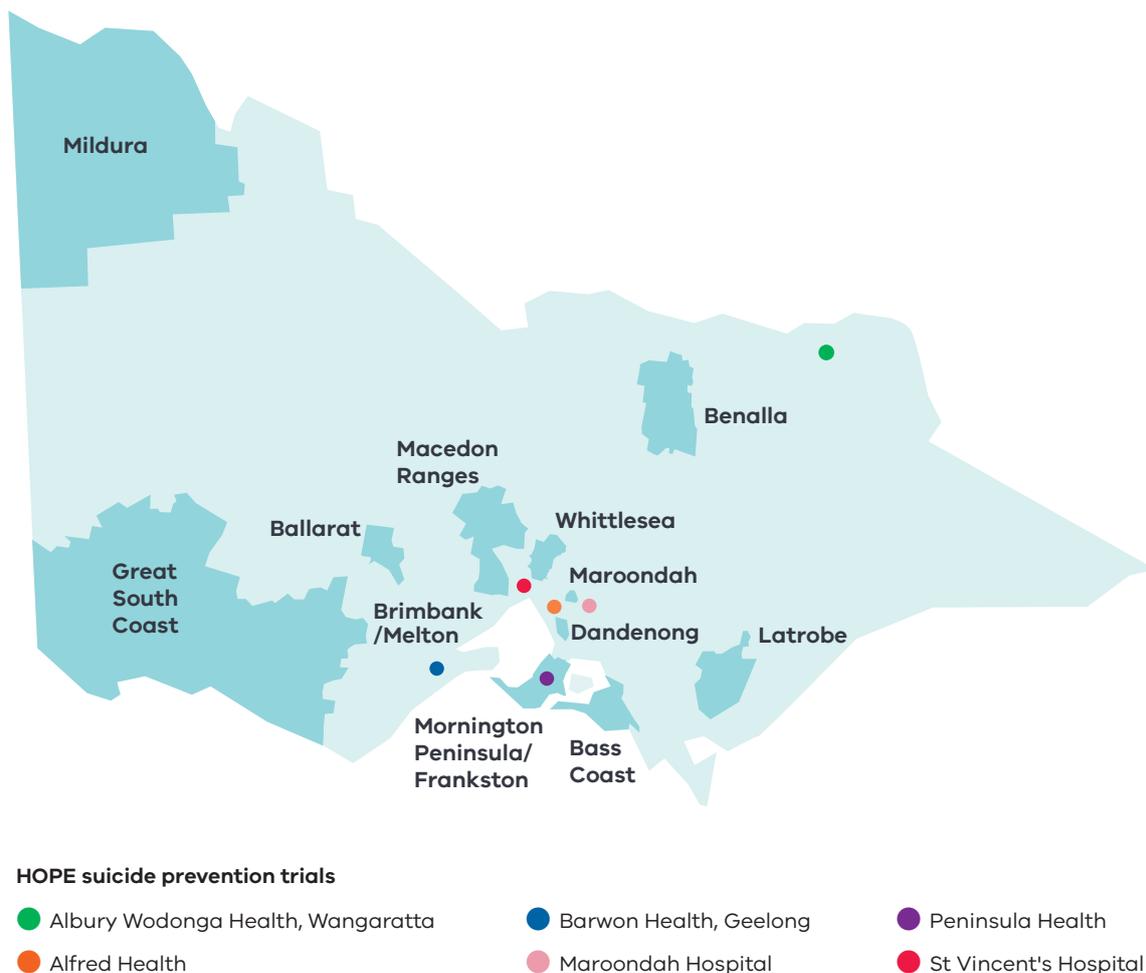
Place-based initiatives are being implemented across 12 Victorian locations: Mornington Peninsula/Frankston, Dandenong, Latrobe Valley, Bass Coast, Brimbank/Melton, Macedon Ranges, Whittlesea, Maroondah, Mildura, Benalla, Ballarat and the Great South Coast (see Figure 1).

The initiatives are well underway. Each site is reviewing the particular priority groups at risk of suicide in their communities and how to best tailor prevention activities to support these groups. Local buy-in is strong and is supporting new ways of working together to prevent suicide. Training is being undertaken to build the confidence of people with lived experience in talking about suicide within their local communities. GPs are also being supported to recognise and help people at risk of suicide. The aim of this work is to help reduce stigma and support help-seeking.

ASSERTIVE OUTREACH SUPPORT

The Hospital Outreach Post-suicidal Engagement (HOPE) initiative is providing assertive outreach support for people leaving hospital following a suicide attempt or intentional self-harm. The program is underway in six sites: St Vincent's Hospital; Alfred Health and Peninsula Health; Barwon Health, Geelong; Maroondah Hospital and Albury Wodonga Health, Wangaratta (see Figure 1) to ensure people get the support they need to recover. Assertive outreach workers are working with, and providing support to, families, friends and carers of people who have attempted suicide.

Figure 1: Location of place-based and HOPE suicide prevention trials



POSITIVE WELLBEING FOR LGBTI VICTORIANS

A range of initiatives focusing on positive wellbeing for lesbian, gay, bisexual, transgender and intersex (LGBTI) communities have also been funded.

This includes support to key specialist agencies such as beyondblue and headspace to provide increased support, resources and counselling for people seeking help, and support for Kunghah – an Aboriginal and Torres Strait Islander gathering of the LGBTI community – to promote inclusion and respond to this group’s health, wellbeing and safety needs and aspirations.

A diverse range of programs to promote the rights, mental health and wellbeing of young LGBTI Victorians are delivered under the Healthy Equal Youth initiative. The Youth Affairs Council of Victoria distributes a small grants program across Victoria, which enables locally driven initiatives to be delivered by a wide range of community organisations



Other initiatives underway include support for dairy farmers and their families experiencing financial and emotional stress, including outreach support, counselling, information and linkages to other local support services. Farming communities have been consulted to ensure the support provided meets people's needs. Partnerships have been formed with local health services, Primary Care Partnerships, PHNs, government departments and industry and local community groups to deliver a range of innovative responses.

The department is also working closely with the Coroners Prevention Unit to improve access to data on suicide.

WORKING TOGETHER TO PREVENT SUICIDE

Eastern Melbourne PHN and Eastern Health are working together to bring Commonwealth and state investments in suicide prevention to the community. Maroondah Hospital is supporting people who present to the hospital following a suicide attempt, and this support will extend to their families. Eastern Melbourne PHN is implementing place-based trials in Whittlesea and Maroondah to help local communities prevent suicide.

A community forum was held in Maroondah in March 2017 to learn from people who have been impacted by suicide. Participants identified ideas and opportunities for improving access to services, providing appropriate support to families and the bereaved, and facilitating positive community attitudes and reducing stigma around suicide.

SUPPORTING CHILDREN AND YOUNG PEOPLE

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

Victoria's 10-year mental health plan recognises the importance of supporting children and young people's mental health. It includes a focus on infants, children, young people and their families.

We want to make sure children and their families have access to the support they need, when they need it. In 2016–17 we increased our investment in early intervention, assessment and treatment for children aged up to 12. Investments include:

- funding to support the statewide rollout of the Child and Adolescent Schools Early Action (CASEA) program
- new funding for the Clinical Specialist Child Initiative
- expansion of child and adolescent mental health services (CAMHS) focusing on children aged up to 12
- statewide rollout of the Families where a Parent has a Mental Illness (FaPMI) program.

CHILD AND ADOLESCENT SCHOOLS EARLY ACTION PROGRAM

The CASEA program is delivered through Victoria's public CAMHS. It provides early identification, assessment, community-based clinical treatment and behavioural plans for children between five and nine years of age with severe conduct disorder at Victorian government schools.

CLINICAL SPECIALIST CHILD INITIATIVE

The Clinical Specialist Child Initiative focuses on engaging, assessing and treating children (from birth to 12 years old) with behavioural disorders linked to mental illness such as conduct disorder and its precursors, anxiety and depression. This early intervention program links children to therapeutic support through appropriate referrals and provides comprehensive treatment and care plans for children presenting with behavioural disorders.

RESPONDING TO THE MENTAL HEALTH NEEDS OF CHILDREN IN OUT-OF-HOME CARE

As part of reforms to improve the lives of vulnerable children, young people and families in Victoria, a new Intensive Support Service (ISS) has been developed for young people 13–16 years old who are in, or at risk of entering, residential care. The ISS is a new approach to supporting young people and their families to develop and reach their full potential. Anglicare Victoria, in partnership with Mind Australia, is working with the Monash Health Early in Life Mental Health Service to deliver the ISS.

The focus is on meeting the needs of individual young people who have highly complex mental health needs and challenging behaviours caused by recent or past histories of sexual, physical or emotional abuse, or placement disruptions. Young people will be engaged in a range of treatment and therapeutic interventions and actively assisted and supported to transition into home-based care (with parents, kinship carers or foster carers) or move directly to independent living.

MEETING THE MENTAL HEALTH NEEDS OF NEW PARENTS

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

PERINATAL MENTAL HEALTH SERVICES

For some women, pregnancy and early parenting can be a time when they experience mental illness. Improving prevention, early intervention and treatment for vulnerable mothers from pregnancy through the postpartum and early infancy period is an important part of our mental health service system. Mental health services work with maternity programs to support and provide referrals to pregnant women and new mothers at risk of experiencing perinatal depression.

In June 2015 the Commonwealth Government stopped funding the National Perinatal Depression Initiative. The Victorian Government has provided funding for perinatal mental health to continue this important work. The Victorian Government has allocated \$2.8 million for perinatal mental health programs. Existing funding for rural health services has been maintained and funding across metropolitan health services has been extended for the first time.

OUR NEW BENDIGO PARENT-INFANT UNIT

About 20 years ago, I heard about a 'mother and baby' room planned for Bendigo's existing adult psychiatric inpatient facility, but it never eventuated. This year the new Bendigo Hospital opened, and we now have a whole dedicated parent-infant unit.

Our unit treats acute mental health disorders in carers while supporting the attachment relationship between the infant and their carer, who could be a mother, father or other carer. Our five-bed, five-cot unit is collocated within the psychiatry precinct of Bendigo Hospital, which allows for the sharing of specialist services and support. Most of our admissions are non-compulsory, which requires families to recognise and acknowledge their own mental health needs and what an inpatient admission can offer them.

People can feel ambivalent or afraid of a psychiatric unit, so we invite people to come and see our unit before admission. They are always pleasantly surprised.

We have not had a family visit our unit and not agree to an admission. Patients and their families say 'Wow, I didn't expect it to be this nice', 'I thought it would be more clinical, more hospital-like', 'This is like a fancy hotel' and 'Everything you need is here'. The unit offers large open spaces for safety and social connection as well as smaller private areas. Partners are welcome to stay, and siblings are encouraged to visit often.

