VICTORIA'S MENTAL HEALTH SERVICES ANNUAL REPORT 2019–20

VICTORIA
State Government

Responsible body's declaration

Minister for Mental Health

Dear Minister

In accordance with section 118(2) of the *Mental Health Act 2014*, I am pleased to submit to you *Victoria's mental health services annual report* for the period 1 July 2019 to 30 June 2020.

Kym Peake
Secretary
Department of Health and Human Services

Contents

Secretary's foreword

I am pleased to present the fifth *Victoria's mental health services annual report* to the Victorian Parliament and community. This report focuses on Victoria's state-funded mental health services and the people who accessed these services for treatment, care and support in 2019–20.

This reporting year has presented extraordinary challenges to the Victorian community, with the effects of drought, bushfires and the coronavirus (COVID-19) pandemic. Victoria's mental health system has responded to these challenges with additional support provided to drought- and bushfire-affected communities and significant adjustments to service delivery to ensure continued access to mental health services. It has been encouraging to see service providers embrace new and innovative ways of delivering services to ensure the safety of staff, consumers, carers and their families during the coronavirus (COVID-19) pandemic. This report tells the story up until the end of June 2020, but I would also like to acknowledge the months of very hard work and the dedication of the staff in the service system between then and now.

This report highlights progress over the past year in implementing key initiatives focused on improving mental health outcomes under *Victoria's 10-year mental health plan*. This includes work to reduce suicide in local communities, to support and strengthen our mental health workforce and to improve resilience, social and emotional wellbeing and mental health in the Victorian Aboriginal community. There has also been a continued focus on engaging with consumers, families and carers in mental health policy development and service design and delivery.

Significant collaboration and cooperation was required during this extraordinary year to ensure people received the mental health services they needed delivered in the most appropriate way, and I would like to thank all services and individuals involved. Specifically, I would like to acknowledge the work of the Mental Health Ministerial Advisory Committee and its subcommittees, the partners in our mental health work, including the Victorian Mental Illness Awareness Council and Tandem, the Mental Health Tribunal, the Mental Health Complaints Commissioner, service providers and consumers and their families and carers.

Victoria's mental health system continues to face challenges associated with increasing demand. The Royal Commission into Victoria's Mental Health System is continuing its work, with its final report expected in February 2021. The royal commission's interim report, released in November 2019, signalled that the recommendations in the final report will lead to significant future mental health service system redesign. Mental Health Reform Victoria has been established to progress this critical reform work and has committed to a collaborative partnership with people with mental health lived experience.

I would also like to acknowledge the evident commitment from the mental health sector to work as a unified system across different service levels, enabling improved service linkages and coordination throughout the coronavirus (COVID-19) pandemic. The strengthening of relationships between the Victorian and Commonwealth Governments, and the development of cross-government commitment to longer term mental health service reform will serve to improve service pathways, and ultimately outcomes, for mental health service consumers in Victoria.

Kym Peake
Secretary
Department of Health and Human Services

The year at a glance

76,441
registered consumers

2.1%
increase in registered consumers overall since 2018–19
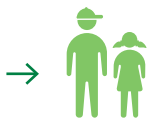
→ **12,076**
child and adolescent consumers

→ **61,101**
adult consumers

→ **8,304**
aged consumers

→ **1,231**
forensic consumers

→ **1,836**
specialist consumers

50.5%
women or girls

33%
live in rural areas

$1.65 billion
clinical services

$111 million
mental health community support services

1. Supporting Victorians through crisis

The 2019–20 financial year has seen unparalleled disruption to the lives of Victorians. Dry conditions following severe drought in 2019 contributed to a severe bushfire season in summer 2019-20, which devastated many Victorian communities. Just as Victorians emerged from the bushfires, the coronavirus (COVID-19) pandemic has presented the state with the biggest health challenge of a generation.

The mental health system has responded to the needs of Victorians through this time. In drought-affected areas, mental health service providers coordinated and provided services, with a focus on mental health capacity building and resilience. In bushfire-affected areas, psychosocial and mental health support services were established, which included access for communities to early intervention, specialist mental health treatment and advisory services.

In addressing the coronavirus (COVID-19) pandemic, the service system response included a wide range of initiatives to support the workforce and to ensure mental health services continued to be provided to consumers while ensuring infection control and prevention measures were in place. A large increase in the use of telehealth services has enabled service providers to continue to provide community-based services to Victorians during the pandemic.

Supporting people experiencing housing stress and homelessness has been a focus area. Importantly, engagement across jurisdictions, especially with the Commonwealth Government, has been critical in responding to both the bushfires and the coronavirus (COVID-19) pandemic. Victoria has worked closely with the Commonwealth and other state governments to develop a *National mental health and wellbeing pandemic response plan*.

National initiative

National mental health and wellbeing pandemic response plan

In response to the coronavirus (COVID-19) pandemic and related impacts on mental wellbeing, the National Mental Health Commission, in collaboration with state governments, developed the *National mental health and wellbeing pandemic response plan*. The plan addresses COVID-specific mental health impacts, as well as further developing cross-government commitment to longer term mental health service reform.

The plan was endorsed by National Cabinet on 15 May 2020.

Under the stewardship of the National Mental Health Commission, all jurisdictions including Victoria have made progress with implementation activities in three key priority areas:

- data sharing and collection to monitor and predict mental health impacts
- ensuring services are available in homes, workplaces, aged care, schools and other community sites to reach people in community
- developing more connectivity through improved service linkage and coordination to provide clear pathways of care.

Funding from the Mental Health and Social Connectedness Package (April 2020) complements and reinforces the Victorian Government's commitment to the objectives of the *National mental health and wellbeing pandemic response plan* by addressing critical enablers of the pandemic response and continuing system reform.

Support to drought- and bushfire-affected communities

Support to drought-affected communities

The 2019 calendar year was Australia's driest on record, intensifying one of the most severe droughts in recent times.

In October 2019, $1.65 million was allocated to support mental health as part of the 2019–20 Victorian Government Drought Response. The focus was on mental health capacity building and resilience, with a component of outreach that included:

- local coordination (with a lead agency identified per area, across both community health services and local councils depending on the focus of the initiatives in the area)
- service-based and outreach counselling (provided by community health services working in collaboration with Primary Health Networks)
- awareness raising and community connectedness training and events (in partnership with local councils)
- mental health screening introduced as part of farmer health checks.

Funding for a further year was allocated to continue the Edenhope and District Hospital Rural Outreach Program model, which has been established successfully in the community. Three outreach workers are employed to support farmers across the West Wimmera region.

Support to bushfire-affected communities

The 2019–20 bushfire season was devastating, affecting East Gippsland and North East Victoria.

In March 2020, the Victorian Government announced the Community Resilience, Psychosocial and Mental Health Response including $23.4 million for psychosocial and mental health support services for people affected by bushfire. This included access for communities to early intervention, specialist mental health treatment and advisory services. This was in addition to $14.4 million to establish the Victorian Bushfire Case Support Program in January 2020.

The department's Mental Health and Drugs Branch worked in partnership with Bushfire Recovery Victoria to support those in the affected regions of East Gippsland and North East Victoria. The package was targeted to:

- people affected by the 2019–20 Victorian bushfires
- people with a mental illness and their carers who required wellbeing checks and support
- Aboriginal people experiencing social and emotional wellbeing issues
- young people disengaging from school or experiencing mental health concerns
- older isolated individuals with minimal informal supports
- support for health and social services workforce supporting individuals in communities affected by the bushfires
- farmers, foresters, timber industry and small business.

The package included $8.75 million to bolster mental health services provided by Albury Wodonga Health and Latrobe Regional Hospital, both of which offer specialist early intervention advice to general practitioners and community clinicians.

Funding was also directed to Austin Health's Victorian Trauma Treatment Service for post-disaster treatment and advisory services, and to Phoenix Australia, to provide training and mentorship to community leaders and mental health providers. The investment included $6.6 million for local community organisations delivering practical mental health support programs.

Beyond Blue was funded to deliver a free and confidential mental health support program designed to teach and provide strategies to people to improve their own mental health and wellbeing. Residents in bushfire-affected areas were given access to free psychology sessions with no general practitioner referral required through Rural Health Connect.

The package provided funding for a broad range of mental health promotion and resilience-building programs such as:

- mental health promotion activities within local sporting clubs and recreation centres
- advice and training to parents to support their children through the long-term process of recovery
- mental health coaching programs for farmers, foresters and small business owners
- health and wellbeing meet-ups such as local exercise groups and social events
- school-based early intervention programs in partnership with mental health services to enable wraparound support and referral to specialist support
- psychology sessions via phone and telehealth.

The Victorian Aboriginal Community Controlled Health Organisation received $3 million to work with Aboriginal-community controlled organisations in bushfire-affected regions to develop social and emotional wellbeing programs and to provide brokerage funding to Aboriginal communities.

Bushfires in East Gippsland

"The mental health teams of Bairnsdale and Orbost were severely affected by the fires in East Gippsland. Outreach services across the region were ceased due to fire activity and road closures. The Prevention and Recovery Care (PARC) service in Bairnsdale was also closed due to fire activity and smoke impacts. Several mental health staff were evacuated from their homes and additional mental health service staff were redeployed from other teams to assist the East Gippsland region. Staff made changes and innovations to their work systems to ensure the continuity of services and support to consumers and the community.

Latrobe Regional Hospital also provided staff health and wellbeing support to Bairnsdale Hospital staff and Victoria Police members affected by the fires. In addition, we worked with the Department of Health and Human Services and the Gippsland Primary Health Network to coordinate psychological first aid responses in communities and relief centres, to map service needs and to provide direct mental health specialist support into Mallacoota and other smaller communities. In 2020, Latrobe Regional Hospital received funding to support bushfire recovery through expanded clinical services in East Gippsland. This expansion includes trauma treatment, mental health promotions, consultation liaison mental health services and increasing child and youth mental health into schools."

– Executive Director Mental Health and Chief Mental Health Nurse, Latrobe Regional Hospital

Coronavirus (COVID-19) and the mental health system

From March 2020, the coronavirus (COVID-19) pandemic changed the way Victorians live, introducing restrictions on how we worked, where we could go and who we could see. For many people, the pandemic has been an uncertain and stressful time. Many Victorians experienced psychological distress for the first time and, for others who already access the mental health system, it exacerbated mental illness. Carers carried a heavy load during these difficult times.

Use of mental health services

The effects of the pandemic were evident in the way Victorians changed the ways they sought and used mental health services. These changes began to take hold in March 2020, late in the third quarter of 2019–20.

At the beginning of the restrictions, Victorians deferred seeking treatment and care for a broad range of medical conditions, including mental illness. Overall, the total number of emergency department (ED) presentations for any reason (including heart attack and stroke) reduced in March 2020 compared with the same time the previous year. Mental health–related ED presentations reduced further during April–June 2020, but not as much as ED presentations overall.

From April to June 2020, there was a shift in the way mental health community services were provided. To increase safety for consumers, carers and staff, face-to-face contact was reduced, and there was an increased use of telehealth and telephone options to ensure that service delivery continued.

Although this corresponded with a reduction in inpatient admissions and lower occupancy rates, particularly in adult acute inpatient units, occupancy remained high overall due to the existing high demand on inpatient beds, settling at 81.6 per cent for the final quarter of the year.

At the same time, mental health services took a range of actions to protect the health and wellbeing of consumers, carers and staff, including implementing contingency plans and reducing admissions to Prevention and Recovery Care services (PARCs) to create alternative treatment settings in the case of a coronavirus (COVID-19) outbreak.

Mental health and coronavirus (COVID-19) survey findings

The Victorian Mental Illness Awareness Council (VMIAC) designed a survey with its members to find out more about the experiences of people with lived experience of mental illness. During the first wave of coronavirus (COVID-19). The survey ran for three weeks from 17 April to 8 May 2020.

The survey found that most respondents (75 per cent) reported that their mental health was worse during coronavirus (COVID-19) than previously. The highest risk age group were those aged under 35 years, with their mental health much worse than any other group.

Almost all (99 per cent) respondents found that the effects of self-isolation, quarantine and social distancing had the most significant impact on their mental health. More than a third of respondents wanted additional mental health service support at this time.

Investment in mental health service delivery and reform

Mental Health and Social Connectedness package

In April 2020, the government announced the $59.4 million Mental Health and Social Connectedness package. This funding was provided to help reduce preventable or worsening mental illness, to promote community connectedness and to protect the health system during the coronavirus (COVID-19) crisis.

The package included $17.8 million towards key recommendations from the Royal Commission into Victoria's Mental Health System's interim report and $6.37 million for psychosocial supports for people with severe mental illness.

The package included population health responses to help Victorians to maintain social connection and practise good mental health during the time of the pandemic.

The social connectedness initiatives that received funding included:

- $5.45 million to expand the statewide coronavirus (COVID-19) phone line to proactively reach out to people known to be isolated or vulnerable – including senior Victorians
- $3.12 million in funding for a range of specific initiatives to help veterans, seniors, new mums, Aboriginal Victorians, multicultural and faith groups, and the LGBTIQ community, as well as vulnerable cohorts including people with eating disorders and victims of family violence
- $2.2 million for youth engagement and wellbeing programs, digital resources for parents with children experiencing anxiety, as well as podcasts for students, teachers and families to provide materials on supporting child and adolescent mental health.

The mental health and wellbeing initiatives that received funding included:

- $7 million to help mental health and alcohol and drugs services deliver supports for people with severe mental illness via phone and video (telehealth) to reduce relapse and ED presentations
- $6.7 million to expand online and phone counselling services through Beyond Blue, Lifeline, Kids Helpline and Suicide Line Victoria and to boost the capacity of the VMIAC and Tandem helplines
- $6 million to fast-track Orygen Youth Health's new digital platform.

Crisis and support helpline services

Beyond Blue set up a coronavirus (COVID-19)-specific telephone counselling service as a result of the pandemic to deal with the expected increase in demand for services. There was a marked increase in the number of calls answered by Beyond Blue's telephone counselling services (general and coronavirus (COVID-19)-specific) from Victorians from March to June 2020 compared with the previous year. The number of calls offered by Lifeline to Victorians also increased from March to June 2020 compared with the previous year.

Mental health service system response to coronavirus (COVID-19)

Telehealth

The enormous increase in the use of telehealth for mental health services is the most substantial service delivery change seen in a long time. Telehealth services have enabled service providers to continue to provide community-based services to Victorians during the pandemic.

As shown in Figure 1, there was a large reduction in face-to-face contacts from March to June 2020 compared with the same period in the previous year. However, there was a corresponding increase in telephone contacts from March to June 2020 compared with the same time the previous year, as demonstrated in Figure 2.

Figure 1: Community-based face-to-face contacts, 2018–19 and 2019–20
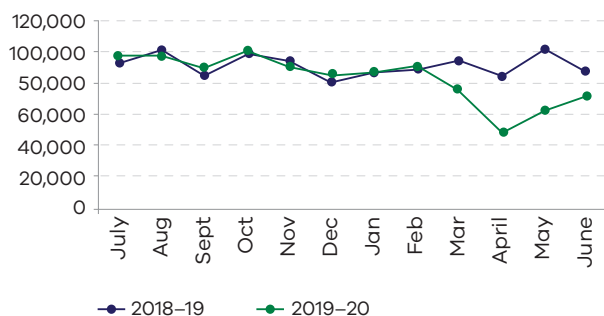
Figure 2: Community-based telephone contacts, 2018–19 and 2019–20
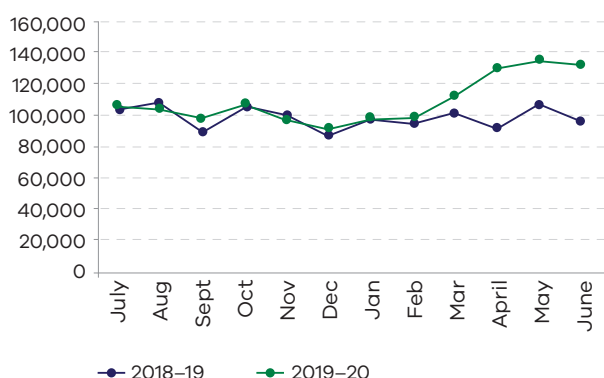
The shift in delivery of contacts was also demonstrated in the increased use of videoconferencing technology, one way of delivering telehealth services. In the final quarter of 2018–19, there was limited use of tele/videoconferencing in delivering clinical mental health services, with just over 1,000 contacts delivered via this means. However, in the final quarter of 2019–20, more than 35,000 mental health contacts were delivered via tele/videoconferencing (Figure 3).

Figure 3: Community-based tele/videoconferencing contacts, 2018–19 and 2019–20
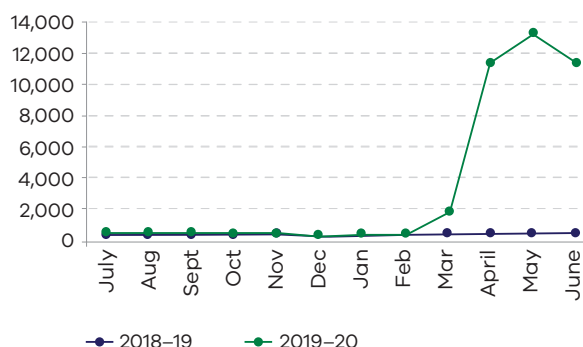
The use of telehealth is being evaluated but we already know it has many benefits and some challenges in the delivery of mental health services. Offering access via telephone, digital and video platforms can support people who are reluctant to seek help for the first time, in addition to being more appropriate for people who may have concerns with face-to-face contact, for whom attending consultations may be challenging due to geographic or historical reasons.

