Victoria's mental health services annual report 2020–21

VICTORIA State Government | Department of Health

Victoria's mental health services annual report 2020–21

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 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.

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

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

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To: Minister for Mental Health

Dear Minister

In accordance with s. 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 2020 to 30 June 2021.

Professor Euan M Wallace AM
Secretary
Department of Health
…../…/2021

Foreword

I am pleased to present our sixth 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 2020–21.

This report shares the story of 2020–21. This year has presented extraordinary challenges to the Victorian community, with particular focus on the effects of the coronavirus (COVID-19) pandemic. Victoria's mental health system responded to these challenges urgently and with agility. More than $220 million was provided to support mental health and wellbeing initiatives to reduce the impact of the pandemic on mental health.

While this is a snapshot of a single year in time, it's necessary to recognise the cumulative and compounding impact that the pandemic, bushfires, floods, storms, and daily life stresses all have on us, whether care professionals, volunteers, carers, or people with lived experienced of mental ill health.

For more than a year, professionals who dedicate their careers to supporting the mental health and wellbeing of Victorians have been asked to do more than ever before. Helplines have expanded, new online platforms have been established, and clinical services have been greatly boosted. I am proud of the mental health response that has been possible during the pandemic and that has only been possible due to dedicated professionals. We are deeply indebted to these professionals for their commitment to the mental health and wellbeing of Victorians.

While 2020–21 has been challenging, it has also been monumental and will be life changing. In March this year the Royal Commission into Victoria's Mental Health System published its final report. In essence, the vision and signposts for the state's future mental health system. A system like no other.

The Victorian Government is committed to delivering every recommendation of the Royal Commission. The report has been years in the making and only made possible thanks to the ongoing advocacy of people with lived experience of poor mental health, carers and professionals. I look forward to continuing to hear, and listen to, the voices of people with lived experience, and of families and carers as we deliver on significant reform over the coming years.

The momentum that has started to build following the Royal Commission is already evident in the report that follows. The collaboration between professionals, volunteers, families, carers and, most importantly, people with lived experience has allowed changes to take place in a short period.

Words will fall short. However, I am determined to continually thank everyone who has supported the mental health and wellbeing of Victorians in 2020–21. Thank you for your advocacy, your commitment, and your sacrifice. But above all, thank you for your vision for our future.

Professor Euan M Wallace AM
Secretary
Department of Health

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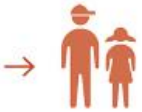
The year at a glance

76,832
registered consumers



12,566
child and adolescent consumers

62,095
adult consumers

8,019
aged consumers

1,177
forensic consumers

1,922
specialist consumers

52.0%
women or girls

33.2%
live in rural areas

$1.94 billion
clinical services

$122 million
mental health community support services

1. Supporting Victorians through crisis

The 2020–21 financial year has seen ongoing disruption to the lives of many Victorians. The effects of bushfires from the summer of 2019–20 are still being felt by many, and the pandemic has presented a number of challenges.

Victoria's mental health system has sought to respond to the needs of Victorians throughout the year. Work to support communities affected by the bushfires continued in 2020–21, with a focus on building both mental health capacity and resilience.

Staff in our mental health services and the wider system have worked hard to continue to provide services to consumers while ensuring infection control and preventive health measures are in place. Many services have been delivered via telehealth, and changes have been made to protect the wellbeing of consumers, carers and staff. Service models have been developed to meet local needs (including dealing with outbreaks) and to address both the effects of lockdowns and different restrictions across the state.

Mental health and wellbeing support during coronavirus (COVID-19)

The pandemic has had a major impact on the way Victorians live. From March 2020, widespread restrictions on movement, physical distancing measures and lockdowns were implemented to reduce the spread of infection, hospitalisations and deaths.

Many Victorians experienced psychological distress during the year, and for some people with an existing mental illness, distress and isolation exacerbated their existing health concerns. Stress, confusion, and anger are commonly reported outcomes of the pandemic and the restrictions necessary to prevent its spread.