A purpose-built unit to meet the needs of families in a world-class hospital in a regional area is something we are very proud of. The physical environment has a profound impact on a family's ability to remain present and allow the therapeutic processes to improve their mental health and relationships with one another, especially their vulnerable infant.

Monique Rosenbauer
Nurse Unit Manager
Parent-Infant Unit, Bendigo Health



SUPPORTING THE AHMADI FAMILY

The Ahmadi family settled in Australia about five years ago, as refugees from Afghanistan.

I met the Ahmadi family when they were referred to a family support worker by their settlement support worker. The family support worker was involved in supporting the whole family, focusing on parenting and care planning, and Mr Ahmadi was separately receiving psychological care from an adult mental health community support service.

The children were worried. Their father had been diagnosed with schizophrenia and was leaving home whenever he felt stressed. His wife would go with him. The children often saw mental health workers in their home talking about medication and thought Dad was being given medication because he was dying – nobody had explained his illness. They needed emotional support and information about what was happening to him.

So FaPMI became involved in the Ahmadi family visits. Our aim was to build the mental health workers' capacity to address the needs of all family members, and help the family support worker to use resources that would explain mental illness to the children. We spoke with Mr Ahmadi about ways to explain his illness in a child-appropriate way.

The children were seen over some time so they could ask questions about their dad. During ongoing discussions using the resources provided by Children of Parents with a Mental Illness, they identified their grandparents as appropriate support people. The grandparents' presence became a strong protective factor for the Ahmadis.

The family support worker organised case conferences attended by the mental health service, the settlement worker and the FaPMI worker to identify the Ahmadi family's practical needs and what available resources might assist.

The children were sleeping on the floor, so we arranged beds and desks to improve their quality of sleep and how they felt at school. Through FaPMI brokerage funding, they participated in family-friendly activities including bowling and visiting an indoor play area (suggested by the children so they could play while their parents enjoyed coffee).

Once the Ahmadis understood the system better and a family care plan was in place, they no longer needed mental health clinical case management or support from the family support worker. The community mental health worker stayed involved, and Mr Ahmadi's GP managed his medication.

Sometime later, the children called their grandparents – Mr Ahmadi had relapsed and needed to return to hospital. When he was re-referred to the mental health clinic, the children rang the support worker. They said their father hadn't been taking his medication and needed another type to help him feel better again. The doctors reviewed Mr Ahmadi's medication and supported him with a new regimen.

He is still linked in and doing well, supported by a family that has greater capacity to recognise the need for, and source, help.

Lisa Tesoriero
FaPMI Coordinator
Monash Health

IMPROVING ACCESS TO SERVICES

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

Victoria's public mental health services are under significant pressure to meet increasing demand, particularly in our outer metropolitan growth corridors and regional areas. The number of admissions to adult acute mental inpatient services increased by three per cent in 2016–17, with increases above the state average in outer suburban growth corridors. The numbers of people presenting to emergency departments across Victoria with mental health concerns also increased in 2016–17.

Recent initiatives to address increased demand include:

- funding more mental health beds to assist in managing critical demand
- funding medical and allied health staff to address increased demand during weekends
- establishing a new prevention and recovery centre (PARC) in Ballarat
- funding to address high demand and wait times in Melbourne's west (Mercy Werribee and Footscray) including additional support for emergency departments
- funding to grow consultation liaison psychiatry across health services.

Taking a longer term approach, high-level design, service and infrastructure planning for Victoria's clinical mental health system over the next 20 years was undertaken during 2016–17. Following on from this work, key system reforms and priorities are being identified for potential investment over the next five years.

South West Healthcare PARC – Warrnambool

For the first time Warrnambool will have a community-based residential mental health service providing 24/7 support and recovery care in a homelike environment. Due to open in late 2017, the new 10-bed PARC service will be run by South West Healthcare Mental Health Services in partnership with a mental health community support service. The centre will provide short-term community-based residential care for people aged over 16 with mental illness, focusing on early intervention for people who are becoming unwell and for those in the early stages of recovery from an episode of acute illness. Supporting people in their recovery goals will be a major focus of the service.



ORYGEN YOUTH MENTAL HEALTH CLINICAL AND RESEARCH FACILITY

The Victorian Government is providing \$60 million to rebuild Orygen Youth Mental Health’s clinical and research facility in Parkville. Construction of the new facility is underway and expected to be completed in 2018–19.

Orygen, The National Centre of Excellence in Youth Mental Health, delivers research, policy development, innovative clinical services, evidence-based training and education to ensure there is continuous improvement in the treatment and care provided to young people experiencing mental ill-health.

Orygen operates four headspace clinics across the north and west metropolitan area at Craigieburn, Glenroy, Sunshine and Werribee. headspace centres provide young people aged 12–25 with advice, assistance, treatment and support in the areas of general health, mental health, education and employment, and alcohol and other drugs. headspace was established and funded by the Commonwealth Government in 2006.



Artist's impression of the new facilities

MAJOR REFORMS IN FORENSIC MENTAL HEALTH

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

Victoria's 10-year mental health plan identified the critical need to better address the requirements of people involved with the justice system at all points of contact: at arrest or apprehension, in police custody, at court, on community-based corrections orders, in prison and at all transition points.

We know that 36.9 per cent of prisoners in Victoria have a psychiatric risk rating on arrival in prison. We want to ensure effective treatment and support is provided to these prisoners and on their return to the community. Investments in the 2017–18 State Budget have expanded mental health support for people who are in, or at risk of entering, the criminal justice system. The reforms aim to improve mental health outcomes, reduce the risk of offending or reoffending and increase community safety.

Six new community forensic mental health programs will be introduced in community health services to provide assessment and treatment for offenders on a community corrections order with an associated mental health treatment and rehabilitation condition.

A new Mental Health Advice and Response Service is being established to facilitate pre-sentence referrals to mental health treatment and provide clinical advice to magistrates, including preparation of pre-sentence assessment reports and court liaison. In late 2017 a triage service response to clinical mental health information requests from Victoria Police will be introduced for high-risk individuals coming before a magistrate during after-hours bail hearings.

Reforms in youth justice will provide more mental health assessment, treatment and support through clinical in-reach for young offenders in the justice system.

A new Forensic Youth Mental Health Service will include an early intervention problem behaviour program, and a secure youth forensic mental health unit will be established.

An additional 18 beds will open at Thomas Embling Hospital during 2017–18. In late 2017 Ravenhall, the new medium-security men's prison, will open in Melbourne's west. Ravenhall will have capacity to provide mental health services to 75 prisoners. Across Victoria, funding has been provided to support planning for more forensic mental health beds.

RECOVERY FROM AN EATING DISORDER – MY EXPERIENCE

When I was 12, something happened that made me feel like I didn't have control over anything, including my body.

I retreated to what I could control – food. I didn't like my image and was trying to lose weight. Eating made me feel guilty. It wasn't enjoyable or satisfying and became a chore. I stopped eating lunch and breakfast. My family were around me at dinner, so I'd pick at my food or pretend I was full from snacks.

It didn't occur to me something was wrong, but looking back I was stressed and lonely. My friends noticed changes. They knew I wasn't eating lunch and told the school counsellor. I felt betrayed at the time. I'm grateful now, because their actions played a big role in my recovery.

Reality hit when the GP I've known since I was little referred me to hospital. He made me realise there was a problem and I had to accept help.

I was diagnosed with anorexia nervosa after my first day at the Royal Children's Hospital. I was annoyed and didn't want to be there. It was overwhelming and exhausting.

My recovery involved family-based therapy treatment. My parents controlled my eating, making me frustrated and stressed. It was our household's main focus and put a heavy strain on everyone. I was weighed weekly at the hospital, but not told my weight, and questioned about my previous week's eating habits.

Returning to school gave me something else to think about, but eating was still the major focus for me and everyone around me.

I'd been away for so long and didn't know what to tell my friends, so there was some distance between us. I was supervised during school recess, drawing more attention to me. I was conscious of when and how much I was eating. I'd not had a regular eating schedule in a long time. The student wellbeing coordinator helped.

More discussion about eating disorders and having teachers more aware of the triggers and symptoms would've helped me when I was at school. Students are often hurting or going through issues teachers can't easily see. They look to teachers to help them.

I want to tell other young people that to deal with something, you firstly – and most importantly – have to acknowledge you have a problem. People around you often see something before you realise. Try listening to and trusting them. They care about you.

I still struggle some days, but I remind myself of the strength I've gained. I have a strong support network I can rely on. I don't have to face issues alone.

I'm no longer the person I was back then. I'm happier.



Isla

MANAGING MY CANCER TREATMENT AND DEPRESSION

I was out of sorts and saw my GP. With a new grandchild and a son with drug addiction who'd moved back home, I was probably stressed and run down.

My blood tests were 'abnormal'. I was referred to the Royal Melbourne Hospital – it's all a blur. I was feeling so sick, I had no energy to think about it. I was diagnosed with blood cancer (acute myeloid leukaemia). I remember worrying about not packing enough clothes. I had no idea I'd be in hospital the rest of that year.



I had chemo – an ugly process of tablets, vomiting, tubes, pain and exhaustion. You feel so sick. It wasn't successful. I needed a bone marrow transplant. Luckily, we found a donor and my transplant was in September.

Finally, things looked up. It was such a relief when I went home in October. But I started vomiting and feeling sick again, and was back to hospital. The infection cleared, but I was still sick. It was one thing after another. Eventually I was diagnosed with graft-versus-host disease. It's very hard to treat. I really started feeling down. It was so frustrating. You're just there, so sick and helpless, all the time. I had no control. My daughter said it was worse seeing me so upset than so physically sick.

I was depressed in 2012 and it was awful – I was starting to worry that I'd feel like that again. They say you lock things up and only cope with them when you have to, like a bucket that overflows. My cancer treatment was going so badly. When things went okay, something else happened.

They wanted to try a new treatment, but I just couldn't face it. I asked to see the consultation liaison psych team, who started visiting me and providing treatment for depression. They hit the nail on the head about what I was feeling. I didn't have to pinpoint it myself. I felt I could cope with the new treatment, and I'm glad I did. It's helped me turn the corner and start getting better.

Seeing the same people every time is comforting. They're part of the bone marrow transplant team, so I don't have to explain everything all the time. I still have good and bad days, but it's definitely played a big part in getting me so close to going home.

Deborah

SUPPORTING AND STRENGTHENING OUR MENTAL HEALTH WORKFORCE

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

Our *Mental health workforce strategy*, released in August 2016, is about supporting all workers, regardless of their role and location, to provide the best possible support, care and treatment. The strategy includes initiatives to strengthen development of Victoria's mental health workforce.

A new Centre for Mental Health Workforce Learning and Development will provide a central access point for mental health learning and development opportunities. It will support people working in specialist mental health services as well as other sectors (including health, human services, justice, education and local government).