However, many consumers of mental health services do not have the means to maintain access to telecommunications or private spaces, and it can also be a difficult medium for effective assessment and diagnostic purposes. Telehealth may be unsuitable for consumers with illnesses with some symptoms such as paranoia, hallucinations or body dysmorphia. Providing telehealth services from home may be challenging for workers who may not always have access to appropriate equipment, supports and supervision.

Improving IT capacity

Funding initiatives to improve the capacity of services to deliver remote service provision and telehealth were well received by the sector. This enables services to adapt to delivering services remotely.

'The generous and timely IT grant we received has assisted us to quickly ramp up our remote service provision and telehealth options. This has enabled us to provide support to people who have been feeling increasingly isolated and stressed during the COVID-19 lockdown. Lessons learnt during this period using the additional infrastructure will also enable us to continue to provide this type of service as a support option into the future.'

– Tom Dalton, Chief Executive Officer, Neami National

Collaboration and information sharing

Mental health service providers have worked hard to ensure they were able to continue to deliver services safely and could respond to the needs of consumers, carers and the workforce.

To do this, significant information sharing has been required across the sector, and service providers have worked collaboratively to design new protocols for the safe provision of services. This has enabled development of new infection prevention and control protocols that respond directly to the circumstances presented by the coronavirus (COVID-19).

Support in other settings

During the pandemic, specialist mental health services have been provided for a range of bed-based services to support vulnerable and at-risk groups. This has included in-reach models to hotels for homeless people, quarantine hotels, people in supported bed-based services, public housing tenants, and people in aged care services.

Hotels for people experiencing homelessness

In response to the coronavirus (COVID-19) pandemic, the government has supported a number of agencies to provide homeless people, including rough sleepers, accommodation in hotels, motels and serviced apartments across Melbourne. Existing homeless mental health service providers have received support to provide additional mental health services to people accessing accommodation as part of the hotels for homeless response. This initiative has provided mental health services with an opportunity to better with engage people with complex mental health needs.

Inpatient and bed-based model of care supports

Changes at inpatient treatment and non-acute bed-based care facilities enabled infection control and prevention measures to be put in place while ensuring that mental health service delivery continued.

In some facilities, there have been staff who tested positive for coronavirus (COVID-19), and as a result other staff were furloughed. However, due to successfully implementing infection control measures at these facilities, there was no further transmission. These facilities remained safe for consumers.

The Orygen COVID-19 quarantine operational procedure

The Orygen Inpatient Unit was one public mental health service to be directly affected by coronavirus (COVID-19), necessitating important changes to usual practice. The structure of the unit's day-to-day routine was revised and modified to ensure the highest standards in infection control and prevention were implemented while ensuring a recovery-focused service continued to be delivered. A comprehensive operations manual, the *Orygen COVID-19 quarantine operational procedure*, was developed to provide staff with a set of processes and guidelines to work within while continuing to deliver a recovery-focused model of care. This manual was then shared broadly across mental health services.

Youth bed-based rehabilitation services

From the onset of the coronavirus (COVID-19) pandemic, restrictions were put in place in public youth bed-based rehabilitation mental health services to protect residents and staff from the virus.

Residents and staff at the 17 youth bed-based rehabilitation services across Victoria brainstormed new and novel ways to keep working together while implementing the physical distancing requirements during the first wave of the pandemic, from March to June 2020.

Service providers quickly adapted their individual and group-based programs to enable them to be provided through telehealth, online or videoconferencing options. This ensured service providers remained connected to the residents and were then able to help residents remain connected with family and friends.

With funding from the department, providers purchased technical equipment and internet capacity to ensure each resident had access to online school, support services and virtual activities. This helped to keep residents connected and supported and to ensure they maintained a daily structure.

A range of new or adapted programs were offered. These included:

- a variety of health information sessions; for example, Eastern Access Community Health (EACH) provided information sessions on building motivation and maintaining routine to tackle amotivation and low mood while restabilising healthy routines during lockdown
- physical health activities to help young people stay active and bikes provided to encourage daily exercise (at EACH)
- 'Zoom'-based programs to keep young people engaged and connected such as karaoke, virtual music groups, trivia nights, drawing competitions, movie nights, virtual cooking classes, newsletters and other creative activities
- self-care groups to build resilience, with some providers providing self-care packs with resources and activities to facilitate art-based mindfulness, puzzles, books, journaling and mood diaries
- virtual tours to 'show' prospective new residents the facilities and to complete phone appointments for pre-entry. This had the added advantage of engaging young people who may have been otherwise anxious to complete the tour in person.

Mental Health Tribunal response

As a result of the coronavirus (COVID-19), the Mental Health Tribunal was not able to conduct in-person hearings safely at health services. From 23 March 2020, most tribunal hearings were conducted by teleconference, with a small number conducted by videoconference for those patients for whom telephone hearings were unsuitable. This shift in work practice necessitated that all hearing materials be provided electronically.

The tribunal's capacity to conduct hearings was initially reduced by more than 50 per cent. In response, the tribunal developed a recovery strategy in three phases:

- conduct all required hearings by teleconference (phase 1)
- implement electronic processes to enable participants to attend from remote settings (phase 2)
- adopt a new videoconference platform to enable fully remote video hearings (phase 3).

Within five weeks the tribunal re-established its capacity to conduct all required hearings. During this period, the tribunal limited the number of missed hearings, prioritising applications for electroconvulsive treatment and for treatment orders for patients who had not had a tribunal hearing during their current episode of treatment.

'We have been able to successfully respond to the needs of a young person at high risk by developing a strong care team around them. Although many of the services this young person needed were only being offered remotely, it was uplifting to see services jump into action, and put the client first, despite the COVID-19 restrictions they faced.'

– cohealth support worker

The shift to electronic processes was progressed quickly, including implementing e-processes for distributing materials prior to hearings, designing e-processes to finalise determinations and orders, and completing e-training for all registry staff and members to access e-materials.

As of June 2020, the tribunal has begun work on phase 3 of the recovery strategy, with preliminary work to include:

- identifying suitable platforms for conducting videoconference hearings
- surveying health services about their IT capabilities to support and participate in videoconference hearings
- exploring methods of supporting consumers and their support people to participate in videoconference hearings.

Workforce support and wellbeing during the coronavirus (COVID-19) pandemic

Workforce surge

During the coronavirus (COVID-19) pandemic the department provided support and guidance to mental health services to ensure continuity and delivery of essential services and to enable workforce supply.

The guidance, including a new framework for mental health care during coronavirus (COVID-19), outlined the changes and planning required by public clinical mental health services to minimise infection risk for staff, consumers and families and to continue safe mental health service delivery. Specific guidance was provided for inpatient settings.

Guidance provided in the *Inpatient consumer pathway - mental health care coronavirus (COVID-19) response* supported service managers, clinicians, consumers and carers with tools and resources to continue safe delivery of therapeutic care, engagement and activities that promote supportive, recovery-focused care. The companion document, *Intensive mental health community care*, provided guidance on models for delivering acute mental health care in the community.

To support increased demand for staff, the *Working for Victoria – Health portal* was established for health and mental health services. The portal, managed by Torrens Health, linked mental health services to central departmental processes for accessing additional short-term surge staff to ensure continuity of essential bed-based services by meeting any staff shortfalls. More than 65,000 people with qualifications and experience in health and mental health services registered via the portal to offer assistance and to support surge workforce needs across both general health and mental health services.

Workforce wellbeing grants program

The department funded a workforce wellbeing grants program for workers in state-funded mental health and alcohol and other drug services. The Mental Health and AOD Workforce Wellbeing Grants recognise the impact of coronavirus (COVID-19) on frontline workers in Victoria's mental health and drug and alcohol services and acknowledge the important work being delivered in difficult and changing circumstances. More than $330,000 was provided to support the grants, with 40 projects and activities receiving funding.

The 40 projects included: facilitated wellbeing forums; self-care, positive culture and resilience workshops; reflective practice and mindfulness sessions; supervision training and support; online peer support; and team building activities. Aboriginal health services were funded for cultural connection programs and materials, Elder services and Ngangkari Traditional Healing and We-Al-Li Training, a culturally informed trauma-integrated healing approach.

Other workforce wellbeing initiatives included self-care and wellbeing supports provided by the Australian and New Zealand College of Psychiatrists Victorian Branch Committee in partnership with the Victorian Psychiatry Training Committee for the medical workforce employed or training in public specialist mental health services.

These wellbeing supports have enabled the workforces to better care for themselves and consumers during the coronavirus (COVID-19) pandemic and recovery period and have complemented other projects led by Safer Care Victoria.

2. Mental health system review and reform

Against the backdrop of significant disruption due to bushfires and the coronavirus (COVID-19) pandemic in 2019–20, the mental health system in Victoria is continuing to undergo review and has begun system reform. The interim report of the Royal Commission into Victoria's Mental Health System was released in November 2019, signalling the intent for reform of the mental health system. Mental Health Reform Victoria was established to progress this work.

Providing advice about mental health reform in Victoria is a key focus area for the Mental Health Ministerial Advisory Committee as it considers recommendations from the royal commission and other federal and state inquiries. Additionally, while the transition to the National Disability Insurance Scheme (NDIS) for people with a severe, enduring psychosocial disability was completed during 2019–20, there are still several reforms underway as the NDIS evolves. These continue to impact on Victorian participants and the providers who support them.

Royal Commission into Victoria's Mental Health System

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

The terms of reference for the royal commission were announced in February 2019. The commission's work has been informed by community consultations, online and written submissions, roundtable discussions, consultations with its Expert Advisory Committee, public hearings, data and research.

A range of agencies were funded to activate and support communities to engage with the royal commission to ensure that a diversity of perspectives were provided. These agencies included VMIAC, Tandem, Victoria Legal Aid, Mental Health Legal Centre and the Victorian Aboriginal Community Controlled Health Organisation.

Royal commission's interim report

The royal commission delivered its interim report to the Victorian Government in November 2019. In the report, the commission identified important themes and individual and system needs, which form the basis of its nine recommendations. Some recommendations are aimed at responding to the most immediate challenges and redressing urgent problems. Other recommendations focus on preparing the ground for further reform to Victoria's mental health services.

Most of the commission's recommendations for change will appear in the final report due in February 2021. The final report will present a comprehensive set of recommendations that will lead to a major system redesign of Victoria's mental health system.

Mental Health Reform Victoria – establishment and progress

In its interim report, the Royal Commission into Victoria's Mental Health System recommended the Victorian Government establishes a new administrative office to lead implementation of its recommendations. In response to this recommendation, Mental Health Reform Victoria was established in February 2020. Mental Health Reform Victoria will operate for two years to implement seven of the nine recommendations made by the royal commission in its interim report.

Productivity Commission's Inquiry into the Social and Economic Benefits of Improving Mental Health

The Productivity Commission has conducted a national inquiry into the role of mental health in supporting economic participation, enhancing productivity and economic growth.

The Productivity Commission will make recommendations about how governments, employers and others can improve population mental health in order to realise economic, social participation and productivity benefits over the long term.

The inquiry released its draft report in October 2019. Key findings of the report included the need to have access to help earlier, have a better experience with mental health care and improve the services outside of traditional healthcare systems.

Five key areas for improvement were identified in the draft report:

- prevention and early intervention for mental illness and suicide attempts
- closing critical gaps in healthcare services
- investment in services beyond health
- assistance for people with mental illness to get into work and enable early treatment of work-related mental illness
- fundamental reform to care coordination, governance and funding arrangements.

The Productivity Commission sought further information and feedback following the release of the draft report, handing its final report to the Australian Government on 30 June 2020. It is expected that this will be released by the Australian Government later in 2020.

Continuing Reform of Victoria's Mental Health System package

Initial funding towards implementing recommendations from the Royal Commission into Victoria's Mental Health System's interim report was included in the Mental Health and Social Connectedness package in April 2020. In May 2020, the Continuing Reform of Victoria's Mental Health System package committed another $19.5 million to deliver essential reform recommendations.

This further investment was provided to address time-critical recommendations and to ensure that reform to mental health services was not significantly delayed due to the impacts of coronavirus (COVID-19). Investment also aimed to address existing and longer term system capacity issues that may constrain the system to manage a potential surge in demand for mental health services due to coronavirus (COVID-19).

This funding aimed to address critical workforce shortages, support the continued rollout of suicide prevention programs, provide new Hospital in the Home beds and provide operational funding for Mental Health Reform Victoria as they work to engage with Victorians with lived experience to deliver the recommendations.

The funding included:

- $7.14 million to continue and scale up Mental Health Reform Victoria operations
- $6.5 million to address workforce challenges including:
  - $2.27 million to begin mandatory junior medical officer rotations in psychiatry
  - $4.28 million to establish 60 new nurse graduate placements
- $0.95 million to extend funding for the three new Hospital Outreach Post-suicidal Engagement (HOPE) sites
- $4.86 million to fund 24 new Hospital in the Home beds.

Mental Health Ministerial Advisory Committee

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

In June 2019, the new Mental Health Ministerial Advisory Committee was established to oversee progress against the plan and related initiatives. In providing advice, the committee considers the conduct and recommendations of relevant royal commissions and federal and state inquiries, including the Royal Commission into Victoria's Mental Health System.

The committee is co-chaired by the Parliamentary Secretary for Mental Health, Harriet Shing MP, and Maggie Toko, a mental health consumer leader. Over the past year, key focus areas for the committee have included mental health reform in Victoria, as well as national initiatives such as the Productivity Commission Inquiry into Mental Health and its implications for Victoria. Between October and December 2019, the committee established a time-limited working group to provide insights and feedback on the Royal Commission into Victoria's Mental Health System's interim report and the Productivity Commission Inquiry into Mental Health's draft report.

In 2020, the committee has focused on the mental health coronavirus (COVID-19) response, sharing insights on opportunities and learnings from Victoria's response.

The committee is supported by two standing subcommittees, the Lived Experience Advisory Group and the Mental Health Workforce Reference Group.

Transition to the National Disability Insurance Scheme

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

Victoria began a staged rollout of the NDIS in 2016. The transition of clients of select state-funded mental health community support service (MHCSS) programs to the NDIS was completed on 31 March 2020. All funding associated with in-scope MHCSS programs has been transferred to the National Disability Insurance Agency (NDIA), forming part of Victoria's $2.5 billion investment in the NDIS. As of June 2020, 14,238 Victorian participants with a primary psychosocial disability had accessed the NDIS or had an approved NDIS plan. Just over 67 per cent of these participants were previously state-funded clients.

The NDIS is evolving and there a number of reforms underway that will affect Victorian participants with a psychosocial disability and the providers who support them. The Victorian Government continues to work collaboratively with the NDIA, Commonwealth Government and other jurisdictions to ensure the NDIS delivers its intended benefits for people with a psychosocial disability.

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

Victoria's 10-year mental health plan was released in November 2015. The plan sets out the government's long-term vision to improve the mental health and wellbeing of all Victorians. In the five years since releasing the plan, investment has focused on meeting growing demand for clinical services, boosting access to community-based services, expanding and diversifying the mental health workforce, suicide prevention, forensic mental health, and Aboriginal social and emotional wellbeing initiatives.

The 10-year plan identifies areas of focus for achieving the government's long-term vision and has a clear focus on monitoring progress and reporting on outcomes. The mental health outcomes framework, initially described in the plan, continues to be further developed and makes an important contribution in measuring outcomes for people with a mental illness.

Several major strategies have been developed under the plan. These strategies help guide investment and delivery of initiatives to improve outcomes for people with mental illness. The strategies include:

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

The 10-year plan describes the importance of engaging and working productively with people with a mental illness and their families and carers, and the value of co-production of policy and services. The role of expert advice and guidance is also a key feature of the plan.

Progress on these focus areas during 2019–20 is outlined here.

Outcomes framework

Monitoring progress and reporting on outcomes under the 10-year plan helps to understand the impact of our programs and services on people's lives over time. Building evidence around what works allows us to assess whether services and programs are effective and to identify what needs improving.

The four domains in the outcomes framework highlight high-level areas of focus, with the 16 outcomes reflecting the long-term goal of improving the mental health of all Victorians. The framework incorporates a range of indicators relating to system performance, clinical outcomes and consumer experience. Indicators are used to track whether initiatives and programs are contributing to better outcomes for people with a mental illness.

The four domains and 16 outcomes are shown in the table below.

This chapter provides a brief summary of the domain, data on key indicators, and progress on implementing projects, strategies and initiatives relevant to the domain.

Results for all indicators are set out in full in Appendix 1, with key indicators to note this year discussed in this section. The most recently available data has been included. It should be noted that updated data is unavailable for indicators relating to the Your Experience of Service (YES) survey (indicators 13.5, 14.6, 15.1, 15.2, 16.6 and 16.7). Updated data was also unavailable for indicators relating to the National Assessment Program – Literacy and Numeracy (NAPLAN) (indicators 7.1, 7.2, 7.3 and 7.4). For these items, data published in the 2018–19 annual report has been reproduced.