Investment in mental health service delivery

Crisis lines are often a first point of contact for Victorians experiencing distress. Others may contact primary care services, such as general practitioners, or need assistance from the state's public mental health services.

Beyond Blue continued its pandemic-specific telephone counselling service to deal with the expected increase in demand for services. With funding provided in the April 2020 pandemic package, the Beyond Blue phone line handled more than 98,000 calls, and Lifeline Australia received in excess of 330,000 calls during 2020–21.

More than $220 million was allocated to address mental health and wellbeing during the pandemic, both across the whole population and to targeted groups. As part of this investment, in August 2020, the Victorian Government committed $59.7 million for clinical mental health services to meet immediate surge demands resulting from the introduction of stage 4 restrictions in metropolitan Melbourne and the return to stage 3 restrictions in regional areas.

The investment meant that:

- More than 4,000 asylum seekers were supported through the Asylum Seeker Resource Centre, Cabrini and Foundation House.
- The Victorian Aboriginal Health Service managed the Yarning Safe and Strong telephone helpline. The line focuses on the social and emotional wellbeing of Aboriginal Victorians and can connect callers with health, family violence, housing and legal services in emergencies.

- Orygen continued developing its Moderated Online Social Therapy (MOST) platform, with an additional feature that allows the platform to reach all young people in Victoria following a referral from headspace or a tertiary mental health service.
- Ambulance Victoria boosted the Tele-PROMPT program, and the pilot was subsequently recognised through receiving the Leadership Award from the Institute of Public Administration Australia Victoria.
- The Victorian Mental Illness Awareness Council (VMIAC) and Tandem, Victoria's peak body for mental health carers, were supported to meet additional demand.

Case study: Partners in Wellbeing

As part of the pandemic mental health response package in April 2020, the 'Partners in Wellbeing' initiative began with $4.97 million funding, delivered in partnership by Neami National, the Australian Community Support Organisation and Eastern Access Community Health. It acknowledges that, for many people, the pandemic has had a significant impact on the mental health and wellbeing of Victorians, providing free one-on-one wellbeing coaching via telehealth. The initiative was further developed in September 2020 in partnership with the Department of Jobs, Precincts and Regions, which invested a further $4.649 million to deliver a range of small business support options, with Financial Counselling Vic providing guidance. Throughout 2020–21 the Partners in Wellbeing service received more than 5,000 contacts and offered support to over 700 ongoing clients (Figure 1).

A personal story from this initiative

A woman in regional Victoria heard the Partners in Wellbeing small business advertisement on the radio and called the 1300 number. The woman reported concern for her husband's wellbeing because he had been struggling with his small business. The staff explained the wellbeing supports and other services. The husband took up the financial counselling and business advisory offer. Upon reflection, the woman realised that their situation had taken a toll on her as well, and she decided to accept mental health and wellbeing support too. They found the coaching and small business support very helpful.

Figure 1: Demand for Partners in Wellbeing (number of clients), 2020–21

Source: Graph and story from Partners in Wellbeing 2020–21 reporting to Department of Health

Children and young people

The mental health of children and young people is a specialist area. Children's health and development occurs within multiple contexts, including their own individual characteristics, their family, school, local neighbourhood and community environments. Family relationships are often the most influential factors in a young person's life. Supporting children and young people with mental health challenges requires a specialist workforce with the right skills, knowledge and attitudes. Workforce is a key enabler for high-quality mental health services.

The Mental Health in Primary Schools pilot, first announced in 2019, was expanded in 2020-21 to 26 government schools, enabling these schools to employ a mental health and wellbeing coordinator in the 2021 school year. This program is a partnership with the Murdoch Children's Research Institute and also supports staff to better understand and respond to student mental health and wellbeing needs.

As part of government's more than $220 million funding to support the mental health and wellbeing needs of Victorians during the pandemic, in August 2020, $28.5 million was provided to expand mental health support in schools, including mental health training for an additional 1,500 school staff, funding Mental Health Practitioners for specialist schools and expanding the capacity of the Navigator and LOOKOUT programs to support the most vulnerable students.

