

Victoria's Mental Health Services Annual Report 2021–22

OFFICIAL



Department
of Health

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 2021 to 30 June 2022.

Professor Euan M Wallace AM
Secretary
Department of Health

The Department of Health proudly acknowledges Victoria's Aboriginal communities and their rich culture and pays respect to their Elders past and present.

We acknowledge Aboriginal people as Australia's first peoples and as the Traditional Owners and custodians of the land and water on which we rely.

We recognise and value the ongoing contribution of Aboriginal people and communities to Victorian life and how this enriches us.

We embrace the spirit of reconciliation, working towards the equality of outcomes and ensuring an equal voice.

To receive this document in another format [email the Office of the Senior Executive Director](mailto:osed-mh-transformation@health.vic.gov.au) <osed-mh-transformation@health.vic.gov.au>.

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Except where otherwise indicated, the images in this document show models and illustrative settings only, and do not necessarily depict actual services, facilities or recipients of services.

In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people.

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Secretary's foreword

I am pleased to present our seventh 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 2021–22.

This year we have sought to meet our community's diverse mental health and wellbeing needs. Needs that have changed and grown as a result of both the COVID-19 pandemic and the 2019–20 bushfires that ravaged many communities immediately before the pandemic. In particular, local support services and Area Mental Health and Wellbeing Services in the north-east of Victoria and East Gippsland have been unwavering in their commitment to their communities as part of the recovery journey.

Speaking of journeys, this report also tells the story of our first steps on our improvement and reform journey, implementing the recommendations from the Royal Commission into Victoria's Mental Health System. With more than 70 recommendations handed down by the Royal Commission, work is already well underway on many of the recommendations.

The Victorian Government is committed to delivering every recommendation of the Royal Commission. The scale of change and reform is genuinely vast. It is a transformation odyssey that will be 10 years in the making, delivering a healthier future for all Victorians. A future built on a new mental health and wellbeing system that meets the needs of the Victorian community. And at central of all is this are people with lived experience – consumers, carers, family members and other supporters.

There is no care without the dedication and expertise of those who provide it. The clinicians, care professionals, and health services that work with such skill and commitment to provide positive mental health and wellbeing outcomes for so many. I am grateful for their engagement, knowledge sharing, and ongoing support for Victorians and for our reforms.

In December 2021 we launched *Victoria's mental health and wellbeing workforce strategy 2021–2024*, a coordinated approach to delivering and supporting a modern mental health workforce, diverse and multidisciplinary, and with the right skills to enable reform and best possible care.

My deep thanks to everyone who has worked with and supported the mental health and wellbeing of Victorians in 2021–22. I am very much looking forward to our shared achievements in the coming year.

Professor Euan M Wallace AM

Secretary

Department of Health

The year at a glance



81,476
registered consumers



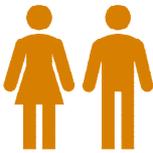
52.9%
women or girls



13,145
child and adolescent
consumers



33.4%
live in rural areas



64,708
adult consumers



\$2.18 billion
clinical services



8,457
aged consumers



\$174 million
mental health community
support services



1,902
forensic consumers



3,953
specialist consumers

Data source: CMI/ODS. Date extracted: 12 August 2022

1. A new approach to mental health and wellbeing

The Royal Commission into Victoria's Mental Health System was established in February 2019 after the Victorian Government recognised the system was failing to support people living with mental illness or psychological distress, families, carers and supporters, as well as those working in the system.

The Royal Commission released an interim report in November 2019, which made nine recommendations as the first steps to reforming Victoria's mental health system. The Royal Commission's final report was tabled in the Victorian Parliament on 2 March 2021, outlining 65 recommendations in addition to the nine interim report recommendations. The Victorian Government has committed to implementing all recommendations.

Transformation will not happen overnight – it's a 10-year reform agenda. Working in partnership with people with lived experience of mental health challenges and/or psychological distress and their families, carers and supporters is at the heart of this once-in-a-generation reform. It is critical to achieving better experiences and outcomes for Victorians.

Mental health transformation

The release of the Royal Commission's final report was a major milestone on the path to completely transforming Victoria's mental health system. The future mental health and wellbeing system will provide people with dependable access to services when and where it will make the most difference. It will be a system where people receive the care they need early, and in their community.

The reform program will be delivered over three major stages, with phase 1 delivered by the end of 2022. The reform is centred on transformational change, with a vision for a system where mental health and wellbeing treatment, care and support are provided in the community, hospitals and other residential settings.

These reforms aim to rebalance the system. More services will be delivered in community settings and extend beyond a health response to a more holistic approach to good mental health and wellbeing. The Royal Commission's final report identifies three capabilities that underpin the mindset shift that is central to reform – embedding lived and living experience, Aboriginal self-determination and cultural safety, and the use of inclusive and participatory approaches.

- **Lived and living experience** is at the heart of structures, processes, capabilities and workforces inside government and across the sector.
- **Aboriginal self-determination** is embedded and visible in the transfer of decision-making power, authority and control to Aboriginal communities. **Cultural safety** is creating an environment that is safe for all Aboriginal and Torres Strait Islander people.
- **Inclusive and participatory approaches** are used to engage differently with partners and communities. They recognise the skills and experience of people, experts and local communities in knowing how to design and implement programs that involve them.

The Department of Health's approach to reform centres on the need to build adaptive mental health and alcohol and other drugs (AOD) systems that continue to evolve and learn over time. It ensures working in partnership with people with lived and living experience continues to be at the core of the reform.

The final report offered specific advice on how the reform activity should be implemented. This guidance gave the starting point for planning and staging the work and has informed the department's approach over the past year.

The sequencing and staging of the reforms consider:

- a balance between the pace and scale of reform and the urgency needed to deal with the depth of the problems in the existing mental health system
- the time required to build enough capacity and readiness for reform while also allowing for the evaluation and learning needed to adapt and scale up successful approaches
- taking a systemic approach to understanding how recommendations work in parallel and how all components of the redesigned system will fit together.

Spotlight: Human Centred Design Hub

The Human Centred Design Hub formed in 2021 to support the department's vision to design and deliver a new system alongside people with lived experience, families, carers and supporters, and communities. This vision requires moving from traditional approaches of informing and consultation to using participatory approaches of human-centred design, co-design and co-production.

Participatory approaches are about designing with, not for, people. They consist of methods and mindsets to solve problems within systems and services by co-creating and testing solutions that meet diverse needs. Importantly, these approaches centre on sharing power and decision making throughout the process, particularly with people who have lived and living experience within the mental health and AOD systems.

The hub is a small team of service designers who offer expertise and guidance to teams in using the participatory approaches of the hub, co-design and co-production across a broad range of mental health and AOD reform initiatives. They offer advice, hands-on support in delivering design work and opportunities for staff to build their capability and confidence through training and upskilling.

In the first 12 months, hub efforts focused on the following strategic priorities.

Working in partnership with people with lived and living experience

Internally, the hub models purposeful partnering with people with lived and living experience, working in close partnership with the Lived Experience Branch to put lived and living experience at the centre of reform initiatives.

Externally, the hub is creating strong connections with our partners in systems reform, including peak bodies such as the Victorian Mental Illness Awareness Council (VMIAC), Tandem and the Self Help Addiction Resource Centre. Together, we are building a shared understanding of participatory design approaches and new ways of working.

Strengthening and supporting reform initiatives

The hub strengthens and supports the reform program by providing expertise in participatory approaches so outputs and outcomes fully address the needs of the people we serve. Advisory services and support are being provided for more than 30 initiatives, from project scoping and planning, through to co-leading projects with members of the Lived Experience Branch and external suppliers.

'New, fresh, innovative ways of working and great way to share ideas – really appreciate the opportunity to work with the [hub].' – Initiative owner

Building individual, team and division-wide capability

A key focus is on building staff capabilities and confidence in using participatory approaches and championing an enabling culture for these methods and mindsets to thrive.

In the first half of 2022 the hub co-designed and co-presented with the Lived Experience Branch a series of Participatory Design Immersion sessions. These were delivered to more than 120 people, including participants from the:

- Department of Health
- Department of Justice and Community Services
- Department of Families, Fairness and Housing
- sector partners VMIAC, Tandem and the Self Help Addiction Resource Centre.

Following the success of the immersion, the hub has initiated a co-design community of practice, with the first meeting in June attracting more than 50 attendees. The community of practice will run monthly and provide opportunities for collaborative learning, knowledge sharing and skill building across the Mental Health and Wellbeing Division.

‘Thank you. I loved that it was co-designed and delivered with lived experience.’ – Immersion attendee

Significant progress has been made

One year after the delivering the final report, huge inroads have been made into reforming the state's mental health and wellbeing services.

The reform work is grouped around the following priority areas:

- a system with community at its core
- services for people's level of need
- good mental health where people live, work and learn
- supporting Victorians to experience their best mental health
- new system foundations
- leading research and innovation
- service planning and critical infrastructure.

Work has now begun on more than 90 per cent of the Royal Commission's recommendations. To lay the foundations for new mental health and wellbeing systems, the department:

- set up the Mental Health and Wellbeing Division in July 2021
- appointed Victoria's first Executive Director of Lived Experience in November 2021 – more work is underway to develop key roles across the mental health and wellbeing system for people with lived experience (recommendations 28 and 30)
- developed the *Victorian Collaborative Centre for Mental Health and Wellbeing Act 2021*, which was passed in the Victorian Parliament in November 2021 – recruitment of the centre's board began in early 2022 (interim report recommendation 1)
- released the *Mental health and wellbeing workforce strategy 2021–2024*, supported by investment in workforce initiatives (recommendation 57)
- announced Turning Point as the statewide service provider for integrated treatment, care and support for people with co-occurring mental illness and substance use or addiction in March 2022 (recommendations 35 and 36)

- appointed chairs of the eight new Interim Regional Bodies in March 2022, with recruitment for remaining membership positions to conclude later in 2022 (recommendation 4.1)
- opened two new scholarship programs in April 2022, supporting 50 postgraduate scholarships for social workers, occupational therapists and psychologists working in state-funded mental health services, and up to 20 postgraduate scholarships for AOD practitioners working in state-funded AOD services. The Lived and Living Experience Workforces Tertiary Scholarship Program supports service management and leadership skill development for lived and living experience workers (recommendation 57 and interim report recommendations 6 and 7)
- signed the *National mental health and suicide prevention agreement* in April 2022 (recommendation 50)
- embarked on repealing and replacing the *Mental Health Act 2014*, with the Mental Health and Wellbeing Bill introduced to the Victorian Parliament in June 2022 (recommendation 42).

Alongside foundational reforms, the department has progressed work to deliver new and expanded mental health services by:

- appointing providers for the first six Local Adult and Older Adult Mental Health and Wellbeing Services, which will offer people the mental health care and support they need much sooner and much closer to their families and communities (recommendation 3.2a)
- working to appoint lead providers for three new hubs for infants, children and families seeking mental health and wellbeing support (recommendation 19.3)
- opening a Youth Prevention and Recovery Care (YPARC) unit and the first Child and Youth Hospital Outreach Post-suicidal after Engagement (HOPE) service at Orygen in Parkville in April 2022 (recommendation 21 and interim report recommendation 3)
- launching the new Centre of Excellence for Aboriginal Social and Emotional Wellbeing – the Balit Durn Burn Centre – in May 2022 (recommendation 33 and interim report recommendation 4)
- announcing a new statewide Specialist Women's Mental Health Service in December 2021, which will offer 35 public mental health beds in private settings, in a partnership between Ramsay Health Care, Alfred Health and Goulburn Valley Health (interim report recommendation 2).

Delivered milestones include the following:

- The first subacute family admissions centre will open in 2022, delivering residential mental health and wellbeing treatment to children under 11 in an environment that allows them to stay with and be supported by their families (recommendation 19).
- Investment has been provided for 22 reformed Adult and Older Adult Area Mental Health and Wellbeing Services. Funding has also been provided for dedicated services to support families through 13 new Infant, Child and Youth Area Mental Health and Wellbeing Services (recommendation 3).
- Construction began on a new 22-bed acute mental health facility at the Royal Melbourne Hospital (interim report recommendation 2).

It will take time to deliver on this bold reform vision. It will also take ongoing action, effort and commitment. The department is working closely with the community, the sector and people with lived and living experience to make the Royal Commission's vision a reality.

Spotlight: Orygen YPARC, Parkville

Victoria's fourth YPARC facility opened in Parkville on 5 April 2022. The 20-bed facility will provide care for around 200 young Victorians every year.

The Parkville YPARC service is located alongside Orygen, the National Centre for Excellence in Youth Mental Health. Being close to the Royal Melbourne Hospital ensures young people have easy access to other support services and there is easy access to transport links for visiting friends and family.

Delivering YPARC services to all regions of Victoria is a key Royal Commission recommendation. YPARCs provide flexible, around-the-clock clinical care for young people aged 16 to 25 years. They reduce pressure on hospital beds by providing early intervention care to prevent admission, or as a step down after hospital treatment before going home.

The Parkville YPARC facility has been co-designed with young people and their families and carers to create a safe, welcoming and therapeutic environment. The home-like facility has 20 private bedrooms with ensuite bathrooms. The communal kitchen, dining and living areas, breakout spaces and garden are designed to promote recovery, support family visits, and encourage young people to continue socialising while receiving education.



Parkville YPARC exterior



Parkville YPARC kitchen

Investing in mental health and wellbeing reform

The 2021–22 Victorian State Budget invested a record \$3.8 billion to create a mental health and wellbeing system that offers holistic treatment, care and support to all Victorians. This investment builds on the \$869 million investment from the 2020–21 State Budget.

The 2021–22 State Budget focused on funding for mental health services to provide greater clinical care and community support services to Victorians in need. This is the start of a 10-year journey and a commitment to long-term mental health reform that will benefit Victorians for generations to come.

Some of the highlights in the 2021–22 State Budget include:

- \$264 million for new local services for adults and older adults, supporting people in their communities
- \$954 million to reform area services to better support the mental health and wellbeing of adults and older adults
- \$196 million to support the mental health and wellbeing of infants, children and families
- \$370 million for new models of care for bed-based services that are safe and compassionate
- \$266 million for supporting the mental health and wellbeing of young people
- \$173 million to facilitate government and community-wide suicide prevention and response efforts
- \$218 million for mental health reform in education, setting up children and young people to thrive
- \$116 million to support Aboriginal social and emotional wellbeing
- \$206 million to enable the mental health and wellbeing workforce to deliver a reformed system
- \$350 million to expand bed-based forensic mental health services at Thomas Embling Hospital in Fairfield
- \$141 million to expand mental health treatment options for Victoria's youth.

Lived and living experience

The Department of Health set up the Mental Health and Wellbeing Division in July 2021. This includes a Lived Experience Branch, which employs lived experience expertise to guide the reforms. Early focus has included building partnerships between the department and the mental health and AOD sectors and their workforces, and people with lived and living experience.

The department has also increased funding to boost the capacity of Victoria's mental health peak bodies – VMIAC, Tandem and Mental Health Victoria – in recognition of their central role in advocacy and support for mental health consumers, families, carers and supporters.

The Lived Experience Branch supports the Mental Health and Wellbeing Division in co-design processes and transformations required to enable genuine lived experience partnership and collaboration across the reforms.

Embedding lived and living experience

The Lived and Living Experience Advisory Hub in the Lived Experience Branch provides strategic lived and living experience advice to executives and staff across the Mental Health and Wellbeing Division and more broadly to the department and government. This includes helping to deliver policies and programs related to the lived or living experiences of mental health challenges or psychological distress, substance use or addiction. The advisory hub is a critical part of the transformation agenda. By providing lived experience perspectives across the reform, the hub

ensures the views of consumers, families, carers and supporters in both mental health and AOD are central to the design, implementation and delivery of mental health and AOD services.