Domain	Outcomes
1. Victorians have good mental health and wellbeing	1. Victorians have good mental health and wellbeing at all ages and stages of life
	2. The gap in mental health and wellbeing for at-risk groups in reduced
	3. The gap in mental health and wellbeing for Aboriginal Victorians is reduced
	4. The rate of suicide is reduced
2. Victorians promote mental health for all ages and stages of life	5. Victorians with mental illness have good physical health and wellbeing
	6. Victorians with mental illness are supported to protect and promote health
3. Victorians with mental illness live fulfilling lives of their choosing, with or without symptoms of mental illness	7. Victorians with mental illness participate in learning and education
	8. Victorians with mental illness participate in and contribute to the economy
	9. Victorians with mental illness have financial security
	10. Victorians with mental illness are socially engaged and live in inclusive communities
	11. Victorians with mental illness live free from abuse or violence, and have reduced contact with the criminal justice system
	12. Victorians with mental illness have suitable and stable housing
4. The service system is accessible, flexible and responsive to people of all ages, their families and carers, and the workforce is supported to deliver this	13. The treatment and support that Victorians with mental illness, their families and carers need is available in the right place at the right time
	14. Services are recovery-oriented, trauma-informed and family-inclusive
	15. Victorians with mental illness, their families and carers are treated with respect by services
	16. Services are safe, of high quality, offer choice and provide a positive service experience

Continued development of the outcomes framework

The outcomes framework, and its indicators, measure and monitor how our programs and services are contributing to improved outcomes for people with mental illness. The framework is intended to be dynamic, and the continuing development of valid and meaningful indicators will require ongoing work across government

The coronavirus (COVID-19) pandemic has affected delivery of some surveys, and the capacity of departments and services to undertake new developmental work on indicators has been reduced. It has therefore not been possible to add new indicators this year, or to provide updated data on all the existing indicators.

In June 2020, the department's Priority Reform Subcommittee of the Executive Board endorsed a new *Mental health performance and accountability framework*. The new framework was subsequently shared with the Royal Commission into Victoria's Mental Health System. Advice on its development was provided by a working group that included representatives from consumer and carer organisations, clinical mental health services, the Mental Health Tribunal, the Mental Health Complaints Commissioner, universities, the Victorian Agency for Health Information, Safer Care Victoria and the Office of the Chief Psychiatrist.

The *Mental health performance and accountability framework* is a companion document to the *Victorian health services performance monitoring framework* and will be used to monitor and support better health outcomes for Victorians. The new framework focuses on the clinical mental health system and aims to provide a clear structure for reporting and monitoring, promoting accountability, and enabling a more systematic and innovative approach to using information.

It is also intended that the framework will align with other monitoring and reporting in mental health. Future work will be carried out to identify indicators in the new framework that can be used to measure progress under *Victoria's 10-year mental health plan* and outcomes for people with mental illness.

Domain 1: Victorians have good mental health and wellbeing

The focus of domain 1 is on reducing the prevalence of psychological distress and mental ill health and increasing the wellbeing of Victorians, reducing the gap for at-risk groups, including Aboriginal Victorians, and reducing the suicide rate.

Data on selected key indicators

Mental health and wellbeing of Aboriginal Victorians

Outcome indicators show that Aboriginal Victorians continue to be over-represented in clinical mental health services. Aboriginal people form about 0.7 per cent of Victoria's population, with 3.1 per cent receiving clinical mental health care, compared with 1.16 per cent of the Victorian population overall. This has been trending upwards over the past five years.

Data from the Victorian Population Health Survey on levels of psychological distress shows that the proportion of adults with high or very high levels of psychological distress was significantly higher in the Aboriginal population compared with the proportion in all adults, at 30.3 per cent compared with 15.0 per cent. Psychological distress is a proxy measure of the overall mental health and wellbeing of the population, and very high levels of psychological distress may signify a need for professional help and provide an estimate of the need for mental health services. Levels for Aboriginal Victorians showed an increase of 5.3 per cent from the 2017 to the 2018 surveys.

For Victorian Aboriginal children, the proportion at high risk of clinically significant problems related to behaviour and emotional wellbeing at school entry reduced slightly from 2017 to 2018 to 18.5 per cent. However, it remains far higher than the proportion for all Victorian children, which is substantially lower at 6.7 per cent.[1]

There is strong evidence that people who are targets of racism are at greater risk of developing a range of mental health problems such as anxiety and depression. Racism is a key determinant of the health of Aboriginal Australians that may explain the unremitting gap in health and socioeconomic outcomes between Aboriginal and non-Aboriginal Australians.[2] Racism directed against Aboriginal Victorians is a significant problem.

Results for these indicators again emphasise the need for ongoing, whole-of-government and community efforts towards social inclusion and equality, as well as sustained efforts to combat racism and tailored responses to support the mental health and wellbeing of Aboriginal Victorians.

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

2 Markwick A, Ansari Z, Clinch D, McNeil J 2019, 'Experiences of racism among Aboriginal and Torres Strait Islander adults living in the Australian state of Victoria: a cross-sectional population-based study', *BMC Public Health*, vol. 19, no. 1, pp. 309.

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
1.1 Proportion of Victorian population with high or very high psychological distress (adults)	2018	n/a[3]	17.3%	14.8%	15.4%	15.0%
1.2 Proportion of Victorian population receiving clinical mental health care	2019–20	1.10%	1.07%	1.15%	1.16%	1.16%
3.1 Proportion of Victorian Aboriginal population who are receiving clinical mental health care	2019–20	2.6%	2.7%	2.8%	2.9%	3.1%
3.2 Proportion of Victorian Aboriginal population with high or very high psychological distress	2018	n/a[3]	17.7%[4]	27.9%	25.0%	30.3%

Suicide rate

Arguably, the suicide rate is the starkest measure of the mental health of a population.[5] There has been a slight increase in the suicide rate for Victoria in 2019, with a rate of 10.7 deaths (per 100,000) compared to 10.4 in 2018. Victoria's age-standardised rate is the lowest of any state or territory and is lower than the national rate of 12.9.

Victoria's rate is fairly stable over the last several years, sitting in the range 10.1–11.1 per 100,000 population. There has been heightened concern about suicide with the coronavirus (COVID-19) pandemic. Data released by the State Coroner indicates that the year-to-date number of suicide deaths in Victoria at the end of September 2020 is at a very similar level to the same period in 2019.

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
4.1 Victoria's rate of deaths from suicide per 100,000	2019	11.1	10.1	11.0	10.4	10.7

3 Due to a change in sampling methodology to include mobile phone users as well as people with landlines, only four years of data from the Victorian Population Health Survey are available. Direct comparisons of this data with previous years can not be accurately made.

4 The 2015 and 2016 estimates of high or very high psychological distress for Aboriginal Victorians have a relative standard error between 2 and 50 per cent and should be used with caution. The estimates from 2015 to 2018 are not significantly different from each other, even though the point estimates appear to show large differences. This is because of the small sample size of the Aboriginal population in the statewide surveys in 2015, 2016 and 2018.

5 National Mental Health Report 2013 <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-report13-toc~mental-pubs-n-report13-3~mental-pubs-n-report13-3-3~mental-pubs-n-report13-3-3-ind9>.

Progressing the Balit Murrup social and emotional wellbeing framework

The *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027* embeds Aboriginal self-determination as the core principle to drive actions to improve the social and emotional wellbeing, resilience and mental health of Aboriginal people, families and communities.

Balit Murrup was developed alongside *Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027* – the overarching framework for action to improve the health, wellbeing and safety of Aboriginal Victorians now and over the next ten years.

Improving mental health outcomes for Aboriginal and Torres Strait Islander people with moderate to severe mental illness (demonstration projects) initiative

Under *Balit Murrup*, the Victorian Government allocated $20.2 million ($7.7 million in 2016–17, $4 million in 2018–19 and $8.5 million in 2019–20) to four demonstration projects to deliver integrated, culturally safe mental health services designed to meet the mental health and social and emotional wellbeing needs of their local Aboriginal communities. The four demonstration projects are testing new service models for Aboriginal people in Victoria and are led by Aboriginal-community controlled organisations in partnership with local public health services.

The four demonstration sites are:

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

Each demonstration project is providing community members with holistic clinical and therapeutic counselling and supports that prioritise connection to Country, culture, spirituality, ancestry, family and community.

Since starting the demonstration projects, more than 400 Aboriginal people who have presented with a moderate to severe mental illness have received support through the demonstration project and 18 children have been reunited with their Aboriginal parents.[6]

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6 This is an accumulated figure from annual reporting across the four demonstration project sites since 2017 and reunified data reported by Ballarat and Districts Aboriginal Cooperative.

Aboriginal Mental Health Traineeship Program

The Aboriginal Mental Health Traineeship Program is a key workforce program under *Balit Murrup* with funding of $3.5 million over three years since 2017–18. The traineeship program is building an Aboriginal mental health workforce that can provide culturally safe and inclusive mental health care for Aboriginal people in Victoria.

Ten Aboriginal mental health trainees employed by area mental health services are provided with supervised workplace training and clinical placements over three years while concurrently completing a Bachelor of Science (Aboriginal Mental Health) degree though Charles Sturt University, New South Wales. Trainees are employees in the mental health service during the three-year program and, following successful completion of the three-year degree, are offered ongoing employment.

Trainees are located at eight area mental health services across metropolitan and rural Victoria – Eastern Health, Bendigo Health, Alfred Health, Peninsula Health, Latrobe Regional Hospital, Mildura Base Hospital, Monash Health and Forensicare.

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

Another key workforce initiative under *Balit Murrup* is the creation of 10 clinical and therapeutic mental health positions in Aboriginal community-controlled organisations across regional and metropolitan Victoria. Funding of $4.9 million over three years (2017–18 to 2019–20) was provided for the ten clinical and therapeutic positions.

The clinical and therapeutic positions are delivering culturally responsive and trauma-informed services to Aboriginal people, families and communities. The clinical and therapeutic mental health positions are highly skilled and come from a broad range of disciplines such as mental health nurses, occupational therapists, psychiatrists, psychologists and social workers.

The clinical and therapeutic mental health positions are located at ten Aboriginal community-controlled organisations:

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

Initiatives under the Victorian suicide prevention framework

The *Victorian suicide prevention framework 2016–2025* provides a government commitment and coordinated strategy to reduce the rate of suicide, with the goal of halving Victoria's suicide rate by 2025. The framework reflects a broad public health approach to suicide prevention and is based on the principle that, while the reasons for suicide are complex, suicide is preventable.

The framework outlines two major initiatives: the rollout of the HOPE program and place-based suicide prevention trials.

Hospital Outreach Post-suicide Engagement program

The HOPE program delivers assertive, tailored outreach support to individuals (aged 18 years or older) who are at significant risk of suicide following hospital discharge for a non-fatal suicide attempt and who do not meet the threshold for tertiary mental health services.

The objectives of the HOPE program include to: improve recovery outcomes for the target cohort through improved connection to carers, family and community and other support services; provide community-based support that enables individuals within the target cohort to build self-resilience and capacity to self-manage distress and other risk factors for suicidality; improve links to community-based support; and improve workforce capacity and capability.

The HOPE program is currently being trialled at 12 sites across Victoria.

In June 2019, Victoria entered into a bilateral agreement with the Commonwealth Government under which the Commonwealth will match Victorian investment in HOPE with four Way Back Support Services. This agreement expands suicide aftercare to 16 sites across Victoria.

In November 2019, the Royal Commission into Victoria's Mental Health System made an interim recommendation that HOPE be expanded to all adult area mental health services, including establishing a regional and subregional health service approach and broadening referrals to include consumers of community-based mental health teams. In addition, the royal commission recommended developing a model specific for children and young people. The royal commission's interim report notes the benefits of collaboration between HOPE and local Aboriginal social and emotional wellbeing teams to help reduce barriers to engagement with mental health services.

Place-based suicide prevention trials

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

Using a community development model, the trials build community capacity and resilience to enable individuals and groups to recognise and appropriately respond to signs of suicidality. This includes 'gatekeeper' training, training for frontline responders to suicidal crises, and post-suicidal crisis aftercare.

The trials were originally funded from 2016–17 to 2019–20. In February 2020, funding for all sites was extended until June 2022. Several Primary Health Networks are planning geographic expansion of trial sites in their catchments based on preliminary outcomes.

The trials are undergoing an independent, external evaluation in three phases: establishment, formative, and summative. The summative evaluation is due to be delivered in mid-2021.

Healthy Equal Youth project and grants

The Healthy Equal Youth (HEY) project and HEY grants are priority actions in the *Victorian suicide prevention framework 2016–25* and aim to raise awareness, promote diversity, eliminate stigma and discrimination, and improve the overall mental health of young LGBTIQ+ people.

The Victorian Government allocated $1.9 million through the HEY project to 16 organisations to undertake mental health promotion and community engagement activities with a focus on LGBTIQ+ young people aged up to 25 years and their families.

The program also delivers up to $100,000 worth of small grants per year through the annual HEY small grants program, coordinated by the Youth Affairs Council of Victoria.

National strategy

National suicide prevention strategy 2020–2023

Victoria has led development of the *National suicide prevention strategy 2020–2023* with advice from the National Suicide Prevention Project Reference Group, a working group of the Mental Health Principal Committee. Australia's journey towards zero suicides is achieved through a suicide prevention system where evidence-informed strategies, programs and services are coordinated across all sectors to:

- promote resilient, mentally strong individuals and communities
- support people at risk
- effectively and compassionately care for people experiencing or affected by suicidal behaviour.

Domain 2: Victorians promote mental health for all ages and stages of life

The focus of domain 2 is on supporting Victorians to have good physical health and to protect and promote their health.

Data on selected key indicators

People with severe mental illness have poorer physical health yet receive less and lower quality health care than the rest of the population.[7] Our indicators for physical health are tobacco use (as a risk factor) and type 2 diabetes (as a preventable illness). Results this year have improved for both a decrease in the proportion of admitted clients who used tobacco and registered clients with type 2 diabetes.

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
5.1 Proportion of unique admitted clients who were discharged and used tobacco	2019–20	37.7%	38.2%	37.1%	36.5%	33.5%
5.2 Proportion of registered mental health clients with a type 2 diabetes diagnosis	2019–20	10.2%	9.8%	9.9%	10.0%	9.6%

Autism spectrum disorder assessment

Funding was provided to improve autism spectrum disorder (ASD) assessment and diagnosis capacity as part of the release of the *Victorian autism plan*. The investment of more than $2 million to the Mindful Centre for Research and Developmental Health aims to improve access to autism assessment, diagnosis and early intervention as part of its autism assessment, diagnosis capacity building project.

The program aims to reduce the wait list for ASD assessments for children and young people across all Victorian child and youth mental health services (CAMHS). This will be achieved through developing local partnerships and expanding telehealth options to make specialised assessments more accessible, particularly for regional areas.

The program also aims to improve the capacity of the adult mental health system to undertake ASD assessments. Adult services will appoint an ASD specialist role for a senior clinician in six adult mental health services as a 12-month trial. The ASD specialist will coordinate the ASD assessment and diagnostic process, ongoing clinical care within the mental health service, facilitate referral pathways to support services and build the capacity of the mental health service.

The project will include the ASD specialists developing, delivering and evaluating online and face-to-face training modules for adult mental health clinicians. Targeted adult ASD training packages will be provided in regional Victoria to build capacity and increase the accessibility of ASD training in rural areas.

7 Department of Health and Human Services 2019, *Equally well in Victoria: Physical health framework for specialist mental health services*, State Government of Victoria, Melbourne.

Partners in Wellbeing

The Partners in Wellbeing initiative acknowledges that, for many people, the coronavirus (COVID-19) pandemic has had a significant impact on mental health and wellbeing. Funded as part of the April 2020 Mental Health and Social Connectedness package, Partners in Wellbeing is a free statewide service for people aged 16 years or older who:

- may be experiencing stress, anxiety or worry or who are feeling overwhelmed;
- where these feelings have lasted more than a few weeks; and
- the person's usual coping strategies are not working.

The service provides one-on-one wellbeing coaching and support and is delivered by Neami National, EACH and the Australian Community Support Organisation.

Domain 3: Victorians with mental illness live fulfilling lives of their choosing, with or without symptoms of mental illness

The focus of domain 3 is on ensuring that Victorians with mental illness participate in learning and education, contribute to the economy and are financially secure. There is also a focus on Victorians with mental illness being socially engaged and free from violence or abuse, having reduced contact with the justice system and being in suitable housing.

Data on selected key indicators

Psychological risk rating for prisoners

In 2019–20, there was a substantial drop in the percentage of prisoners receiving a psychiatric risk rating (P-rating) on entry to prison. A P-rating is not a clinical diagnosis but a rating applied to a prisoner to aid decisions about their placement and to flag any treatment requirements. P-ratings vary and range from a prisoner indicating that they have a history of mental illness to acute problems where intensive mental health treatment is required immediately. At this stage, it is not known if the change in the data relates to the coronavirus (COVID-19) pandemic.