On 11 June 2021, the Government announced funding of $2.24 million, matched dollar-for-dollar by the Commonwealth Government, to increase access to Victoria's headspace services for young people. The funding will urgently deliver surge teams of clinicians in each of Victoria's 13 specialist child and youth mental health services (CYMHS), each of which will work with their local headspace centres.

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

Workforce support and wellbeing during the pandemic

During the pandemic, the department worked collaboratively with services to support mental health programs, ensuring continuity and delivery of essential services and to enable workforce supply.

Guidance provided in *Planning mental health workforce responses in coronavirus (COVID-19) recovery and outbreaks* supported area mental health services to prepare their own contingency plans to address potential workforce shortfalls due to a pandemic outbreak in a mental health service or local geographical area. The guidance provided strategies, workforce models and case studies so service managers, clinicians and the lived experience workforce had the tools and resources to continue safe service delivery.

Case study: Alfred Health alternative care for people relocated from a private hospital

Alfred Health Mental and Addiction Health responded to a pandemic outbreak in a local private hospital by setting up an isolation unit to deliver day-to-day medical care alongside ongoing treatment and care planning.

A flexible mixed-staff model gave consumers access to a dual-speciality style of care. General nurses experienced in supporting patients with the pandemic and in using personal protective equipment worked as contact nurses. The nurses were supported and supervised by a team of

mental health clinicians including senior registered nurses, a psychiatrist, a registrar and an allied health team consisting of a social worker, occupational therapist, pharmacist and allied health assistant.

The education team actively supported general nurses with an online 'Introduction to Psychological First Aid' e-module and listening sessions.

Alfred's Mental and Addiction Health worked in partnership with consumers to develop consumer wellness plans addressing their specific care needs and preferences. Isolation activity kits and apps were provided along with virtual check-in and follow-up work by lived experience and family support staff. Telehealth meetings were used to maintain family and carer involvement. Most consumers returned home at the end of the isolation period and were linked with community supports for ongoing follow-up.

Case study: Split teams and zoned working arrangements

As a rural health service with limited local outside supports, Mildura Health developed guidelines for medical staff as part of the hospital-wide pandemic plan to protect the whole medical workforce from unexpected staff absences. The guidelines had strategies designed to minimise the number of medical staff on sick leave at any one time and to reduce the burden on other hospital medical staff, particularly in the emergency department (ED).

Under the new working arrangements, two groups of staff ('hot area staff' and 'cold area staff') managed different areas of the organisation.

Medical consultant reviews were conducted via telehealth, with a single consultant working in 'hot areas' for two weeks on a rotating basis with reduced outpatient load to allow flexibility to attend to duties in hot areas. These duties included face-to-face reviews and delivering early intervention services.

Consultants from cold areas provided cover for outpatient duties including clinical consultations and supported allied health staff. They also participated in an on-call roster in inpatient units and the ED.

Junior doctors worked on inpatient units and participated in the on-call roster as well. This gave them the capacity to provide after-hours support to ED staff with assessments and admissions and by addressing physical or medical issues.

The psychiatric registrar sat with patients during telehealth reviews conducted by a cold area consultant psychiatrist via an iPad or laptop.

Telehealth ensured family and carer involvement in meetings.

Responses in the pandemic outbreaks surge and hot spot teams for clinical mental health services enabled area mental health services to plan to keep mental health inpatient units operating where a high proportion of staff were furloughed in a pandemic outbreak.

The guidance advised area mental health services on how to support a joint, first-line service response to a pandemic outbreak in shared residential accommodation settings that house vulnerable populations with significant mental health needs. Responses included managing the initial outbreak to stop the spread of infections and setting up and staffing an alternative, time-limited residential facility in a health service.

Case study: Alfred Health outreach to supported residential services

Alfred Health Mental and Addiction Health deployed an in-reach team to local supported residential care services with residents with significant mental health needs.

The in-reach team engaged local residential accommodation services early to establish working relationships, support infection control and prevention, and to prepare clinical plans for the mental health needs of all residents in the event of an outbreak.

During the pandemic outbreak the in-reach team formed part of a local organising response led by the department's Outbreak Management Team, Accommodation Response Team and the lead health service.