In 2021–22 the hub has worked across various reform projects and recommendations. Significant examples showing the hub's impact include the following:

- The Royal Commission recommended supporting good mental health and wellbeing and monitoring and improving mental health and wellbeing service provision (recommendations 1 and 49). The hub's advice on required system changes and guidance on the processes of partnering with people with lived and living experience enabled the project team to recruit diverse people with lived and living experience for project work and translate and collate insights to inform the draft framework.
- The Royal Commission recommended improving outcomes for people living with mental illness and substance use or addiction (recommendation 35). The hub's guidance and linkages within the AOD sector enabled the project team to swiftly carry out recruitment and interviewing of people with lived and living experience and collate and translate findings to inform the integrated treatment care and support guidelines, published in July 2022.
- The Royal Commission recommended setting up a Victorian Collaborative Centre for Mental Health and Wellbeing (interim report recommendation 1). The hub has supported:
 - recruitment and orientation processes for the centre's board and interim executive director
 - development of the pre-design report for the board in conjunction with the department-led project team
 - structure and staffing plans for the centre, ensuring perspectives of people with lived and living experience were central.

Lived experience policy

The Lived Experience Branch also develops and implements systemic and operational policy to enable leadership and engagement of people with lived and living experience across the mental health and wellbeing system. In 2021–22 its focus was on embedding people with lived and living experience across the Mental Health and Wellbeing Division. The branch holds key relationships with Victoria's lived and living experience peak bodies and works in partnership with them to build lived and living experience organisational and sector capacity. In addition, the team is responsible for specific recommendations from the Royal Commission that relate to supporting consumers, families, carers and supporters. Major projects the branch has undertaken include the following:

- Developing a new opt-out non-legal advocacy model and Mental Health Tribunal legal representation approach for people experiencing or at risk of compulsory treatment (recommendation 56), using consumer-driven consultation. The team undertook a series of consultations and extensive reviews of evidence from across the mental health sector to develop a detailed advocacy model.
- Working closely with Tandem and VMIAC to support the partnership between the department and peak bodies, including implementing and continuing to deliver the consumer and family carer Participation Registers. The registers have played an increasingly critical role in ensuring people with lived and living experience are engaged in all aspects of advancing the Royal Commission's recommendations.

Lived experience program design and management

The Lived Experience Branch is responsible for scoping, planning and delivering priority projects relating to lived experience services and entities. Two projects achieved key milestones in 2021–22:

- Victoria's first residential mental health service designed and delivered by people with lived experience (interim report recommendation 5). The service will provide a genuine alternative to an acute inpatient hospital admission by offering a new model of healing delivered in a home-like setting by a majority lived-experience workforce. In 2021 extensive co-design and co-evaluation of the process took place with consumers and families, carers and supporters to produce service principles and critical service elements. A co-designed commissioning framework and process has supported the appointment of a consortium led by a community mental health support service in partnership with an Area Mental Health Service to plan for service delivery.
- Working to set up eight family carer-led centres (recommendation 31(1)) to ensure the value of families, carers and supporters is promoted across the system. The department is working in partnership with Tandem to set up new family and carer-led centres in each of the eight regions across Victoria. A funded partnership with Tandem in early 2022 has allowed extensive co-design of the model with families, carers and supporters. Tandem and the department have worked in partnership to develop a commissioning framework to appoint providers for the centres in each of the eight regions, including participating in the decision-making process.

Spotlight: co-design initiatives for Child and Youth HOPE

Four new Child and Youth HOPE services have been set up at the Royal Children's Hospital, Monash Children's Hospital, Alfred Health and Orygen. The services offer support for children and young people at risk of suicide, and their families and carers.

A co-design process with children and young people and their families and carers was undertaken to develop the overarching *Child and youth service framework* and local service models.

Through this process, the health services and the department sought to understand:

- the experiences of young people and their carers and families when receiving mental health and practical support after self-harm, suicidal thoughts or a suicide attempt, including what has and has not worked, from their perspective
- the service expectations of young people, their carers and families for a new Child and Youth HOPE service, the core characteristics of the service and the experience they wish to have
- how a prototype of the service aligns with their expectations and how the early model needs to change before the service is piloted.

Co-planning

The department first engaged a co-design agency (Today) to co-plan the new Child and Youth HOPE service with young people, families, carers and the four health services. Today delivered service guidelines that outlined what people with lived experience most wanted and needed from the service.

All health services employed lived experience leads in their design teams, who worked alongside clinicians and other service providers. This required clinicians and managers to:

- broaden their perspectives
- practise sharing power
- balance the needs of each group
- create a safe and ethical approach to participation.

Co-design

The department engaged a co-design coach (Portable) to build co-design capability and to support each health service in using a consistent approach to designing their local Child and Youth HOPE service, in partnership with children, young people and their families and carers.

The four health services partnered with a broad range of people with experience of the mental health system. This included carers, young people, children, clinicians, external service providers (including education institutions and headspace) and health service stakeholders (including NDIS Leads, Aboriginal health services and refugee health services).

The co-design process also included lived experience representatives from groups who are disproportionately impacted by suicide such as Aboriginal people, trans and gender diverse people, LGBTIQ+ people, people with experience of family violence, people with experience of the justice system, and neurodivergent people.

Portable also partnered with Aboriginal consultancy Wan Yaari as cultural experts for the project. Wan Yaari provided coaching and consultation to the health service design teams, advising on facilitating co-design activities with young Aboriginal people in a culturally safe way, and helping to ensure models of care were culturally appropriate and responsive to the needs of Aboriginal and Torres Strait Islander young people and their families and carers.

Engagement

Stakeholder engagement

Transforming Victoria's mental health and wellbeing system requires partnership and collaboration with people with lived and living experience, health services, not-for-profit organisations, the workforce and the broader community. The department has adopted an engagement approach to support broad participation of partners and stakeholders in policy and program design and delivery.

The following two case studies offer insights into the engagement approaches of the many reform initiatives implemented over the past 12 months.

Spotlight: Mental Health and Wellbeing Act

The Royal Commission recommended that the Victorian Government replace the current Act with a new Mental Health and Wellbeing Act. The Royal Commission gave clear advice about many details of the new Act, based on extensive consultation.

The department's engagement process sought feedback where more input was needed to ensure the Royal Commission's recommendations could be effectively implemented in the new Act, and in practice. Feedback was provided through a survey on the public Engage Victoria website, email submissions and spoken and written input through targeted engagement sessions.

Through the engagement process, the department received feedback on the policy proposals from:

- consumers of mental health and wellbeing services
- carers, family members and supporters
- workers and service providers
- peak bodies representing consumers and carers, families or supporters
- peak bodies representing the sector
- academics and legal providers
- statutory entities.

The department received 283 submissions in response to the update and engagement paper. Of those, 170 were from individuals and 113 from organisations. The department attended 28 targeted engagement sessions and heard from more than 500 people through these sessions.

More consultation throughout the drafting period informed the Bill, including a four-week targeted engagement process during April and May 2022. During this period, 54 people and representative groups gave feedback on draft provisions of the Bill and identified barriers to implementation.

In June 2022 the Victorian Government introduced the new Mental Health and Wellbeing Bill into the Victorian Parliament. Once passed, the new Act will come into effect no later than 1 September 2023.

Spotlight: Workforce Strategy

Recommendation 7 of the Royal Commission's interim report sets out actions to strengthen and expand the workforce. These actions will build an evidence base to plan, project and respond to future needs and demand. The final report builds on these foundations, with recommendation 57 requiring the development, implementation and maintenance of a workforce strategy to create a workforce of the appropriate size, diversity and composition to deliver services to Victorians in the reformed system.

Engagement for developing *Victoria's Mental Health and Wellbeing Workforce Strategy 2021–2024* centred on sector expertise including frontline workers, people with lived experience (including consumer and carer peak bodies, VMIAC and Tandem) and system stewards such as other government departments. The Department of Health undertook several consultation activities, collectively reaching more than 2,200 people with representation from over 100 organisations. Activities included:

- a workforce forum
- six engagement workshops
- a public consultation process
- a workforce census and personnel survey.

The strategy launched in December 2021. It sets out priority activities to:

- address existing challenges in the workforce pipeline
- build attractive and rewarding workplaces
- pursue excellence in practice and outcomes.

The Victorian Government has committed to refreshing the strategy every two years to reflect the changing needs of the system, the community and the mental health and wellbeing workforce.

Mental Health Ministerial Advisory Committee

A new Mental Health Ministerial Advisory Committee was set up to offer strategic guidance to the Victorian Government on the mental health transformation agenda and advocate for system transformation, service improvement and better consumer outcomes.

The committee's role is to identify and provide advice on emerging issues and best practice nationally and internationally in mental health care, shaping the reforms and identifying opportunities for more collaboration and innovation.

The committee includes representatives of the Victorian Aboriginal Community Controlled Health Organisation, Transgender Victoria, Foundation House, Turning Point, VMIAC, Tandem, Thorne Harbour Health, the Victorian Multicultural Commission and other peak bodies.

Two subcommittees support the committee: the Interdisciplinary Clinical Advisory Group and the Lived Experience Advisory Group, which is to be replaced by Lived Experience Strategic Partnership in late 2022.

Interdisciplinary Clinical Advisory Group

The Interdisciplinary Clinical Advisory Group was set up to represent diverse sector views and technical expertise. It extends beyond traditional medical and nursing roles to include allied and other sector perspectives. The group plays a pivotal role in supporting the Mental Health Ministerial Advisory Committee by helping ensure the Royal Commission's recommendations are implemented across the clinical sector.

The group provides strategic guidance to the Victorian Government and to the ministerial advisory committee on the mental health reform agenda and provides leadership for system transformation, service improvement and better consumer outcomes.

Lived Experience Advisory Group

The Lived Experience Advisory Group is an advisory body developed to provide lived experience leadership, advice and strategic guidance on the mental health transformation agenda and advocate for system transformation, service improvement and better consumer and carer outcomes.

A new mental health and wellbeing Act

The Royal Commission recommended the Victorian Government replace the 2014 Mental Health Act with a new Mental Health and Wellbeing Act (recommendation 42) in 2022.

To meet this recommendation, the Mental Health and Wellbeing Bill was introduced to the Victorian Parliament on 21 June 2022. The new Act will lay the legal foundations to rebuild the mental health and wellbeing system.

The new Act will support the Royal Commission's vision for an integrated, contemporary and adaptable mental health and wellbeing system, aiming to:

- promote good mental health and wellbeing for all Victorians
- reset the legislative foundations for the mental health and wellbeing system
- support the delivery of services respond to the needs and preferences of Victorians
- set up new roles and entities recommended by the Royal Commission
- put the views, preferences and values of people living with mental illness or psychological distress, families, carers and supporters at the forefront of service design and delivery.

The legislation contains new rights-based objectives and principles to drive the highest attainable standard of mental health and wellbeing for Victorians.

Development of the Bill was informed by the Mental Health and Wellbeing Act Expert Advisory group, public engagement and ongoing consultation with key stakeholders with lived experience and clinical experience.

The Victorian Government has also commissioned an independent review of Victoria's compulsory treatment criteria and the alignment of the new Mental Health and Wellbeing Act with other

decision-making laws. The review panel, led by the Hon Justice Shane Marshall, AM, will begin its work in October 2022 and deliver a final report to the Minister for Mental Health by October 2023. The terms of reference for the review will be developed collaboratively by consumers and carers with lived experience, advocates and clinicians with relevant expertise.

This is the first stage of the legislative reform process. There will be another review of the new Mental Health and Wellbeing Act after its first five years of operation.

Mental health and wellbeing workforce strategy

The Royal Commission's final report recommended developing a mental health workforce strategy (recommendation 57) and for a refreshed strategy to be released every two years.

In December 2021 the Minister for Mental Health launched *Victoria's mental health and wellbeing workforce strategy 2021–2024*. This strategy sets out a coordinated approach to delivering and supporting a mental health workforce that is diverse and multidisciplinary, and with the right skills, composition and size to enable reform.

The strategy outlines four central and interrelated priorities to achieving this objective:

- building workforce supply
- building workforce skills, knowledge and capabilities
- supporting the safety, wellbeing and retention of the workforce
- building system enablers for excellence.

Investment of \$372 million in the 2022–23 State Budget will support the strategy's rollout. This includes a \$41 million immediate implementation package announced with the launch of the strategy. It builds on previous investment of \$51 million to support and grow the lived experience workforces in the 2021–22 and 2020–21 State Budgets.

Building supply

The \$372 million investment to implement the strategy will help deliver more than 1,500 new workers across the system. This includes more than 400 nurses, 600 allied health clinicians, 300 psychologists and 100 psychiatrists.

These new workers will be trained as mental health clinicians through supported learning pathways that include supervision supports and structures.

Building workforce skills, knowledge and capabilities

Alongside the release of the strategy, the department also released *Victoria's mental health and wellbeing workforce capability framework*, as per recommendation 58 of the Royal Commission's final report.

Rollout of the framework is underway, with the development of tools and resources in progress. A tailored advisory body is also being set up to support implementation.

More activity to complement the framework and further support capability includes:

- developing clinical supervision training for senior clinicians
- a service capability program to better support diverse communities
- planning work to set up a new Statewide Capability Entity.

Supporting the safety, wellbeing and retention of the workforce

The mental health and wellbeing workforce has faced significant challenges to their physical safety and psychological wellbeing. These issues have been exacerbated through the pandemic and have been identified in the strategy and Royal Commission as a key concern.

In 2021–22 the department partnered with WorkSafe to set up a new Mental Health Workforce Safety and Wellbeing Committee, per recommendation 59. This committee monitors workforce wellbeing, identifies risks and offers advice to government on wellbeing matters.

The department also launched a new annual wellbeing survey in 2021 to support the committee's role in tracking wellbeing issues. This survey will continue in 2022 and onwards to support this.

Building system enablers for excellence

Systemic architecture to enable reform will be critical to realising objectives for the mental health and wellbeing workforces. The release of the strategy is a critical milestone in supporting system reform.

In continuing its commitment to the spirit and recommendations of the Royal Commission, funding has been committed for the continued delivery and rollout of a series of the workforce strategy and future iterations, with the next strategy due for release in mid-2024. This iterative process will help the system to keep responding to evolving needs.

To further support system enablers, in 2021 the department also undertook its first annual workforce census. The census provides the first comprehensive snapshot and profile of the workforce across the clinical service. Results have been used to develop a department-led supply and demand model to estimate future system needs. This census will continue to ensure the strategy can accurately guide reform activity and meet the emerging needs of the mental health and wellbeing system.

Suicide Prevention and Response Office

The Royal Commission's final report recommended setting up a Suicide Prevention and Response Office within the Department of Health, led by a State Suicide Prevention and Response Adviser (recommendation 26.1).

Formally set up on 1 July 2022, the office strengthens Victoria's suicide prevention and response efforts in partnership with people with lived experience, communities and across government.

The office is responsible for implementing the Royal Commission's suicide prevention and response recommendations. It has a core set of functions that enable it to:

- coordinate and lead a system-based, community-wide and whole-of-government approach to suicide prevention and response
- employ and work with people with lived experience of suicidal behaviour, family members and carers, and people with lived experience of bereavement by suicide
- work closely with the Commonwealth Government to ensure suicide prevention and response efforts in Victoria are coordinated with, and complement, national approaches.

The Royal Commission also recommended government-wide governance structures to elevate suicide prevention and response across all decision making (recommendation 46.2.b). A Suicide Prevention and Response Victorian Secretaries' Board Subcommittee was set up in April 2022 to provide oversight and accountability for suicide prevention and response. The subcommittee includes senior executives from all Victorian Government departments, the Coroners Court of Victoria, WorkSafe Victoria and Victoria Police.

The office and the Suicide Prevention and Response Victorian Secretaries' Board Subcommittee will be supported by a Suicide Prevention Expert Advisory Committee. Comprised of a range of experts, including people with lived experience and sector representatives, the expert advisory committee will provide advice on evidence-informed approaches to suicide prevention and response.

The expert advisory committee will ensure:

- that lived experience knowledge and insights are integrated into government decision making
- diverse and intersectional perspectives of suicide prevention and response are valued and inform government policies and programs
- lived experience is central to the oversight, monitoring and evaluation of suicide prevention and response efforts.

Hospital Outreach Post-suicidal Engagement program

The HOPE initiative provides tailored, holistic and responsive outreach support for people following an attempted suicide, serious planning or intent. HOPE teams include peer support workers, wellbeing workers and mental health clinicians who support individuals and their personal support networks (family, friends and other carers) for up to three months, helping them to identify and build protective factors against suicide. Since it was set up in 2017, HOPE has supported more than 5,400 people in their recovery journeys.