The centre will provide:

- help to identify learning and development opportunities for mental health workers
- strategic advice on workforce development and career pathways for services and training organisations
- advice and support to ensure training and other workforce interventions are delivered in the right format at the right time, to be effective as possible
- promotion of training and events through a consolidated statewide calendar
- networking opportunities
- access to evidence and other practice support tools and resources.

The centre will also provide consultancy services in specific areas of need such as supporting the lived experience workforce, consumer and carer engagement, trauma-informed practice and managing complexity.



Carol and Bree, Bendigo Health

HELLO OPEN MINDS

Attracting and retaining a skilled and sustainable workforce is a vital part of Victoria's mental health workforce strategy.

Developed in 2017, our Hello Open Minds campaign focuses on recovery as a shared process. It shares the many positive aspects of working in mental health and the realities of what these roles require, including a strong skills base and an open mind.

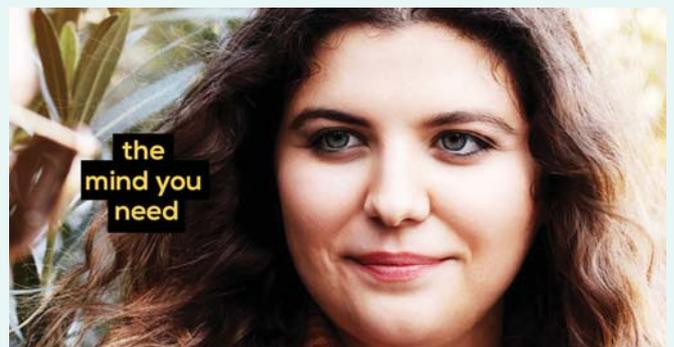
Videos featuring mental health workers and consumers appeared across digital advertising, social media and a dedicated website for those interested in a career in mental health.

Breeanna, a mental health worker, puts it this way:

'Being collaborative is vital for the consumer's mental health recovery. It not only helps them to become more independent and have a positive internal narrative, but also ensures a longer term, more sustainable recovery and approach to other difficulties that come up in life.'

'It's incredibly important to have an open mind, be curious and allow the individual to describe their own interpretation and perspective. I find mental health to be an incredibly meaningful career.'

The videos and a range of campaign resources can be found at <www.helloopenminds.vic.gov.au>.



ABORIGINAL SOCIAL AND EMOTIONAL WELLBEING

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

Our *10-year mental health plan* aims to reduce the gap in mental health and wellbeing for Aboriginal Victorians, and this is clearly articulated in the outcomes framework. We know Aboriginal Victorians experience much higher rates of psychological distress than most Victorians, and more Aboriginal children have emotional and behavioural problems when they start school.

National data indicates that self-harm and suicide rates are far greater than comparable rates for non-Aboriginal people.

An Aboriginal social and emotional framework has been developed under the *10-year mental health plan. Balit Murrup – Aboriginal social and emotional wellbeing framework* focuses on Aboriginal healing, trauma-informed practice and recovery and, most importantly, self-determination.

It commits to action to deliver locally designed community responses and to build a more culturally responsive service system with an expanded skilled Aboriginal workforce.

Initiatives supporting the strategic priorities in *Balit Murrup* include:

- three demonstration projects to test new service models for Aboriginal Victorians with moderate to severe mental illness, trauma and other complex social support needs – each site will provide culturally responsive mental health care, treatment, counselling and care coordination
- expanding our Aboriginal mental health and drug and alcohol workforce through a new Aboriginal mental health workforce training program – this will be supported by 15 new traineeship positions for Aboriginal Victorians in mental health services to enhance culturally appropriate care and 10 clinical mental health positions in Aboriginal community-controlled organisations.



Uncle Gilbert, Njernda, Echuca

HEALING AND RECOVERY – WADAMBA WILAM (RENEW SHELTER)

At the age of six, I suffered pretty bad child abuse and was placed in foster care through the Department of Human Services. For 10 years I was moved from house to house and family to family that always ended in failure and resulted in me feeling unwanted. After many failed placements and getting over the system I eventually got independent living at age 16 where I was studying, on Centrelink and supporting myself.

Even though I thought things would now start to work out, I had some really difficult times. From age 17 I was in and out of psychiatric units every couple of months for about five years. I was diagnosed with severe depression and post-traumatic stress disorder due to my past.

I started using drugs daily to block out everything that I was feeling. I had become numb and lost myself, lost interest in the things I had loved doing and had become what the system told me to be.

When I first met my Wadamba Wilam workers four years ago, I was in hospital and I was in a pretty bad state. I had given up on the system and workers but they seemed different right from the start. They weren't all about the past and what had gone wrong; they focused on the present and the future.

They started to build me up, and my self-confidence started to come back. I never felt judged or unheard. Whatever was important to me was important to them. We do a lot of goal setting and I've been able to achieve a lot of them, building up to bigger goals. Everything is based on me, my strengths and my abilities. We focus on what I have achieved and build up from there.

It's great! In the last few years I have accomplished so much and feel a whole lot better about myself. My confidence still grows daily and I am sure that I can be more assertive and express my feelings better than I ever could before.

I am still working on myself every day, but I am feeling like the old me again – before depression, before diagnosis. Mental illness is just a small part of me. I think it's important to remember who you are and not lose track of that. I can always rely on Wadamba Wilam for support.

I'm confident I can overcome any obstacle now that I have the knowledge, confidence and life skills to achieve my goals and better my future.

Chantelle

KIM'S EXPERIENCE WITH THE HOMELESS OUTREACH SERVICE

Kim is 58 and a consumer of the Inner West Area Mental Health Service. She grew up in Eaglemont, started law and arts degrees, and enjoyed working. Despite a diagnosis of schizophrenia and an admission to Larundel Hospital, Kim maintained stable mental health for 20 years with private care.

Unfortunately, Kim's mental health deteriorated after a lower-leg amputation due to complications related to type 2 diabetes mellitus. During this time, she experienced financial hardship and a housing crisis, which left her homeless in a wheelchair in Melbourne's CBD.

Kim was referred to the Homeless Outreach Mental Health Service (HOMHS) in 2014. Kim was suffering from a psychotic relapse with paranoid delusions. She was highly vulnerable, using alcohol to cope with her distress. Her physical health had also deteriorated significantly.

Kim was admitted to the Royal Melbourne Hospital, under the *Mental Health Act*, to be treated for her schizophrenia and diabetes. Kim's physical and mental health improved, and she was transferred to Arion PARC for ongoing rehabilitation.

While there, VCAT placed Kim on an administration order to assist her with financial planning. She soon received an offer of public housing in the Older Person's High Rise complex in Carlton.

HOMHS supported Kim with her transition to independent living in Carlton. Kim started forming connections with a nearby church and familiarising herself with the local shops and cafes. She participates in various groups facilitated by CoHealth at her housing complex, which include gardening, cooking, and market shops, and attends regular coffee catch-ups.

Kim demonstrated capacity to live independently in safe, secure and affordable housing and was successfully maintaining stable mental health. She was subsequently discharged from her community treatment order. Kim transitioned from injectable treatment to oral medication, and meets with her GP to manage her mental health. Kim expressed her wish to manage her finances independently and was supported by her treating team to achieve this.

Kim says, 'It sounds silly' but she feels much happier with her life following the amputation of her right leg. She attributes this to securing safe and affordable housing, making connections in her local community, and receiving the support she needed from assertive community services.

Terry Runciman
Program Manager/Clinical Psychologist
Inner West Area Mental Health Service
The Royal Melbourne Hospital

RESPONDING TO HOMELESSNESS

OUTCOME: Victorians with mental illness have suitable and stable housing

Our outcomes framework tells us that a significant number of Victorians with a serious mental illness do not have suitable and stable housing. We also know that more than 25 per cent of people accessing homelessness services identify mental illness as a contributing factor to their homelessness, and that the longer someone is sleeping rough, the greater the impact on their mental health.

In January 2017 the Victorian Government announced Towards Home, an investment of \$9.8 million to rehouse vulnerable rough sleepers in inner Melbourne and provide them with targeted supports to maintain their housing. As part of this work, a long-term, statewide rough sleeping strategy is being developed, which includes a focus on mental health.

Initiatives in Towards Home include:

- access to 40 transitional housing units across Melbourne until new additional permanent housing is in place by the end of 2017
- 30 new modular and relocatable homes on public land in place by the end of 2017
- case management and targeted flexible support packages for 40 vulnerable rough sleepers for up to two years to help them maintain their housing.

These flexible support packages will be targeted at people living in the 30 relocatable homes and those with complex needs in a dispersed setting. This includes expanding the existing Homeless Mental Health and Housing Service in the CBD, which provides people who experience severe and enduring mental illness and a history of repeated homelessness with a pathway to better health, secure housing and increased social and economic participation.

Towards Home builds on the government's \$109 million Response to Homelessness package announced in November 2016. Over five years, assistance will be provided to 19,000 people at risk of, or experiencing, homelessness, including young people, rough sleepers, veterans and people experiencing chronic homelessness.

Rough sleeping strategy

As part of Towards Home, Tony Nicholson, executive director of the Brotherhood of St Laurence, is providing independent expert advice about implementing Towards Home initiatives and developing a long-term, statewide rough sleeping strategy to reduce rough sleeping in Victoria.

This builds on the work of the Rough Sleeping Response Taskforce set up in July 2016 in response to the significant rise in people sleeping rough in inner Melbourne. The taskforce, chaired by Dr Ruth Vine of Melbourne Health, is providing advice on implementation of the Towards Home and Response to Homelessness packages, and the statewide rough sleeping strategy. The taskforce is focused on developing practical solutions and systems change to better target and deliver housing and support for rough sleepers in the central city area.



Artist's impression of a relocatable home



Aunty Louise,
carer

SUPPORTING WOMEN WHO HAVE EXPERIENCED FAMILY VIOLENCE

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

The groundbreaking work of the Royal Commission into Family Violence provided practical recommendations to prevent and address family violence in Victoria, based on an examination of the current service system and best practice approaches.

The Victorian Government has allocated an unprecedented \$1.91 billion to implement all 227 royal commission recommendations. *Ending family violence: Victoria's plan for change* and the *Family violence rolling action plan 2017–2020* outline how the recommendations will be delivered to promote survivor safety and build a future where Victorians live free from family violence. This includes:

- establishing 17 Support and Safety Hubs across the state
- extending after-hours crisis support, counselling and therapy for tens of thousands of women and their children
- establishing a hospital-wide system response to identify and respond to family violence.

SUPPORTING OUR CONSUMERS, THEIR FAMILIES AND CARERS

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

TRANSITION TO THE NATIONAL DISABILITY INSURANCE SCHEME

The National Disability Insurance Scheme (NDIS) is reshaping how psychosocial disability services are provided to many Victorians currently receiving state-funded mental health community support services (MHCSS) and those who will need this support in the future.