The team provided personal protective equipment, advised on infection control in conjunction with Alfred Health Infection Prevention Surveillance Services and provided mental health assessments, treatment and psychosocial and physical health supports for residents exposed to the pandemic and in quarantine.

Alfred Health Mental and Addiction Health staffed a fixed-term, alternative residential facility on the hospital grounds to accommodate and care for people with mental health needs living in a supported residential service that was closed for deep cleaning.

Mental Health Tribunal response

The tribunal saw another increase in hearings during 2020–21. More than 9,500 patient hearings were conducted, and the tribunal made substantive decisions in more than 8,000 hearings (Table 1).

Table 1: Mental Health Tribunal statistics, 2018–19 to 2020–21

Measure	2018–19	2019–20	2020–21
Hearings conducted	8,635	8,786	9,543
Decisions made	7,751	7,761	8,212

Patient attendance at hearings increased during the pandemic to more than 60 per cent (Table 2). The attendance of patients at hearings is important for existing *Mental Health Act 2014* principle (c) *'that persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected'*.

In addition to fully implementing a 10-step action plan to increase hearing attendance and participation (a plan developed in consultation with consumers and carers), teleconferencing use (hearings by telephone) has also contributed to this increase. Driven by the pandemic, the flexibility, convenience and ease of participating by telephone has most likely enabled this increase in patient attendance. And, while there are important reasons to enable face-to-face hearings either virtually or in person as soon as possible, the tribunal is committed to incorporating flexibility in its 'COVID-normal' service model and working out ways to offer all parties flexible options for how they take part in hearings.

Table 2: Mental Health Tribunal – patient attendance at hearings, 2018–19 to 2020–21

Attendee	2018–19: no. (%)	2019–20: no. (%)	2020–21: no. (%)
Patient	4,826 (56%)	5,042 (59%)	5,956 (63%)
Family member	1,522 (18%)	1,544 (18%)	1,713 (18%)
Carer	440 (5%)	372 (4%)	373 (4%)

Sector support, collaboration and information sharing

The impact of the pandemic saw the then Mental Health and Drugs Branch pivot to new ways of working and supporting the mental health services sector in its continuity of care and service delivery. The emphasis has been on ensuring the safety of staff, consumers and carers and continued care and delivery of mental health services.

In the second half of 2020 the branch partnered with Mental Health Reform Victoria to continue its weekly communiques and guidance to sector leaders and clinicians on a range of matters related to the pandemic. The communiques covered such topics as:

- key principles to guide the pandemic response in Victoria's mental health system
- the State of Emergency and what it meant in practice
- advising on current restrictions and their impact for health services and workplaces
- infection control
- inpatient consumer pathways in mental health care during the pandemic
- proper use of personal protective equipment
- family and carer information.

Eating disorders

The Royal Commission into Victoria's Mental Health System noted that over the past decade, there has been an increase in the number of Victorians presenting with eating disorders. Since the pandemic began in early 2020, there has been a further increase in these presentations, including growing numbers of children and young people seeking support.

Research suggests that there may be a number of contributing factors to the recent change. Disruptions to daily routines and constraints on outdoor activities may increase people's weight and shape concerns, and negatively impact eating, exercise and sleeping patterns, potentially increasing eating disorder risk. Increased stress and increased social media use may also have increased the risk of eating disorders for some people. Protective factors such as social support, may have been reduced through pandemic and social restrictions[1].

A further $2 million in new funding for Victorians with eating disorders was announced in January 2021, to support:

- six metropolitan services to provide specialist mental health clinicians to care for young people with eating disorders; and
- additional funding to Eating Disorders Victoria to:
  - create a new dedicated program for people with severe and enduring eating disorders.
  - expand intensive one on one support, coaching programs and online forums; and

[1] Rodgers RF, Lombardo C, Cerolini S, et al. The impact of the COVID-19 pandemic on eating disorder risk and symptoms. Int J Eat Disord. 2020;1–5. Also Touyz et al. Eating disorders in the time of COVID-19, Journal of Eating Disorders (2020)8:19

- implement a Patient Pathways Telehealth Nurse Service

Support to bushfire-affected communities

Some communities affected by the 2019–20 bushfires faced further challenges in 2020–21, with severe storms, floods and border closures due to the pandemic, travel restrictions, tariffs changes, declines in tourism and a mouse plague.