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
11.1 Proportion of Victorian prison entrants who, at prison reception assessment, are allocated a psychiatric risk rating	2019–20	38.0%	36.9%	37.2%	36.2%	30.6%

Registered clients living in stable housing

People with mental illness are at greater risk of being or becoming homeless than the general population. Having unstable housing is also a significant destabilising factor and may contribute to the risk of developing or exacerbating mental illness. The data suggests that although most clients are in stable housing, the proportion with unstable housing is large in comparison with the general population, and is increasing.

A recent review of the evidence on housing and mental health[8] found a lack of affordable, safe and appropriate housing for people with mental ill health, and that secure tenure allows people to focus on mental health treatment and rehabilitation. Housing, homelessness and mental health are interrelated, and the health and mental health of Victorians relies in part on access to housing.

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
12.1 Proportion of registered clients living in stable housing	2019–20	81%	81%	80%	80%	79%

The In2School program

The In2School program was developed in response to increasing school refusal referrals to the Travancore School, which is a special education setting with a focus on mental health. Specifically, the number of young people referred to Travancore School due to school refusal increased from 21 in 2009 to 47 in 2013.

Short-term effects of school refusal include poor academic performance, school dropout in adolescence, family difficulties and worsening peer relationships. Long-term consequences can include academic underachievement, employment difficulties, increased risk of mental illness and economic and social problems in adulthood.

The program is targeted to consumers aged between 11 and 15 years who meet the access criteria. The 10-week program involves a partnership between the young person, their family, a clinician and a teacher. The teacher and mental health clinician work with the family and young person in their home, conducting core assessments and building rapport. The student then attends a transitional classroom at Travancore School, where the therapeutic process is continued and academic and social and emotional skills are built, before re-integrating into their mainstream school setting.

The average attendance rate for young people referred to Travancore School is 25 per cent before treatment. School attendance results show that attendance in the In2School classroom is 86 per cent, and the average attendance six months after return to mainstream school is 71 per cent.

8 Australian Housing and Urban Research Institute (AHURI) 2018, *Housing, homelessness and mental health: towards system change*, Nicola Brackertz, Alex Wilkinson and Jim Davison for the National Mental Health Commission.

In2School program case study

Lucy is 13 years old and enrolled in Year 7 at a local P–9 college.

Lucy was referred to the In2School program by her mental health case manager at the Royal Children's Hospital. At the time of referral, Lucy was re-enrolled in Year 7 because she had not attended any school the previous year. She often reported physical symptoms including feeling sick when planning to attend school and sometimes she engaged in deliberate self-harm.

At the start of the program, Lucy described her attendance at school as 'horrible'. She attended the In2School classroom four days a week. As Lucy became more confident in the classroom she began asking for help and articulating what support she needed and when. Lucy participated in most tasks and seemed to enjoy working with a partner.

When Lucy started her transition to her enrolled school, her initial visits were only to meet with her key support person. Staff at her school were supportive and flexible with her timetable and made quiet spaces in the school available to her. Her support team agreed that the only expectation would be for Lucy to make an attempt towards attending school in some way every day. School work would be optional.

Throughout the transition her key support person at school checked in with Lucy daily to build a relationship. They used the opportunity to talk about any worries she might have and to make plans to manage those worries. After several weeks of daily support from In2School, her confidence to attend most subjects independently had increased enough for her to go on her own. At the end of the program, Lucy described her own attendance as 'excellent' and reported feeling 'more confident and resilient'. Lucy achieved 96 per cent attendance for the last five weeks of the program.

Early Intervention Psychosocial Support Response

The Early Intervention Psychosocial Support Response (EIPSR) program provides much-needed support to people with psychosocial disability who are not eligible for the NDIS or who need help while they go through the NDIS access process.

In 2019–20, this statewide service provided psychosocial supports to approximately 2,260 people. During this period 224 people living with a significant, enduring psychosocial disability were supported while they completed the NDIS access process and became an NDIS participant. Many people had intensive support needs, which is defined as requiring support at least five or more times a week or multiple times a day (ranging from 44 per cent to 54 per cent of all people over the 2019–20 reporting quarters). A significant proportion require moderate-level support, defined as one to less than five episodes of support each week (ranging from 32 per cent to 46 per cent of all clients over the 2019–20 reporting quarters).

The Victorian Government committed funding of $50 million over two years to 16 health services across Victoria to deliver this service in partnership with community-managed mental health providers. The initiative began in January 2019. Health services and the community-managed mental health providers are working together to provide people with a psychosocial disability with integrated treatment and psychosocial recovery care in the community. This will reduce the impact that mental illness can have on people's ability to self-manage their mental illness, form meaningful relationships and participate in community life.

'EACH's community mental health and peer workers in the EIPSR program have developed strong partnerships with clinical mental health teams in Monash and Eastern Health to deliver an integrated service which is responsive to the needs of consumers with mental illness. EIPSR teams provide coordinated pathways between clinical, community and social supports so that consumers get the right support at the right time. There is strong alignment in the values of staff from the community and the hospital sectors, recognising each other's strengths and contributions to consumer recovery as the centre of our work.

This wraparound and integrated approach has been particularly appreciated by consumers through the COVID lockdown. Consumers have commented that they feel more connected through the regular wellbeing checks being provided by their EIPSR workers. They also feel more confident that re-engagement with clinical services is available if required. The care and support has been really valued.'

– Peter Ruzyla,
 Chief Executive Officer, EACH

Domain 4: The service system is accessible, flexible and responsive to people of all ages, their families and carers, and the workforce is supported to deliver this

The focus of domain 4 is on ensuring that Victorians with mental illness and their families and carers are able to get the treatment and support they need and are treated with respect. Services are safe, appropriate and of high quality.

Data on selected key indicators

Preadmission contact and post-discharge follow-up

Rates of preadmission contact increased to 60.6 per cent in 2019–20 from 58.7 per cent the previous year, and the rate of post-discharge follow-up within seven days is trending upwards. Results for both of these indicators correspond to increased funding for community service hours in 2019–20. Contact resulting in a planned admission means that an individual is less likely to present in crisis, and follow-up soon after discharge enhances continuity of care at a time when consumers often require additional supports.

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
13.1 Rate of preadmission contact	2019–20	57.2%	51.8%	59.4%	58.7%	60.6%
13.2 Rate of readmission within 28 days	2019–20	13.9%	13.4%	13.8%	13.3%	14.3%
13.3 Rate of post-discharge follow-up	2019–20	84.2%	77.6%	87.0%	88.0%	89.6%

Compulsory treatment and restrictive interventions

The proportion of compulsory inpatient admissions has increased, as has the duration of compulsory treatment and the rate of seclusion episodes. These results are explored in detail in section 4 of this report.

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
16.1 Rate of seclusion episodes per 1,000 occupied bed days (inpatient)	2019–20	9.2	9.9	9.7	8.5	9.6
16.4 Proportion of inpatient admissions that are compulsory	2019–20	52.2%	51.4%	50.3%	49.7%	51.0%
16.5 Average duration of compulsory orders (days)	2019–20	59.3	64.1	76.6	75.6	82.9

Progressing the mental health workforce strategy

The *Mental health workforce strategy* was developed to strengthen the mental health workforce in a rapidly changing environment characterised by growing demand, increasingly diverse and complex consumer circumstances and an ageing population. In 2019–20, $9.0 million was invested to support the mental health workforce, particularly around growing the capacity and capability of the workforce. These initiatives are outlined below.

Growing the capacity of the clinical mental health workforce

A key element of the *Mental health workforce strategy* for 2019–20 has been to meet service demand for staff by increasing the mental health workforce capacity.

Workforce Strengthening Project

The Workforce Strengthening Project aims to boost workforce capacity by increasing the number of mental health positions in the workforce, including mental health nursing training positions, community mental health engagement worker positions and clinical nurse consultant positions.

In 2019–20, the Workforce Strengthening Project has delivered funding for 119.5 new fulltime-equivalent mental health positions. The new positions in 2019–20 include:

- 30 transition to mental health nursing positions for enrolled nurses and general nurses
- 30 mental health nursing postgraduate positions
- 23 community mental health engagement workers
- 25 clinical nurse consultants.

All Victorian mental health services were allocated positions as part of this project in 2019–20. By June 2020, 97 per cent of the positions had been filled. An implementation evaluation for this project has been undertaken and results highlight the important factors in integrating the new positions within the existing work programs. Results demonstrate:

- The new positions have been well received by existing staff and act to increase mental health workforce capacity, skills and expertise.
- Staff recruited into the new positions report their roles are significant in supporting teams and improving the outcomes for consumers of the mental health services.
- The roles have had a positive impact on clinical practice due to the increased capacity provided. Examples include reduced use of restrictive practices, fidelity and sustainability of the Safewards Program and implementation of the *Mental health intensive care framework*.

Services have described the positive impact of the new positions:

- New **postgraduate positions in community mental health teams** enable a protected learning space and for competencies to be built gradually. The nature of the position, and the support provided, has attracted staff who may otherwise have been reluctant to take on a new role with more autonomy and a greater scope of practice.
- The **clinical nurse consultant position** provides a senior presence on the floor other than line management, giving junior nursing staff another mentor and resource. Staff can then gain increased confidence and exposure to the different ways in which clinical care is provided, which will benefit care outcomes for consumers.

Hello Open Minds – phase 2

The Hello Open Minds workforce attraction campaign aims to promote careers in mental health. It is designed to grow workforce numbers and support other initiatives in the *Mental health workforce strategy* to further develop and support specific disciplines in mental health.

In 2019–20, investment in additional strategies boosted workforce supply through phase 2 of the Hello Open Minds initiative, including:

- The Rural Workforce Agency Victoria managed and operated a mental health relocation grants program. This program has been designed to support mental health workers to relocate and take up roles in public specialist mental health services operating in rural or remote areas of Victoria. The program offers financial incentives and tailored support.
- Pre-qualification employment programs at select mental health services offered employment opportunities to students registered in a Bachelor of Nursing program. The employment programs aim to increase students' interest, skills and confidence to provide recovery-oriented and person-centred care to consumers, families and carers and to ultimately encourage them to take up future employment at a mental health service. Early evaluation results have been encouraging, with program participants reporting they are consolidating and gaining valuable skills. Most program participants reported considering a career in mental health (90 per cent intending to apply for a graduate position at a mental health service) and that in the absence of the program they would have sought employment opportunities in health but not in mental health specifically.

Students commented that the program gives a 'head start' to fresh graduates entering the job market and provides an understanding of working in an inpatient setting with actual responsibilities.

Initiatives to support workforce capability

In 2019–20, further investment supported the skills and capability of the mental health workforce, as outlined below.

Centre for Mental Health Learning

The Centre for Mental Health Learning is the centrepiece for mental health learning in Victoria, leading and driving innovation that strengthens and sustains a flexible, curious, knowledgeable and recovery-focused workforce. In 2019–20, the centre received more funding to deliver and support health service workforce development, to progress statewide training provider collaboration and evaluation, and to expand its website to include a supervision database, educator resources and new online learning content.

Lived experience workforce initiatives

Several initiatives focused on practice support and development for lived experience workforces in 2019–20. These included:

- access to supervision for lived experience workers
- consumer perspective supervision training
- intentional peer support five-day core training (online)
- online co-reflection for lived experience workers trained in intentional peer support
- online co-reflection via the Centre for Mental Health Learning.

Supports for psychiatry

A number of initiatives were introduced in 2019–20 to better support psychiatrists. These have focused on training, mentoring and improving digital skills including two new key positions to support training: the Director of Training for Specialist International Medical Graduates, based at Goulburn Valley Health, and the Director of Advanced Training – Addiction Psychiatry at Turning Point.

Psychiatry Workforce Development Grants to support and promote leadership in priority areas and increase the use of digital technology among the workforce were awarded in May 2020.

Engagement with consumers, families and carers

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

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

The *10-year mental health plan outlines* the importance of engaging and working productively with people with a mental illness and their families and carers and of co-producing policies and services. Some examples of consumer engagement in Victoria are outlined here.

Lived Experience Advisory Group

The Lived Experience Advisory Group (LEAG) was established to provide consumers, families and carers, safeguarding agencies and the department's Mental Health and Drugs Branch with the opportunity to work in partnership to embed lived experience perspectives at the statewide level.

The LEAG is co-chaired by the CEOs of VMIAC and Tandem and the executive director of the Mental Health and Drugs Branch, and is informed by the principles outlined in the department's *Lived experience engagement framework*. The LEAG provides expert advice on lived experience perspectives in a range of areas such as increasing supported decision making and supporting the lived experience workforce (including consumer and carer consultants). The LEAG is also a key partner in the implementing the recommendations from the Royal Commission into Victoria's Mental Health System, providing advice and guidance to Mental Health Reform Victoria from lived experience perspectives.

Participation registers

The lived experience participation registers have been established to ensure the voice of lived experience directly informs project, policy, planning and evaluation work undertaken by the Mental Health and Drugs Branch. Critically, the registers enable consumers, families and carers to be engaged at the outset of new work.

The registers allow a consistent approach to engaging a diverse range of consumers, families and carers. The registers are managed by VMIAC and Tandem and have also been used by several areas within the department and other agencies. Register participants are inducted by peers at VMIAC and Tandem and are supported and remunerated during participation activities. While there are challenges both for participants and departmental staff in learning how to work together, there is a growing understanding of how to do this work safely and effectively. Working with register participants allows unique and valuable perspectives to be incorporated into the branch's work and ensures that work is grounded in the lived experiences of those who use services, and their families and carers.

Consumer consultants – lived experience representation for systemic change in public mental health services

Lived experience representation in the workforce is an enormously valuable component of the public mental health service system. This representation includes consumer and carer consultants and peer support workers. The department introduced the roles of consumer and carer consultants within services to ensure that consumer, family and carer perspectives inform all aspects of service planning and delivery. The roles play a separate but equally important function to the individual peer support workforce, in that their focus is improvement at the health service and system levels.

A consumer consultant has a lived experience of mental illness and an understanding of the public mental health service system, with capacity to draw on personal experience as well as feedback from other consumers to contribute to system improvements. The positions are undertaken by people who have been a consumer of mental health services themselves who now act as consumer representatives across the service. Consumer consultants may receive direct feedback from consumers, represent consumers at meetings, have input into policy making and training, and promote consumer-focused, recovery-oriented, humanistic service delivery. They promote consumer participation in all levels of decision making and are placed at the centre of policy and practice change, as partners in co-design and co-production. Consultants are employed in each area mental health service across Victoria, having local influence and working together across services to ensure higher level mental health reform.

The Statewide Consumer Consultant Council was established in 2019 to provide an opportunity for consumer consultants to connect and develop the role and related work priorities. The department supports the council as part of its commitment to include the lived experience perspective. At a statewide forum in late 2019, consumer consultants identified key barriers and opportunities for this role. The council continues to meet regularly to progress this work, with an immediate focus on increasing the profile of the role and to better embed its functions into mental health services.

Work is also being undertaken to support the carer and family workforce, in partnership with the carer lived experience workforce, the Centre for Mental Health Learning and the Bouverie Centre.

Consumer consultant at Bendigo Mental Health Services

Stacey is a consumer consultant who also holds a separate role as a peer support worker (post discharge) with Bendigo Mental Health Services. This area mental health service provides psychiatric care over an area a quarter of the size of Victoria. This is an expanding regional health service offering a range of clinical services to consumers across all ages through inpatient, bed-based, specialist units and community teams in the Loddon Mallee region.

With a clinical background, Stacey never thought she would become a consumer of public mental health services and then go on to represent other consumers to make system change and support her peers. After years of her own acute mental illness and ongoing recovery, she now uses her insights to help others. Although at times representing and advocating for consumers at higher management levels can be daunting, it enables her to make real change in the lives of others.

As a peer support worker, she works in the community team and provides a mutual connection and support to adult consumers after an admission to help with recovery, staying well and reducing relapse. She also co-designed and runs the Living Well Peer Led Group for the community team's consumers. She finds her consumer roles equally if not more rewarding than her previous clinical career. She works alongside clinical staff and feels her role is valued and consumer perspective respected. She is passionate about regional consumers' care and is excited about proposed wider mental health service reform and further expansion of the lived experience workforce.

Craig's experience

'Working in the lived experience workforce has changed my life. I took what I saw at the time as a substantial risk and declared my lived experience of mental ill health and recovery professionally in 2011. It's the best thing I ever did in my career. My darkest hours, my desperate moments, the hospitalisations in a system that couldn't provide me safety, let alone care, all became useful as I focused on supporting others in their recovery journeys. Later on, other aspects of the mental health system became my focus as I worked in an NDIS project role as an advocate for people being treated against their will, as I had been in 1997, and in a Lived Experience Workforce Development role.

More recently I have been one of the Independent Consumer Members of the Lived Experience Advisory Group (LEAG), an advisory group to the Department of Health and Human Services' Mental Health Branch. The first meeting (in person) was extremely daunting, sitting around the table at 50 Lonsdale St with a bunch of incredibly talented and passionate people, including high-level bureaucrats, CEOs of peak organisations and other members. It took me a while to survey the landscape but I soon landed a few points, respectfully disagreed with some others and found my place at the table, or videoconference.

I'm now working as Senior Adviser Lived Experience (Consumer) at Mental Health Reform Victoria (MHRV). Talk about another place with incredibly talented and passionate people! Fortunately, my role at MHRV means I will continue to work with the LEAG but now with the LEAG advising MHRV on some of the recommendations we at MHRV are implementing. There are so many different consumer views on every aspect of the reform of Victoria's mental health system and the huge responsibility I am tasked with is to ensure these voices are heard, honoured, valued and responded to as we create a paradigm shift in mental health service delivery in Victoria.