Throughout 2016–17 clients living in the North East Melbourne area, Central Highlands and Loddon began transitioning to the NDIS. This process will pick up pace in 2017–18 when a further seven areas begin the changeover.

Many people with a psychosocial disability who have transitioned to the NDIS have had a positive experience and are receiving supports. Clients of individualised client support packages, adult residential rehabilitation services and most supported accommodation services are automatically eligible for the NDIS, provided they meet age and residency requirements. Support will continue to be provided for clients of these programs who are ineligible for the NDIS due to age and residency.

The department is working closely with MHCSS providers and the National Disability Insurance Agency (NDIA) to support clients' smooth transition. When the rollout is complete, the NDIS is expected to support approximately 15,000 Victorians with a psychosocial disability.

The department provided funding during 2016–17 to VICSERV, the Victorian Mental Illness Awareness Council (VMIAC) and Tandem to support community-managed mental health organisations, people with a psychosocial disability and their carers to transition to the NDIS.

The department is working with Austin Health, St Vincent's Hospital, Melbourne Health and the NDIA to build effective collaborative practice models between specialist clinical mental health services, the NDIA and funded providers. Learnings will be shared with Victorian health services to assist them to prepare for the NDIS. The department is also providing funding to selected health services to assist with effective NDIA partnering.

The Victorian Government continues to fund a number of MHCSS programs outside the NDIS including mutual support and self-help, planned respite, youth residential rehabilitation, supported accommodation services that have a homelessness focus and Aboriginal mental health. Victorians accessing these services will remain supported to ensure their needs are met.

SUPPORTING OUR CONSUMER AND CARER ORGANISATIONS

Mental health consumer and carer organisations are critically important in providing practical support, information, advocacy and education. They also provide a powerful voice for consumers, their families and other carers about how services may or may not be working. Working closely with the department, these organisations provide guidance on emerging and current policy issues, providing key insights into how the service system operates.

The department funds and works with a number of organisations including VMIAC, Tandem, Wellways, MIND Australia, Carers Victoria, the Mental Health Foundation, Spiritual Health Victoria and a number of specialised mutual support and self-help organisations.

In 2016–17 funding was provided to VMIAC and Tandem to develop consumer and carer participation registers to draw on lived experience of living with or supporting someone with mental illness. These registers will build a network of people who are able to engage with government to influence the nature of supports and services needed to achieve better mental health outcomes.

They have also managed a small grants program to improve the mental health and wellbeing of immigrant and refugee background communities by building capacity through a range of community-led initiatives. The grants are aimed at people of all ages within ethnic communities, including those living in rural Victoria. They will focus on those experiencing or at risk of mental illness, their families and carers to better understand mental wellbeing, mental illness and the impacts of trauma. They have also received funding to provide information and support about the NDIS to assist people with a psychosocial disability to understand how to access the scheme.

2

MAKING A DIFFERENCE – SAFETY AND QUALITY IN OUR MENTAL HEALTH SERVICES

2. MAKING A DIFFERENCE – SAFETY AND QUALITY IN OUR MENTAL HEALTH SERVICES

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

We are working with our mental health services to make sure they are safe places for consumers, families, carers, staff and visitors. Consumers have told us how important it is to feel safe during an inpatient admission and that use of restrictive interventions such as seclusion or restraint can be harmful and delay recovery.

We report on these practices in our outcomes framework, with a goal of reducing them wherever possible.

SAFER CARE VICTORIA

Supporting health services to provide safe, high-quality care to patients, every time, everywhere is a goal of Safer Care Victoria. Safer Care Victoria oversees and monitors standards of care provided and partners with consumers and their families, clinicians and health services to support the continuous improvement of healthcare.

Safer Care Victoria was established in January 2017 in response to recommendations within the report *Targeting zero: supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care*.

Targeting zero includes a number of recommendations specific to clinical networks, which are being revitalised to better meet the changing needs of consumers and health services. A Mental Health Clinical Network will be established during 2017–18 to drive quality and safety across our mental health service system and improve consumer outcomes and experience. The network will provide advice and expert knowledge directly into Safer Care Victoria and the broader Department of Health and Human Services. It will focus on improving quality and safety through service and system-level approaches to decreasing practice variation and supporting evidence-based practice.



VICTORIAN AGENCY FOR HEALTH INFORMATION

The Victorian Agency for Health Information was established in 2017. It analyses and shares information across Victoria's public healthcare system to provide an accurate picture of hospital and health service performance.

The agency's role is to ensure data and information on the performance of Victoria's public healthcare system is readily available to health service boards, chief executives, lead clinicians, the Department of Health and Human Services, Safer Care Victoria, other government agencies, the public and researchers.

The agency measures and monitors indicators of quality care and outcomes for patients for the purpose of public reporting, oversight and clinical improvement. It will:

- collect, analyse and share data so the community and health services are better informed about health service performance
- provide health service boards, executives and clinicians with the information they need to best serve their communities
- provide patients and carers with meaningful and useful information about care in their local area
- improve researchers' access to data so they can create evidence to inform better, safer care.

VICTORIA'S CHIEF PSYCHIATRIST

Victoria's Chief Psychiatrist is responsible for overseeing system-wide continuous improvement in the quality and safety of public clinical mental health services, and for promoting the rights of people receiving treatment in public mental health services.

The Chief Psychiatrist provides clinical leadership through expert advice, training, education and published guidelines. The Chief Psychiatrist monitors service provision and may conduct investigations, clinical audits or clinical service reviews to improve patient safety and wellbeing.

In 2016–17 the Office of the Chief Psychiatrist undertook a number of investigations and clinical service reviews. These included formal investigations under the Mental Health Act relating to services with high clinical risks identified through scheduled visits of the Chief Mental Health Nurse, following serious incidents in inpatient units or in response to allegations of staff misconduct.

The Office of the Chief Psychiatrist also led a number of clinical service reviews at the request of mental health services to give clear guidance in efforts to ensure the safest and highest quality mental health treatment. A unique feature of the investigations and review projects undertaken is the extensive follow-up support provided to services to assist in achieving practice and cultural change. This collaborative approach is highly valued by services and encourages service leaders to work with the department to undertake continuous and meaningful improvement.

REDUCING RESTRICTIVE PRACTICES

Reducing seclusion in clinical mental health services is a national safety priority. Seclusion involves a person being confined alone in a room or area from which it is not within their control to leave. Bodily restraint, including physical and mechanical restraint, involves methods that prevent a person having free movement of their limbs.

Bodily restraint and seclusion may only be used after all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable. We know that for consumers who are secluded or restrained, this can cause reactivation of previous trauma.

After a number of years of steadily falling seclusion rates, the rate increased in 2015–16 and 2016–17. The drivers for this change are not clear, but an increased focus on more rigorous reporting of episodes of seclusion and restraint may have played a part. Rates of bodily restraint decreased significantly during 2016–17. Further detail on the use of restrictive interventions is contained in section 3 of this report.

STATEWIDE ROLLOUT OF SAFEWARDS

Our Safewards program is one of a range of initiatives focused on consumer and staff safety. Building on earlier work, statewide implementation began in 2016–17 in acute inpatient units. Safewards provides a model of engagement and practical options to enable staff and consumers to address conflict behaviours together. One aim of the Safewards model is to reduce the use of seclusion and restraint.

Safewards can improve the quality of interactions between staff and consumers, as well as enhance the support consumers provide to each other, resulting in better experiences of care and improving the safety and wellbeing of consumers and staff.

In 2016–17 the Office of the Chief Mental Health Nurse established a Safewards team to assist services to implement Safewards. Over the next four years the team will provide training, mentorship and guidance to services to support implementation and embed the model into practice.

A pilot program has also been established to trial Safewards in a medical unit at Peninsula Health. Planning is underway to extend the trial to nine emergency departments and a further nine acute medical units across the state.

Victorian Safewards information and training resources are available on the Department of Health and Human Services website at <<https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/safewards>>.

SAFEWARDS GIVES US HOPE

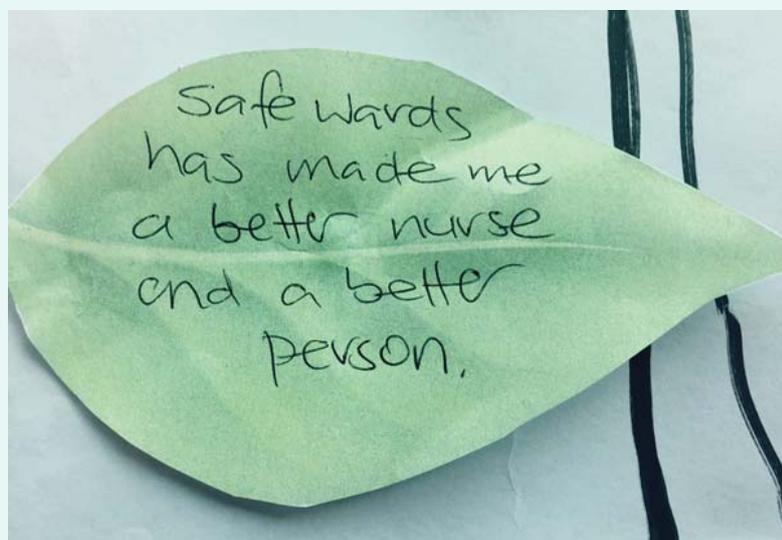
Safewards is being rolled out to inpatient mental health units across the state, including adult, adolescent, aged and secure units. The rollout incorporates comprehensive staff training, engagement with consumers, implementation support and resources, and evaluation.

Hope can be one of the first casualties of mental illness, so finding and holding onto hope is an important part of recovery. In Safewards, we know that hope can be most powerful when it comes from our peers – that is, people who've had a similar experience to ourselves. Safewards tells us that this kind of hope does more than aid recovery – it can also be an effective way to reduce conflict and increase safety in mental health services.

One of the Safewards interventions, called Discharge Messages, is all about growing hope through mutual support. It starts with creating a large mural of a tree in each mental health inpatient unit.

Consumers are invited to grow the tree by adding a leaf or flower that includes their own message of hope for other consumers to read. The messages grow over time and become a resource for all consumers who stay on the unit. Across Victoria, consumers and staff at different hospitals have been working together to create beautiful trees that inspire hope.

In a parallel process, Safewards has been inviting staff from inpatient units to complete their own leaves of hope that are passed on to staff at other services. The Safewards team shares these messages with staff when they attend Safewards training. These messages have been powerful motivators for staff and services to embrace the value of Safewards.



LISTENING TO CONSUMERS

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

Listening and responding to the experiences of people who use our public mental health services is a fundamental part of identifying what is working well and what needs improving.

The YES survey is an important tool for understanding how people experience our public clinical mental health services and our MHCSS. YES captures information about people's experience of care, including the development of care plans and how the service supports their ability to manage their day-to-day lives.