HOPE was originally designed for adults aged 18 years or older. It offers much needed follow-up care that was often missing for those who presented to an emergency department (ED) with suicidal concerns.

Initially funded in six area mental health services across Victoria as part of the 2016–17 Victorian State Budget, the HOPE initiative was expanded to another six health services in 2019 as part of the 2018–19 State Budget.

Following an interim report recommendation from the Royal Commission (recommendation 3), work has progressed to improve and expand the program.

State Budget investment of \$27.3 million in 2020–21, followed by another \$159.9 million in 2021–22, has supported the statewide expansion of the HOPE program. HOPE is now operating in all 21 area mental health services, with outreach from regional HOPE teams to their subregional areas. Broader access is also being set up through enhanced referral pathways and extended service hours.

Since 2019 the Commonwealth and Victorian governments have matched investment to deliver eight additional aftercare services in Victoria using Beyond Blue's The Way Back Support Service. This agreement has expanded suicide aftercare to 29 sites across Victoria.

The Way Back Support Service is a non-clinical support service developed by Beyond Blue. It offers practical psychosocial support to people experiencing a suicidal crisis or who have attempted suicide for up to three months after discharge from hospital.

Child and Youth HOPE

The Royal Commission's interim report identified a gap in suicide prevention and response services for children and young people at risk of suicide and self-harm.

The Royal Commission recommended that the Victorian Government fund the Royal Children's Hospital, Monash Children's Hospital, Alfred Health and Orygen to work in partnership to create, deliver and evaluate the first phase of an aftercare service for children (under 12 years) and young

people (between 12 and 25 years) who have attempted suicide, have self-harmed or are at risk of suicide.

The 2021–22 State Budget provided \$16 million as part of the total \$159.9 million HOPE expansion investment to design and deliver the four Child and Youth HOPE services.

The Royal Commission stipulated that the new child and youth aftercare service be informed by the experiences of children and young people, as well as their families and carers, and by the program guidelines of the existing adult aftercare service (the HOPE program). In response, each health service set up a co-design project team, including people with lived experience, to design their service model (see Spotlight on [page 15](#)).

The new Child and Youth HOPE service is now running at all four sites. An evaluation is underway to inform further rollout of the service.

The expansion of both the Adult and Child and Youth HOPE programs means that Victorians of all ages now have access to intensive wraparound support for up to three months following a suicide attempt, serious planning or intent.

Other activities

Towards regional governance

The Royal Commission recommended a new governance approach to support mental health and wellbeing services to be planned and organised in a way that better responds to community needs. The new approach will be based around eight new regions, designed for planning and governance purposes.

New Regional Mental Health and Wellbeing Boards will drive this new approach, with a dedicated focus on local mental health and wellbeing needs.

Devolving the current centralised governance model is a significant change for the mental health system. In recognition of this, the Royal Commission recommended a gradual and coordinated process of change, with the Regional Boards to be set up by no later than the end of 2023. Each Regional Board will have at least one member with lived experience as a consumer and one member with lived experience as a family member or carer.

The setting up of eight Interim Regional Bodies represents the start of this shift. The Interim Regional Bodies will work alongside the department to lay the groundwork to support the setting up of their respective Regional Boards by:

- building relationships with stakeholders
- creating strong community participation processes
- providing advice to the department informed by local perspectives.

The Interim Regional Bodies were set up in March 2022 with the appointment of a chair to each of the eight regions through an open and competitive selection process. The chairs and department have worked together to identify key priorities, develop terms of reference and begin to recruit members for each of the Interim Regional Bodies, including people with lived experience.

The Victorian Government allocated \$5.2 million in the 2021–22 State Budget to implement this new approach to regional governance.

Establishing the Victorian Collaborative Centre for Mental Health and Wellbeing

The Royal Commission recommended setting up a new Victorian Collaborative Centre for Mental Health and Wellbeing to bring together people with lived experience, researchers and health professionals to lead critical improvements in the mental health system. The centre will lead cutting-edge research, provide treatment, care and support to adults and older adults, and serve as the 'engine room' for reform across the mental health sector and its workforce.

This financial year saw significant progress in setting up the centre. In November 2021 the Victorian Collaborative Centre for Mental Health and Wellbeing Bill 2021 passed in the Victorian Parliament. This legislation created the centre as a statutory entity and ensured representation of people with consumer and carer lived experiences on the skills-based board. It also set up an innovative co-director model of executive leadership.

In early 2022 the department opened an expression of interest process for appointments to the centre's board, who were formally appointed in July 2022. The new board is made up of diverse experience and expertise who will bring a range of professional and personal experiences.

A key focus of 2021–22 has been to ensure the centre's early priorities and its inaugural board are developed. This includes implementation and governance planning to enable smooth stand-up of its operations and conducting a pre-design study to investigate best practice spaces developed by national and international collaborative centres.

Transforming Adult and Older Adult Area Mental Health Services

The Royal Commission recommended setting up a responsive and integrated mental health and wellbeing system in which people receive most services locally and in the community throughout Victoria, close to their families, carers, supporters and networks.

The early implementation focus for Adults and Older Adults Area Mental Health and Wellbeing Services has been on creating the new age-based stream and identifying the foundational reform elements for transformation. Area Mental Health and Wellbeing Services (Area Services) have been using transformation plans to focus on a number of expanded functions including helping to set up the two age-based Area Service streams and expanding service delivery to address the new community core functions requirements.

An early reform priority for both the Adult and Older Adult and Infant, Child and Youth streams is for all Area Services to deliver wellbeing supports through partnerships with non-government organisations (NGOs). At the end of 2022, partnership models and parameters will be co-designed, and Area Services and NGOs will decide on their preferred partners and begin the process of partnering. These partnerships will enable NGOs to provide direct assistance to consumers who are not eligible for NDIS supports to address their wellbeing needs.

Also by the end of 2022 within Adult and Older Adult Area Services, an integrated mental health and wellbeing service stream for older Victorians will be set up. This will focus on improving mental health and wellbeing outcomes by ensuring older Victorians have access to the same mental health treatment, care and support as the rest of the adult population.

A significant amount of the reformed Area Services will be designed over the next two years, with bed-based reform occurring by 2026. The current focus is on building a picture of how to phase this reform to design connected reform packages that:

- incorporate workforce supply and capability considerations
- support services to balance current service delivery with future service vision.

Transforming Infant Child and Youth Mental Health Services

The Royal Commission's recommendations to reform the infant child and youth mental health and wellbeing system are far-reaching.

Reforms include creating a dedicated mental health and wellbeing system with streams of care for infants, children and their families (from birth to 11 years) and young people aged 12 to 25 years.

Area Services are developing plans that outline how they will reorganise themselves into the new age-based service streams and expand their service offering so it is more holistic and better meets the needs of consumers, families and carers. This reform is significant and will take time. The department will work alongside Area Services to build on existing services and expertise and implement the required changes, in line with the Royal Commission's expected 2026 delivery timeframe. As a priority, funding has been provided to allow these services to see more infants, children and young people, and to ensure they receive the right amount of treatment care and support they need to improve.

Reforms also include delivering targeted programs to improve access and create services tailored to the specific needs and preferences of these cohorts.

Work is underway to set up graduated tiers of parenting programs and parenting supports (recommendation 19.4, 19.5). These programs will build parents' skills and confidence to support children experiencing mental health and wellbeing challenges. The online parenting program is the first of these tiers that aim to address the gap between universally available parenting supports and more intensive parenting supports.

Establishing a second Family Admission Centre that will offer a short-stay residential service for highest intensity family supports (located in regional Victoria) is in the early design phase. It is on track for completion by 2026.

The Royal Commission recommended a YPARC unit be set up in each of the eight regions for young people aged 16 to 25 years. The expansion of these services will strengthen psychosocial recovery for young people and help them maintain their connection to community and education. Work has begun to set up five new YPARC units and refurbish three existing YPARC units. A common statewide service framework will support this work. The framework is being co-designed with young people and their families, carers and supporters, as well as service providers. It will be delivered by the end of 2022.

In line with recommendation 21.3, a formal review of the Youth Residential Rehabilitation program is being undertaken in consultation with young people and their families, carers and supporters. The program is a bed-based psychosocial rehabilitation service for young people aged 16 to 25 with a mental illness or mental health condition. The review will inform the role of the program in the context of the future youth bed-based service stream. An external consultant has been engaged to deliver the review by the end of 2022.

New statewide services under development include the Statewide Youth Forensic Mental Health Service (recommendation 37.4) and the Statewide Trauma Service (recommendation 23).

The expansion of specialist youth forensic mental health programs to a statewide model, including across the 13 Infant, Child and Youth Area Mental Health and Wellbeing Services by the end of 2024, is in its first design phase. The Department of Health is working with the Department of Justice and Community Safety and key stakeholders to design the new service and plan for building increased forensic specialist capacity in Area Services.

Aboriginal social and emotional wellbeing

The department is working in partnership with Aboriginal organisations and communities to ensure Aboriginal peoples living in Victoria can access safe, inclusive and respectful social and emotional wellbeing care and mental health services for themselves, their families and their communities.

Our shared vision is for a mental health and wellbeing system where Aboriginal self-determination is respected and upheld, and where the physical, emotional, social and spiritual aspects of health and wellbeing are seen and understood to be interconnected.

This shared vision is one where Aboriginal ways of knowing, being and doing are practised and valued, and where Aboriginal people have genuine choice in how and where they receive care.

The Royal Commission revealed the difficulties that many Aboriginal people have faced – and continue to face – in accessing appropriate treatment, care and support.

A significant number of people, communities and organisations contributed to the Royal Commission, sharing their stories and experiences in accessing services: what worked for them and what did not.

Drawing on these experiences and expertise, the Royal Commission agreed that social and emotional wellbeing supports and services should be holistic, culturally appropriate and healing-focused.

The Royal Commission's final report resulted in a record investment in Aboriginal social and emotional wellbeing. The Victorian State Budget 2021–22 included funding of \$116 million to support social and emotional wellbeing initiatives that are Aboriginal-led and ensure safe and respectful care in both mainstream and Aboriginal community-controlled organisations.

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and the Department of Health are working together to deliver on a number of the Royal Commission's recommendations.

Since the release of the Royal Commission's final report in March 2021, the department, in partnership with VACCHO has:

- launched the Aboriginal Social and Emotional Wellbeing Scholarship Program to upskill and grow the workforce – 13 scholarship recipients have now started their studies in mental health related disciplines, with more scholarships to be awarded later in 2022 and over the coming years
- set up the Balit Durn Durn Centre (the Aboriginal Social and Emotional Wellbeing Centre of Excellence), led by VACCHO.

The department has also provided continued funding to 22 Aboriginal Community Controlled Health Organisations (ACCHOs) to expand their Aboriginal social and emotional wellbeing teams. This will ensure they can deliver multidisciplinary community-based support. This funding will help create 50 new positions and secures the continued employment of another 16 existing positions in ACCHOs.

Funding was also allocated to support ACCHOs to bring in external health specialists to provide additional social and emotional wellbeing support. This enables ACCHOs to identify and respond to the needs and strengths of their communities and provide on-site care and support where community members feel safest.

Spotlight: Balit Durn Durn Centre opening

VACCHO launched the Balit Durn Durn Centre of Excellence in Aboriginal Social and Emotional Wellbeing (Balit Durn Durn Centre) at Federation Square in Melbourne on 17 May 2022.

The Balit Durn Durn Centre is a key outcome from the Royal Commission into Victoria's Mental Health System. The Royal Commission ensured, for the first time in history, that Aboriginal leaders, organisations, people, families, carers and communities were given the opportunity to have their voices and experiences included in a redesign of Victoria's mental health system.

Building on the strength and advocacy of Aboriginal communities and leaders, the centre is designed to foster innovation and improvement in social and emotional wellbeing practice, policy and research in ACCOs and in mainstream mental health services.

The centre's aim is to ensure there is 'no wrong door' for Aboriginal people seeking a culturally safe social and emotional wellbeing service, easily accessed via mainstream health providers and local ACCOs.

The centre draws on clinical, research and community expertise to coordinate best practice across services through:

- clinical, organisational and cultural governance planning and development
- workforce development – training, professional development activities and supporting the Aboriginal Social and Emotional Wellbeing scholarship program
- guidance and practical supports to build clinical effectiveness in assessment, diagnosis and treatment
- developing and circulating research and evidence for social and emotional wellbeing models and for convening associated regional and local communities of practice.

Balit Durn Durn means strong brain, mind, intellect and sense of self in the Wurundjeri/Woiwurrung language.

New Commonwealth bilateral agreement and national partnership

The Royal Commission recommended that the Victorian Government work with the Commonwealth Government and the National Cabinet Reform Committee to deliver a long-term, coordinated approach to investment and reform through the new *National mental health and suicide prevention agreement*. In early April 2022 Victoria endorsed the national agreement and finalised the associated *Bilateral mental health and suicide prevention agreement 2022–2026* between the Commonwealth and Victorian governments.

The national agreement sets out the shared intention of the Commonwealth and state and territory governments to work in partnership to deliver comprehensive, coordinated, consumer-focused and compassionate mental health and suicide prevention systems for all Australians. The national agreement will also:

- progress improvements in mental health supports and services for Australians of all ages
- improve data collection
- reduce gaps in the system of care
- expand and enhance the workforce including the peer workforce
- improve suicide prevention programs in all states and territories.

The associated bilateral agreement will ensure Victoria can work with the Commonwealth in an enduring and unified way to deliver landmark reforms and address critical workforce shortages. The bilateral agreement supports a range of key mental health reform initiatives in Victoria including:

- workforce growth and development
- improved data collection and sharing

- services to support the 'missing middle' – Infant Child and Family Hubs, enhanced headspace services, and Adult and Older Adult Local Mental Health and Wellbeing Services
- an expanded, improved and consistent approach to suicide prevention and response through universal access to follow-up care after a suicide attempt, trialling two Distress Brief Intervention program sites for adults experiencing psychological distress, and ensuring postvention support services are available and accessible to Victorians bereaved by suicide
- enhanced and consistent collection and reporting of perinatal mental health screening data
- improved integration and coordination of services through consistent approaches to intake, initial assessment and referral
- collaborative approaches to strengthen regional planning and commissioning of mental health and suicide prevention services.

Lived and living experience perspectives will inform the rollout of the bilateral agreement to enable person-centred care. It will ensure the needs of vulnerable populations groups are addressed and delivered in a culturally appropriate way.

Victoria's contribution to the bilateral agreement will total \$564.72 million for mental health supports and suicide prevention over five years, with a Commonwealth contribution of \$247.86 million.

2. Supporting Victorians through crisis

Over the course of the COVID-19 pandemic the Government has invested more than \$252 million¹ across a wide range of initiatives to ensure Victorians have access to the mental health and wellbeing supports they need.

Before the pandemic (from November 2019 to February 2020) eastern Victoria experienced horrific bushfires. More than 150 fires devastated 1.5 million hectares of land, tens of thousands of people were displaced or lost their homes and more than 60,000 people were evacuated in East Gippsland alone. A State of Disaster was declared in parts of Victoria that lasted 10 days. Of most concern were the lives lost and thousands of people traumatised by this natural disaster.

Given the significance of the bushfires, the Victorian Government allocated a range of rapid response supports including \$23.4 million to specifically support mental health issues in affected communities. The Commonwealth Government provided \$5 million to support Victoria's mental health and wellbeing initiatives through the Commonwealth's Community and Emergency Services Mental Health Program.

Mental health and wellbeing support during the COVID-19 pandemic

During 2021–22 the government funded a range of community services and initiatives to support the mental health and wellbeing of Victorians impacted by the COVID-19 pandemic. The following organisations received extra funding to meet an increase in calls to their helplines: Lifeline, Beyond Blue, On the Line Australia, Kids Helpline, Anxiety Recovery Centre Victoria and Perinatal Anxiety and Depression Australia.

The Partners In Wellbeing program was created in 2020 to target:

- people experiencing poor psychosocial health and mental ill health
- people who are homeless
- people experiencing societal disadvantage/vulnerability.