Nothing I've done has been without the support of many beautiful people and I am so grateful for that.'

Michelle's experience

'Mental health families and carers often feel unrecognised, excluded and undervalued by mental health services even though they provide invaluable support to people experiencing poor mental health. As such, families and carers have their own specific needs and perspective in relation to the reforms required for Victoria's mental health system.**

After a considerable career as a legal executive for several law firms, I made the decision to change direction and move into mental health as a carer peer support worker. I wasn't sure if I was the right person for the role; however, I was assured I was exactly the type of person they were looking for. That was back in 2002. I never imagined being a mental health carer for my mother from a very early age would allow me to undertake such meaningful and rewarding work. Since then I also became a qualified social worker and have worked in many carer-specific roles including carer consultant, carer advisor and carer advocate.

Over the years I have been involved with the development of many policies, projects, programs and pieces of legislation. I joined the Tandem board in 2016 and served as their chair from 2017 to 2019. I was also a member of Minister Foley's Expert Mental Health Taskforce for three years (2016–2018) and the DHHS Mental Health Workforce Reference Group for four years (2016–2019). For six years I was employed as the Carer Advisor for NorthWestern Mental Health and at the end of 2019 I began a secondment with the Office of the Chief Mental Health Nurse in DHHS as their Senior Carer Advisor.

Now I am working as the Senior Adviser, Lived Experience (Carer) at Mental Health Reform Victoria. I feel privileged to be working towards major reform of our mental health system and bring with me the experiences and voices of the carers and families I have listened to and supported over many years. I have been afforded this once-in-a-lifetime opportunity to ensure all Victorians receive safe mental health care and treatment that meets their needs, and for families, carers and friends to be listened to, respected and effectively responded to along the way.'

Your Experience of Service survey and Carer Experience Survey

The YES survey has run annually since 2016. It is a national survey and provides a way of ensuring that people who have contact with public mental health services have a say about their experiences. The national reporting of YES occurs through the Australian Institute of Health and Welfare, and the results from the survey provide key information at the state and local levels towards improving the safety and quality of mental health services in Victoria.

The survey usually runs in the first part of each year, but in 2020 concerns were raised about whether it could be safely administered during the coronavirus (COVID-19) pandemic. In consultation with YES champions in services, including the lived experience workforce, a decision was taken not to conduct the survey in 2020, and results for relevant indicators in the outcomes framework are therefore unchanged from last year.

However, mental health services are committed to ensuring that consumer perspectives continue to inform all service delivery. The department has worked with services and other agencies to help ensure that the consumer voice is heard at this difficult time, and to work towards implementing the YES survey in 2021. There are several other research projects that will help give insight into the experience of consumers during the coronavirus (COVID-19) pandemic, and individual services have been implementing alternative ways to include consumer perspectives at the local level at this time.

Preparations for the Carer Experience Survey have continued in collaboration with services. This new survey will be implemented for the first time in Victorian area mental health services from September to December 2020. This postal survey will provide carers and families with an additional way to be heard and to shape the services that support both them and their family member or friend.

4. Public mental health services in 2019–20

1,439,992
total service hours

100,945
ED presentaions

Overview

The data in this section of the report and in Appendix 2 helps us to understand who accesses public mental health services (and how), the service settings and circumstances in which treatment is provided. It also tells us about demand for, and use of, services. Key aspects of this data are incorporated in the outcomes framework (see Appendix 1), including data about the use of compulsory treatment and restrictive interventions.

The coronavirus (COVID-19) pandemic has changed the way Victorians have lived their lives in 2020. This has affected all aspects of our lives, including our mental health and how public mental health services have been delivered. These changes began to take hold in March 2020, late in the third quarter of 2019–20.

In looking at the data for the year, the effects of the pandemic are evident. At the beginning, Victorians deferred seeking treatment and care for a broad range of medical conditions, including mental illness. Overall, the total number of ED presentations for all reasons (including heart attack and stroke) reduced in March 2020 compared with the same time in the previous year.

Although the total number of mental health ED presentations dropped across all age groups in quarter 4, the proportion of total ED presentations that were mental-health related rose slightly (see Table 1).

Table 1: Mental health–related ED presentations as a proportion of all ED presentations during the coronavirus (COVID-19) pandemic, 2019–20

Quarter	Mental health ED presentations	Mental health–related ED presentations as a percentage of total presentations
Q1	24,585	5.24%
Q2	26,489	5.62%
Q3	25,840	5.64%
Q4	24,031	6.86%
Total	100,945	5.77%

In relation to acute inpatient and bed-based care, and services in the community, the pandemic also had effects.

Services took a range of actions to protect the health and wellbeing of consumers, carers and staff, including implementing contingency plans and reducing admissions to PARCs to create alternative treatment settings for the case of a coronavirus (COVID-19) outbreak. Some services with rooms where there are shared facilities had to reduce available bed numbers. Overall, there was a reduction the number of acute mental health separations in quarter 4 in comparison to previous quarters (Table 2).

Table 2: Mental health acute separations (excluding same days) for each quarter, 2019–20

Quarter 1	Quarter 2	Quarter 3	Quarter 4
7,905	8,074	7,888	7,183

Bed occupancy dropped somewhat in quarter 3 and more substantially in quarter 4, as shown in Table 3. Although this was most marked in acute admitted care, occupancy levels were still slightly above desirable maximum occupancy for acute inpatient settings in non-pandemic conditions.

Table 3: Quarterly bed occupancy levels, 2019–20

Setting	Q1	Q2	Q3	Q4
Admitted – acute	88.5%	88.4%	87.1%	81.6%
Admitted – non-acute	88.0%	89.0%	91.2%	91.6%
Non-admitted – bed-based	86.1%	83.8%	83.3%	83.2%
Non-admitted – subacute (CCU)	80.8%	80.5%	81.6%	78.1%
Non-admitted – subacute (PARC)	80.3%	80.1%	75.1%	54.9%
Total	**86.1%**	**85.7%**	**84.9%**	**79.9%**

There was a contrasting upswing in community contacts, which increased substantially in quarter 4 across adult, aged, CAMHS and specialist services. Table 4 shows the increase in adult community contacts during the final quarter of 2020 compared with 2019. The mode of contacts changed substantially during the pandemic away from face-to-face service delivery and towards phone and videoconferencing.

Adult community service contacts for each quarter, 2018-19 and 2019-20

Year	Q1	Q2	Q3	Q4
2018–19	466,015	463,752	467,620	466,335
2019–20	481,900	472,910	473,617	524,083

Despite the pandemic, the data shows a small increase in the overall number of consumers in 2019–20, spread unevenly across groups. The increase in our largest consumer group, adults, was 2.4 per cent, and in CAMHS the increase was 1.1 per cent. Forensic services, the smallest part of our service system, increased consumer numbers by 24.6 per cent, relating in part to more beds becoming available at Melbourne Assessment Prison for prisoners who accessed mental health services voluntarily. There was a small increase in consumer numbers for aged persons mental health (2.6 per cent) and a drop in the number of people receiving specialist mental health services (–13.5 per cent).

An increase in service contacts overall (5.1 per cent) can be broken down to substantial increases in specialist, aged, CAMHS and adult services. There is almost no change for forensic consumer contacts.

Total service hours increased by 5.0 per cent overall, but the impact varied across different groups. The increase in adult service hours was 6.1 per cent, with smaller increases in other groups: 3.5 per cent in aged, and 2.5 per cent in CAMHS. Specialist hours were static and for forensic consumers, following an increase of 34.4 per cent noted in last year's annual report, there was a drop of 7.1 per cent.

Consistent with previous years, the data shows that adult inpatient services were under pressure to meet demand in 2019–20. The number of adult inpatient admissions for mental illness are generally increasing (albeit a slight reduction this year due to coronavirus (COVID-19), adult services have very high occupancy levels, and the trimmed average length of stay is under 10 days and has been since before 2015–16 (Table 5). Forensic services for compulsory treatment are also under pressure, with very high bed occupancy and only a small number of separations.

Table 5: Trimmed average length of stay (≤ 35 days), 2015–16 to 2019–20

Population	2015 –16	2016 –17	2017 –18	2018 –19	2019 –20
Adult	9.6	9.5	9.1	9.2	9.5
Aged	16.0	15.7	15.5	15.1	15.4
CYMHS	7.5	6.9	6.6	6.5	6.3
Forensic	18.8	20.5	21.7	24.0	21.8
Specialist	16.7	15.8	15.3	16.0	15.6
Total	10.1	10.0	9.6	9.6	9.8

Who accessed our public mental health services in 2019–20?

76,441
registered consumers,
an increase of 2.1%

There was a small increase in the number of children and young people, adults and forensic consumers accessing public mental health services during 2019–20. The total number of people accessing services was 76,441, up 2.1 per cent from the previous year. Consumer numbers held fairly steady across the four quarters for adults, older people, children and adolescents. A drop in the number of forensic and specialist consumers was evident in quarter 4, falling 9.6 per cent and 14.5 per cent respectively compared with quarter 3. Forensic services are a relatively small part of the service system. Specialist consumers received a higher intensity of service, with more contacts and service hours per person in the last 12 months compared with the previous year.

About two-thirds of adult, aged and specialist consumers, and more than half of children and young people, had previously had contact with mental health services during the past five years. Just over half of registered consumers (50.5 per cent) were women or girls, and a third (33.0 per cent) lived in rural areas. A small proportion of registered consumers (1,679 people) used both clinical and mental health community support services. This number is reducing as mental health community support services transition to the NDIS.

How were people referred to our clinical services in 2019–20?

Most people were referred to clinical mental health services by hospitals, as shown in Figure 4. More than a quarter of referrals were from EDs (26.1 per cent), and Figure 5 demonstrates that the proportion of referrals from EDs has generally been increasing over time – that is, from 21.2 per cent in 2015–16. A further 22.0 per cent of referrals came from acute health. The latter group may include people who were admitted with a physical illness or injury and were subsequently referred for mental health treatment. General practitioners continued to be a key source of referrals (9.9 per cent) as did families (6.7 per cent).

A small proportion of consumers (6.5 per cent) were taken to an ED by police or protective services officers under s. 351 of the *Mental Health Act 2014.* This occurs if a police officer or protective services officer is satisfied that a person appears to have a mental health issue and, because of the apparent issue, the person needs to be apprehended to prevent serious and imminent harm to themselves or another person. The purpose of the apprehension is to facilitate examination of the person by a doctor or assessment by a mental health practitioner. During 2019–20, there were 6,543 presentations to EDs under s. 351, spread fairly evenly over the year. The vast majority (85.1 per cent or 5,566 people) related to adults aged 18 to 65 years. This was followed by people aged under 18, who accounted for 763 or 11.7 per cent of these presentations.

There were 100,945 mental health–related ED presentations in 2019–20, a 3.3 per cent increase from the previous year, spread across all age groups (Table 6). Across the age spectrum, there were 26,654 separations in mental health acute inpatient units in 2019–20, which was very similar to 2018–19. There has been a slight upward trend in the proportion of compulsory admissions this year, following a small but steady decrease each year since 2015–16. In 2019–20, 51.0 per cent of admissions were compulsory. The increase may relate to the impact of the coronavirus (COVID-19) and the lower number of admissions overall.

Figure 4: Source of mental health referrals, 2019–20

Legend:
- Acute health
- Emergency department
- General practitioner
- Family
- Consumer/self
- Community health services
- Police
- Others and unknown
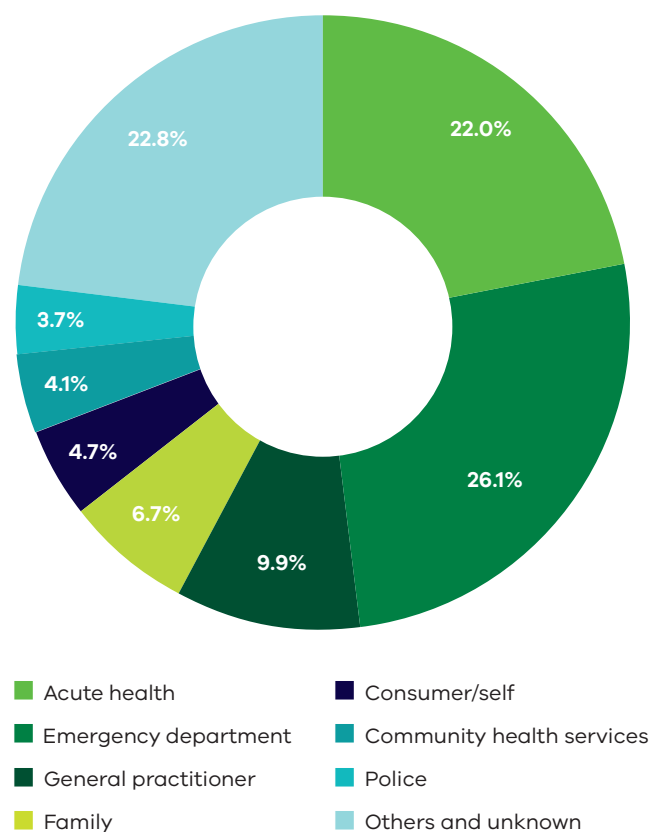
Figure 5: Source of referrals (newly referred consumers only), 2015–16 to 2019–20

Percentage (%)

Categories (top to bottom): Acute health, Emergency department, General practitioner, Family, Consumer/self, Community health services, Police, Others and unknown

Legend: 2015–16 | 2016–17 | 2017–18 | 2018–19 | 2019–20
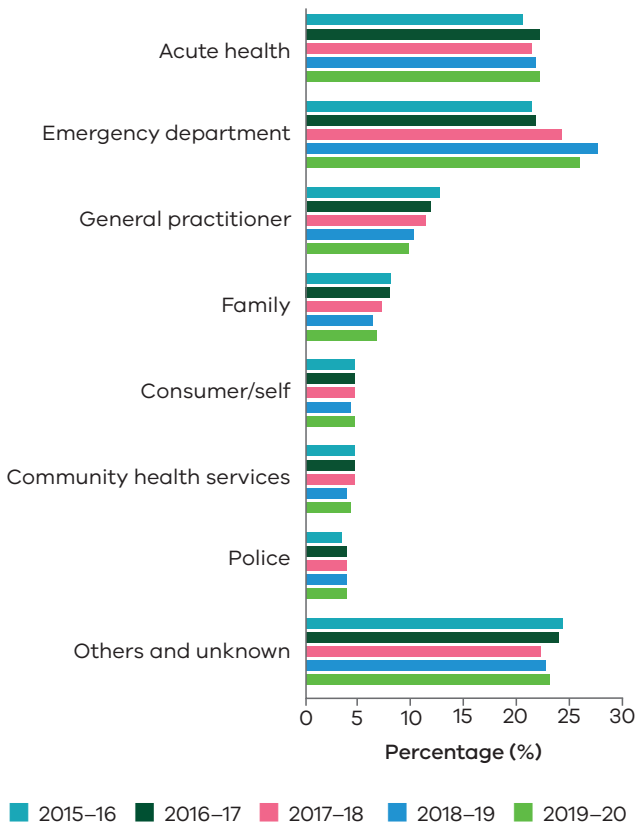
Table 6: Mental health–related emergency department presentations, 2015–16 to 2019–20

Population	2015–16	2016–17	2017–18	2018–19	2019–20
Adult	67,869	69,870	73,623	77,576	79,818
Aged	7,796	7,735	8,328	8,694	9,460
CYMHS	7,603	9,592	10,659	11,461	11,667
Total	**83,268**	**87,197**	**92,610**	**97,731**	**100,945**

How did people experience our services?

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

As noted in section 3 of this report, the YES survey was not conducted in early 2020, as a result of the impact of coronavirus (COVID-19). Where possible, feedback on consumer experiences of services has been sought via other means.

Child and adolescent mental health services

12,076
CAMHS consumers
an increase of 1.1 per cent[9]

2,279
separations

There was a small increase in both inpatient and community clinical mental health service activity in 2019–20. Most children and young people receive clinical treatment in the community. In 2019–20, a higher proportion of service hours (19.1 per cent) were delivered to unregistered consumers than for adults and older people. This may have included contacts where a child or young person was referred to community mental health and assessed but it was found that their needs would be best met by a different type of service. In this instance they may have been referred to a service, such as school-based mental health services, private psychiatry or psychology services, and would not be registered as a public mental health services consumer.

In 2019–20, there were 12,076 registered CAMHS consumers, a slight increase of 1.1 per cent.

Some children and young people in Victoria require inpatient treatment for mental illness. During the year, there were 2,279 separations of children and young people for mental illness, an increase of 7.1 per cent over the previous year. Compulsory admissions dropped slightly from 21.9 to 20.5 per cent, and this remains substantially lower than the level of compulsory treatment for other age groups. Although the average duration of a period of compulsory treatment dropped slightly to 24.7 days in 2019-20, it nevertheless remains in the range of 23-25 days, where it has consistently sat over the past five years. The proportion of children and young people receiving treatment in the community on a community treatment order remained low and stable at 1.0 per cent.