Announced in March 2020, the Community Resilience, Psychosocial and Mental Health Response ($23.4 million) continued service delivery and support throughout 2020–21 and will continue into 2022. The package funds mental health and wellbeing supports and services including access to early intervention, specialist mental health treatment and advisory services.

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

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

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

Funding was also directed to Phoenix Australia, who are world leaders in trauma recovery based at the University of Melbourne. Phoenix Australia continued to provide training and mentorship to community leaders and mental health providers.

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

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

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

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

The investment included $6.6 million across a range of community organisations delivering practical mental health support programs.

Spotlight: Connect Well partnership

Connect Well was founded through a partnership of key organisations in the Outer Gippsland area (East Gippsland and Wellington Shires), with the aim to improve the mental health and wellbeing of people in the region who have been affected by drought or fire. The partnership, auspiced by Gippsland Lakes Complete Health, includes Central Gippsland Health, Lifeline Gippsland, Orbost Regional Health, Omeo District Health, Relationships Australia Victoria, the Royal Flying Doctor Service Victoria and the Yarram and District Health Service.

'Beyond the Fire' docuseries

The Connect Well partnership supported the production of the *Beyond the Fire* documentary. The seven-part series aired on Channel 10, reaching more than one million viewers. There is strong evidence that this initiative has touched people deeply and achieved its objectives of providing a healing and restorative experience for viewers and those engaged in its production. Ninety-four per cent of the 31 people surveyed thought the television series represented the community's experience 'extremely well'.

> Every single episode, I think I cried all the way through them. It was my Saturday afternoon ritual: grab the box of tissues and sit there for the seven episodes. It was hard. But it's also good, part of recovery as well ... The series really came at the right time to help people to actually move on, for me anyway.
>
> – Interview participant, Connect Well Q4 2020–21 report

The Lay of the Land calendar

The Lay of the Land calendar was co-founded by Sallie Jones and has recently been boosted with the support of Connect Well. Sallie co-founded the calendar following the suicide of her father, a farmer in Gippsland. The Lay of the Land calendar begun during a time of deep grief and has been a passion project of Sallie's as she continues to run and grow Gippsland Dairy through the challenges of loss, drought, fire, storms and floods. Sallie has used the calendar to allow farmers to share their honest stories of struggle and resilience. The calendar raises awareness of the challenges associated with poor mental health and wellbeing and aims to decrease stigma, increase early help-seeking behaviours and to start important conversations among mates. A project that started during a time of drought has now continued through fire, storms and a pandemic and will continue to share stories of the resilience and recovery of Victoria's farmers. Sallie has her own story to tell, and part of the story is giving a platform to other producers to share theirs.

Mallacoota: Stand-Up Paddle-Boarding Helps to Heal

From: Callista Cooper, Reclink Australia Q4 2020–21 report

Fog is lifting off the hills that provide the backdrop to 'The Narrows' – a picturesque waterway in Mallacoota surrounded by the Croajingolong National Park, a forest still showing signs of its bushfire scars, 18 months on from The Black Summer. The Stand-Up Paddle Boarding Program transpired through a generous donation from Windermere – an independent community service

organisation working across southeast Victoria, and is delivered by Reclink Australia, a national charity providing sports and recreational opportunities to the far eastern Victorian bushfire-hit communities of Mallacoota, Genoa and Cann River. Surfing Victoria and the Coasting Initiative came on board with training for two Reclink staff to become appropriately qualified to facilitate the weekly sessions.