The survey was first carried out between March and May 2016, and the second survey took place in the same period this year. An annual approach allows services to measure and monitor experience over time and to assess whether actions and changes implemented at services are improving the quality of consumers' experiences.

The data from YES used in this report focuses on clinical mental health services including inpatient and community services. A total of 2,170 surveys were completed in 2017. The results show that many consumers had positive experiences, although there is scope for improvement in a number of areas. About two-thirds of people (65.1 per cent) rated their experience of care with a service in the last three months as very good or excellent. Eighty-eight per cent of consumers reported that their individuality and values were usually or always respected.

A statistical analysis was undertaken to better understand what drives positive experiences of clinical services. The single largest factor driving a positive overall experience was *staff showing respect for your feelings*. 'Feeling respected' was in turn influenced by *feeling welcome, staff making an effort to see you when you wanted, staff showing hopefulness for the future, respect for individual values and feeling safe* (see Figure 2).

Figure 2: Most important drivers of a positive overall experience, based on YES survey data, 2016



These findings indicate that ensuring consumers feel respected through making them feel welcome, feel safe, accommodating their needs and showing hopefulness for their future generates a more positive overall experience of care.

Using the YES survey to improve our service at NorthWestern Mental Health

The 2016 YES survey has helped strengthen consumer and carer involvement in our service. Our Continuous Improvement Committee took the lead in reviewing the survey results. They asked consumer and carers, as well as staff members, to rate each survey item according to how important the question was to them and how concerning the survey result was.

Survey questions/results that were considered both 'important' and 'concerning' were prioritised for action. Our wonderful consumer and carer consultants developed a poster to explain these changes to our service users and staff, and to promote the 2017 YES survey. Our plan is to produce a regular poster to keep consumers, carers and staff informed of our survey results, intended actions and outcomes.

EXPANDING OUR PEER SUPPORT WORKFORCE AND PROGRAMS

Being able to transition safely and securely from an acute inpatient service to the community is a major factor in enabling people to remain well and out of hospital settings. Peer support workers and programs are playing an increasingly important support role in our services, especially during this period of transition.

Under our Expanding Post Discharge Support Initiative, all adult mental health services received ongoing funding in 2016–17 to employ peer support workers to provide follow-up support for consumers, their families and carers following discharge from an acute inpatient service. Peer support workers contribute to effective discharge planning and provide at least three community follow-up contacts within the first 28 days following discharge.

PEER SUPPORT FOR KIDS WHOSE PARENT HAS A MENTAL ILLNESS

CHAMPS is a structured peer support program for children aged eight to 12 who have a parent with mental illness. The aim of CHAMPS is to provide age-appropriate information and support to the children and their families through a broad range of peer support activities such as kids clubs, school holiday programs, networking opportunities, martial arts therapy and other coping strategies. Peer support programs like CHAMPS are core to the work of the FaPMI program.

State Budget funding in 2016–17 enabled statewide coverage of the FaPMI program and opportunities for CHAMPS to be implemented across the state.

MY RECOVERY

Ten years ago I was diagnosed with anxiety and depression. During the first years of my experience, I didn't have a clear understanding of my identity. My psychotherapist suggested I try alternative relaxing therapies. At the time I didn't pay much attention as I wanted to be 'fixed' as quickly as possible.

Later, while I was spending my life on and off medication in order for me to be productive, functional and sociable, I remembered his suggestion. I started looking online for potential meditation opportunities.

Meditation became an integral part of my life. I learned how to study myself and question my thoughts and beliefs. I explored things I'd never discussed before – love, kindness, peace. I started reading books for the first time in my life. I stopped watching TV; I started exercising. This combination gave me insight into the person I'd been ignoring for 33 years. I felt connected with everything around me.

In the bubble of depression, and especially in Greece, I was living in darkness. Maybe there were opportunities back then, but I couldn't see them. For the past five years I've created a whole new life. I have all these opportunities and possibilities and am catching up on all that lost time.

My recovery journey inspired me to contribute to improving people's mental health and wellbeing by sharing my experience and the tools I used myself to create the change in me. I started working in the mental health field as a peer support worker.

Gradually I developed my own self-care workshop about increasing resilience and hope and creating healthy habits to make a better life for ourselves. This program is based on my experience. I run it for people accessing mental health services, for staff as part of their professional development, and everyone interested in experiential wellbeing training. My message is that life can be hard but it is possible to live it differently with determination and readiness.

I also work as a learning and development consultant at Mind Recovery College developing and delivering learning programs in mental health settings, as a mentor with beyondblue attending to the needs of at risk diverse populations, and collaborate with Spiritual Health Victoria to raise awareness about spiritual care.



Anton

GOOD ENOUGH MUM!

When my eldest daughter and I were initially referred to the CHAMPS program, I was overwhelmed.

Caring for three children with a range of medical and psychological issues, as well as my own mental illness and health, we were doing the best that we could. Our communication was breaking down, everyone felt stressed and worried, and we were having less 'good' days and more 'bad' days. I felt inadequate, unsupported and alone. I constantly questioned if I was a good parent.

CHAMPS was unique from any other program that I knew of. It helped me connect to other parents, as well as to my daughter. The kids were picked up on the bus from school, and they would meet us parents at the centre. I really looked forward to having afternoon tea with my daughter and being able to check-in and focus just on her. We then would split into a parent focus group and the kids would head off to their group.



I witnessed her connecting with other children who understood what home life is like when you have a parent with mental illness. She was guided to understand what my diagnosis meant to me and how to access help if she felt that either she or I needed support. The group leaders did an amazing job to draw her out of herself. She learned that other families are just like ours and came away with friendships and skills to help support herself.

Engaging with the facilitators and the other parents, I began to realise that parenting is hard in general and my situation isn't unique.

The group felt more like a parenting group who were drawn together through our experiences with mental illnesses. We were parents and grandparents, but so many times I found myself listening and thinking 'Oh my gosh, someone else understands!' I felt I could connect with the other group members better than a regular parenting group (which I had previously tried attending). It was a safe space with no judgement, which was really important for some of the issues and problems we discussed.

CHAMPS will have a lifelong effect on my family. I now feel more confident in my parenting and more connected to my children, and I know that bad days don't define who I am as a parent.

Kate Mason
GEM (Good Enough Mum!)

3

YEAR IN REVIEW – PUBLIC MENTAL HEALTH SERVICES IN 2016–17

3. YEAR IN REVIEW – PUBLIC MENTAL HEALTH SERVICES IN 2016–17

OVERVIEW

The data in this section of the report helps us 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, including data about the use of compulsory treatment and restrictive interventions. Our aim is to drive service improvement and improve community understanding of Victoria's public mental health services.

The data shows that services, particularly inpatient services for adults, are under increasing pressure to meet demand. Hospitalisations of adults for mental illness are increasing, many services have very high occupancy levels, and people are being discharged after a relatively short time.

WHO RECEIVES PUBLIC MENTAL HEALTH TREATMENT?



HOW LONG DOES TREATMENT LAST?



53.1%
of adult admissions
had a preceding
community contact



9.5 days
average length of adult
inpatient stay (trimmed)



79.4%
of adults were followed
up with a community
mental health contact
within 7 days of discharge

HOW DO WE KNOW IF WE'RE MAKING A DIFFERENCE IN PEOPLE'S LIVES?

People using services want to know how they're going. Sharing information on outcomes is one way of doing this because it looks at how a person's health, wellbeing and circumstances change over time. It helps consumers and clinicians to work together to map recovery journeys.

In Victoria, one of the tools used to understand consumer outcomes is the Health of the Nation Outcome Scales (HoNOS). This information is used at the local, state and national levels to assess the effectiveness of services.

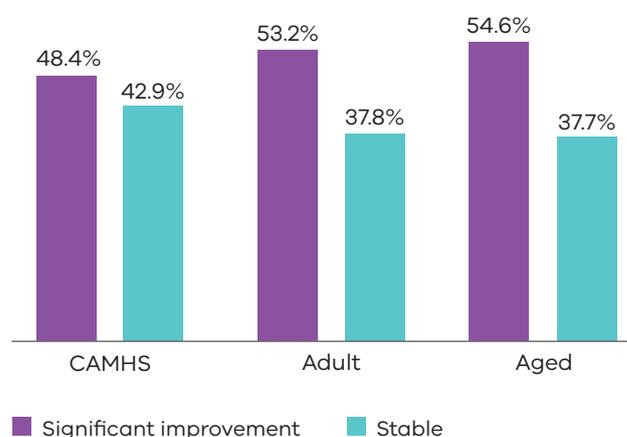
HoNOS has slightly different measures for young people, adults and older people. For adults, the 12 outcome scales cover issues grouped into four areas: behaviour, symptoms, impairment and social functioning. This allows a range of issues to be considered such as problems at work or in relationships, hallucinations and physical illness.

HoNOS measures are recorded at various points – for example, on admission and discharge. A higher HoNOS score means a more severe problem.

Our outcomes framework reports on change for consumers in the community at the end of a period of treatment. People require assistance for different lengths of time, but on average, people receiving clinical services in the community receive treatment for about six months.

The majority of CAMHS, adult and aged clients in Victoria had stable or improved clinical outcomes in 2016–17 (see Table 2). As in physical health, we are increasingly focused on ensuring our care contributes to better outcomes for clients and their families. Forensic and specialist outcomes data applies to smaller groups of clients and shows significant volatility. Over the past four years, the overall percentage of consumers with significantly improved or stable outcomes by age group has been consistent (see Appendix 2).

Table 2: Improvements in mental health outcomes, 2016–17



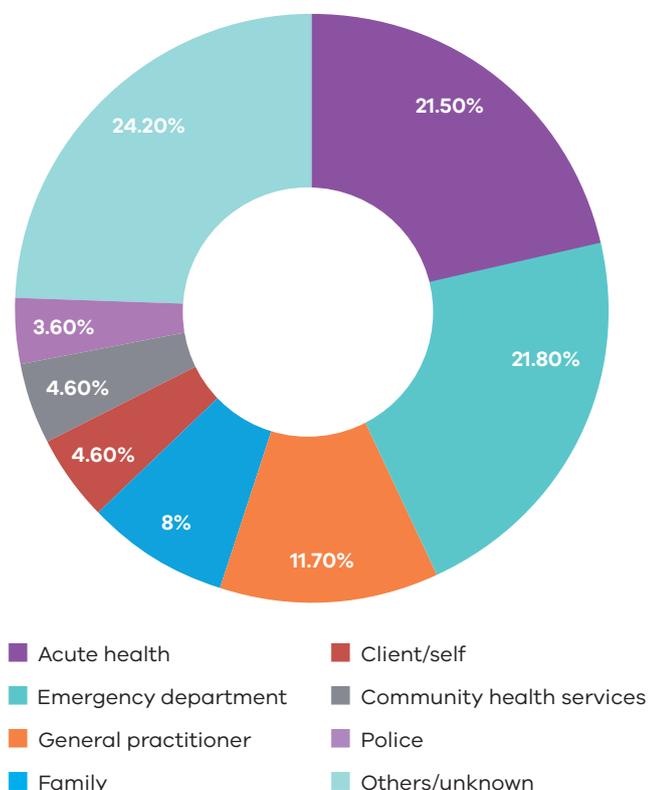
WHO ACCESSED OUR PUBLIC MENTAL HEALTH CLINICAL SERVICES IN 2016–17?