The trimmed average length of stay (< 35 days) for CAMHS is experiencing a slight downward trend and was 6.3 days in 2019–20 (Table 5). The long-term trend for length of stay has been downwards since 2008–09 when it was 10.3 days. Children and young people who stayed longer than 35 days accounted for 9.6 per cent of all CAMHS bed days. The bed occupancy rate is steady at 61.0 per cent (Table 7). The readmission rate for CAMHS is high in comparison with other age groups, at 21.8 per cent in 2019–20. This can reflect models of care that may involve a relatively short length of stay (reflecting concern about disconnecting children and young people from their family, friends and networks longer than necessary) but capacity to readmit the child or young person as required.

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9 Note that the number of CYMHS consumers reported in *Victoria's mental health services annual report 2018–19* was inflated by the categorisation of a subcentre of one rural area mental health service as a CYMHS, when in fact the services were provided to a non-age specific target population and were predominantly adult services. It should also be noted that this number refers to consumers accessing CYMHS services. Each service is classified based on the service or funded program type and not the age of the consumer

Community contacts are the largest part of CAMHS work. They may involve activities such as assessment and treatment, adolescent day programs, or intensive outreach for young people. CAMHS teams often involve parents and siblings, as well as schools, in supporting a young person. In 2019–20, there were 352,576 reported contacts, an increase of 5.0 per cent, which builds further on a smaller increase in service activity in 2018–19.

Table 7: CYMHS bed occupancy rate (including leave, excluding same days), 2015–16 to 2019–20

Setting	2015 –16	2016 –17	2017 –18	2018 –19	2019 –20
Admitted-acute	63.9%	60.9%	62.6%	60.4%	61.0%
Total	63.9%	60.9%	62.6%	60.4%	61.0%

Adult mental health services

61,101
adult consumers[10]

20,862
separations

Inpatient services

In 2019–20, there were 20,862 separations of adults for mental illness, a decrease of 1.1 per cent from last year. Admissions overall dipped in the last quarter as the effects of the pandemic built. The most common diagnoses were schizophrenia and mood disorders such as depression and bipolar disorder. Stress and adjustment disorders were the third most common diagnoses. The proportion of compulsory admissions increased slightly to 56.0 per cent.

Bed occupancy for adult inpatient services remained high at 92.6 per cent (Table 8), which probably dipped slightly only because of the pandemic. Occupancy levels of around 95 per cent have been sustained for several years and present significant ongoing challenges for services.

There has been a welcome slight upward trend in the trimmed length of stay for adults over the past two years, following a decline from 2010–11 onwards (refer back to Table 5), although this dipped again in the final quarter of 2019–20 due to the pandemic.

10 This number refers to consumers accessing adult services. Each service is classified based on the service or funded program type, and not the age of the consumer.

Of the adults who were admitted as inpatients, 61.8 per cent had contact with a community service before admission. The post-discharge follow-up rate was 91.1 per cent, although 14.6 per cent of people were readmitted to hospital within 28 days of discharge, compared with 13.7 per cent in 2018–19. Pressure on beds for adults is evident and may result in shorter-than-optimal hospital stays, with a higher risk of relapse and readmission.

Table 8: Adult bed occupancy rates (including leave, excluding same day), 2016–19 to 2019–20

Setting	2015 –16	2016 –17	2017 –18	2018 –19	2019 –20
Admitted – acute	94.2%	95.0%	94.6%	94.6%	92.6%
Admitted – non-acute	90.7%	88.5%	82.7%	83.4%	87.6%
Non-admitted – subacute (CCU)	79.1%	78.6%	80.1%	80.9%	80.3%
Non-admitted – subacute (PARC)	77.8%	80.7%	76.1%	79.4%	72.6%
Total	87.3%	87.9%	86.8%	87.7%	86.0%

Clinical mental health services delivered in the community

1,952,053
contacts

1,039,862
service hours

The number of recorded community contacts for adults in 2019–20 was 1,952,053, an increase of 4.7 per cent over the previous year. Service hours show an increase of 6.1 per cent. The mode of service delivery changed substantially with the impact of the pandemic. Face-to-face contacts reduced substantially from March 2020 and were increasingly replaced by phone and videoconference contacts. Consistent with the previous four years, 15.0 per cent of adult consumers receiving treatment in the community were on community treatment orders.

Prevention and recovery care

3,362
separations

72.6%
bed occupancy

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

Service activity in PARCs was down on the previous year due to the coronavirus (COVID-19) pandemic. Separations reduced by 5.2 per cent to 3,362, with a drop evident in quarter 4. Occupied bed days reduced this year by 8.3 per cent and bed occupancy was at 72.6 per cent, down from 79.4 per cent the year before. Occupancy varies between services and tends to be higher in urban areas. During the pandemic, admissions for some PARCs were limited to step-down care from inpatient units to ensure greater infection control and to meet workplace physical distancing requirements. Some consumers chose their home environment rather than a PARC because of concerns about infection. Additionally, some PARCs scaled down service delivery as part of a strategy to potentially use PARCs as extension services for inpatient units if required.

Aged persons mental health services

8,304
aged consumers[11]

249,954
community contacts

The number of aged consumers using public mental health services increased slightly by 2.6 per cent in 2019–20 to 8,304. Most of this group had previous contact with mental health services, with 34.9 per cent being new consumers. During the year, there were 2,385 separations of Victorians aged 65 years or older. Bed occupancy decreased this year (Table 9), consistent with fewer ED presentations of older people during the coronavirus (COVID-19) pandemic.

The trimmed average length of stay remained steady at 15.4 days. This is much longer than the adult length of stay. The longer length of stay partly reflects the time that is sometimes required to find safe, appropriate accommodation, or to put in place appropriate discharge supports for unwell elderly people. Sometimes a consumer cannot be discharged to return home, or a nursing home may decline to have them return to that service. It may be necessary to find alternative accommodation and undertake processes such as applications to VCAT for guardianship and administration orders.

11 This number refers to consumers accessing aged persons' services. Each service is classified based on the service or funded program type, and not the age of the consumer.

More women than men use these services, reflecting in part the population profile for older Victorians. The preadmission contact rate was the highest of all groups in 2019–20 at 63.5 per cent; however, the gap is shrinking with performance in adult and CYMHS improving this year. Half of all admissions were compulsory, and this has been fairly stable over the past four years. The post-discharge follow-up rate was 94.9 per cent, again the highest of all groups. Readmissions within 28 days were relatively low at 9.1 per cent, but this has been trending up for older people.

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

For mental health bed-based aged care services, there were 221 separations in 2019–20, a small increase from last year, although the bed occupancy rate was steady at 84.3 per cent. They provided 145,660 occupied bed days, fractionally down from last year. Aged care bed-based facilities have faced particular risks from the coronavirus (COVID-19) pandemic, and it is not surprising to see some reductions in this part of the sector.

There were 249,954 community contacts in 2019–20, an increase of 7.6 per cent. Service hours were up slightly at 129,127 hours (an increase of 3.5 per cent).

Table 9: Aged persons bed occupancy rates (including leave, excluding same day), 2016–17 to 2019–20

Setting	2015–16	2016–17	2017–18	2018–19	2019–20
Admitted – acute	84.9%	85.2%	87.0%	87.7%	81.0%
Non-admitted – bed-based	88.3%	86.9%	87.3%	87.0%	84.3%
Total	**87.3%**	**86.4%**	**87.2%**	**87.2%**	**83.2%**

Forensic mental health services

1,231
consumers

137
separations

23,709
community contacts

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

The number of consumers increased by 24.6 per cent to 1,231 in 2019–20, building on an increase of 12.9 per cent the previous year. The increasing number of forensic consumers reflects in part the re-opening of beds in the Melbourne Assessment Prison, which is the reception prison for men in Victoria. It has a 16-bed short stay assessment unit providing voluntary treatment to prisoners. Referrals are made on entry to the Melbourne Assessment Prison and from other male prisons in the state. The number of consumers seen at Melbourne Assessment Prison rose from 20 in 2018–19 to 311 in 2019–20. Overall, there were 137 separations of people from acute forensic mental health inpatient units during the year, an increase of 33 from 2018–19. Pressure on forensic inpatient beds remains high, with a bed occupancy rate of 95.0 per cent (Table 10).

Forensic consumers had the longest average duration of compulsory treatment, at 100.6 days. This part of the service system had the lowest proportion of new consumers at 17.2 per cent – most had some engagement with services in the preceding five years.

Table 10: Forensic bed occupancy rates (including leave, excluding same day), 2016–17 to 2019–20

Setting	2015–16	2016–17	2017–18	2018–19	2019–20
Admitted – acute	93.6%	95.0%	96.6%	95.5%	95.0%
Non-admitted – bed-based	95.4%	94.4%	93.1%	94.5%	96.4%
Total	**94.8%**	**94.6%**	**94.3%**	**94.8%**	**95.9%**

Specialist mental health services

1,836
consumers

991
separations

28,702
community contacts

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

These services delivered a 12 per cent increase in service contacts in 2019–20, even though the number of consumers receiving specialist services dropped by 13.5 per cent to 1,836. Some bed-based services in this category were temporarily delivered in the community to reduce the risks of the coronavirus (COVID-19) to consumers, carers and workforce.

There were 991 separations from specialist services, 3.8 per cent more than last year. The trimmed average length of stay (≤ 35 days) was similar to the past three years at 15.6 days and was substantially longer than the comparable figure for adults not receiving specialist services. People who stayed longer than 35 days accounted for 16 per cent of occupied bed days, with the highest rate observed at Austin Health, which hosts the rehabilitative Brain Disorder Unit. The preadmission contact rate improved, and post-discharge follow-up continued a substantial upward trend from 2016–17. However, both rates remained relatively low at 39.5 per cent and 65.4 per cent respectively. Readmissions within 28 days are unusual, with a rate of 2.1 per cent in 2019–20.

Admitted acute occupied bed days dropped slightly to 22,629, and the bed occupancy rate, which is variable, was 66.7 per cent. There are a small number of specialist bed-based services and bed occupancy for these services rose to 79.2 per cent from 69.7 per cent.

Compulsory treatment

Victorians with severe mental illness have also been affected by the pandemic and the changes and stresses that have accompanied restrictions. Changes have occurred in the data relating to compulsory treatment, with the proportion of adult and aged clients on a community treatment order increasing in quarter 3 and again in quarter 4. The proportion of clients on an order for more than 12 months has not changed and is at a similar level to the past two years. Whether the pandemic substantially affected aspects of mental health service delivery, including compulsory orders, will be clearer in next year's report. Restrictions began in March but were still very much underway in the first and second quarters of 2020–21, when this report was being finalised.

More generally, with the exception of CAMHS, the average duration of compulsory treatment in the service system is continuing to trend upwards over time, as shown in Table 11. Research shows that in one of every five hearings the tribunal made a treatment order of different (usually shorter) duration to that requested by the treating team.[12] Departmental data shows that relatively few orders expire, suggesting that there is active consideration of the need to continue or discontinue them. Many services review orders at the point where they are approaching expiry and either revoke them or, as is required under the Mental Health Act, seek another order via the tribunal. Although the use and duration of compulsory community treatment orders have reduced under the 2014 Mental Health Act compared with the previous Mental Health Act (1986),[13] the duration of compulsory treatment has been trending upwards again since 2015–16.

12 Taylor-Sands M, Nicholson Z 2020, 'The role of the Mental Health Tribunal in setting duration of compulsory treatment in Victoria', *Psychiatry, Psychology and Law*, doi: 10.1080/13218719.2020.1775153.

13 Vine R, Tibble H, Pirkis J, Judd F, Spittal M 2019, 'Does legislative change affect the use and duration of compulsory treatment orders?', *Australian and New Zealand Journal of Psychiatry*, vol. 53, no. 5, pp. 433–440.

Table 11: Average duration (days) of a period of compulsory treatment by cohort, 2015–16 to 2019–20

Population	2015 –16	2016 –17	2017 –18	2018 –19	2019 –20
Adult	59.8	64.5	76.7	75.7	83.1
Aged	47.8	50.5	61.4	66.1	69.7
CAMHS	25.4	23.8	23.5	25.3	24.7
Forensic	72.1	79.5	87.3	91.5	100.6
Specialist	36.9	39.7	49.6	54.0	61.4
Total	59.3	64.1	76.6	75.6	82.9

Seclusion and restraint

Seclusion and restraint are intrusive practices that should only be used after all possible less restrictive options have been tried or considered and have been found to be unsuitable. There is a strong emphasis on the accurate recording of restrictive interventions by services, as part of good clinical governance.

Data on seclusion is well established, but data on restraint is continuing to develop. Every piece of data reflects a person's experience of seclusion and restraint, which can be a traumatic event for them. Public reporting enables services to review their individual results against state and national rates and those for like services. This reporting, and regular discussion between services and the Office of the Chief Psychiatrist and the Office of the Chief Mental Health Nurse about their results, supports service reform, quality improvement and better experiences of mental health services.

The rate of seclusion rose to 9.6 episodes per 1,000 occupied bed days in 2019–20, from a rate of 8.5 in 2018–19 (Table 12). This rate was across all services, which masks the frequency of the intervention with different consumer groups. It is rare for an aged person or a person admitted to a specialist service such as a Parent and Infant Unit to be secluded. Consumers with a forensic background are secluded at a higher rate, and for this group the rate was 33.0 per 1,000 occupied bed days. This year the rate for children and young people increased to 14.4. This result is affected by outlier data in a small population size. This is under review by the Office of the Chief Psychiatrist.

Work is underway with all services to reduce the use of restrictive interventions, including work with CAMHS. Over the past 10 years, the overall trend for adults, older people and specialist consumers is a decreasing seclusion rate. Results for CAMHS and forensic services are trending upwards.

Some consumers with a forensic background present with behaviours of concern. Thomas Embling Hospital continued a substantial effort to reduce the use of restrictive interventions during 2019–20, developing tailored behavioural programs and intensifying staffing efforts.

The average duration of seclusion has decreased from 20.0 hours in 2018–19 to a length of 13.8 hours (Table 13). This figure includes consumers with a forensic background for whom the average duration of seclusion was 40.5 hours. Nonetheless, this amount of time is half the duration of 2018–19, when the average duration was 81.4 hours. The corresponding figure for adults was 6.0 hours, continuing a downward trend from the 2016–17 level of 9.6 hours. For children and young people, the average duration of seclusion increased substantially this year to 3.2 hours from 1.0 hour the previous year. This increase relates to the duration of seclusion episodes for young people aged from 18 to 24 included in this category.

The bodily restraint rate reduced this year from 25.8 to 20.7 per 1,000 occupied bed days. The rate varied from 0.8 for specialist consumers to 90.3 per 1,000 occupied bed days for consumers with a forensic background, reducing from 162.1 in 2018–19. The average duration of restraint rose to 18 minutes in 2019–20, up from 12 minutes the previous year.

Table 12: Seclusion episodes per 1,000 occupied bed days, 2015–16 to 2019–20

Population	2015 –16	2016 –17	2017 –18	2018 –19	2019 –20
Adult	11.9	11.3	10.5	9.3	9.7
Aged	1.0	1.8	1.2	0.7	0.6
CAMHS	5.5	5.4	8.8	12.0	14.4
Forensic	13.1	28.7	34.3	26.8	33.0
Specialist	0.5	3.1	0.6	0.4	0.5
Total	9.2	9.9	9.7	8.5	9.6

Table 13: Average inpatient seclusion duration (hours), 2015–16 to 2019–20

Population	2015 –16	2016 –17	2017 –18	2018 –19	2019 –20
Adult	8.4	9.6	8.9	6.3	6.0
Aged	3.6	5.0	5.5	4.4	6.5
CAMHS	2.1	1.1	1.5	1.0	3.2
Forensic	99.9	52.2	48.5	81.4	40.5
Specialist	144.6	94.6	9.4	2.3	3.8
Total	16.4	17.4	16.7	20.0	13.8

Appendix 1: Mental health reporting based on the outcomes framework

The outcomes framework, and its indicators, measure and monitor how our programs and services are contributing to improved outcomes for people with mental illness. The framework is intended to be dynamic, but unfortunately this year it has not been possible to add new indicators or update data on all the existing indicators. The coronavirus (COVID-19) pandemic has affected the delivery of some surveys, and the capacity of departments and services to undertake new developmental work on indicators has been reduced.

Domain 1: Victorians have good mental health and wellbeing

Outcome 1: Victorians have good mental health and wellbeing at all ages and stages of life, and Outcome 2: The gap in mental health and wellbeing for at-risk groups is reduced

Data for outcomes 1 and 2 is drawn from the 2018 Victorian Population Health Survey (VPHS) and reflects the wellbeing of Victorians prior to the coronavirus (COVID-19) pandemic. About every three years, the survey runs a larger sample size of some 34,000 Victorians. This enables data analysis at the local government level and for some subpopulations. The 2017 survey was a large sample year; however, 2018 was not.

The VPHS data showed that levels of psychological distress vary among different population groups. Older people (65+ years of age) continued to report significantly lower levels (9.2 per cent) of high or very high psychological distress compared with the proportion in all adults (15.0 per cent). The proportion of adults with high or very high levels of psychological distress was not significantly different in people who spoke a language other than English at home (13.8 per cent) or rural Victorians (17.1 per cent). However, the proportion of adults with high or very high levels of psychological distress was significantly higher in the Aboriginal subpopulation compared with the proportion in all adults, at 30.3 per cent. This showed an increase of 5.3 per cent over 12 months; however, the difference was not statistically significant. Questions relating to LGBTIQ+ Victorians were not included in the 2018 VPHS survey.