Helping bushfire recovery with a stand-up paddle-boarding program is unique in Australia – free weekly sessions to local residents as a way to heal from the compounding effects of bushfires and multiple coronavirus (COVID-19) lockdowns. For some, the effects have been astounding – as well as learning a new skill, also finding the physical and mental health benefits that abound through the sport. One participant reflected on the significant mental health benefits of stand-up paddle-boarding:

> I have found that after the fires I've struggled with 'busy brain' where my thoughts flit from one thing to another. The mindfulness involved with learning to SUP has been very beneficial. I find myself coming away from these sessions very happy and refreshed.

Another participant found the marriage of exercise and meditation in the stand-up paddle-boarding sessions was the perfect antidote to stress:

> Thanks for delivering a program that is so welcoming and inclusive and gives those of us with no experience in an activity the ability to join in and feel completely welcomed, no matter our experience level.

Reclink also invites mental health practitioners to attend our sessions so they can meet community members in a non-clinical environment.

The collaboration to deliver this program is a testament to the support both from within and from outside our communities to assist us all in our bushfire recovery journey.

2. Mental health system review and reform

Against the backdrop of significant disruption due to the pandemic in 2020–21, reform of Victoria's mental health system has continued, most importantly with the conclusion of the Royal Commission into Victoria's Mental Health System.

Royal Commission's final report

The final report and recommendations of the Royal Commission into Victoria's Mental Health System were tabled on 2 March 2021 in a historic special sitting of the Victorian Parliament at the Royal Exhibition Building.

The Royal Commission was established in February 2019 and undertook a landmark review of Victoria's mental health system. It provided a comprehensive set of recommendations on how best to support the mental health and wellbeing of Victorians into the future. The final report addresses the reform needed in specialist mental health care as well as recognising the importance of homes, schools, workplaces and communities in supporting mental health. The involvement of, and engagement with, consumers, carers, families and supporters has been a key part of the process.

The Victorian Government has undertaken to implement all 65 recommendations from the final report, together with the nine recommendations from the interim report. The recommendations set out a 10-year vision for a future mental health system where people can access coordinated, high-quality treatment close to their homes and in their communities.

Special sitting of parliament

A special Covid-safe sitting of the Legislative Assembly and Legislative Council was held at the Exhibition Building in March. Speakers included Penny Armytage, AM, chair of the Royal Commission; Patrick McGorry, AO, Chair of the Commission's expert advisory committee; Ms Amelia Morris and Mr Alistair Gabb, both lived experience advocates; the Premier; the Leader of the Opposition; the Minister for Mental Health; and the Shadow Minister for Mental Health.

Penny Armytage, Chair, Royal Commission- picture JMP5081

'The mental health system has catastrophically failed to live up to expectations and is woefully unprepared for current and future challenges. The 2019-20 severe bushfire season and the COVID-19 pandemic have shone further light on the pressures on the system…Despite many members of the mental health workforce doing their best, demand has outstripped supply, the system reacts to mental health crises rather than preventing them and the preferences of consumers are often ignored. The view of families are too often dismissed and their needs inadequately supported.' Hansard 2 March 2021

Amelia Morris- lived experience of mental health issues. Photo JMP 5165

'The Royal Commission into Victoria's Mental Health System is a crucial opportunity. It is a chance for real and meaningful change to ensure that the mental health system can properly respond to those who turn to it. I am hopeful that we can begin to repair the system to ensure that it stops failing the people that need it most. I hope for a system that values and centres lived experience at the core of every decision.' Hansard, 2 March 2021

Alistair Gabb- lived experience of mental health issues- photo JMP 5200

'I am pretty sure everybody in this room can relate somehow personally. Through extended family or friends, they will know someone who has struggled through mental illness or of a condition that has impacted somebody they know or love in a serious way. So, let us all imagine something for a moment. How good would it be for a future patient to be able to walk into any of our healthcare facilities knowing that they would be walking into not only the best available care in the world but also a system where they would get the needed support that they require as an individual, allowing not only themselves but their friends and family the assurance that they will be cared for?' Hansard

Tandem photo L to RJennette Coffey (Tandem) , Sarah Irving (Tandem), the Premier, Associate Professor Melissa Petrakis (Tandem Chair), Katrina Clarke (Tandem Board and CLEW).