This program has provided support to more than 4,000 people with an telehealth option to access wellbeing support. Another expansion of this program delivered in partnership with the Department of Jobs Precincts and Regions has supported more than 1,000 small business owners with wellbeing support.² Partners In Wellbeing is delivered by the NGOs Neami National, EACH and Australian Community Support Organisation.

Recognising the particular impact on young people, the government has rolled out extra supports in response to the pandemic including:

- \$2.24 million for 'surge teams' of clinicians (matched by the Commonwealth Government) to the 13 Infant, Child and Youth Area Mental Health and Wellbeing Services to work in headspace centres to address waiting times
- \$1 million to expand the Triple P parenting programs, supporting more than 20,000 Victorian families whose children are facing anxiety

¹ Refer to the [Premier's website](https://www.premier.vic.gov.au/mental-health-support-through-and-beyond-pandemic) <<https://www.premier.vic.gov.au/mental-health-support-through-and-beyond-pandemic>>.

² Department of Health, data and information from agency reporting 2020 to 2022

- \$1.5 million to allow the Royal Children's Hospital, VicHealth and key partners to better support the most vulnerable groups of children and young people.

Mental health service system response to COVID-19

From early in the pandemic, there were signs that restrictive lockdowns were effective at reducing the spread of COVID-19, but demand also rose for mental health services.³ Over the past two years, the mental health system has reported extensive strain across systems and the workforce.

On 18 January 2022 a coordinated Pandemic Code Brown was implemented across all public metropolitan and major regional hospitals. This put in place a formal emergency management structure to make the best use of hospital resources as Victoria battled the global outbreak of the Omicron subvariant. This coordinated approach was necessary to help health services – including Ambulance Victoria – work together rather than in isolation, in the face of overwhelming demand. Mental health services worked in partnership, especially to coordinate bed management pressure across the system.

Extra supplies of rapid antigen tests and personal protective equipment were made available to community services including community-based mental health and wellbeing services. This ensured the workforce could continue to operate safely, reducing the spread of infection while the outbreak was having a very broad impact across the state.

Mental Health and Wellbeing Hubs

To make sure more Victorians have access to the mental health and wellbeing supports they need, in September 2021 the Victorian Government announced \$22 million to deliver fast-tracked, tailored care to Victorians who need it, reducing the burden on EDs. This included an investment of \$13.3 million to deliver 20 pop-up mental health and wellbeing hubs, which were operational within five weeks of being announced.

The hubs act as a welcoming 'front door' to the mental health system, providing support without any eligibility criteria. They allow referrals for any Victorian, regardless of age, and without the need for a GP referral. This ensures wellbeing support, such as counselling, is more accessible and offered closer to home.

The hubs leveraged the existing Early Intervention Psychosocial Response programs, due to their existing statewide platform, in consultation with services. NGOs deliver these programs in partnership with health services.

Thirty hubs are now operating across the state. They supported 2,269 Victorians during the first nine months of operation. The hubs can help people with a range of issues including lowered mood, anxiety, substance use or addiction, or distress. They also support people to address life stressors such as homelessness, financial difficulties and social isolation. With various ways to access support, including a helpline or webchat feature delivered by Partners In Wellbeing, people can walk in to any of the hubs and ask for help, or more information.

³ Refer to [Mental health services in Australia](https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-impact-of-covid-19) <<https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-impact-of-covid-19>>.

Spotlight: Mental Health and Wellbeing Hubs

The Mental Health and Wellbeing Hubs are an example of a service that has embraced the Royal Commission's principle for people with lived and living experience of mental illness to be central to delivering support.

Mellisa is a peer worker at the Star Health hub in St Kilda. As part of her role, she supported Brad through a difficult time. Mellisa visited the boarding house where Brad was living and, at first, he was sceptical and reluctant to accept the support he needed. Having someone who knew what he was going through, who has lived it themselves, made it easier for Brad to open up. With support from Mellisa, Brad moved to living in private rental accommodation. He also accessed psychiatric care and has been connected to dental health services.

That's what the Mental Health and Wellbeing Hubs can do – they connect Victorians to the wraparound services they need to improve their mental health and get back on track in all aspects of their lives.

Support to bushfire and drought-affected communities

In 2021–22 locally led initiatives continued to support individuals, families and communities impacted by the 2019–20 bushfires. Local support services and Area Services in the north-east of Victoria and East Gippsland have shown an unwavering commitment to their communities as part of the recovery journey.

In March 2020 the government announced \$23.4 million to support community resilience and provide mental health support services. Funding provided to support people's mental health and wellbeing throughout the COVID-19 pandemic boosted this investment.

The COVID-19 funding packages built on the \$23.4 million investment and ensured there was a range of counselling, telehealth sessions and a broad range of physical health and mental health and wellbeing services, in line with a local stepped care approach. The funding will continue in 2022–23 as the recommendations from the Royal Commission continue to be implemented.

In 2021–22 the program supported a range of local and statewide services including:

- Aboriginal co-ops supporting social and emotional wellbeing in Victoria's north-east and East Gippsland
- Mungabareena, which worked with Wangaratta Art Gallery to deliver the virtual reality film Bitja Wokka through the Spark Exhibition
- Mungabareena women's camps, bringing together multiple generations of women to share knowledge and to build connection
- Moodji in Orbost, which worked with local community members to propagate yam seeds, bring community members together through activities and support healing through art
- Corryong Health, to deliver a wide range of community engagement activities
- Walwa Bush Nursing Service, to deliver community engagements activities
- Albury Wodonga Health, delivering specialist mental health community outreach services
- Alpine Health and NESAY Youth Service, to provide counselling support to young people
- Mallacoota Medical Centre, to run a local teen drop-in clinic
- Surfing Victoria, to deliver mental health first aid through surf clubs
- Latrobe Regional Hospital, to deliver training and outreach to bush nursing centres, GPs, schools and health and community centres in East Gippsland
- Reclink Australia, using sport and recreation to build community connection

- Rural Health Connect's telepsychology platform, providing mental health GP referrals, no-gap psychological and financial counselling
- Triple P Parenting Support, providing face-to-face and online parent education
- the Resilience Project, to provide face-to-face support in Mallacoota primary and secondary school and Teen clinic, jointly with the local GP
- Phoenix Australia, to provide training and education to community members and mental health professionals
- Beyond Blue's New Access program, providing free, low-intensity cognitive behavioural therapy face-to-face in the north-east and via telehealth.

Spotlight: social prescription in far east Gippsland

Reclink activities have made a positive impact on increasing participants' mental health and wellbeing, particularly for some of the isolated older women in the community with a history of trauma, accommodation issues and other social stressors. Feedback from Reclink's free weekly art program included comments like, 'I desperately needed an outlet after the bushfires and COVID. The company and chitchat have been missing throughout COVID. I feel spoilt.'

A social prescription initiative, which is a collaboration between Reclink Australia and the Mallacoota Medical Centre, has been pivotal in far east Gippsland as part of the bushfire recovery journey after the Black Summer bushfires of 2019–20.

Dr Sara Renwick-Lau, Practice Principal of the Mallacoota Medical Centre, provides GP care in Mallacoota. Sara has helped coordination and deliver bushfire recovery services in Mallacoota since the Black Summer fires.

Reclink Australia is funded by the Department of Health as part of the Bushfire Recovery Response. Reclink is funded to deliver recreational opportunities with a focus on social inclusion and improving mental health outcomes within the Mallacoota and Cann Valley districts.

In relation to Reclink, Sara commented:

'Reclink is a perfectly formed social prescribing resource that has been unearthed through the bushfire recovery needs of the far east Gippsland communities of Mallacoota, Genoa and Cann River.

'Reclink staff understand and prioritise the important role of the Reclink program to not just create opportunities for activity but as a social prescribing resource for those with mental illness, trauma, social anxiety, social disconnection, chronic illness, limited financial resources and other barriers to social connection.

'The effectiveness of the Reclink programs in Mallacoota District and the Cann Valley lies in their long-term relationships, "boots on the ground" awareness of the local context as well as regular meetings and networking with larger agencies and also those providing local health care and programs.

'Through working with local health professionals, Reclink is able to provide the missing link for our unwell patients to access a path to their health and wellbeing as well as play an important role in the prevention of chronic physical and mental illness.'

Reclink ensured that the staff on the ground were local to the area, which supported a key aspect of the rollout of recreational programs; to collaborate with service agencies, particularly the Mallacoota Medical Centre.

Reclink's Eastern Victoria Manager Callista Cooper said:

'The Reclink staff were local to the community, had been through the bushfire and were in an advantaged position to have an understanding and insight into community needs and experience. We were able to network with local agencies and outside services through wellbeing recovery groups, and we had a vested interest in ensuring programs suited the needs of our community in collaboration with Dr Sara and her team, alongside other health and wellbeing professionals.

'Reclink created and delivered a weekly program with a range of activities including artistic journaling, stand-up paddle-boarding, a running group, boxing fitness and pop-up sports for children. Posters of the activities were advertised on the big screen in the Mallacoota Medical Centre waiting room, with the Mallacoota Medical Centre team referring patients into the program. Reclink also ensured all health and wellbeing services in the region had access to Reclink's program to ensure there were strong pathways for referral.

'Strong relationships and trust are required between agencies in a small community. Local networking with community groups and support agencies was important to be able to ensure that not only services were referring clients into the Reclink activities but Reclink staff could also refer participants to services that were available to locals. Reclink staff often found themselves as the first or a key point of connection for individuals in their recovery journey. These two-way pathways had significant outcomes for some impacted by the bushfires and the COVID pandemic.

'Social prescribing is an integrated model of care, built on trust, that links clinical care to supportive community-based programs or activities to improve a person's health and wellbeing.'

– by Callista Cooper, Sport and Recreation Manager – Regional East Victoria| Reclink Australia

3. Public Mental Health Services 2021–22

Key statistics for 2021–22:

Total service hours: 1,347,831
Emergency department presentations: 96,133

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
- the circumstances in which treatment is provided.

It also tells us about demand for, and use of, services. Key aspects of this data are included in the current outcomes framework (refer to Appendix 1), including data about the use of compulsory treatment and restrictive interventions.

The COVID-19 pandemic continues to affect Victorians, influencing and impacting the ways they seek support and access mental health services.

Measures taken to control the pandemic, such as restrictions on movement and activity, have helped save lives by preventing the spread of infectious disease. However, some of these measures, such as the closure of schools and limited access to friendship groups, can cause acute anxiety and stress in young people.⁴ Loneliness is a risk factor for mental ill health, as well as being distressing in its own right.⁵

In looking at clinical mental health data for the year, the effects of the pandemic remain evident but, for some measures, not as acute as seen in 2020–21. During lockdowns, 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 reduced in 2021–22 compared with the previous year. The reporting year began with restrictions in place in Victoria, which became more severe in August and remained in place for months, easing on 22 October 2021. Subsequently there were other outbreaks of COVID-19, resulting in more restrictions and service system impacts.

The Victorian healthcare system faced additional and extraordinary pressure due to the Omicron outbreak in early 2022. Hospital admissions surged, and there were severe workforce shortages across the system including acute care, community care, aged care and ambulance services. High demand and declining resource availability contributed to the department issuing a coordinated 'Pandemic Code Brown', triggering public hospitals to activate Code Brown plans on 19 January 2022.⁶ The Pandemic Code Brown was stood down on 14 February 2022.

⁴ Cowie H, Myers C-A 2021, 'The impact of the COVID-19 pandemic on the mental health and well-being of children and young people', *Children and Society* 35:62–74. Coronavirus (COVID-19) has caused unprecedented disruptions: in April 2020 schools were suspended nationwide in 188 countries – refer to Lee J 2020, 'Mental health effects of school closures during COVID-19', *The Lancet Child & Adolescent Health*, 4(6):421.

⁵ AIHW 2021, *The first year of COVID-19 in Australia: direct and indirect health effects*, Cat. No. PHE 287, AIHW, Canberra.

⁶ Department of Health 2022, Pandemic Code Brown to support hospitals. Retrieved 11 March 2022, <<https://www.premier.vic.gov.au/pandemic-code-brown-support-hospitals>>.

The total number of mental health ED presentations was lower than it had been the previous year, decreasing by 9.1 per cent. The proportion of total ED presentations that were mental health–related declined slightly (Table 1).

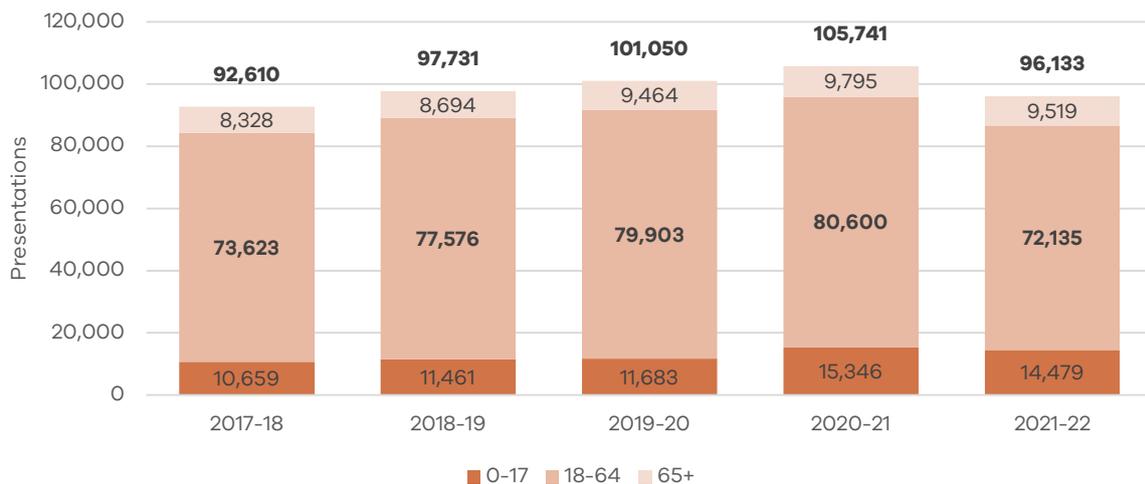
Table 1: Mental health–related ED presentations as a proportion of all ED presentations

Service setting	2017–18	2018–19	2019–20	2020–21	2021–22
18–64	7.64%	7.73%	8.15%	8.28%	7.08%
65+	2.18%	2.18%	2.40%	2.52%	2.44%
0–17	2.59%	2.72%	3.11%	4.10%	3.54%
Total	5.27%	5.36%	5.78%	6.09%	5.29%

In recent years the number of young people presenting to Victorian EDs with mental health concerns has steadily increased. Although some effects of the virus and its related restrictions continue to emerge, the overall impact is complex and not yet fully understood. The effect of the pandemic on young people can also be dynamic and outcomes can change quickly – for example, mental wellbeing and social connectedness when conditions change (such as introducing or easing restrictions).⁷

Compared with older age groups, young people have experienced high rates of psychological distress, loneliness, educational disruption, unemployment, housing stress and domestic violence, most notably during the first year of the pandemic.⁸ The number of mental health–related ED presentations among children and young people had been slowly increasing in recent years, with 2021–22 presentation rates 5.7 per cent lower than the recent peak seen in 2020–21. Presentations by adults and older people rose slightly but were similar to the levels of the previous year (Figure 1).

Figure 1: Emergency department presentations, by age, 2017–18 to 2021–22



Data source: VEMD

⁷ [COVID-19 and the impact on young people](https://www.aihw.gov.au/reports/children-youth/COVID-19-and-young-people) <https://www.aihw.gov.au/reports/children-youth/COVID-19-and-young-people>

⁸ Ibid.

Hospital admissions for mental health have also dropped this year, with a 4.1 per cent decrease in separations from acute inpatient units (Table 2) and a corresponding 3.5 per cent decrease in the number of occupied bed days. This could represent reduced demand for bed-based care as the needs of Victorians become less acute and can be effectively managed in the community.