Indicators for Outcome 1	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
Indicator						
1.1 Proportion of Victorian population with high or very high psychological distress (adults)	2018	n/a*	17.3%	14.8%	15.4%	15.0%
1.2 Proportion of Victorian population receiving clinical mental health care	2019–20	1.10%	1.07%	1.15%	1.16%	1.16%
1.3 Proportion of Victorian young people with positive psychological development†	2018	68.8%	n/a	67.3%	n/a	67.3%
1.4 Proportion of Victorian older persons (65 years or older) with high or very high psychological distress	2018	n/a*	10.8%	8.5%	10.0%	9.2%
1.5 Proportion of children at school entry at high risk of clinically significant problems related to behaviour and emotional wellbeing	2019	n/a	4.8%	4.9%	5.6%	6.7%

† The Victorian Student Health and Wellbeing Survey is carried out every two years.

* Due to a change in sampling methodology to include mobile phone users as well as people with landlines, only four years of data from the VPHS are available. Direct comparisons of this data with previous years cannot accurately be made.

Indicators for Outcome 2	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
Indicator						
2.1 Proportion of Victorian population who speak a language other than English at home with high or very high psychological distress (adults)	2018	n/a*	18.0%	17.2%	17.3%	13.8%
2.2 Proportion of Victorian rural population with high or very high psychological distress (adults)	2018	n/a*	15.9%	14.6%	16.3%	17.1%
2.3 Proportion of Victorian population who identify as LGBTI with high or very high psychological distress (adults)	2018	n/a	n/a	n/a	22.1%	Not available for 2018

* Due to a change in sampling methodology to include mobile phone users as well as people with landlines, only four years of data from the VPHS are available. Direct comparisons of this data with previous years cannot accurately be made.

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

As discussed in section 3 of this report, outcome indicators relating to Aboriginal Victorians show that they continue to be over-represented in clinical mental health services. Aboriginal people form about 0.7 per cent of Victoria's population, yet the proportion of the Aboriginal population receiving clinical mental health care sits at 3.1 per cent and has been trending upward over the past five years. The proportion of Victorian Aboriginal children at school entry at high risk of clinically significant problems related to behaviour and emotional wellbeing reduced slightly this year to 18.5 per cent. Although the proportion for all Victorian children rose in 2019, at 6.7 per cent it is substantially lower than the proportion for Victorian Aboriginal children.[14]

Indicators for Outcome 3	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
Indicator						
3.1 Proportion of Victorian Aboriginal population who are receiving clinical mental health care)	2019–20	2.6%	2.7%	2.8%	2.9%	3.1%
3.2 Proportion of Victorian Aboriginal population with high or very high psychological distress	2018	n/a*	17.7%#	27.9%	25.0%	30.3%
3.3 Proportion of Victorian Aboriginal children at school entry at high risk of clinically significant problems related to behaviour and emotional wellbeing	2019	n/a	15.6%	14.4%	19.0%	18.5%

* Due to a change in sampling methodology to include mobile phone users as well as people with landlines, only four years of data from the VPHS are available. Direct comparisons of this data with previous years cannot accurately be made.

\# The 2015 and 2016 estimates of high or very high psychological distress for Aboriginal Victorians have a relative standard error between 2 and 50 per cent and should be used with caution. The estimates from 2015 to 2018 are not significantly different from each other, even though the point estimates appear to show large differences. This is because of the small sample size of the Aboriginal population in the statewide surveys in 2015, 2016 and 2018.

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

Outcome 4: The rate of suicide is reduced

Data for this indicator is drawn from the Australian Bureau of Statistics *Causes of death* publication. There has been a revision of Victoria's suicide data for 2019 and previous years in this report. Changes made in the registration system at the Victorian Registry of Births, Deaths and Marriages caused under-reporting of some deaths in the 2018 edition of *Causes of death*.

There has been a slight increase in the suicide rate for Victoria in 2019, with a rate of 10.7 deaths (per 100,000) compared to 10.4 in 2018. Victoria's age-standardised rate is the lowest of any state or territory in Australia and is lower than the national rate of 12.9. Victoria's rate has been fairly stable over the last several years, sitting in the range 10.1-11.1 per 100,000 population. There has been heightened concern about suicide with the coronavirus (COVID-19) pandemic. Data released by the State Coroner indicates that the year-to-date number of suicide deaths in Victoria at the end of September 2020 is at a very similar level to the same period in 2019.

Indicators for Outcome 4	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
Indicator						
4.1 Victoria's rate of deaths from suicide per 100,000	2019	11.1	10.1	11.0	10.4	10.7

Domain 2: Victorians promote mental health for all ages and stages of life

Outcome 5: Victorians with mental illness have good physical health and wellbeing

Current indicators for physical health are tobacco use (as a risk factor) and type 2 diabetes (as a preventable illness). As discussed in section 3 of this report, results this year have improved; however, the data for this indicator draws on inpatient admission information for physical or mental ill health in registered consumers. Data quality for this year may therefore be affected by changed patterns of admission due to the coronavirus (COVID-19) pandemic.

Indicators for Outcome 5	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
Indicator						
5.1 Proportion of unique admitted clients who were discharged and used tobacco	2019–20	37.7%	38.2%	37.1%	36.5%	33.5%
5.2 Proportion of registered mental health clients with a type 2 diabetes diagnosis	2019–20	10.2%	9.8%	9.9%	10.0%	9.6%

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

Indicators yet to be developed.

Domain 3: Victorians with mental illness live fulfilling lives of their choosing, with or without symptoms of mental illness

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

The data analysis required to update the National Assessment Program – Literacy and Numeracy (NAPLAN)-related indicators could not be undertaken during 2020, therefore the results relating to children and young people with mental illness and NAPLAN in the outcomes framework are unchanged from last year's report.

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

Indicators for Outcome 7	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
Indicator						
7.1 Proportion of Year 3 students receiving clinical mental health care at or above the national minimum standard for reading	2018	n/a	n/a	68.1%	64.3%	59.5%
7.2 Proportion of Year 3 students receiving clinical mental health care at or above the national minimum standard for numeracy	2018	n/a	n/a	67.9%	66.0%	64.8%
7.3 Proportion of Year 9 students receiving clinical mental health care at or above the national minimum standard for reading	2018	n/a	n/a	59.2%	52.5%	49.1%
7.4 Proportion of Year 9 students receiving clinical mental health care at or above the national minimum standard for numeracy	2018	n/a	n/a	60.1%	56.3%	50.3%

Outcome 8: Victorians with mental illness participate in and contribute to the economy

Indicators yet to be developed.

Outcome 9: Victorians with mental illness have financial security

Indicators yet to be developed.

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

Indicators yet to be developed.

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

This indicator reports on the percentage of prisoners receiving a Psychiatric Risk Rating (P-rating) on entry to prison. A P-rating is not a clinical diagnosis but a rating applied to a prisoner to aid decisions about prisoner placement and to flag treatment requirements. P-ratings vary and range from a prisoner indicating that they have a history of mental illness to acute problems where intensive mental health treatment is required immediately. There has been a substantial drop this year in the percentage of prisoners receiving a P-rating on entry to prison, but it is not known at this stage whether this change relates to the pandemic.

Indicators for Outcome 11	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
Indicator						
11.1 Proportion of Victorian prison entrants who, at prison reception assessment, are allocated a psychiatric risk rating	2019–20	38.0%	36.9%	37.2%	36.2%	30.6%

Outcome 12: Victorians with mental illness have suitable and stable housing

This indicator draws on data from the Health of the Nation Outcome Scale 65+ and reflects the percentage of public mental health service consumers who are considered, at baseline rating, to have no significant problems with their accommodation as rated on scale 11 (Problems with living conditions). As discussed in section 3 of this report, the data suggests that although most clients are in stable housing, the proportion with unstable housing is large in comparison with the general population and increasing.

Indicators for Outcome 12	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
Indicator						
12.1 Proportion of registered clients living in stable housing	2019–20	81%	81%	80%	80%	79%

Domain 4: 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

Outcome 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

See explanation under Outcome 16.

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

See explanation under Outcome 16.

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

See explanation under Outcome 16.

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

Indicators for outcomes 13 to 16 draw on the public mental health service data reported in Appendix 2 and are discussed in greater detail in section 3 of this report. Many of these indicators have remained stable or only fluctuated slightly. This includes rates of preadmission contact and rates of readmission within 28 days. The rate of post-discharge follow-up within seven days is trending upwards. Follow-up soon after discharge enhances continuity of care at a time when consumers often require additional supports.

Clinically reported improved or stable outcomes for child and adolescent, adult and aged clients are also stable. Results for forensic and specialist clients have not been shown because the numbers are too small to be meaningful.

The proportion of compulsory inpatient admissions has increased. The duration of compulsory treatment has also increased, with the proportion of people receiving compulsory community treatment fairly stable, and this is discussed in detail in section 4 of this report.

Six indicators in this domain draw on data from the YES survey, which gathers the views of consumers of Victoria's clinical mental health services. As noted in section 3 of this report, the YES survey was not conducted as usual this year due to the coronavirus (COVID-19) pandemic. This data is therefore unchanged from last year's annual report.

Indicators for Outcome 13	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
Indicator						
13.1 Rate of preadmission contact	2019–20	57.2%	51.8%	59.4%	58.7%	60.6%
13.2 Rate of readmission within 28 days	2019–20	13.9%	13.4%	13.8%	13.3%	14.3%
13.3 Rate of post-discharge follow-up	2019–20	84.2%	77.6%	87.0%	88.0%	89.6%
13.4 New registered clients accessing public mental health services (no access in last five years)	2019–20	35.7%	36.6%	36.8%	35.9%	35.3%
13.5 Proportion of consumers reporting the effect the service had on their ability to manage their day-to-day life was very good (29.4%) or excellent (26.7%)	2018–19[*]	n/a	n/a	53.6%	55.2%	56.1%

* Data is from 2018–19 because the YES survey was not conducted in early 2020.

Indicators for Outcome 14	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
Indicator						
14.1 Proportion of registered clients experiencing stable or improved clinical outcomes (adults)	2019–20	91.1%	91.1%	91.2%	91.2%	91.1%
14.2 Proportion of registered clients experiencing stable or improved clinical outcomes (CAMHS)	2019–20	90.6%	91.3%	90.7%	91.0%	91.3%
14.3 Proportion of registered clients experiencing stable or improved clinical outcomes (aged persons)	2019–20	93.9%	92.3%	92.5%	93.6%	93.6%
14.4 Proportion of registered clients experiencing stable or improved clinical outcomes (forensic)[†]	2019–20	n/a	n/a	n/a	n/a	n/a
14.5 Proportion of registered clients experiencing stable or improved clinical outcomes (specialist)[†]	2019–20	n/a	n/a	n/a	n/a	n/a
14.6 Proportion of consumers who reported they usually (17.8%) or always (72.3%) had opportunities for family and carers to be involved in their treatment or care if they wanted	2018–19[*]	n/a	n/a	82.5%	83.8%	82.5%

† Sample size for forensic and specialist clients is too low for the data to be considered reliable.

* Data is from 2018–19 because the YES survey was not conducted in early 2020.

Indicators for Outcome 15	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
Indicator						
15.1 Proportion of consumers reporting their individuality and values were usually (17.8%) or always (72.3%) respected	2018–19*	n/a	n/a	88.0%	88.7%	90.1%
15.2 Proportion of people with a mental illness reporting a care plan was developed with them that considered all their needs as very good (23.3%) or excellent (40.1%)	2018–19*	n/a	n/a	63.0%	62.5%	63.4%

* Data is from 2018–19 as the YES survey was not conducted in early 2020.

Indicators for Outcome 16	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
Indicator						
16.1 Rate of seclusion episodes per 1,000 occupied bed days (inpatient)	2019–20	9.2	9.9	9.7	8.5	9.6
16.2 Rate of bodily restraint episodes per 1,000 occupied bed days (inpatient)	2019–20	25.7	19.0	22.6	25.8	20.7
16.3 Proportion of community cases with client on a treatment order	2019–20	11.1%	11.1%	11.4%	11.0%	11.3%
16.4 Proportion of inpatient admissions that are compulsory	2019–20	52.2%	51.4%	50.3%	49.7%	51.0%
16.5 Average duration of compulsory orders (days)	2019–20	59.3	64.1	76.6	75.6	82.9
16.6 Proportion of consumers who rated their experience of care with a service in the last three months as very good (27.7%) or excellent (37.8%)	2018–19*	n/a	n/a	65.1%	65.4%	65.5%
16.7 Proportion of consumers reporting the effect the service had on their overall wellbeing was very good (28.2%) or excellent (30.0%)	2018–19*	n/a	n/a	56.3%	57.8%	58.1%

* Data is from 2018–19 because the YES survey was not conducted in early 2020.

Appendix 2: Public mental health service data

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

Other collections from which this appendix draws include the Mental Health Establishments National Minimum Dataset 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 source: CMI/ODS, or as footnoted otherwise
Date extracted: 21 August 2020, or as footnoted otherwise
Date generated: 17 September 2020

Whole population					
Measure	**2015–16**	**2016–17**	**2017–18**	**2018–19**	**2019–20**
Total estimated bed-based population in Victoria (based on mental health area) ('000)*	6,117	6,228	6,339	6,452	6,570

People accessing mental health services					
Measure	**2015–16**	**2016–17**	**2017–18**	**2018–19**	**2019–20**
Mental health–related emergency department presentations	83,268	87,197	92,610	97,731	100,945
Emergency department presentations that were mental health–related (%)	5.06%	5.14%	5.27%	5.36%	5.77%

People accessing clinical mental health services						
Measure		**2015–16**	**2016–17**	**2017–18**	**2018–19**	**2019–20**
Consumers accessing clinical mental health services[†‡]		67,563	66,490	72,905	74,834	76,441
Proportion of population receiving clinical care (%)*		1.10%	1.07%	1.15%	1.16%	1.16%
Consumer location	**Area**	**2015–16**	**2016–17**	**2017–18**	**2018–19**	**2019–20**
	Metro	62.5%	64.4%	64.1%	64.0%	63.6%
Consumer bed-based location (%)	Rural	34.9%	32.7%	32.9%	32.7%	33.0%
	Unknown/ other	2.6%	3.0%	3.0%	3.3%	3.4%

Consumer demographics	Description	2015–16	2016–17	2017–18	2018–19	2019–20
Gender (%)	Female	50.4%	50.4%	50.3%	50.4%	50.5%
	Male	49.5%	49.5%	49.6%	49.4%	49.3%
	Other/ unknown	0.1%	0.1%	0.2%	0.2%	0.2%
Age group (%)	0–4	0.8%	0.8%	0.8%	0.8%	0.7%
	5–14	7.5%	8.2%	8.2%	8.5%	8.0%
	15–24	19.0%	19.1%	19.3%	19.6%	19.8%
	25–34	17.8%	17.9%	17.6%	18.0%	18.4%
	35–44	18.6%	18.2%	18.0%	17.3%	17.4%
	45–54	14.5%	14.6%	14.8%	15.1%	14.8%
	55–64	8.7%	8.8%	8.7%	8.8%	9.0%
	65–74	6.1%	6.1%	6.2%	6.1%	6.1%
	75–84	4.6%	4.3%	4.2%	4.0%	4.1%
	85–94	2.3%	1.9%	1.8%	1.7%	1.7%
	95+	0.2%	0.2%	0.2%	0.2%	0.2%
Consumers of culturally and linguistically diverse backgrounds (%)	Culturally and linguistically diverse	14.0%	13.6%	13.8%	13.8%	14.0%
Aboriginal or Torres Strait Islander status (%)	Indigenous	2.6%	2.7%	2.8%	2.9%	3.1%

Consumer demographics	Description	2015–16	2016–17	2017–18	2018–19	2019–20
Country of birth (top 10 non-English speaking) (%)	Italy	1.1%	1.0%	1.0%	0.9%	0.8%
	Vietnam	0.9%	0.8%	0.9%	0.8%	0.8%
	India	0.6%	0.7%	0.8%	0.8%	1.0%
	Greece	0.8%	0.8%	0.8%	0.7%	0.7%
	China (excludes SARs and Taiwan)	0.6%	0.6%	0.7%	0.7%	0.7%
	Sri Lanka	0.4%	0.5%	0.5%	0.5%	0.5%
	Turkey	0.4%	0.4%	0.4%	0.4%	0.4%
	Philippines	0.4%	0.4%	0.5%	0.4%	0.4%
	Sudan	0.3%	0.3%	0.4%	0.4%	0.4%
	Iran	0.4%	0.4%	0.4%	0.4%	0.4%
Preferred language other than English (top 10) (%)	Vietnamese	0.6%	0.5%	0.5%	0.5%	0.5%
	Italian	0.6%	0.5%	0.5%	0.4%	0.4%
	Greek	0.5%	0.4%	0.5%	0.4%	0.4%
	Arabic	0.3%	0.3%	0.3%	0.3%	0.4%
	Mandarin	0.3%	0.3%	0.3%	0.3%	0.4%
	Persian (excluding Dari)	0.2%	0.2%	0.2%	0.2%	0.2%
	Turkish	0.2%	0.2%	0.2%	0.2%	0.2%
	Macedonian	0.1%	0.1%	0.1%	0.2%	0.2%
	Cantonese	0.2%	0.1%	0.1%	0.1%	0.1%
	Spanish	0.1%	0.1%	0.1%	0.1%	0.1%