The majority of the 66,445 registered clients in 2016–17 were adults. Children, adolescents and older Victorians make up smaller groups. Most clients had previous contact with mental health services. Just over half (50.4 per cent) were women, while nearly 33 per cent live in rural areas. About 4,500 registered clients used both clinical and mental health community support services.

HOW WERE PEOPLE REFERRED TO OUR CLINICAL SERVICES IN 2016–17?

Most people were referred to clinical mental health services by hospitals (including emergency departments) (43 per cent), GPs (12 per cent) or their families (eight per cent) (see Figure 3).

Figure 3: Source of mental health referrals, 2016–17



There were 52,427 mental health-related emergency department presentations in 2016–17, a slight increase from 2015–16. Across all age groups there were 24,314 hospitalisations in mental health acute inpatient units in 2016–17. Of these admissions, 52 per cent were compulsory.¹ This has been consistent over the past three years.

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

 **10,723**
clients

 **278,673**
community contacts

 **1,835**
hospitalisations

Most children and young people receive clinical treatment in the community. A small proportion of children and young people in Victoria require inpatient treatment for mental illness. In 2016–17 there were 10,723 registered CAMHS clients and 1,835 CAMHS hospitalisations. Seventeen per cent of inpatient admissions to hospital were compulsory – a much lower proportion than for adults or aged persons (56.9 and 48.2 per cent respectively). Very few CAMHS clients were on a community treatment order (1.1 per cent).

The 28-day readmission rate for CAMHS was 17.6 per cent in 2016–17, a small increase from the previous year. This is a relatively high rate compared with other age groups and may reflect the severity of illness experienced by some young people. It may also reflect health service practice in relation to trialling of discharge for a child or young person.

The trimmed average length of stay (≤ 35 days) for most CAMHS inpatients was 6.9 days, slightly less than last year. Inpatients who stayed longer than 35 days accounted for 9.6 per cent of all CAMHS bed days.²

Community contacts are a key part of CAMHS work. Community contacts may involve activities such as assessment and treatment, adolescent day programs or intensive outreach for young people. CAMHS teams often involve parents and siblings, as well as schools, in supporting a young person. In 2016–17 there were 278,673 community contacts, a small increase from the previous year.

ADULT MENTAL HEALTH SERVICES



51,735
clients



3%
increase in
admissions

INPATIENT SERVICES

In 2016–17 there were 19,228 hospitalisations of adults for mental illness in a public hospital, continuing a pattern of steady increase since 2008. People aged 26–34 accounted for 27 per cent of admissions, with people aged 35–44, accounting for 26 per cent of admissions. The most common diagnoses were schizophrenia and mood disorders such as depression or bipolar disorder. Fifty-seven per cent of hospitalisations were compulsory.

In the past two years (2015–16 and 2016–17) admissions increased by eight per cent and three per cent respectively, with even higher increases above the state average in outer suburban growth corridors.

On average, adult inpatient services continued to operate at 95 per cent occupancy throughout 2016–17. The trimmed average length of stay (≤ 35 days) has dropped slightly over the past three years, continuing a trend from 2010–11. People who stayed longer than 35 days accounted for 10.3 per cent of all adult inpatient bed days. About half of the people who became inpatients (53 per cent) had contact with a community service before they were admitted to hospital. The post-discharge follow-up rate is high (at 79 per cent), although 14 per cent of people were readmitted within 28 days of discharge. Pressure on beds may result in shorter-than-optimal hospital stays and a higher risk of relapse and readmission.

CLINICAL MENTAL HEALTH SERVICES DELIVERED IN THE COMMUNITY

Community clinical services include assessment, treatment and support. Community contacts for adults have reduced – a total of 1,188,980 community contacts were recorded during the year, down from 1,400,443 community contacts recorded in 2015–16.³ However, this is largely due to under-reporting of service contacts during the first half of 2016–17. Fifteen per cent of adult clients receiving treatment in the community were on community treatment orders, similar to the previous year.

PREVENTION AND RECOVERY CARE

Although they are a relatively small element of the service system, PARC services are steadily growing, with 3,402 separations in 2016–17. These short-term services in residential settings generally provide care for up to 28 days when a person is either becoming unwell or is in the early stages of recovery from an acute admission.

The PARC occupancy rate was 81.5 per cent, and occupied bed days increased from 63,425 in 2015–16 to 66,354 in 2016–17. This may be due to new services (opened in 2015–16) becoming fully operational.

ADULT RESIDENTIAL SERVICES

Residential services provide homelike environments for people with mental illness. There were 681 separations from community care units in 2016–17, similar to the previous year. Occupancy is steady at 80 per cent. There were 104,488 occupied bed days in community care units in 2016–17, again little changed from the previous year. Other specialist residential services include accommodation for people with borderline personality disorder and brain disorders.

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 188 separations from secure extended care units in 2016–17, a small decrease from the level of the prior two years. Occupied bed days increased to 44,391 over the same period, resulting in an average occupancy rate of 92.1 per cent.

AGED PERSONS MENTAL HEALTH SERVICES

AGED PEOPLE



7,396
aged clients



168,672
community contacts



2,234
hospitalisations

Over the past three years the number of registered clients accessing aged persons mental health services decreased, which may reflect a wider range of service options for aged clients more generally.

In 2016–17 there were 2,234 hospitalisations of Victorians aged 65 years or older in acute inpatient services. Fifty-four per cent of registered clients had had preadmission contact with the service. On average, aged persons inpatient units were operating at 85.4 per cent occupancy throughout the year. Seven per cent of registered clients were readmitted to an inpatient service within 28 days of discharge. The post-discharge follow-up rate was 74.6 per cent.

Some 48.2 per cent of admissions were compulsory, rising from 45.4 per cent in 2014–15. This may reflect the same level of acuity in a smaller client group. The trimmed average length of stay (≤ 35 days) for most people was 16 days, which has been relatively stable over the past three years. People who stayed more than 35 days accounted for 27 per cent of all aged persons bed days.

Aged care residential services (hostels and nursing homes) are provided for people with high levels of persistent cognitive, emotional or behavioural disturbance. For these services, there were 225 separations in 2016–17, and the bed occupancy rate was 87 per cent. A wider range of community-based care options has contributed to older people delaying entry into public residential aged care services, and some public facilities have closed.

There were 168,672 community contacts involving aged persons in 2016–17, a significant decrease that may reflect under-reporting. Community contacts can involve assessment, treatment and intensive support.⁴

FORENSIC MENTAL HEALTH SERVICES



There were 751 registered forensic clients in 2016–17, a substantial increase over the previous year. This is a result of additional resourcing, which has allowed more clients to be seen. Community contacts were steady at 17,382, as were service hours to forensic clients in the community at 10,762 (from 10,597 in 2015–16).

SECLUSION AND RESTRAINT

After a number of years of steadily falling seclusion rates, the rate of seclusion in inpatient units increased from 9.1 per 1,000 occupied bed days in 2015–16 to 9.9 in 2016–17. An increased focus on more rigorous reporting of episodes of seclusion and restraint may have contributed to this change.

Definitions and reporting requirements on restraint changed following the introduction of the 2014 Mental Health Act, making it difficult to compare with data prior to that time. The rate of bodily restraint in inpatient units during 2016–17 was 19.0 per 1,000 bed days, a substantially improved result from 25.6 in the previous year.

PHYSICAL HEALTH

OUTCOME: Victorians with mental illness have good physical health and wellbeing

People with severe mental illness have poorer physical health, shorter life expectancy, and die younger than the general population.⁵

Type 2 diabetes and tobacco use contribute to physical illness and early death for people with mental illness, and the proportion of registered clients accessing hospital based care with a diagnosis of diabetes or tobacco use has been reviewed over a recent six year period.⁶

We found that although six per cent of Victorian adults had ever been diagnosed with type 2 diabetes,⁷ the proportion of registered mental health clients with a recorded diagnosis of type 2 diabetes during 2015–16 was almost double at 10.6 per cent.

In 2015–16, 33.4 per cent of registered clients of Victorian public mental health services who were hospitalised were smokers. The high proportion of young people with mental illness who smoke is at odds with the general population, where considerable progress has been made.^{8, 9}

Smoking and type 2 diabetes increase the burden of ill-health on people with mental illness, and contribute to their lower life expectancy. Chronic diseases and related risk factors are common in people using Victoria's mental health services, and efforts are required across the health system, including public mental health services, to improve the physical health of clients receiving mental health treatment.

APPENDIX 1: OUTCOMES FRAMEWORK

APPENDIX 1: 10YP OUTCOMES AND INDICATORS FRAMEWORK

ADDITIONAL MEASURES

The suite of indicators established for the *10-year mental health plan* outcomes framework has been expanded this year. Progress has been made in a number of areas, including physical health and respect, with new indicators for both these outcomes. Although 14 indicators have been added, we are aware that we don't have all the information we need to monitor outcomes. We will continue to grow the indicator set over time, as further valid and reliable Victorian data becomes available.

Many of the outcomes are ambitious. Some focus on improved mental health and wellbeing for all Victorians, while others address aspects of our specialist mental health services for people with severe mental illness. Further indicators have been added this year for children and Aboriginal Victorians.

We have introduced new indicators this year in relation to tobacco and diabetes. Physical health and wellbeing is an example of an outcome where achieving improvements will require a range of organisations to work together. Responsibility for physical health does not sit entirely with the department or any one organisation. All levels of the health system need to work together, with the non-government sector and the community, to improve physical health and wellbeing of people with mental illness.