'Victoria can potentially have a world class mental health system. This system must be safe, inclusive, fair and well-funded. It must challenge the stigma that those with mental health issues and their carers face. It must have the resources to address all people's issues and to ensure that families and friends are seen as a critical part of the team that treat and manage mental health issues'. Submission by Tandem to the Royal Commission

Premier: 'We need to build a new mental health system from the ground up, ensuring care for those who need it when they need it and whenever they need it.' Hansard 2 March 2021

All photo credits should be attributed to Janusz Molinski and the Parliament of Victoria.except for the photo of Tandem representatives with the Premier (which Tandem provided).

Mental Health Reform Victoria

Mental Health Reform Victoria was established in February 2020 to operate for a time-limited period and implement seven of the royal commission's nine interim recommendations[2]. During 2020–21, several key recommendations from the interim report were progressed:

- co-design commencement for the lived experience residential service
- planning for the Aboriginal social and emotional wellbeing centre hosted by VACCHO, with initial staff appointed, and four lapsing Social and Emotional Wellbeing Teams funded
- expansion of Hospital Outreach Post-suicidal Engagement (HOPE), detailed later in the report
- lived experience peer (carers and consumers) workforce cadets piloted across six community organisations
- lived experience workforce organisational readiness, framework development
- lived experience led quality and experience data collection pilot
- phase one development of a standardised training package for lived experience workforce
- review of the Certificate IV in mental health peer work and development of a student supervision framework for lived experience workers
- Lived Experience Workforces Leadership Pathways and Development package
- increasing psychiatry rotations for junior medical officers
- increasing graduate mental health nursing positions
- development of a foundational allied health graduate program model to support additional allied health positions
- improving workforce data capabilities, beginning with a workforce census and survey
- planning for a broad, multidisciplinary and collaborative leadership network
- postgraduate scholarships for mental health nurse education, with 124 postgraduate nurse scholarships awarded in 2021.

Increased investment in mental health reform

The Royal Commission's interim report recommended reviewing, reforming and implementing multidisciplinary care for bed-based services in a range of settings, including a person's home and fit-for-purpose hospital settings. The Commission's interim report recommended providing additional youth and adult acute mental health beds to help address critical demand pressures.

The Victorian State Budget 2020–21 included $868.6 million for reform and development – the biggest mental health investment in the state's history at the time. The funding included $492 million for 120 mental health beds in Geelong, Epping, Sunshine and Melbourne. The construction of the new mental health beds will gradually be completed between mid-2022 and early 2024 including:

- a new 16-bed mental health facility at the McKellar Centre in Geelong
- a new 30-bed mental health facility at Northern Hospital in Epping
- a new 52-bed mental health facility at Sunshine Hospital in St Albans
- 22 more mental health beds at The Royal Melbourne Hospital in Parkville.

The models of care for these new mental health beds have been designed with input from the consumer and carer lived experience workforce and the clinical workforce in each of these services,

[2] Following release of the royal commission's final report, the then Mental Health and Drugs Branch and Mental Health Reform Victoria integrated into a new Mental Health and Wellbeing Division for the start of 2021-22.

keeping in mind the Royal Commission's recommendations for co-design and partnership approaches.

The 2020–21 funding also included support for designing and implementing a mental health Hospital in the Home (HiTH) program, a new service for consumers who are experiencing acute mental ill health. It provides care in the patient's home or usual place of residence that would otherwise need to be delivered within a hospital. Mental Health HiTH is a 24-hour service delivering a multidisciplinary approach to care while focusing on the psychosocial needs of consumers, families, carers and supporters.

Oyrgen Youth Health, in partnership with Melbourne Health, will provide 15 of these beds with a focus on young people. The first six of these youth HiTH beds opened in December 2020. Barwon Health will provide the remaining nine beds for adults. The first three of these beds opened in March 2021.

Unfortunately, workforce shortages have delayed full implementation of HiTH. The program will continue to expand throughout 2021–22.

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

The Productivity Commission conducted a national inquiry into the role of mental health in supporting economic participation and enhancing productivity and economic growth. The inquiry final report was publicly released on 16 November 2020.