Table 2: Mental health acute separations (excluding same days), 2017–18 to 2021–22

Setting	2017–18	2018–19	2019–20	2020–21	2021–22
Admitted – acute	26,124	26,693	26,660	26,913	25,812
Admitted – non-acute	222	274	245	263	259
Non-admitted – bed-based	247	205	229	182	181
Non-admitted – subacute (CCU)	650	545	565	622	556
Non-admitted – subacute (PARC)	3,460	3,547	3,374	3,675	3,792
Total	30,703	31,264	31,073	31,655	30,600

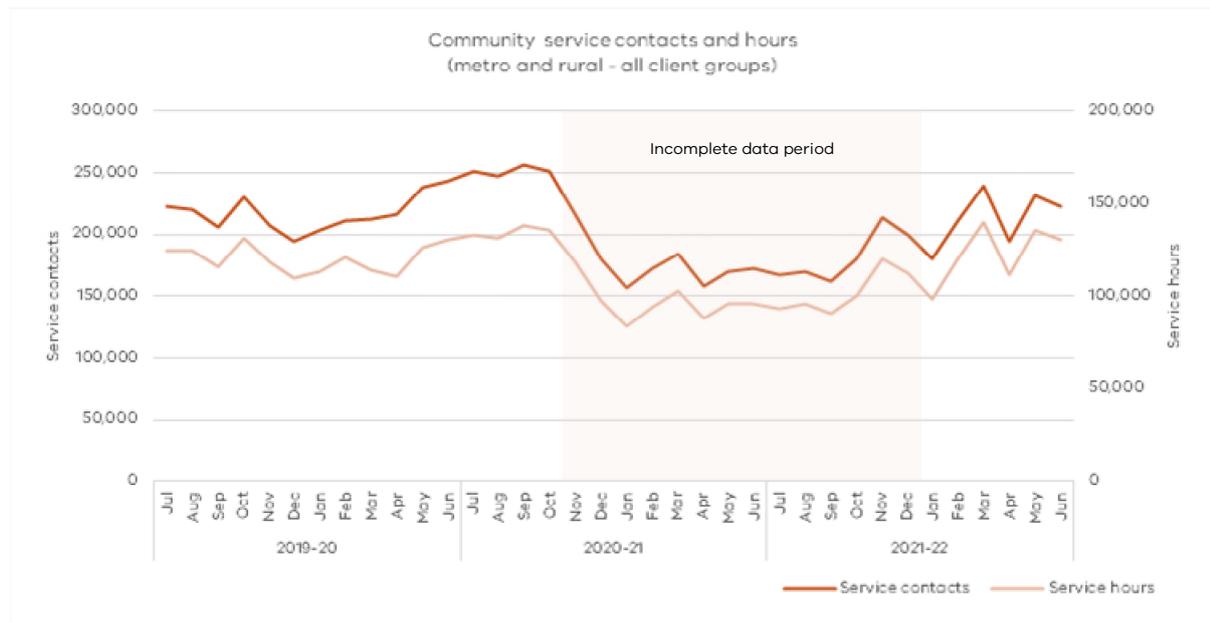
Bed occupancy continued to decrease in 2021–22, as shown in Table 3. Occupancy levels of below 85 per cent are considered desirable and support an environment where optimal care can be provided to each person.

Table 3: Percent of bed occupancy (excluding same days), 2017–18 to 2021–22

Setting	2017–18	2018–19	2019–20	2020–21	2021–22
Admitted – acute	88.5%	88.8%	86.1%	82.1%	76.6%
Admitted – non-acute	85.7%	86.9%	89.9%	89.4%	86.2%
Non-admitted – bed-based	87.4%	86.2%	83.7%	84.7%	81.9%
Non-admitted – subacute (CCU)	80.1%	80.9%	80.3%	79.9%	79.5%
Non-admitted – subacute (PARC)	75.7%	79.0%	71.3%	69.0%	66.7%
Total	85.6%	86.1%	83.8%	81.7%	77.9%

Community contact data for 2021–22 shows a reduction in the number of contacts provided (Figure 2). However, at the same time, the number of service hours increased, suggesting providers are spending longer with consumers each time they engage.

Figure 2: Community service contacts and hours, 2018–19 to 2021–22



Data source: CMI/ODS. Date extracted: 12 August 2022

The overall number of consumers in 2021–22 increased by 5.9 per cent to 81,476 clients accessing clinical mental health services. However, this is a relatively small increase that masks changes between different groups. There was a substantial increase in forensic and specialist services, with an increase of 61.5 and 38.8 per cent respectively. Consumers of child and adolescent/youth (CAMHS/CYMHS), adult and aged clinical mental health services also increased by between 4.8 per cent for adults and 6.6 per cent for CAMHS/CYMHS.

While there was a slight decrease in contacts provided within CAMHS/CYMHS (–7.8 per cent) and adult (–1.3 per cent) services, modest increases were reported for aged (0.4 per cent), forensic (5.3 per cent) and specialist (7.6 per cent) services.

Total service hours increased by 2.7 per cent overall. The largest increase was reported by specialist services, providing 17.0 per cent more hours in 2021–22 compared with the previous year, and a 5.4 per cent increase in aged and 3.7 per cent increase in adult services. There was a slight reduction in the service hours provided through forensic services (4.3 per cent) and CAMHS/CYMHS (5.1 per cent).

Data shows a reduction in CAMHS inpatient activity during 2021–22, following significant increase in demand experienced in 2020–21. Both occupancy and average length of stay for this cohort have decreased (Table 4). Reductions in bed occupancy rates and average length of stay have been reported across all service types in 2021–22.

Table 4: Trimmed average length of stay (≤ 35 days), 2017–18 to 2021–22

Population	2017–18	2018–19	2019–20	2020–21	2021–22
Adult	9.1	9.2	9.5	9.4	9.5
Aged	15.5	15.1	15.4	15.7	15.1
CYMHS	6.6	6.4	6.2	5.8	5.6
Forensic	21.7	24.0	21.8	19.1	18.5
Specialist	15.3	16.0	15.6	14.9	14.6

Population	2017–18	2018–19	2019–20	2020–21	2021–22
Total	9.6	9.6	9.8	9.7	9.8

Who accessed public mental health services in 2021–22?

Key statistic for 2021–22:

81,476 consumers accessed mental health services, slightly higher than last year

There was a slight increase in the number of children and young people, and adult consumers, accessing public mental health services in 2021–22. The total number of people accessing services was 81,476, slightly higher than the previous year, with the majority being adult and specialist consumers. Child and adolescent consumer numbers were also slightly higher (6.6 per cent) than the previous year. Forensic and specialist services saw a significant increase, though are a relatively small part of the service system.

About two-thirds of adult and aged consumers, and almost half of specialist, children and young people, previously had contact with mental health services during the past five years. Just over half of registered consumers (52.9 per cent) were women or girls and a third (33.4 per cent) lived in rural areas.

How were people referred to clinical services in 2021–22?

Most people were referred to clinical mental health services by hospitals, as shown in Table 5. About a quarter of referrals were from EDs (23.3 per cent), and Table 6 shows that the proportion of referrals from EDs has fluctuated slightly in the past five years but has returned to similar levels in 2021–22 (23.3 per cent) compared with 2017–18 (24 per cent). Another 26.7 per cent of referrals came from acute health, a 3.4 per cent increase on 2020–21 results. The latter group may include people who were admitted with a physical illness or injury and were subsequently referred for mental health treatment. GPs continued to be a key source of referrals (9 per cent), as did families (6.4 per cent).

There were 96,133 mental health-related ED presentations in 2021–22, a 9.1 per cent decrease from the previous year, spread across all age groups (Table 7). Across the age spectrum, there were 30,600 separations in mental health acute inpatient units in 2021–22, which was similar and slightly lower than 2020–21. There has been a further decrease in the proportion of compulsory admissions this year (2.3 per cent), with fluctuation in a narrow range over the past five years. In 2021–22, 47.9 per cent of admissions were compulsory.

Table 5: Source of mental health referrals, 2021–22

Referral source	2021–22
Acute health	26.7%
Emergency department	23.3%
General practitioner	9.0%
Family	6.4%
Client/self	4.9%
Community health services	3.3%

Referral source	2021–22
Police	3.8%
Others and unknown	22.6%

Table 6: Source of referrals (newly referred consumers only), 2017–18 to 2021–22

Source	2017–18	2018–19	2019–20	2020–21	2021–22
Acute health	21.7%	21.8%	22.2%	23.3%	26.7%
Emergency department	24.0%	27.2%	25.9%	24.3%	23.3%
General practitioner	11.5%	10.3%	9.8%	9.7%	9.0%
Family	7.1%	6.4%	6.6%	6.8%	6.4%
Client/self	4.8%	4.3%	4.8%	4.8%	4.9%
Community health services	5.0%	4.1%	4.3%	4.2%	3.3%
Police	3.7%	3.6%	3.8%	3.9%	3.8%
Others and unknown	22.2%	22.4%	22.7%	23.1%	22.6%

Table 7: Mental health–related emergency department presentations, 2017–18 to 2021–22

Population	2017–18	2018–19	2019–20	2020–21	2021–22
Adult	73,623	77,576	79,903	80,600	72,135
Aged	8,328	8,694	9,464	9,795	9,519
CYMHS	10,659	11,461	11,683	15,346	14,479
Total	92,610	97,731	101,050	105,741	96,133

How did people experience our services?

Information about people's experience of our services, and about their outcomes, is captured in different ways. The 'Your Experience of Service' (YES) survey helps us understand how people experience mental health treatment and care, including whether they feel they were respected, and the impact of the service on their overall wellbeing. Last year, the department began implementing the 'Carer Experience Survey' (CES) to measure how carers, family members and supporters experienced mental health services in their capacity as a carer. Questions contained in the CES relate to opportunities to be involved in care and decision making, support and relevant information provided to the carer and the overall impact the service had.

Many results for the YES survey dropped slightly this year, with staff shortages and increased demand pressures exacerbated by the ongoing COVID-19 pandemic continuing to affect health service delivery. Results show approximately one-third of consumers rated their experience of care with a service in the preceding three months as excellent (33.8 per cent), with another 25.4 per cent responding that their experience was very good. While most consumers, a combined 60.3 per cent of excellent and very good responses, considered their experience with the service as positive, there is clear room for improvement for some consumers.

We saw a similar trend in results for the CES, with a reduction in the proportion of carers reporting positive experiences compared with the previous year. In 2021–22, 18.9 per cent of respondents considered their experience as a carer with the service in the past three months to be excellent,

while 20.5 per cent stated it was very good and another 18.3 per cent reporting that it was good. Together, 57.7 per cent of carers reported having a positive experience, substantially less than the proportion of consumers reporting a positive experience. These results suggest there is significant opportunity for services to improve their approach to engaging with the carers, family members and supporters of consumers.

More information about CES is in the Carer Experience Survey section, and results for the YES survey outcome indicators are in Appendix 1.

Child and adolescent mental health services

Key statistics for 2021–22:

13,145 CAMHS consumers, an increase of 6.6 per cent
2,393 separations

There was an increase in the number of children and adolescents accessing community clinical mental health services in 2021–22. However, inpatient separations in this cohort decreased from a high in the previous year. Most children and young people receive clinical treatment in the community. In 2021–22 a higher proportion of service hours (13.5 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 consumer.

In 2021–22, there were 13,145 registered CAMHS consumers, a substantial increase of 6.6 per cent.

Some children and young people in Victoria require inpatient treatment for mental illness. During the year, there were 2,393 separations of children and young people for mental illness, a decrease of 8.9 per cent from the previous year. Compulsory admissions were at 18.5 per cent, and this remains substantially lower than the level of compulsory treatment for other age groups. The average duration of a period of compulsory treatment was 22.2 days in 2021–22, an increase of 18.1 per cent from the previous year. However, was lower than average durations reported in 2019–20 and 2018–19. The proportion of children and young people receiving treatment in the community on a community treatment order remained low and stable at 1.3 per cent.

The trimmed average length of stay (< 35 days) for CYMHS is experiencing a slight downward trend and was 5.6 days in 2021–22 (Table 4, earlier). The average length of stay is much shorter compared with adult, aged and other inpatient services. The bed occupancy rate decreased from the previous year to 52.0 per cent (Table 8). The readmission rate for CAMHS decreased slightly this year, but it is high in comparison with other age groups, at 22.6 per cent in 2021–22. 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.

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 2021–22, there were 327,001 reported contacts, a decrease of 7.8 per cent, reflecting similar decreases seen for this cohort in inpatient mental health services.

Table 8: CYMHS bed occupancy rate (including leave, excluding same days), 2017–18 to 2021–22

Setting	2017–18	2018–19	2019–20	2020–21	2021–22
Admitted – acute	62.6%	60.4%	60.9%	66.4%	52.0%

Adult mental health services

Key statistics for 2021–22:

64,708 adult consumers⁹

24,653 separations

Inpatient services

In 2021–22, there were 24,653 separations of adults for mental illness, very similar to but slightly lower than last year (3.0 per cent). 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 was slightly lower at 53.3 per cent.

Bed occupancy for adult inpatient services was high at 78.6 per cent (Table 9) but continued a downward trend seen since 2019–20, potentially because of the pandemic. The trimmed length of stay for adults remained steady at 9.5 days.

Of the adults who were admitted as inpatients, 63.4 per cent had contact with a community service before admission. The post-discharge follow-up rate was 85.4 per cent, but the data is incomplete. In 2021–22, 15.3 per cent of people were readmitted to hospital within 28 days of discharge compared with 15.1 per cent in 2020–21. Pressure on beds for adults remains evident and may result in shorter-than-optimal hospital stays, with a higher risk of relapse and readmission.

Table 9: Adult bed occupancy rates (including leave, excluding same day), 2017–18 to 2021–22

Service setting	2017–18	2018–19	2019–20	2020–21	2021–22
Admitted – acute	94.4%	94.4%	92.2%	86.3%	80.5%
Admitted – non-acute	82.7%	83.4%	87.6%	86.4%	85.5%
Non-admitted – subacute (CCU)	80.1%	80.9%	80.3%	79.9%	79.5%
Non-admitted – subacute (PARC)	75.7%	79.0%	71.3%	69.0%	66.7%
Total	86.6%	87.5%	85.6%	82.1%	78.6%

⁹ 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.

Clinical mental health services delivered in the community

Key statistics for 2021–22:

1,746,893 contacts
959,656 service hours

The number of recorded community contacts for adults in 2021–22 was 1,746,893, a slight decrease of 1.3 per cent over the previous year, with service hours showing an increase of 3.7 per cent. The mode of service delivery has changed substantially with the impact of the pandemic. Face-to-face contacts have reduced substantially from March 2020, with a significant number of contacts now occurring by phone and videoconference. Just over 15 per cent of adult consumers receiving treatment in the community were on community treatment orders, a slight decrease of 0.1 per cent on 2020–21 figures.

Prevention and recovery care

Key statistics for 2021–22:

3,792 separations
66.7 per cent bed occupancy

PARC services offer 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 four YPARCs for young people aged 16 to 25 years in Bendigo, Frankston, Dandenong and Parkville. Young people may also attend an adult PARC, but it is rare for 16- to 18-year-olds to do so.

Service activity in PARCs has fluctuated due to the COVID-19 pandemic. Separations increased by 3.2 per cent to 3,792. Occupied bed days decreased this year by 3.1 per cent and bed occupancy was at 66.7 per cent, continuing the decline seen during the pandemic over the past two years. During this pandemic period, 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. Occupancy varies between services and tends to be higher in urban areas.

Aged person mental health services

Key statistics for 2021–22:

8,457 aged consumers¹⁰
218,437 community contacts

¹⁰ 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.

The number of aged consumers using public mental health services increased by 5.5 per cent in 2021–22 to 8,457. Most of this group had previous contact with mental health services, with 40.1 per cent being new consumers. During the year, there were 2,351 separations of Victorians aged 65 years or older. Bed occupancy decreased this year (Table 10).

The trimmed average length of stay remained steady at 15.1 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 other accommodation and undertake processes such as applications to VCAT for guardianship and administration orders.

The preadmission contact rate was 65.6 per cent, up 4.7 per cent from the previous year. This reflects better continuity of care provided by services. Almost half of all admissions were compulsory (44.6 per cent), and this has been fairly stable over the past four years. The post-discharge follow-up rate was 88.7 per cent, a drop from the previous year. Readmissions within 28 days were low at 6.2 per cent, continuing to drop from previous years. There are good reasons with the ongoing pandemic to try, wherever possible, to keep older people out of health services.