APPENDIX 1: MENTAL HEALTH OUTCOMES FRAMEWORK

Outcome and related indicators	Most current data	Year
1. Victorians have good mental health and wellbeing at all ages and stages of life		
1.1 Proportion of Victorian population with high or very high psychological distress (adults) [∞]	17.3%	2015
1.2 Proportion of Victorian population receiving clinical mental healthcare	1.1%	2016–17
1.3 Proportion of Victorian young people with positive psychological development	68.8%	2016
1.4 Proportion of Victorian older persons (65 years or older) with high or very high psychological distress [∞]	10.8%	2015
1.5 Proportion of children at school entry at high risk of clinically significant problems related to behaviour and emotional wellbeing	5.3%	2016
2. The gap in mental health and wellbeing for at-risk groups is reduced		
2.1 Proportion of Victorian population who speak a language other than English at home with high or very high psychological distress (adults) [∞]	18.0%	2015
2.2 Proportion of Victorian rural population with high or very high psychological distress (adults) [∞]	15.9%	2015
3. The gap in mental health and wellbeing for Aboriginal Victorians is reduced		
3.1 Proportion of Victorian Aboriginal population who are receiving clinical mental healthcare	2.5%	2016–17
3.2 Proportion of Victorian Aboriginal population with high or very high psychological distress ¹²	35.8%	2015
3.3 Proportion of Aboriginal children at school entry at high risk of clinically significant problems related to behaviour and emotional wellbeing	16.0%	2016
4. The rate of suicide is reduced		
4.1 Victoria's rate of deaths from suicide per 100,000	9.9	2016
5. Victorians with mental illness have good physical health and wellbeing		
5.1 Proportion of registered mental health clients with a tobacco use related diagnosis	33.4%	2015–16
5.2 Proportion of registered mental health clients with a type 2 diabetes diagnosis	10.6%	2015–16
6. Victorians with mental illness are supported to protect and promote health		
7. Victorians with mental illness participate in learning and education		
8. Victorians with mental illness participate in and contribute to the economy		
9. Victorians with mental illness have financial security		
10. Victorians with mental illness are socially engaged and live in inclusive communities		
11. Victorians with mental illness live free from abuse or violence, and have reduced contact with the criminal justice system		
11.1 Proportion of Victorian prison entrants who, at prison reception assessment, are allocated a psychiatric risk rating	36.9%	2016–17
12. Victorians with mental illness have suitable and stable housing		
12.1 Proportion of registered clients living in stable housing	81%	2016–17

Outcome and related indicators	Most current data	Year
13. The treatment and support that Victorians with mental illness, their families and carers need, is available in the right place at the right time		
13.1 Rate of preadmission contact	51.8%	2016–17
13.2 Rate of readmission within 28 days	13.4%	2016–17
13.3 Rate of post-discharge follow-up	77.7%	2016–17
13.4 New registered clients accessing public mental health services (no access in last five years)	36.6%	2016–17
13.5 Proportion of consumers reporting the effect the service had on their ability to manage their day-to-day life was very good (28.4%) or excellent (25.2%)	53.6%	2016–17
14. Services are recovery-oriented, trauma-informed and family-inclusive		
14.1 Proportion of registered clients experiencing stable or improved clinical outcomes (adults)	91.0%	2016–17
14.2 Proportion of registered clients experiencing stable or improved clinical outcomes (CAMHS)	91.3%	2016–17
14.3 Proportion of registered clients experiencing stable or improved clinical outcomes (aged persons)	92.3%	2016–17
14.4 Proportion of registered clients experiencing stable or improved clinical outcomes (forensic)	78.6%	2016–17
14.5 Proportion of registered clients experiencing stable or improved clinical outcomes (specialist)	95.4%	2016–17
14.6 Proportion of consumers who reported they usually (22.4%) or always (60.1%) had opportunities for family and carers to be involved in their treatment or care if they wanted	82.5%	2016–17
15. Victorians with mental illness, their families and carers are treated with respect by services		
15.1 Proportion of consumers reporting their individuality and values were usually (19.7%) or always (68.3%) respected (such as culture, faith or gender identity)	88.0%	2016–17
15.2 Proportion of people with a mental illness reporting a care plan was usually (24.2%) or always (38.8%) developed with them that considered all their needs (such as health, living situation, age)	63.0%	2016–17
16. Services are safe, of high quality, offer choice and provide a positive service experience		
16.1 Rate of seclusion episodes per 1,000 occupied bed days (inpatient)	9.9	2016–17
16.2 Rate of bodily restraint episodes per 1,000 occupied bed days (inpatient)	19.0	2016–17
16.3 Proportion of community cases with client on a treatment order	11.0%	2016–17
16.4 Proportion of inpatient admissions that are compulsory	51.5%	2016–17
16.5 Average duration (days) of a period of compulsory treatment	64.2	2016–17
16.6 Proportion of consumers who rated their experience of care with a service in the last three months as very good (28.1%) or excellent (37.1%)	65.1%	2016–17
16.7 Proportion of consumers reporting the effect the service had on their overall wellbeing was very good (28.4%) or excellent (27.9%)	56.3%	2016–17

∞ The sampling approach used in the Victorian Population Health Survey changed in 2015 to include mobile phone users as well as people with landlines. Direct comparisons of this data with previous years are problematic and should not be made.

Note that some data may not sum due to rounding

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

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

Data sourced from CMI/ODS with most recent update of: 04/08/2017.

Whole population				
	2014–15	2015–16	2016–17	
Total estimated residential population in Victoria (based on mental health area) ('000)*	5,951	6,059	6,168	
People accessing mental health services				
	2014–15	2015–16	2016–17	
Mental health-related emergency department presentations	47,231	51,668	52,427	
Emergency department presentations that were mental health-related (%)	2.99%	3.14%	3.09%	
People accessing clinical mental health services				
Clients				
	2014–15	2015–16	2016–17	
Total clients accessing clinical mental health services**	67,030	67,570	66,445	
Proportion of population receiving clinical care (%)*	1.13%	1.12%	1.08%	
Client location				
	2014–15	2015–16	2016–17	
Client residential location (%)	Metro	63.1%	62.7%	
	Rural	34.7%	34.8%	
	Unknown/other	2.2%	2.5%	
			2.9%	

Client demographics		2014–15	2015–16	2016–17	
Gender (%)	Female	50.8%	50.5%	50.4%	
	Male	49.1%	49.5%	49.5%	
	Other/unknown	0.1%	0.1%	0.1%	
Age group (%)	0–4	0.9%	0.8%	0.9%	
	5–14	7.4%	7.5%	8.2%	
	15–24	18.4%	19.0%	19.1%	
	25–34	17.7%	17.8%	17.9%	
	35–44	18.6%	18.6%	18.2%	
	45–54	14.3%	14.5%	14.6%	
	55–64	8.6%	8.7%	8.8%	
	65–74	6.4%	6.1%	6.1%	
	75–84	4.9%	4.6%	4.3%	
	85–94	2.6%	2.3%	1.9%	
Clients of culturally and linguistically diverse backgrounds (%)	CALD	14.3%	13.9%	13.6%	
	Aboriginal or Torres Strait Islander status (%)	Indigenous	2.3%	2.4%	2.5%
	Country of birth (top 10 non-English speaking) (%)	Italy	1.2%	1.1%	1.0%
		Vietnam	1.0%	0.9%	0.8%
		Greece	0.9%	0.8%	0.8%
		India	0.7%	0.6%	0.7%
		China (excluding SARs and Taiwan)	0.5%	0.6%	0.6%
		Sri Lanka	0.4%	0.4%	0.5%
		Turkey	0.4%	0.4%	0.4%
		Philippines	0.4%	0.4%	0.4%
Iran		0.4%	0.4%	0.4%	
Germany		0.4%	0.4%	0.3%	
Preferred language other than English (top 10) (%)	Italian	0.7%	0.6%	0.5%	
	Vietnamese	0.6%	0.6%	0.5%	
	Greek	0.6%	0.5%	0.4%	
	Arabic	0.4%	0.3%	0.3%	
	Mandarin	0.3%	0.3%	0.3%	
	Persian (excluding Dari)	0.2%	0.2%	0.2%	
	Turkish	0.2%	0.2%	0.2%	
	Macedonian	0.1%	0.1%	0.1%	
	Cantonese	0.2%	0.2%	0.1%	
Croatian	0.2%	0.1%	0.1%		

Treatment		2014–15	2015–16	2016–17
Total clients accessing clinical mental health services**#	Adult	51,972	52,724	51,735
	Aged	8,489	8,077	7,396
	CAMHS	10,251	10,456	10,723
	Forensic	684	700	751
	Specialist	1,593	1,783	1,817
Diagnosis (%)	Schizophrenia, paranoia and acute psychotic disorders	23.4%	23.8%	23.9%
	Mood disorders	20.7%	20.3%	20.0%
	Stress and adjustment disorders	7.8%	8.0%	8.2%
	Personality disorders	5.1%	5.5%	5.9%
	Anxiety disorders	4.9%	5.2%	5.2%
	Substance abuse disorders	3.1%	3.6%	3.5%
	Organic disorders	3.4%	3.0%	2.6%
	Disorders of childhood and adolescence	1.8%	1.9%	1.9%
	Eating disorders	1.4%	1.5%	1.5%
	Disorders of psychological development	1.4%	1.6%	1.8%
	Other	1.0%	1.1%	1.0%
	Obsessive compulsive disorders	0.5%	0.5%	0.5%
	Unknown	25.6%	24.1%	23.7%
	Referral source (newly referred clients only) (%)	Acute health	20.5%	20.5%
Emergency department		20.2%	21.2%	21.8%
General Practitioner		13.6%	12.6%	11.7%
Family		8.3%	8.0%	8.0%
Client/Self		4.8%	4.6%	4.6%
Community Health Services		4.7%	4.7%	4.6%
Police		4.0%	4.0%	3.6%
Others and Unknown		23.8%	24.4%	24.2%
New clients accessing services (no access in prior 5 years) (%)	Total	36.3%	35.7%	36.6%
Clients accessing services for more than 5 years (%)	Total	14.4%	14.4%	14.2%

Service activity – bed-based	Setting	2014–15	2015–16	2016–17
Total number of separations (excluding same days)	Admitted - Acute	21,886	23,665	24,314
	Admitted - Non Acute	231	230	218
	Non Admitted - Residential	308	238	232
	Non Admitted - Sub Acute (CCU)	557	675	681
	Non Admitted - Sub Acute (PARC)	3,141	3,257	3,402
	Total	26,123	28,065	28,847
Occupied bed days (including leave, excluding same days) [†]	Admitted - Acute	348,096	356,784	365,385
	Admitted - Non Acute	69,923	71,105	71,495
	Non Admitted - Residential	188,776	174,918	163,668
	Non Admitted - Sub Acute (CCU)	105,873	105,371	104,488
	Non Admitted - Sub Acute (PARC)	59,821	63,425	66,354
	Total	772,490	771,604	771,392
Bed occupancy rate (including leave, excluding same days) [†]	Admitted - Acute	88.6%	88.7%	89.0%
	Admitted - Non Acute	90.8%	92.1%	92.8%
	Non Admitted - Residential	89.6%	87.9%	86.6%
	Non Admitted - Sub Acute (CCU)	81.3%	80.9%	80.3%
	Non Admitted - Sub Acute (PARC)	77.2%	77.8%	81.5%
	Total	86.9%	86.7%	86.9%
Service activity – community	Population	2014–15	2015–16	2016–17
Total service contacts, by sector**	Adult	1,482,886	1,400,443	1,188,980
	Aged	248,265	219,341	168,672
	CAMHS	289,902	275,038	278,673
	Forensic	15,780	17,998	17,382
	Specialist	22,074	22,271	20,844
	Total	2,058,909	1,935,093	1,674,553
Total service hours, by sector**	Adult	691,022	665,745	585,176
	Aged	110,033	103,599	86,108
	CAMHS	178,251	171,287	179,928
	Forensic	10,248	10,597	10,762
	Specialist	21,841	20,674	19,728
	Total	1,011,396	971,904	881,704
Unregistered clients service hours, by sector (%)**	Total	15.1%	15.5%	15.7%