Treatment	Cohort	2015–16	2016–17	2017–18	2018–19	2019–20
Consumers accessing clinical mental health services[†‡^]	Adult	52,729	51,790	57,642	59,650	61,101
	Aged	8,065	7,373	8,279	8,096	8,304
	CAMHS	10,456	10,716	11,693	11,944	12,076
	Forensic	700	752	875	988	1,231
	Specialist	1,783	1,821	2,187	2,123	1,836
Diagnosis (%)	Schizophrenia, paranoia and acute psychotic disorders	23.9%	24.2%	23.3%	22.9%	22.7%
	Mood disorders	20.3%	20.2%	19.7%	19.1%	18.7%
	Stress and adjustment disorders	8.0%	8.5%	8.8%	9.1%	8.7%
	Personality disorders	5.5%	6.0%	6.3%	6.5%	6.6%
	Anxiety disorders	5.2%	5.3%	5.7%	5.8%	6.0%
	Substance abuse disorders	3.5%	3.5%	3.5%	3.3%	3.3%
	Organic disorders	3.0%	2.7%	2.6%	2.2%	2.1%
	Disorders of psychological development	1.6%	1.9%	1.9%	2.1%	2.0%
	Disorders of childhood and adolescence	1.9%	2.0%	1.9%	1.9%	1.9%
	Eating disorders	1.5%	1.5%	1.5%	1.6%	1.6%
	Other	1.1%	1.1%	1.0%	1.0%	1.0%
	Obsessive compulsive disorders	0.5%	0.5%	0.5%	0.5%	0.5%
	No mental health diagnosis recorded	23.9%	22.5%	23.3%	24.0%	24.7%
Referral source (newly referred consumers only) (%)	Acute health	20.7%	22.0%	21.5%	21.6%	22.0%
	Emergency department	21.2%	21.9%	24.2%	27.4%	26.1%
	General practitioner	12.5%	11.6%	11.5%	10.3%	9.9%
	Family	7.9%	7.9%	7.2%	6.5%	6.7%
	Client/self	4.7%	4.6%	4.7%	4.2%	4.7%
	Community health services	4.8%	4.7%	4.9%	4.0%	4.1%
	Police	4.0%	3.6%	3.7%	3.7%	3.7%
	Other/unknown	24.2%	23.8%	22.3%	22.4%	22.8%

Treatment	Cohort	2015–16	2016–17	2017–18	2018–19	2019–20
New consumers accessing services (no access in the prior 5 years)[‡] (%)	Total	35.7%	36.6%	36.8%	35.9%	35.3%
Consumers accessing services during each of the previous 5 years[‡] (%)	Total	14.3%	14.1%	13.5%	13.4%	13.5%

Service activity – bed-based	Setting	2015–16	2016–17	2017–18	2018–19	2019–20
Total number of separations (excluding same days)	Admitted – acute	23,664	24,334	26,124	26,692	26,654
	Admitted – non-acute	230	219	222	274	245
	Non-admitted – bed-based	240	239	247	205	224
	Non-admitted – subacute (CCU)	675	682	650	545	565
	Non-admitted – subacute (PARC)	3,257	3,406	3,459	3,547	3,362
	Total	**28,066**	**28,880**	**30,702**	**31,263**	**31,050**
Occupied bed days (including leave, excluding same days)	Admitted – acute	355,994	364,468	375,273	388,556	385,762
	Admitted – non-acute	71,105	71,470	74,409	78,148	81,575
	Non-admitted – bed-based	169,490	157,508	156,890	154,927	151,457
	Non-admitted – subacute (CCU)	105,371	104,625	105,072	104,852	103,634
	Non-admitted – subacute (PARC)	63,425	65,915	66,056	70,420	64,602
	Total	**765,387**	**763,988**	**777,703**	**796,905**	**787,032**

Service activity – bed-based	Population	2015–16	2016–17	2017–18	2018–19	2019–20
Bed occupancy rate (including leave, excluding same days)	Admitted – acute	88.5%	88.7%	88.6%	89.0%	86.4%
	Admitted – non-acute	92.1%	90.5%	85.7%	86.9%	89.9%
	Non-admitted – bed-based	88.4%	87.1%	87.4%	86.3%	84.1%
	Non-admitted – subacute (CCU)	79.1%	78.6%	80.1%	80.9%	80.3%
	Non-admitted – subacute (PARC)	77.8%	80.7%	76.1%	79.4%	72.6%
	Total	**86.4%**	**86.3%**	**85.7%**	**86.2%**	**84.2%**

Service activity – community	Population	2015–16	2016–17	2017–18	2018–19	2019–20
Total service contacts, by sector‡	Adult	1,400,505	1,189,771	1,791,497	1,863,612	1,952,053
	Aged	219,374	168,748	243,552	232,229	249,954
	CAMHS	275,042	278,792	329,318	335,907	352,576
	Forensic	17,998	17,265	19,648	23,797	23,709
	Specialist	22,369	21,189	22,863	25,629	28,702
	Total	**1,935,290**	**1,675,767**	**2,406,880**	**2,481,176**	**2,606,995**
Total service hours, by sector‡	Adult	665,771	585,321	909,940	980,488	1,039,862
	Aged	103,619	86,138	125,695	124,749	129,127
	CAMHS	171,290	180,015	217,911	225,274	231,008
	Forensic	10,597	10,652	12,189	16,403	15,244
	Specialist	20,701	19,778	20,916	24,648	24,749
	Total	**971,979**	**881,906**	**1,286,653**	**1,371,563**	**1,439,992**
Unregistered consumer service hours‡	**Total**	**15.5%**	**15.7%**	**15.6%**	**15.9%**	**15.5%**

Service performance	Population	2015–16	2016–17	2017–18	2018–19	2019–20
Re-admission to inpatient rate 28 day (lagged 1 month)	Adult	14.9%	14.3%	14.5%	13.7%	14.6%
	Aged	7.0%	6.8%	8.5%	7.6%	9.1%
	CAMHS	16.8%	17.6%	19.4%	19.9%	21.8%
	Forensic	10.0%	12.3%	7.8%	6.0%	7.5%
	Specialist	2.0%	2.0%	1.2%	1.9%	2.1%
	Total	**13.9%**	**13.4%**	**13.8%**	**13.3%**	**14.3%**
Pre-admission contact rate, all consumers[‡]	Adult	58.2%	53.1%	60.2%	59.7%	61.8%
	Aged	64.8%	54.0%	65.0%	65.7%	63.5%
	CAMHS	53.8%	49.5%	58.2%	57.4%	61.1%
	Forensic	18.6%	17.6%	21.6%	26.8%	16.0%
	Specialist	34.5%	30.6%	38.5%	30.9%	39.5%
	Total	**57.2%**	**51.8%**	**59.4%**	**58.7%**	**60.6%**
Post-discharge follow up rate (lagged seven days)[‡]	Adult	85.7%	79.3%	88.4%	89.2%	91.1%
	Aged	90.0%	74.6%	93.2%	94.5%	94.9%
	CAMHS	85.8%	83.9%	86.3%	87.4%	87.0%
	Forensic	36.8%	31.2%	26.4%	28.4%	28.6%
	Specialist	44.0%	41.1%	53.3%	60.9%	65.4%
	Total	**84.2%**	**77.6%**	**87.0%**	**88.0%**	**89.6%**
Trimmed average length of stay ≤ 35 days – inpatient	Adult	9.6	9.5	9.1	9.2	9.5
	Aged	16.0	15.7	15.5	15.1	15.4
	CAMHS	7.5	6.9	6.6	6.5	6.3
	Forensic	18.8	20.5	21.7	24.0	21.8
	Specialist	16.7	15.8	15.3	16.0	15.6
	Total	**10.1**	**10.0**	**9.6**	**9.6**	**9.8**

Compulsory treatment	Population	2015–16	2016–17	2017–18	2018–19	2019–20
Community cases with consumers on treatment order (%)	Adult	15.0%	14.6%	14.9%	14.4%	15.0%
	Aged	4.2%	4.5%	5.1%	5.3%	5.0%
	CAMHS	0.9%	1.1%	1.1%	1.1%	1.0%
	Forensic	15.0%	16.0%	13.2%	14.2%	13.7%
	Specialist	1.8%	2.2%	5.5%	3.5%	1.8%
	Total	**11.1%**	**11.1%**	**11.4%**	**11.0%**	**11.3%**
Compulsory admissions – inpatient (%)	Adult	57.8%	56.9%	55.3%	54.3%	56.0%
	Aged	46.0%	48.2%	46.8%	46.7%	50.0%
	CAMHS	16.6%	17.0%	20.2%	21.9%	20.5%
	Forensic	100.0%	100.0%	100.0%	100.0%	100.0%
	Specialist	11.3%	8.8%	8.9%	11.2%	9.4%
	Total	**52.2%**	**51.4%**	**50.3%**	**49.7%**	**51.0%**
The average duration (days) of a period of compulsory treatment	Total	59.3	64.1	76.6	75.6	82.9
Consumers on an order for more than 12 months (%)	Total	11.5%	12.4%	13.0%	12.9%	13.1%
Adult (18+) consumers who have an advance statement recorded (%)	Total	2.03%	2.38%	2.61%	2.85%	2.94%
Adult (18+) consumers who have a nominated person recorded (%)	Total	1.91%	2.40%	2.44%	2.60%	2.55%

Restrictive practice	Population	2015–16	2016–17	2017–18	2018–19	2019–20
Seclusion episodes per 1,000 occupied bed days – inpatient	Total	9.2	9.9	9.7	8.5	9.6
Average inpatient seclusion duration (hours)	Total	16.4	17.4	16.7	20.0	13.8
Bodily restraint episodes per 1,000 occupied bed days – inpatient	Total	25.7	19.0	22.6	25.8	20.7
Average inpatient bodily restraint duration (hours)	Total	0.6	0.4	0.3	0.2	0.3

Clinician-reported outcome	Population	2015–16	2016–17	2017–18	2018–19	2019–20
Community cases with significant improvement at case closure[‡] (%)	Adult	53.0%	53.3%	52.7%	51.6%	53.6%
	Aged	54.3%	54.5%	56.3%	59.0%	59.9%
	CAMHS	48.4%	48.1%	44.8%	43.9%	47.2%
	Forensic	**	**	**	**	**
	Specialist	24.3%	20.5%	24.1%	32.3%	61.9%
	Total	**52.2%**	**52.2%**	**51.6%**	**51.2%**	**53.4%**
Community cases stable at case closure[‡] (%)	Adult	38.1%	37.8%	38.5%	39.6%	37.5%
	Aged	39.6%	37.8%	36.2%	34.6%	33.7%
	CAMHS	42.2%	43.2%	45.9%	47.1%	44.1%
	Forensic	**	**	**	**	**
	Specialist	70.6%	75.0%	72.4%	67.1%	28.6%
	Total	**39.4%**	**39.2%**	**39.7%**	**40.4%**	**38.0%**
Community cases with significant deterioration at case closure[‡] (%)	Adult	8.9%	8.9%	8.9%	8.8%	9.0%
	Aged	6.1%	7.7%	7.5%	6.4%	6.4%
	CAMHS	9.4%	8.7%	9.3%	9.0%	8.8%
	Forensic	**	**	**	**	**
	Specialist	5.1%	4.5%	3.5%	0.6%	9.5%
	Total	**8.4%**	**8.6%**	**8.6%**	**8.4%**	**8.6%**

Funding		2015–16	2016–17	2017–18	2018–19	2019–20
Total output cost - actual (as published in Department of Health and Human Services Annual Reports) ($ million)#	Clinical mental health	1,141.9	1,258.2	1,372.7	1,542.1	1,650.0
	Mental health community support services	128.1	124.8	120.0	118.5	111.0

Service Inputs		2015–16	2016–17	2017–18	2018–19	2019–20
Specialist mental health beds (from policy and funding guidelines)	Admitted – acute	1,098	1,162	1,174	1,205	1,211
	Admitted – non-acute	212	244	244	250	250
	Admitted total	1,310	1,406	1,418	1,455	1,461
	Non-admitted – bed-based	525	525	495	495	495
	Non-admitted – subacute (CCU)	358	358	358	348	348
	Non-admitted – subacute (PARC)	230	230	250	250	252
	Non-admitted total	1,113	1,113	1,103	1,093	1,095
	Total	**2,423**	**2,519**	**2,521**	**2,548**	**2,556**
Full-time equivalent staff by workforce type§	Administrative and clerical staff	566	571	440	684	n/a
	Allied health and diagnostic professionals	1,420	1,500	1,590	1,753	n/a
	Carer workers	17	18	35	31	n/a
	Consumer workers	18	18	42	39	n/a
	Domestic staff	153	174	158	153	n/a
	Medical officers	812	848	871	956	n/a
	Nurses	3,999	4,180	4,260	4,727	n/a
	Other personal care staff	222	239	195	267	n/a

People accessing mental health community support services					
Measure	**2015–16**	**2016–17**	**2017–18**	**2018–19**	**2019–20**
Total consumers accessing mental health community support services#	12,354	10,051	8,605	5,732	5,818

Consumer demographics	**Description**	**2015–16**	**2016–17**	**2017–18**	**2018–19**	**2019–20**
Gender (%)	Female	55.4%	56.2%	57.3%	57.3%	54.3%
	Male	44.0%	43.2%	41.9%	41.8%	44.2%
	Other/ unknown	0.6%	0.6%	0.7%	0.8%	1.5%
Age group (%)	0–4	0.3%	0.3%	0.3%	0.2%	0.3%
	5–14	1.6%	1.7%	2.1%	3.4%	6.2%
	15–24	13.3%	13.6%	13.1%	13.9%	19.2%
	25–34	19.1%	19.3%	18.8%	17.2%	14.9%
	35–44	24.1%	23.3%	22.6%	20.6%	17.7%
	45–54	23.0%	23.5%	24.7%	25.3%	20.9%
	55–64	13.4%	14.0%	14.9%	16.3%	15.4%
	65–74	1.8%	1.9%	1.9%	2.6%	4.5%
	75–84	0.3%	0.3%	0.3%	0.4%	0.8%
	85–94	0.0%	0.0%	0.0%	0.0%	0.0%
	95+	2.5%	1.6%	0.9%	0.0%	0.1%
	Unknown	0.6%	0.5%	0.5%	0.0%	0.0%
Aboriginal or Torres Strait Islander (%)	Indigenous	2.2%	2.3%	1.9%	2.2%	2.8%
Culturally and linguistically diverse status (%)	Yes	4.4%	4.3%	3.9%	4.8%	5.4%

Service activity	2015–16	2016–17	2017–18	2018–19	2019–20
Community service units	790,213	767,261	635,040	338,835	128,007
Bed-based rehabilitation bed days	78,456	82,322	81,435	62,417	51,029

Service Inputs	Population	2015–16	2016–17	2017–18	2018–19	2019–20
Bed-based rehabilitation beds	Other***	101	101	102	22	0
	Youth	159	159	159	159	159
	Total	260	260	261	181	159

Notes and annotations

Data in this report exclude Albury New South Wales.

* Population estimate is based on *Victoria in Future 2016* estimated bed-based population at 30 June.

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

^ Note that the number of CYMHS consumers reported in *Victoria's mental health services annual report 2018–19* was inflated by the categorisation of a subcentre of one rural area mental health service as a CYMHS, when in fact the services were provided to a non-age specific target population and were predominantly adult services. It should also be noted that this number refers to consumers accessing CYMHS services. Each service is classified based on the service or funded program type and not the age of the consumer.

‡ 2015–16 and 2016–17 data were affected by industrial activity, impacting the collection of non-clinical and administrative data and recording of ambulatory mental health service activity and consumer outcome measures. This industrial activity began in May 2016 and was resolved by February 2017. Affected data reported during this period should be interpreted with caution.

§ Sourced from the Mental Health Establishments National Minimum Dataset.

Impacted by the reduction in mental health community support services progressively transferring to the National Disability Insurance Scheme (NDIS).

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

*** Bed-based rehabilitation beds transitioned to the NDIS during 2018–19 and 2019–20.

n/a: No data available for this period.

Note that some data may not sum due to rounding.

Appendix 3: Victoria's public mental health system

Victoria's clinical mental health service system

Area-based clinical services[15]

Child and adolescent services/child and youth services[16]

- Acute inpatient services
- Autism assessment
- Consultation and liaison psychiatry
- Continuing care

- Day programs
- Intensive mobile youth outreach services
- School-based early intervention programs

Adult services

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

- Continuing care
- Consultation and liaison psychiatry
- Community care units
- Prevention and recovery care (PARC)
- Early psychosis (16–25 years)
- Youth PARC (16–25 years)

Aged persons services (65+ years)

- Acute inpatient services
- Aged persons mental health bed-based services

- Aged persons mental health community teams

Statewide specialist services

- Aboriginal services
- Brain disorder services
- Dual diagnosis services

- Dual disability services
- Eating disorder services

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

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