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 home-like atmosphere, and residents are encouraged to take part 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 174 separations in 2021–22, similar to the figure reported in the previous year. The bed occupancy rate was steady at 82.9 per cent. They provided 142,537 occupied bed days, 2.7 per cent lower than last year.

There were 218,437 community contacts in 2021–22, only 0.4 per cent lower than the previous year. Despite a reduction in contacts, the number of service hours delivered increased by 5.4 per cent to 112,961 hours, suggesting providers were spending longer with clients when they received a service contact.

Table 10: Aged persons bed occupancy rates (including leave, excluding same day), 2017–18 to 2021–22

Setting	2017–18	2018–19	2019–20	2020–21	2021–22
Admitted – acute	87.0%	87.7%	80.9%	79.8%	74.6%
Non-admitted – bed-based	87.3%	86.9%	83.9%	85.0%	82.9%
Total	87.2%	87.2%	82.9%	83.3%	79.4%

Forensic mental health services

Key statistics for 2021–22:

1,902 consumers

186 separations

21,980 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 treated in forensic mental health services increased by 61.5 per cent, which followed a decrease of 4.8 per cent seen in 2020–21 on the previous year. Overall, there were 186 separations of people from acute forensic mental health inpatient units during the year, a decrease of 24 from 2020–21. Forensic mental health service provision has increased in recent years. Pressure on forensic inpatient beds remains high, with a bed occupancy rate of 95.2 per cent (Table 11).

Forensic consumers had the longest average duration of compulsory treatment, at 112 days. This part of the service system had the lowest proportion of new consumers at 35.1 per cent but the highest proportion of consumer engagement with services in the preceding five years, at 25.2 per cent.

Table 11: Forensic bed occupancy rates (including leave, excluding same day), 2017–18 to 2021–22

Service setting	2017–18	2018–19	2019–20	2020–21	2021–22
Admitted – acute	96.6%	95.5%	95.0%	96.9%	93.8%
Admitted – non-acute	93.1%	94.5%	96.4%	95.7%	96.1%
Total	94.3%	94.8%	95.9%	96.2%	95.2%

Specialist mental health services

Key statistics for 2021–22:

3,953 consumers

1,017 separations

56,751 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 autism).

There was a 7.6 per cent increase in service contacts in 2021–22. There was a substantial increase in the number of consumers accessing specialist mental health services, a 38.8 per cent increase from the previous year. This increased service activity is likely due to more investment in eating disorder and perinatal mental health services, provided to meet the demand emerging throughout the COVID-19 pandemic.

There were 1,017 separations from specialist services, 2.2 per cent more than last year. The trimmed average length of stay (≤ 35 days) was similar to the past three years at 14.6 days and was substantially longer than the comparable figure for adults not receiving specialist services. The preadmission contact rate continues to improve, although the post-discharge follow-up rate decreased slightly by 1.8 per cent. Both rates have remained relatively low at 46.4 per cent and

66.8 per cent respectively. Readmissions within 28 days are unusual, with a rate of 2.4 per cent in 2021–22.

Admitted acute occupied bed days rose slightly to 21,182, and the bed occupancy rate, which is variable, was 59.2 per cent. There are a small number of residential bed-based services, and bed occupancy for these services dropped substantially to 58.4 per cent from 74.1 per cent.

Compulsory treatment

The new Mental Health and Wellbeing Act being considered by Parliament and recommended by the Royal Commission outlines ways in which the mental health and wellbeing system is to use compulsory assessment/treatment, seclusion and restraint to reduce the rates and negative impacts of such treatments. The Royal Commission recommendation includes targets to reduce the use and duration of compulsory treatment on a year-by-year basis and gathering and publishing service-level and system-wide data in this regard.¹¹

The proportion of consumers on a community treatment order has been steady over time, with an average of 15.0 per cent of adults over the past five years on such an order. Very few CAMHS consumers are on community treatment orders, with an average rate of 1.1 per cent over the same period. Community orders are also relatively unusual for aged persons and specialist services clients, with rates in 2021–22 of 4.2 and 3.6 per cent respectively.

The average duration of compulsory treatment in the service system has been trending slightly upwards over time, as shown in Table 12. However, for aged consumers, the average rate declined this year compared with 2020–21.

Table 12: Average duration (days) of a period of compulsory treatment by cohort, 2017–18 to 2021–22

Service setting	2017–18	2018–19	2019–20	2020–21	2021–22
Adult	76.7	75.7	83.1	77.4	85.9
Aged	61.5	66.1	70.3	75.4	69.9
CAMHS/CYMHS	21.9	24.6	24.4	18.8	22.2
Forensic	87.3	91.5	100.6	106.0	112.0
Specialist	51.2	52.8	67.8	44.3	45.3
Total	76.6	75.6	82.9	78.2	86.9

Seclusion and restraint

Key statistics for 2021–22:

Seclusion rate – 8.5 per 1,000 occupied bed days (adults)

Average inpatient seclusion duration – 6.7 hours (adults)

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. The Royal

¹¹ Recommendation 55

Commission recommended that the government acts immediately to reduce the use of seclusion and restraint, with the aim to eliminate these practices within 10 years.¹²

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 fell to 9.8 episodes per 1,000 occupied bed days in 2021–22, from a rate of 10.3 in 2020–21 (Table 13). 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 65.8 per 1,000 occupied bed days. This year the rate for children and young people decreased to 7.7.

Table 13: Seclusion episodes per 1,000 occupied bed days, 2017–18 to 2021–22

Population	2017–18	2018–19	2019–20	2020–21	2021–22
Adult	10.5	9.5	10.0	9.5	8.5
Aged	1.2	0.7	0.6	0.6	0.2
CAMHS	8.8	12.0	14.4	10.7	7.7
Forensic	34.3	26.8	33.0	58.7	65.8
Specialist	0.6	0.4	0.5	3.2	10.6
Total	9.7	8.6	9.7	10.0	9.8

Work is underway with all services to reduce the use of restrictive interventions, including work with CAMHS. For 2021–22, differentiated service targets have been set that reflect the differences between different groups. For example, the target rate for seclusion among older people is lower than the target for adults and children/adolescents, reflecting what we know occurs in services, but seeking a reduction in seclusion in all services. Over the past 10 years the overall trend for adults, older people and specialist consumers is a decreasing seclusion rate. Results for CAMHS were trending up but have shown a welcome decline over the past two years. 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 2021–22, developing tailored behavioural programs and intensifying staffing efforts.

The average duration of seclusion has increased from 15.3 hours in 2020–21 to 18.5 hours (Table 14). This figure includes consumers with a forensic background for whom the average duration of seclusion was 41.1 hours. Nonetheless, this amount of time is half the duration of 2018–19, when the average duration was 81.4 hours. The downward trend, albeit from a high base, is positive.

¹² Recommendation 54

Table 14: Average inpatient seclusion duration (hours), 2017–18 to 2021–22

Population	2017–18	2018–19	2019–20	2020–21	2021–22
Adult	8.9	6.3	6.0	7.3	6.7
Aged	5.5	4.4	6.5	2.9	2.9
CAMHS	1.5	1.0	3.2	2.5	2.0
Forensic	48.5	81.4	40.5	34.5	41.1
Specialist	9.4	2.3	3.8	27.4	19.1
Total	16.7	20.0	13.8	15.3	18.6

The corresponding figure for adults was 6.7 hours, a reduction from last year's figure of 7.3 hours. For children and young people, the average duration of seclusion decreased to 2.0 hours from 2.5 hours the previous year.

The bodily restraint rate has decreased slightly this year to 19.8 compared with 20.9 per 1,000 occupied bed days in 2020–21. The rate varied from 6.4 for aged consumers to 67.4 per 1,000 occupied bed days for CAMHS. Rates of bodily restraint within CAMHS inpatient settings have been increasing since 2017–18 and will require close monitoring to ensure reduction targets set out by the Royal Commission are achieved. The average duration of restraint increased to 18 minutes in 2021–22, from 12 minutes the previous year.

Appendix 1: Mental health reporting based on the outcomes framework

The current outcomes framework, and its indicators, measure and monitor how our programs and services are contributing to improved outcomes for people with mental illness. The 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.

The Royal Commission recommended developing a new mental health and wellbeing outcomes framework (recommendation 1) to drive collective responsibility and accountability for mental health and wellbeing outcomes across government portfolios. It also recommended developing a performance framework to ensure mental health and wellbeing services are delivering improved experiences and outcomes for consumers, families, carers and supporters (recommendation 49). The design of the new framework is a key priority, and when implemented it will:

- address the recommendations of the Royal Commission (and assist with related recommendations from the recent Victorian Auditor-General's report, *Measuring and reporting on service delivery* (May 2021)).
- articulate what a high-quality, contemporary mental health and wellbeing system looks like for Victoria
- represent a public commitment to the vision for a transformed system
- support stakeholders to work together with a shared understanding and direction
- enable collective accountability for improving mental health and wellbeing outcomes across portfolios that influence mental health
- inform the development of new Budget Paper No. 3 measures and the refinement of existing measures
- drive decisions about prioritising investments and trade-offs
- provide information to assess the benefits, including the economic benefits, of early intervention.

While the new mental health and wellbeing outcomes and performance framework is being developed, the current outcome indicators guide the department's activities for mental health service delivery and access.

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 2020 Victorian Population Health Survey and other sources. It reflects the wellbeing of Victorians during the COVID-19 pandemic.

The potential for the pandemic to affect mental health and wellbeing was recognised early. Apart from concerns about contracting the virus, some of the measures necessary to contain its spread were also likely to have a negative impact on mental health.¹³ Across 2020 and 2021, widespread restrictions of movement, physical distancing measures and physical isolation or lockdowns were

¹³ National Mental Health Commission 2020, *National mental health and wellbeing pandemic response plan*, Australian Government, Canberra.

put in place. Sudden loss of employment and social interaction, and the added stressors of moving to remote work or schooling with periods of lockdown, have affected the mental health of many Victorians.

There has been a sharp and statistically significant increase in psychological distress among adults in Victoria, and also among Aboriginal and LGBTIQ+ Victorians. Older people (65+ years of age) continued to report significantly lower levels (14.2 per cent) of high or very high psychological distress compared with the proportion in all adults (23.4 per cent). The proportion of adults with high or very high levels of psychological distress was not significantly different in people who spoke a language other than English at home (23.3 per cent) or rural Victorians (22.0 per cent). Psychological distress is a risk factor for a number of diseases and conditions, including cardiovascular disease, chronic obstructive pulmonary disease, injury, obesity and depression.

The proportion of children at school entry at high risk of clinically significant problems related to behaviour and emotional wellbeing has been trending slightly upwards since 2018. It is possible this may relate to the pandemic and to disruptions to early childhood education and families.

The *National mental health and wellbeing pandemic response plan* prioritises the mental health of Australians in line with physical health and sets out a direction for navigating through the pandemic. With states and territories working together with the Commonwealth, a core objective of the plan is to meet the mental health and wellbeing needs of all Australians to reduce the negative impacts of the pandemic in the short and long term.

Indicators for outcome 1

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) ¹⁴	2020	14.8%	15.4%	15.0%	18.1%	23.4%
1.2 Proportion of Victorian population receiving clinical mental health care	2021–22	1.13%	1.13%	1.14%	1.12%	1.16%
1.3 Proportion of Victorian young people with positive psychological development ¹⁵	2018	68.8%	n/a	67.3%	n/a	67.3%
1.4 Proportion of Victorian older	2020	8.5%	10.0%	9.2%	11.9%	14.2%

¹⁴ The increase in the overall proportion of adults aged 18 years or older who had high or very high levels of psychological distress in 2020 compared with 2019 was influenced by an increase in the proportion of adults aged 18 to 64 years.

¹⁵ The Victorian Student Health and Wellbeing Survey is usually carried out every two years. It was not carried out in 2020 because of the pandemic.

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
persons (65 years or older) with high or very high psychological distress						
1.5 Proportion of children at school entry at high risk of clinically significant problems related to behaviour and emotional wellbeing	2021	4.9%	5.6%	6.7%	7.4%	7.1%

Indicators for outcome 2

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
2.1 Proportion of Victorian population who speak a language other than English at home with high or very high psychological distress (adults)	2020	17.2%	17.3%	13.8%	19.6%	23.3%
2.2 Proportion of Victorian rural population with high or very high psychological distress (adults)	2020	14.6%	16.3%	17.1%	17.1%	22.0%
2.3 Proportion of Victorian population who identify as LGBTIQ+ with high or very high psychological distress (adults)	2020	n/a	22.1%	Not available	Not available	36.6%

Last year was the second year that data relating to LGBTIQ+ Victorians has been reported. This is possible when there is a larger sample size for the Victorian Population Health Survey, about every third year. Although most LGBTIQ+ Australians live healthy, happy lives, LGBTIQ+ people experience significant health inequalities.¹⁶ Mental health and general physical health are poorer for

¹⁶ Rosenstreich G 2013, *LGBTI people mental health and suicide*, revised 2nd edition. National LGBTI Health Alliance, Sydney.

LGBTIQ+ adults compared with non-LGBTIQ+ adults, and a higher proportion have two or more chronic illnesses.¹⁷ Discrimination and exclusion are key contributors to elevated health risks, and this is sometimes referred to as minority stress.

As well as health disparities, a significantly higher proportion of LGBTIQ+ adults have a total annual household income of less than \$40,000, could not raise \$2,000 in two days in an emergency, and experience food insecurity.¹⁸ It is possible that relative economic disadvantage in the LGBTIQ+ community may have been worsened by pandemic restrictions affecting employment and businesses. The proportion of LGBTIQ+ adults with high or very high levels of psychological distress was significantly higher than the proportion in all adults, at 36.6 per cent compared with 23.5 per cent. Supporting the wellbeing of LGBTIQ+ Victorians requires ongoing, whole-of-government and community efforts towards social inclusion and equality, as well as targeted interventions.

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

Outcome indicators relating to Aboriginal Victorians show they continue to be over-represented in clinical mental health services. Aboriginal people form about 1.0 per cent of Victoria's population, yet the proportion of the Aboriginal population receiving clinical mental health care sits at 3.5 per cent and has been trending upwards over the past five years.

More generally, data from the Victorian Population Health Survey 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 31.8 per cent compared with 23.5 per cent. Psychological distress is a proxy measure of the overall mental health and wellbeing of the population. Very high levels of psychological distress may signify a need for professional help and provide an estimate of the need for mental health services. Levels for Aboriginal Victorians showed significant increases compared with the corresponding estimate for Victoria as a whole in both 2019 and 2020.

The link between poorer physical and mental health and racism is well documented. There is strong evidence that people who are targets of racism are at greater risk of developing a range of mental health problems such as anxiety and depression. Studies that examine racism as a determinant of ill health have concluded that there is a correlation between the experience of racism and poorer mental and physical health outcomes for Aboriginal Australians. Other factors linked to poor social and emotional wellbeing include grief, past and ongoing child removals, unresolved trauma, economic and social disadvantage, substance use and poor physical health.¹⁹

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

¹⁷ Victorian Agency for Health Information 2020, *The health and wellbeing of the lesbian, gay, bisexual, transgender, intersex and queer population in Victoria: findings from the Victorian Population Health Survey 2017*, State of Victoria, Melbourne

¹⁸ *Ibid.*, Table 4.

¹⁹ Zubrick S, et al. 2014, 'Social determinants of social and emotional wellbeing', in Dudgeon, P, Milroy H, Walker R (eds) *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice*, Department of Prime Minister and Cabinet, Canberra.