Service performance	Population	2014–15	2015–16	2016–17
Readmission to inpatient rate 28 day (lagged 1 month)	Adult	14.3%	14.9%	14.3%
	Aged	7.9%	7.0%	6.8%
	CAMHS	20.1%	16.8%	17.6%
	Forensic	7.0%	10.0%	12.3%
	Specialist	1.9%	2.0%	2.0%
	Total	13.8%	13.9%	13.4%
Preadmission contact rate, all clients**	Adult	59.8%	58.2%	53.1%
	Aged	68.8%	64.6%	54.0%
	CAMHS	57.7%	53.8%	49.5%
	Forensic	17.4%	18.6%	17.6%
	Specialist	39.3%	34.5%	30.5%
	Total	59.4%	57.2%	51.8%
Post-discharge follow up rate (lagged seven days)**	Adult	86.8%	85.7%	79.4%
	Aged	89.2%	89.8%	74.6%
	CAMHS	84.4%	85.8%	83.9%
	Forensic	38.4%	36.8%	31.2%
	Specialist	60.9%	44.0%	41.0%
	Total	85.7%	84.2%	77.7%
Trimmed average length of stay ≤35 days – inpatient	Adult	9.8	9.6	9.5
	Aged	15.1	16.0	15.7
	CAMHS	7.4	7.5	6.9
	Forensic	21.0	18.8	20.5
	Specialist	17.6	16.7	15.8
	Total	10.2	10.1	10.0

Compulsory treatment	Population	2014–15	2015–16	2016–17
Community cases with client on treatment order (%)	Adult	14.9%	14.9%	14.5%
	Aged	3.8%	4.2%	4.5%
	CAMHS	0.7%	0.9%	1.1%
	Forensic	14.2%	15.4%	16.0%
	Specialist	1.0%	1.8%	2.2%
	Total	10.8%	11.1%	11.0%
Compulsory admissions – inpatient (%)	Adult	57.3%	57.8%	56.9%
	Aged	45.4%	46.0%	48.2%
	CAMHS	18.4%	16.7%	17.0%
	Forensic	100.0%	100.0%	100.0%
	Specialist	13.0%	11.3%	8.6%
	Total	51.9%	52.2%	51.5%
The average duration (days) of a period of compulsory treatment			59.4	64.2
Clients on an order for more than twelve months (%)			11.5%	12.5%
Adult (18+) clients who have an advance statement recorded (%)		1.39%	2.02%	2.34%
Adult (18+) clients who have a nominated person recorded (%)		1.41%	1.90%	2.43%
Restrictive practice	Population	2014–15	2015–16	2016–17
Seclusion episodes per 1,000 occupied bed days – inpatient	Total	8.0	9.1	9.9
Bodily restraint episodes per 1,000 occupied bed days – inpatient	Total	17.5	25.6	19.0

Client outcomes	Population	2014–15	2015–16	2016–17
Community cases with significant improvement at case closure (%)**	Adult	53.4%	53.0%	53.2%
	Aged	51.1%	54.2%	54.6%
	CAMHS	50.4%	48.4%	48.4%
	Forensic	20.0%	28.6%	42.9%
	Specialist	60.4%	24.3%	20.8%
	Total	52.4%	52.1%	52.2%
Community cases stable at case closure (%)**	Adult	37.6%	38.1%	37.8%
	Aged	31.9%	39.6%	37.7%
	CAMHS	41.4%	42.2%	42.9%
	Forensic	60.0%	50.0%	35.7%
	Specialist	30.7%	70.6%	74.6%
	Total	37.1%	39.4%	39.1%
Funding		2014–15	2015–16	2016–17
Total output cost (Budget paper 3) (\$ million)^	Clinical mental health	1,082.0	1,142.0	1,258.0
	Mental health community support services	123.4	128.1	124.8
Service inputs		2014–15	2015–16	2016–17
Specialist mental health beds (from policy and funding guidelines)	Admitted - Acute	1,089	1,098	1,162
	Admitted - Non Acute	212	212	244
	Admitted Total	1,301	1,310	1,406
	Non Admitted - Residential	603	525	525
	Non Admitted - Sub Acute (CCU)	358	358	358
	Non Admitted - Sub Acute (PARC)	230	230	230
	Non Admitted Total	1,191	1,113	1,113
	Total	2,492	2,423	2,519
Full-time equivalent staff by workforce type	Administrative and clerical staff	546	566	n/a
	Allied health and diagnostic professionals	1,404	1,420	n/a
	Carer workers	19	17	n/a
	Consumer workers	19	18	n/a
	Domestic staff	152	153	n/a
	Medical Officers	771	812	n/a
	Nurses	4,028	3,999	n/a
	Other personal care staff	214	222	n/a

People accessing mental health community support services					
Clients		2014–15	2015–16	2016–17	
Total clients accessing mental health community support services ^		11,918	12,354	11,337	
Client demographics		2014–15	2015–16	2016–17	
Gender (%)	Female	52.9%	55.4%	56.0%	
	Male	45.6%	44.0%	43.4%	
	Other/ unknown	1.5%	0.6%	0.6%	
Age group (%)	0–4	0.5%	0.3%	0.3%	
	5–14	1.1%	1.6%	1.8%	
	15–24	10.3%	13.3%	13.0%	
	25–34	18.5%	19.1%	19.1%	
	35–44	25.4%	24.1%	23.1%	
	45–54	24.4%	23.0%	23.6%	
	55–64	14.6%	13.4%	14.5%	
	65–74	2.8%	1.8%	2.0%	
	75–84	0.5%	0.3%	0.4%	
	85–94	0.1%	0.0%	0.0%	
	95+	0.9%	2.5%	1.8%	
	Unknown	0.9%	0.6%	0.3%	
Aboriginal or Torres Strait Islander (%)	Indigenous	4.7%	2.2%	2.2%	
CALD status (%)	Yes	4.3%	4.4%	4.4%	
Service activity		2014–15	2015–16	2016–17	
Community Service Units (CSUs)		661,855	790,213	757,236	
Residential Rehabilitation Bed Days		73,672	78,456	81,130	
Service inputs		Population	2014–15	2015–16	2016–17
Residential Rehabilitation Beds	Other	103	101	101	
	Youth	159	159	159	
	Total	262	260	260	

Key and notes

* Population estimate is based on *Victoria in Future 2014* projections.

** 2015–16 and 2016–17 data collection was affected by industrial activity. The collection of non-clinical and administrative data was affected, with impacts on the recording of community mental health service activity and client outcome measures.

Sum of rows will not equal total as one client can access multiple services

† Calculation of Occupied Bed Days and Bed Occupancy Rates modified to include episodes still open at time of data extraction

n/a: No data available for this period

^ Apparent reduction in MHCSS figure due to transfer to NDIS

Note that some data may not sum due to rounding

APPENDIX 3: VICTORIA'S PUBLIC MENTAL HEALTH SYSTEM

APPENDIX 3

VICTORIA'S PUBLIC MENTAL HEALTH SERVICE SYSTEM

AREA-BASED CLINICAL SERVICES*

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

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

ADULT SERVICES (16–64 YEARS)**

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

AGED PERSONS SERVICES (65+ YEARS)

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

STATEWIDE SPECIALIST SERVICES

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

MENTAL HEALTH COMMUNITY SUPPORT SERVICES

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

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

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

ABBREVIATIONS USED IN THIS REPORT

CAMHS	child and adolescent mental health services	ISS	Intensive Support Service
CASEA	Child and Adolescent Schools Early Action [program]	LGBTI	lesbian, gay, bisexual, transgender and intersex
FaPMI	Families where a Parent has a Mental Illness [program]	MHCSS	mental health community support services
GP	general practitioner	NDIA	National Disability Insurance Agency
HoNOS	Health of the Nation Outcomes Scales	NDIS	National Disability Insurance Scheme
HOPE	Hospital Outreach Post-suicidal Engagement	PARC	prevention and recovery care
		PHN	Primary Health Network
		VMIAAC	Victorian Mental Illness Awareness Council

ENDNOTES

- 1 Compulsory treatment is governed under *Victoria's Mental Health Act 2014*. Treatment orders are made where a person with a mental illness needs immediate treatment to prevent serious deterioration in their mental or physical health, or to prevent serious harm to the person, or any other person.
- 2 In order to distinguish between clients requiring very long admissions and other clients, data on length of stay refers to stays under and over a certain number of days. For people requiring acute bed-based care, 'trimmed length of stay' refers to people who are admitted for a period of up to and including 35 days.
- 3 This data was affected by industrial activity during the year. The collection of non-clinical and administrative data was affected, with impacts on the recording of community mental health service activity and client outcome measures.
- 4 This data may have been affected by industrial activity during the year. The collection of non-clinical and administrative data was affected, with impacts on community mental health service activity and client outcome measures.
- 5 National Mental Health Commission, *Equally Well Consensus Statement: Improving the physical health and wellbeing of people living with mental illness in Australia*, Sydney NMHC, 2016. Victoria Institute of Strategic Economic Studies 2016, *The economic cost of serious mental illness and comorbidities in Australia and New Zealand*, Royal Australian and New Zealand College of Psychiatrists, Melbourne.
- 6 The data relating to diabetes and tobacco is based on registered mental health clients who have had a hospital admission (for any cause) during the year.
- 7 Department of Health and Human Services 2017, *Victorian Population Health Survey 2015: Selected survey findings*, State of Victoria, Melbourne available at <<https://www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians/survey-data-and-reports/victorian-population-health-survey/victorian-population-health-survey-2015>> accessed 20 July 2017>.
- 8 For registered clients aged 15-19 years, the smoking rate is 26.6 per cent. In the general population both 12-17 and 18-19 year olds have reported significant declines in daily smoking between 2013 and 2016 (from 3.4 per cent to 1.5 per cent and 10.8 per cent to 4.6 per cent respectively). The daily smoking rate for teenagers has declined by approximately 80 per cent since 2001.
- 9 The Victorian Population Health Survey does not record tobacco information relating to people aged under 18 years, hence national data has been used. See <<http://www.aihw.gov.au/alcohol-and-other-drugs/data-sources/ndshs-2016/tobacco/>>.