Indicators for outcome 3

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
3.1 Proportion of Victorian Aboriginal population who are receiving clinical mental health care	2021–22	2.9%	3.1%	3.3%	3.4%	3.5%
3.2 Proportion of Victorian Aboriginal population with high or very high psychological distress	2020	27.9%	25.0%	30.3%	45.9%	31.8%
3.3 Proportion of Victorian Aboriginal children at school entry at high risk of clinically significant problems related to behaviour and emotional wellbeing	2020	15.6%	14.4%	19.0%	18.5%	19.7%

Outcome 4: The rate of suicide is reduced

There has been a slight decrease in the suicide rate for Victoria in 2020, with a rate of 10.1 deaths (per 100,000) compared with 10.7 in 2019. Victoria's age-standardised rate is the lowest of any state or territory in Australia and is lower than the national rate of 12.1. Victoria's rate has been fairly stable over the past several years, sitting in the range of 10.1–11.1 per 100,000 population. There has been heightened concern about suicide with the 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 June 2022 at 354 suicide deaths is similar to the same time in the previous three years (2019–2021).²⁰

Supporting people's mental health is important, and for Victorians experiencing stress related to the ongoing impacts of the pandemic, extra support services set up to address these needs such as the Mental Health and Wellbeing Hubs continue to be available. Further expansion of the Hospital Outreach Post-suicidal Engagement (HOPE) program, which supports people immediately following a suicide attempt or intentional self-harm, also occurred in 2021–22. Greater access to mental health supports may have contributed to the relatively stable suicide rate, despite the increased stress experienced by Victorians throughout the pandemic.

²⁰ Coroners Court of Victoria (July 2022) 'Coroners Court monthly suicide data report, June 2022 update' available at <<https://www.coronerscourt.vic.gov.au/sites/default/files/2022-07/CCOV%20Public%20Suicide%20Report%20-%20June%202022%20update.pdf>>.

Indicator for outcome 4

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	2020	10.1	11.1	10.5	10.7	10.1

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). 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 and is therefore a limited subset of consumers accessing mental health services.

Nonetheless there is a reduction in tobacco use, which is trending down. Tobacco smoking is Australia's leading cause of preventable death and disease. Some disadvantaged groups, including people with mental illness, have substantially higher smoking prevalence than the general population. Although this indicator is trending down, there remains substantial room for improvement. The latest data estimated that 11.6 per cent of Australian adults smoked daily in 2019, a rate that has halved since 1991 (25 per cent).²¹

The proportion of registered clients with a type 2 diabetes diagnosis is slightly reduced this year, but the level has been fairly stable over the last five years at or around 10 per cent. This is almost double the prevalence in the general population, which is estimated at 5.3 per cent. The complications of diabetes can be severe and include heart disease, stroke, blindness, kidney disease, nerve damage and amputations.

Indicators for outcome 5

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	2021–22	38.2%	37.1%	36.5%	36.5%	32.7%
5.2 Proportion of registered mental health clients with a type 2 diabetes diagnosis	2021–22	9.8%	9.9%	10.0%	10.1%	9.3%

²¹ [Tobacco smoking snapshot](https://www.aihw.gov.au/reports/australias-health/tobacco-smoking) <https://www.aihw.gov.au/reports/australias-health/tobacco-smoking>

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 was not undertaken during 2022, therefore the results relating to children and young people with mental illness and NAPLAN in the outcomes framework are unchanged from 2020, and date back to 2018. NAPLAN was not carried out in 2020 because of the pandemic.

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.

When this analysis was done with 2018 results, it was not possible to obtain data that was directly comparable with national benchmarks. Mental illness at a young age can affect schooling and other factors that influence opportunities over a person's lifetime. Education can enable increased workforce participation and higher earnings, as well as other private and social benefits such as improved health. However, the age of onset of mental illness, often in adolescence and young adulthood, can disrupt education.

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

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
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	2018	n/a	n/a	67.9%	66.0%	64.8%

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
minimum standard for numeracy						
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

The data analysis required to update the percentage of prisoners receiving a psychiatric risk rating (P-rating) on entry to prison indicator was not undertaken during 2022, therefore the results are unchanged from 2020, and date back to 2016.

The data shows a significant increase in people allocated a P-rating. These ratings range from a stable psychiatric condition requiring continuing treatment or monitoring, through to a serious psychiatric condition requiring intensive and/or immediate care. Data also captures people with a suspected psychiatric condition requiring assessment. The increase may be partly attributable to the impact of COVID-19 restrictions on Victorians in the community, consistent with other data in this report. Measures required to reduce the risk of transmitting COVID-19 in prisons (including

protective quarantine and suspension of face-to-face visits) may also play a role, though these are less likely to have an impact on reception. Additional distress intervention services are in place for people in protective quarantine. When compared with P-rating data on reception day and the day after (43.2 per cent), it can be deduced that most of the impact would have occurred before incarceration.

Indicator for outcome 11

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	2020–21	36.9%	37.2%	36.2%	30.6%	44.6%

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

This indicator draws on data from the Health of the Nation Outcome Scales 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). The data suggests that although most clients are in stable housing, the proportion with unstable housing is large in comparison with the general population.

Indicator for outcome 12

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 ²²	2021–22	80.1%		79.4%	78.9%	79.4%	77.7%

²² 2020–21 and 2021–22 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. Industrial activity in 2020–21 and 2021–22 began in November 2020 and was resolved by November 2021. Affected data reported during this period should be interpreted with caution.

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. 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 has increased slightly this year to 84.9 per cent. However, this is lower than the average for 2019–20 (89.4 per cent) and 2018–19 (88 per cent). Follow-up soon after discharge enhances continuity of care at a time when consumers often need extra supports. The number of new registered clients has increased in the past year and at 39.4 per cent is the highest proportion of new clients in services since 2017–18.

The proportion of consumers where a significant improvement in clinically reported outcomes has decreased slightly for child and adolescent, adult and aged clients in 2021–22 compared with the previous year. Conversely, this proportion increased for forensic and specialist service clients.

The duration of compulsory treatment and proportion of community clients on a compulsory treatment order has increased. However, the proportion of people receiving compulsory inpatient treatment has decreased slightly. These points are discussed in detail in the 'Compulsory treatment' section 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. Results for many of the YES indicators have dropped slightly. The strongest result was for the proportion of consumers reporting their individuality and values were usually (21.9 per cent) or always (66.7 per cent) respected.

This was followed by the proportion of consumers who reported their experience of the service developing a care plan, with them, that considered all their needs was 'excellent' (35.9 per cent), 'very good' (24.5 per cent) or 'good' (22.7 per cent).

Results for the YES survey show that one-third of consumers rated their experience of care with a service in the preceding three months as excellent (32.1 per cent) and another third as very good

(28.3 per cent). Although a further substantial proportion rated their experience of care as good (24.9 per cent), there is clear room for improvement for some consumers. Nationally reported data indicates that voluntary patients generally report a more positive experience than consumers with a compulsory legal status.

Indicators for outcome 13

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
13.1 Rate of preadmission contact ²³	2021–22	59.4%	58.7%	60.6%	58.7%	62.9%
13.2 Rate of readmission within 28 days	2021–22	13.8%	13.3%	14.2%	14.8%	14.9%
13.3 Rate of post-discharge follow-up	2021–22	86.9%	88.0%	89.4%	84.5%	84.9%
13.4 New registered clients accessing public mental health services (no access in past five years)	2021–22	40.6%	37.6%	35.3%	34.8%	39.4%
13.5 Proportion of consumers reporting the effect the service had on their ability to manage their day-to-day life was good, very good or excellent	2022	81.8%	81.0%	n/a	79.9%	82.7%

Indicators for outcome 14

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
14.1 Proportion of registered clients experiencing stable or improved clinical outcomes (adults) ²⁴	2021–22	91.1%	91.2%	91.1%	91.5%	90.9%

²³ Ibid.

²⁴ Ibid.

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
14.2 Proportion of registered clients experiencing stable or improved clinical outcomes (CAMHS) ²⁵	2021–22	92.5%	93.6%	93.5%	93.7%	94.2%
14.3 Proportion of registered clients experiencing stable or improved clinical outcomes (aged persons) ²⁶	2021–22	90.7%	91%	91.2%	90.8%	91.0%
14.4 Proportion of registered clients experiencing stable or improved clinical outcomes (forensic) ²⁷	2021–22	n/a	n/a	n/a	n/a	n/a
14.5 Proportion of registered clients experiencing stable or improved clinical outcomes (specialist) ²⁸	2021–22	n/a	n/a	n/a	n/a	n/a
14.6 Proportion of consumers who reported they usually or always had opportunities for family and carers to be involved in their treatment or care if they wanted	2021–22	83.8%	82.4%	n/a ²⁹	80.6%	78.6%

²⁵ Ibid.

²⁶ Ibid.

²⁷ Sample size for forensic and specialist clients is too low for the data to be considered reliable.

²⁸ Ibid.

²⁹ Because of the pandemic, the YES survey was not conducted in 2019–20.

Indicators for outcome 15

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
15.1 Proportion of consumers reporting their individuality and values were usually or always respected	2022	88.7%	90.1%	n/a	88.4%	88.6%
15.2 Proportion of people with a mental illness reporting a care plan was developed with them that considered all their needs as good, very good or excellent	2022	82.3%	82.4%	n/a	79.2%	83.1%

Indicators for outcome 16

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)	2021–22	9.9	8.8	10.0	10.3	9.8
16.2 Rate of bodily restraint episodes per 1,000 occupied bed days (inpatient)	2021–22	22.7	25.8	20.7	20.9	19.8
16.3 Proportion of community cases with client on a treatment order	2021–22	11.5%	11.1%	11.3%	11.4%	11.1%
16.4 Proportion of inpatient admissions that are compulsory	2021–22	50.3%	49.6%	51.0%	50.2%	47.9%
16.5 Average duration of compulsory orders (days)	2021–22	76.6	75.6	82.9	78.2	86.9
16.6 Proportion of consumers who	2021–22	65.2%	65.5%	n/a	61.1%	60.3%

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
rated their experience of care with a service in the past three months as very good or excellent						
16.7 Proportion of consumers reporting the effect the service had on their overall wellbeing was very good or excellent	2021–22	57.7%	58.1%	n/a	54.7%	53.8%

Appendix 2: Public mental health service data

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

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

Data source: CMI/ODS, or as footnoted otherwise

Date extracted: 12 August 2022, or as footnoted otherwise

Date generated: 16 August 2022

Please note that the data in this report exclude Albury in New South Wales. Some data may not sum due to rounding.

Whole population

Measure	2017–18	2018–19	2019–20	2020–21	2021–22
Total estimated residential population in Victoria ('000) *	6,461	6,596	6,730	6,862	6,992

People accessing mental health services

Measure	2017–18	2018–19	2019–20	2020–21	2021–22
Mental health–related emergency department presentations	92,610	97,731	101,050	105,741	96,133
Emergency department presentations that were mental health–related (%)	5.27%	5.36%	5.78%	6.09%	5.29%

People accessing clinical mental health services

Measure	2017–18	2018–19	2019–20	2020–21	2021–22
Consumers accessing clinical mental health services ^{† ‡ §§}	72,905	74,831	76,495	76,921	81,476
Proportion of population receiving clinical care ^{* † ‡ §§} (%)	1.13%	1.13%	1.14%	1.12%	1.17%

Consumer location	Area	2017–18	2018–19	2019–20	2020–21	2021–22
Consumer residential location (%)	Metro	64.0%	63.8%	63.5%	63.5%	63.0%
	Rural	33.0%	32.8%	33.0%	33.2%	33.4%
	Unknown/other	3.0%	3.4%	3.5%	3.3%	3.7%

Consumer demographics	Description	2017–18	2018–19	2019–20	2020–21	2021–22
Gender (%)	Female	50.2%	50.3%	50.5%	52.0%	52.9%
	Male	49.6%	49.4%	49.3%	47.7%	46.7%
	Other/unknown	0.2%	0.3%	0.3%	0.3%	0.4%
Age group (%)	0–4	0.8%	0.8%	0.7%	0.6%	0.8%
	5–14	8.2%	8.5%	8.0%	8.6%	8.8%
	15–24	19.3%	19.6%	19.8%	20.2%	20.6%
	25–34	17.6%	18.0%	18.3%	18.6%	18.4%
	35–44	18.0%	17.3%	17.4%	16.8%	16.1%
	45–54	14.8%	15.1%	14.8%	14.6%	14.3%
	55–64	8.7%	8.8%	9.0%	9.0%	9.1%
	65–74	6.2%	6.1%	6.1%	6.0%	6.1%
	75–84	4.2%	4.0%	4.1%	3.9%	4.1%
	85–94	1.8%	1.7%	1.7%	1.6%	1.7%
95+	0.2%	0.2%	0.1%	0.1%	0.1%	
Consumers from culturally diverse backgrounds (%)	Culturally diverse	13.8%	13.8%	14.0%	14.0%	13.7%
Aboriginal or Torres Strait Islander status (%)	Indigenous	2.9%	3.1%	3.3%	3.4%	3.5%
Country of birth (top 10 non-English speaking) (%)	India	0.8%	0.9%	1.0%	1.0%	1.0%
	Vietnam	0.9%	0.8%	0.8%	0.8%	0.8%
	China (excludes SARs and Taiwan)	0.7%	0.7%	0.7%	0.7%	0.8%
	Italy	1.0%	0.9%	0.8%	0.7%	0.7%
	Greece	0.8%	0.7%	0.7%	0.7%	0.7%
	Sri Lanka	0.5%	0.5%	0.5%	0.6%	0.5%
	Philippines	0.5%	0.4%	0.4%	0.5%	0.5%
	Sudan	0.4%	0.4%	0.4%	0.4%	0.4%
	Iran	0.4%	0.4%	0.4%	0.4%	0.4%
Turkey	0.4%	0.4%	0.4%	0.4%	0.3%	
Preferred language other than English (top 10) (%)	Vietnamese	0.5%	0.5%	0.5%	0.5%	0.5%
	Greek	0.5%	0.4%	0.4%	0.4%	0.4%
	Mandarin	0.3%	0.4%	0.4%	0.4%	0.4%
	Italian	0.5%	0.4%	0.4%	0.3%	0.3%
	Arabic	0.3%	0.3%	0.4%	0.3%	0.3%

Consumer demographics	Description	2017–18	2018–19	2019–20	2020–21	2021–22
	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%	0.2%	0.2%	0.1%	0.1%
	Cantonese	0.1%	0.1%	0.1%	0.1%	0.1%
	Dari	0.1%	0.1%	0.1%	0.1%	0.1%

Treatment	Cohort	2017–18	2018–19	2019–20	2020–21	2021–22
Consumers accessing clinical mental health services [†] ‡ §§	Adult	57,396	59,454	61,038	61,736	64,708
	Aged	8,269	8,096	8,290	8,014	8,457
	CAMHS	11,585	11,585	11,516	12,329	13,145
	Forensic	875	988	1,237	1,178	1,902
	Specialist	2,903	2,988	2,927	2,849	3,953
Diagnosis (%)	Schizophrenia, paranoia and acute psychotic disorders	23.3%	22.9%	23.0%	22.7%	20.9%
	Mood disorders	19.7%	19.1%	18.8%	18.4%	17.6%
	Stress and adjustment disorders	8.8%	9.1%	8.8%	9.0%	10.2%
	Personality disorders	6.3%	6.6%	6.6%	6.6%	6.7%
	Anxiety disorders	5.7%	5.8%	6.1%	6.3%	6.6%
	Substance abuse disorders	3.5%	3.3%	3.3%	3.2%	3.8%
	Organic disorders	2.6%	2.2%	2.1%	2.1%	2.2%
	Disorders of psychological development	1.9%	2.1%	2.0%	2.1%	2.2%
	Disorders of childhood and adolescence	1.5%	1.6%	1.6%	2.0%	2.1%
	Eating disorders	1.9%	1.9%	1.9%	1.9%	2.0%
	Other	1.0%	0.9%	1.0%	1.0%	1.3%
	Obsessive compulsive disorders	0.5%	0.5%	0.6%	0.6%	0.7%
	No mental health diagnosis recorded	23.3%	23.9%	24.2%	24.1%	23.8%
Referral source (newly referred)	Acute health	21.7%	21.7%	22.2%	23.3%	26.7%
	Emergency department	24.0%	27.2%	25.8%	24.3%	23.3%

Treatment	Cohort	2017–18	2018–19	2019–20	2020–21	2021–22
consumers only) (%)	General practitioner	11.5%	10.3%	9.8%	9.6%	9.0%
	Family	7.2%	6.4%	6.6%	6.8%	6.4%
	Client/self	4.8%	4.3%	4.8%	4.8%	4.9%
	Community health services	4.9%	4.1%	4.3%	4.2%	3.3%
	Police	3.7%	3.6%	3.8%	3.9%	3.8%
	Other/unknown	22.2%	22.4%	22.7%	23.1%	22.6%
New consumers accessing services (no access in the prior 5 years) † §§ (%)	Total	36.8%	36.0%	35.3%	34.8%	39.4%
Consumers accessing services during each of the previous 5 years † §§ (%)	Total	13.5%	13.4%	13.5%	13.6%	13.0%

Service activity – bed-based	Setting	2017–18	2018–19	2019–20	2020–21	2021–22
Total number of separations (excluding same days)	Admitted – acute	26,124	26,693	26,660	26,913	25,812
	Admitted – non-acute	222	274	245	263	259
	Non-admitted – bed-based	247	205	229	182	181
	Non-admitted – subacute (CCU)	650	545	565	622	556
	Non-admitted – subacute (PARC)	3,460	3,547	3,374	3,675	3,792
	Total	30,703	31,264	31,073	31,655	30,600
Occupied bed days (including leave, excluding same days)	Admitted – acute	374,908	387,988	384,825	380,231	366,791
	Admitted – non-acute	74,409	78,148	81,575	81,231	80,517
	Non-admitted – bed-based	156,890	154,823	150,705	151,835	146,800
	Non-admitted – subacute (CCU)	105,072	104,852	103,634	100,597	100,163
	Non-admitted – subacute (PARC)	65,712	70,063	63,397	64,538	62,535
	Total	776,993	795,876	784,138	778,433	756,808
	Admitted – acute	88.5%	88.8%	86.1%	82.1%	76.6%

Service activity – bed-based	Setting	2017–18	2018–19	2019–20	2020–21	2021–22
Bed occupancy rate (including leave, excluding same days)	Admitted – non-acute	85.7%	86.9%	89.9%	89.4%	86.2%
	Non-admitted – bed-based	87.4%	86.2%	83.7%	84.7%	81.9%
	Non-admitted – subacute (CCU)	80.1%	80.9%	80.3%	79.9%	79.5%
	Non-admitted – subacute (PARC)	75.7%	79.0%	71.3%	69.0%	66.7%
	Total	85.6%	86.1%	83.8%	81.7%	77.9%

Service activity – community	Population	2017–18	2018–19	2019–20	2020–21	2021–22
Total service contacts, by sector [‡]	Adult	1,784,325	1,851,856	1,936,772	1,769,897	1,746,893
	Aged	243,537	232,202	249,924	217,523	218,437
	CAMHS/CYMHS	326,921	330,938	344,181	354,777	327,001
	Forensic	19,648	23,797	23,772	20,881	21,980
	Specialist	32,070	41,195	53,020	52,743	56,751
	Total	2,406,503	2,479,989	2,607,671	2,415,824	2,371,063
Total service hours, by sector [‡]	Adult	904,328	972,427	1,031,434	925,731	959,656
	Aged	125,676	124,716	129,047	107,166	112,961
	CAMHS/CYMHS	216,092	221,594	223,956	229,764	218,136
	Forensic	12,189	16,403	15,278	14,238	14,845
	Specialist	27,932	34,359	38,849	36,087	42,231
	Total	1,286,219	1,369,501	1,438,566	1,312,988	1,347,831
Unregistered consumer service hours ^{‡ §§}	Total	15.6%	16.0%	15.5%	16.0%	12.0%

Service performance	Population	2017–18	2018–19	2019–20	2020–21	2021–22
Percentage of consumers readmitted within 28 days of separation – inpatient	Adult	14.4%	13.7%	14.6%	15.1%	15.3%
	Aged	8.5%	7.6%	9.0%	7.1%	6.2%
	CAMHS	19.3%	20.1%	21.8%	23.4%	22.6%
	Forensic	7.8%	6.0%	7.5%	5.0%	17.4%
	Specialist	1.2%	1.9%	2.1%	1.8%	2.4%
	Total	13.8%	13.3%	14.2%	14.8%	14.9%
Percentage of admissions with a preadmission contact	Adult	60.2%	59.7%	61.7%	59.0%	63.4%
	Aged	65.0%	65.7%	63.6%	60.9%	65.6%
	CAMHS	58.0%	56.7%	60.7%	64.2%	66.9%

Service performance	Population	2017–18	2018–19	2019–20	2020–21	2021–22
– inpatient (all consumers) [‡]	Forensic	21.6%	26.8%	16.0%	16.2%	18.9%
	Specialist	38.5%	30.9%	39.5%	43.5%	46.4%
	Total	59.4%	58.6%	60.6%	58.5%	62.7%
Percentage of consumers followed up within 7 days of separation – inpatient [‡]	Adult	88.4%	89.1%	90.9%	84.9%	85.4%
	Aged	93.2%	94.5%	94.9%	89.4%	88.7%
	CAMHS	86.2%	87.0%	86.6%	86.1%	86.9%
	Forensic	26.4%	28.4%	28.6%	37.6%	64.7%
	Specialist	53.3%	60.9%	65.5%	68.6%	66.8%
	Total	86.9%	88.0%	89.4%	84.5%	84.9%
Trimmed average length of stay (≤ 35 days)	Adult	9.1	9.2	9.5	9.4	9.5
	Aged	15.5	15.1	15.4	15.7	15.1
	CAMHS	6.6	6.4	6.2	5.8	5.6
	Forensic	21.7	24.0	21.8	19.1	18.5
	Specialist	15.3	16.0	15.6	14.9	14.6
	Total	9.6	9.6	9.8	9.7	9.8

Compulsory treatment	Population	2017–18	2018–19	2019–20	2020–21	2021–22
Percentage of open community cases where the consumer was on a CTO	Adult	15.1%	14.6%	15.1%	15.2%	15.1%
	Aged	5.1%	5.4%	5.0%	5.0%	4.2%
	CAMHS	1.1%	1.1%	1.0%	1.0%	1.3%
	Forensic	12.8%	13.8%	13.3%	13.8%	6.3%
	Specialist	4.7%	4.0%	3.4%	4.6%	3.6%
	Total	11.5%	11.1%	11.3%	11.4%	11.1%
Percentage of admissions for compulsory treatment – inpatient	Adult	55.3%	54.3%	56.0%	55.5%	53.3%
	Aged	46.8%	46.7%	50.1%	48.7%	44.6%
	CAMHS	20.1%	21.3%	20.3%	21.3%	18.5%
	Forensic	100.0%	100.0%	100.0%	100.0%	100.0%
	Specialist	8.9%	11.2%	9.5%	8.5%	8.8%
	Total	50.3%	49.6%	51.0%	50.2%	47.9%
The average duration (days) of a period of compulsory treatment	All	76.6	75.6	82.9	78.2	86.9
Consumers on an order for more than 12 months (%)	All	13.0%	12.9%	13.1%	13.3%	14.9%
Adult (18+) consumers who have	All	2.61%	2.86%	2.96%	3.20%	3.02%

Compulsory treatment	Population	2017–18	2018–19	2019–20	2020–21	2021–22
an advance statement recorded (%)						
Adult (18+) consumers who have a nominated person recorded (%)	All	2.41%	2.57%	2.51%	2.51%	2.36%

Restrictive practice	Population	2017–18	2018–19	2019–20	2020–21	2021–22
Rate of seclusion episodes per 1,000 occupied bed days – inpatient	Total	9.9	8.8	10.0	10.3	9.8
Average duration (hours) of seclusion episodes – inpatient	Total	16.7	20.0	13.8	15.3	18.5
Rate of bodily restraint episodes per 1,000 occupied bed days – inpatient	Total	22.7	25.8	20.7	20.9	19.8
Average duration (hours) of bodily restraint episodes – inpatient	Total	0.3	0.2	0.3	0.2	0.3

Clinician-reported outcome	Population	2017–18	2018–19	2019–20	2020–21	2021–22
Percentage of closed community cases with significant improvement at case closure [†]	Adult	53.3%	52.0%	54.1%	55.5%	54.9%
	Aged	56.4%	58.9%	59.8%	60.6%	54.3%
	CAMHS/CYMHS	44.7%	44.2%	47.8%	45.8%	40.8%
	Forensic	**	**	**	**	**
	Specialist	31.0%	37.5%	41.9%	47.2%	51.0%
	Total	51.9%	51.5%	53.7%	54.3%	52.0%
Percentage of community cases closed with no 'significant' change in HoNOS score at case start and end [‡]	Adult	37.8%	39.2%	37.0%	37.5%	35.3%
	Aged	36.1%	34.6%	33.7%	37.0%	37.2%
	CAMHS/CYMHS	46.1%	46.8%	43.4%	48.2%	48.6%
	Forensic	**	**	**	**	**
	Specialist	64.2%	57.2%	45.5%	45.6%	42.6%
	Total	39.5%	40.1%	37.7%	39.6%	38.4%
Percentage of community cases with 'significant deterioration' in	Adult	8.9%	8.8%	8.9%	8.5%	9.1%
	Aged	7.5%	6.4%	6.5%	6.3%	5.8%
	CAMHS/CYMHS	9.3%	9.0%	8.8%	9.2%	9.0%

Clinician-reported outcome	Population	2017–18	2018–19	2019–20	2020–21	2021–22
HoNOS scales at case closure [‡]	Forensic	**	**	**	**	**
	Specialist	4.8%	5.3%	12.6%	9.5%	3.7%
	Total	8.6%	8.4%	8.6%	8.3%	8.5%

Note: Data for forensic patients has been excluded from the above table because further analysis of clinical outcomes data for these clients indicates that the sample size is too low for the data to be reliable.

Funding		2017–18	2018–19	2019–20	2020–21	2021–22
Total output cost (Budget Paper No. 3) (\$ million) ^{# ††}	Clinical mental health	1,372.7	1,542.1	1,650.0	1,937.6	2,178.6
	Mental health community support services	120.0	118.5	111.0	121.8	173.7

Service inputs		2017–18	2018–19	2019–20	2020–21	2021–22
Specialist mental health beds (from policy and funding guidelines)	Admitted – acute	1,174	1,205	1,211	1,212	1,212
	Admitted – non-acute	244	250	250	250	250
	Admitted total	1,418	1,455	1,461	1,462	1,462
	Non-admitted – bed-based	495	495	495	491	491
	Non-admitted – subacute (CCU)	358	348	348	338	338
	Non-admitted – subacute (PARC)	250	250	252	264	264
	Non-admitted total	1,103	1,093	1,095	1,093	1,093
	Total	2,521	2,548	2,556	2,555	2,555
Full-time equivalent staff by workforce type [§]	Administrative and clerical staff	440	451	711	n/a	n/a
	Allied health and diagnostic professionals	1,590	1,636	1,800	n/a	n/a
	Carer workers	35	31	34	n/a	n/a
	Consumer workers	42	39	40	n/a	n/a
	Domestic staff	158	118	151	n/a	n/a
	Medical officers	871	915	985	n/a	n/a
	Nurses	4,260	4,548	4,909	n/a	n/a
Other personal care staff	195	248	190	n/a	n/a	

People accessing mental health community support services

Consumers	2017–18	2018–19	2019–20	2020–21	2021–22
Total consumers accessing mental health community support services [#]	8,605	5,732	5,818	3,180	2,535

Consumer demographics ^{\$\$\$}	Description	2017–18	2018–19	2019–20	2020–21	2021–22
Gender (%)	Female	57.3%	57.3%	54.3%	54.8%	n/a
	Male	41.9%	41.8%	44.2%	43.7%	n/a
	Other/unknown	0.7%	0.8%	1.5%	1.6%	n/a
Age group (%)	0–4	0.3%	0.2%	0.3%	0.1%	n/a
	5–14	2.1%	3.4%	6.2%	0.3%	n/a
	15–24	13.1%	13.9%	19.2%	20.4%	n/a
	25–34	18.8%	17.2%	14.9%	16.3%	n/a
	35–44	22.6%	20.6%	17.7%	18.4%	n/a
	45–54	24.7%	25.3%	20.9%	21.7%	n/a
	55–64	14.9%	16.3%	15.4%	17.4%	n/a
	65–74	1.9%	2.6%	4.5%	4.3%	n/a
	75–84	0.3%	0.4%	0.8%	0.9%	n/a
	85–94	0.0%	0.0%	0.0%	0.1%	n/a
	95+	0.9%	0.0%	0.1%	0.1%	n/a
Unknown	0.5%	0.0%	0.0%	0.1%	n/a	
Aboriginal or Torres Strait Islander (%)	Indigenous	1.9%	2.2%	2.8%	2.9%	n/a
Culturally diverse status (%)	Yes	3.9%	4.8%	5.4%	7.2%	n/a

Service activity	2017–18	2018–19	2019–20	2020–21	2021–22
Community service units	635,040	338,835	128,007	2,703	46,619
Bed-based rehabilitation bed days	81,435	62,417	51,029	46,542	48,997

Service input	Population	2017–18	2018–19	2019–20	2020–21	2021–22
Bed-based rehabilitation beds	Other	101	102	22	0	13
	Youth	159	159	159	159	159
	Total	260	261	181	159	172

Notes and annotations

Data in this report excludes Albury New South Wales.

* Population estimate is based on *Victoria in Future 2019* estimated residential population at 30 June. Refer to the [Department of Environment, Land, Water and Planning website](https://www.planning.vic.gov.au/land-use-and-population-research/victoria-in-future) <<https://www.planning.vic.gov.au/land-use-and-population-research/victoria-in-future>> for information on Victoria in Future projections.

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

‡ 2020–21 and 2021–22 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. Industrial activity in 2020–21 and 2021–22 began in November 2020 and was resolved by November 2021. 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 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.

§§ Impacted by changes to Victoria's consumer registration process, which came into effect from 1 July 2021. Under the new registration process, consumers accessing community-based services are registered when they receive a face-to-face psychiatric examination.

§§§ Demographic data for consumers accessing mental health community support services were not collected during 2021–22.

†† 2021–22 data represent expected outcomes

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

Area-based clinical services³⁰

Child and adolescent services/child and youth services³¹

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

³⁰ 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.

³¹ 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).

Statewide specialist services

Aboriginal services

Brain disorder services

Dual diagnosis services

Dual disability services

Eating disorder services

Mother and baby services

Neuropsychiatry

Personality disorder services

Torture and trauma counselling

Victorian Institute of Forensic Mental Health (Forensicare)

Victorian Transcultural Mental Health

Transition support units

Appendix 4: Raw data for Figures 1 and 2

Figure 1

Age	2017–18	2018–19	2019–20	2020–21	2021–22
Total	92,610	97,731	101,050	105,741	96,133
0–17 years	10,659	11,461	11,683	15,346	14,479
18–64 years	73,623	77,576	79,903	80,600	72,135
65+ years	8,328	8,694	9,464	9,795	9,519

Data source: VEMD

Figure 2

Raw data: 2019–20

Month	Service hours	Service contacts
July	124,194	223,142
August	124,772	220,675
September	115,742	206,233
October	130,983	230,941
November	117,966	206,652
December	109,331	194,640
January	112,859	203,901
February	121,041	210,966
March	114,364	212,760
April	110,237	215,703
May	126,389	238,277
June	130,688	243,783

Raw data: 2020–21

Month	Service hours	Service contacts
July	132,753	251,217
August	130,986	246,803
September	138,550	256,963
October	135,615	250,847
November	117,959	215,747
December	97,416	180,434

Month	Service hours	Service contacts
January	83,411	156,713
February	94,021	172,759
March	102,656	183,767
April	88,057	157,986
May	95,672	170,013
June	95,893	172,576

Raw data: 2021–22

Month	Service hours	Service contacts
July	93,221	166,721
August	95,969	170,294
September	90,675	161,771
October	99,922	179,787
November	120,216	213,828
December	112,328	199,344
January	98,170	180,565
February	120,457	210,658
March	139,762	239,738
April	111,226	194,364
May	135,789	231,838
June	130,097	222,157

Data source: CMI/ODS. Date extracted: 12 August 2022