The report made 21 recommendations under the overarching theme of building a person-centred mental health system. Within the report, five key themes emerged:

- prevention and early help for people
- improve people's experiences with mental health care
- improve people's experiences with services beyond the health system
- increase people's participation in further education and work
- instil incentives and accountability for improved outcomes.

The Productivity Commission recommended that all Australian governments should develop a National Mental Health and Suicide Prevention Agreement to clarify responsibilities and the new role of the National Mental Health Commission. The new agreement should also specify additional mental health and psychosocial support funding contributions by each level of government. In December 2020, the National Federation Reform Council agreed to deliver a new Mental Health and Suicide Prevention Agreement. The Commonwealth and states and territories have committed to working together to finalise this Agreement by 30 November 2021.

Mental Health Ministerial Advisory Committee

In June 2019, the Mental Health Ministerial Advisory Committee was established to oversee progress of *Victoria's 10-year mental health plan 2015–2025*, following earlier work by the Mental Health Expert Taskforce. In providing advice, the committee considered the conduct and recommendations of relevant federal and state inquiries, including the Royal Commission into Victoria's Mental Health System's interim report.

The committee comprised mental health and alcohol and other drugs sector leaders and experts, in areas including service delivery, lived experience and workforce. Key focus areas for the committee included mental health reform in Victoria and national initiatives such as the final report of the Productivity Commission's Inquiry into Mental Health and its implications for Victoria. In 2020–21, the committee focused on the mental health coronavirus (COVID-19) response, sharing insights on opportunities and lessons from Victoria's response.

Two standing subcommittees have supported the committee: the Lived Experience Advisory Group and the Mental Health Workforce Reference Group.

National Disability Insurance Scheme

The NDIS is the national approach for providing support to Australians with a disability, their carers and families. This includes people with a severe, enduring psychosocial disability. The NDIS is evolving, and there are a number of reforms underway that will affect Victorian participants with a psychosocial disability and the providers who support them.

In July 2020, the NDIS introduced the Psychosocial Recovery Coach to support participants with psychosocial disabilities to live a full and contributing life. The Victorian Government continues to work collaboratively with the National Disability Insurance Agency, the Commonwealth Government and other jurisdictions to ensure the NDIS delivers its intended benefits for people with a psychosocial disability. Health services have been funded to employ 'NDIS-Health service interface lead roles' to build capacity of the mental health workforce to facilitate an effective relationship with NDIS functions such as access, planning and local area coordination.

New mental health and alcohol and drug community hub underway in Geelong

Work has commenced on the new Barwon Health Central Geelong Mental Health and Drug and Alcohol Services Community Hub initiative, MHDAS Central. The hub will provide consumers and carers with access to comprehensive and integrated assessment, treatment and support services in central Geelong.

MHDAS Central in Moorabool Street Geelong will be a welcoming contemporary facility that will provide support and an alternative to the emergency department for people seeking immediate support and care. The hub will consolidate existing services onto one site and provide extended operating hours, including weekends and public holidays. Services will include assessment, navigation, care planning, treatment, wellbeing support and education. Accessing services can be confusing and complicated; MHDAS Central is an important step in making it easier for consumers, carers, families and stakeholders to access help when required.

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

Victoria's 10-year mental health plan was released in November 2015. The plan sets out the Government's long-term vision to improve the mental health and wellbeing of all Victorians. In the six years since releasing the plan, investment has focused on:

- meeting growing demand for clinical services
- boosting access to community-based services
- expanding and diversifying the mental health workforce
- suicide prevention
- forensic mental health
- Aboriginal social and emotional wellbeing initiatives.

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

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

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

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

Progress on these focus areas during 2020–21 is outlined below.

Outcomes framework

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

The four domains in the outcomes framework highlight high-level areas of focus, with the 16 outcomes reflecting the long-term goal of improving the mental health of all Victorians (Table 3). The framework incorporates a range of indicators relating to system performance, clinical outcomes and consumer experience. Indicators are used to track whether initiatives and programs are contributing to better outcomes for people with a mental illness.

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

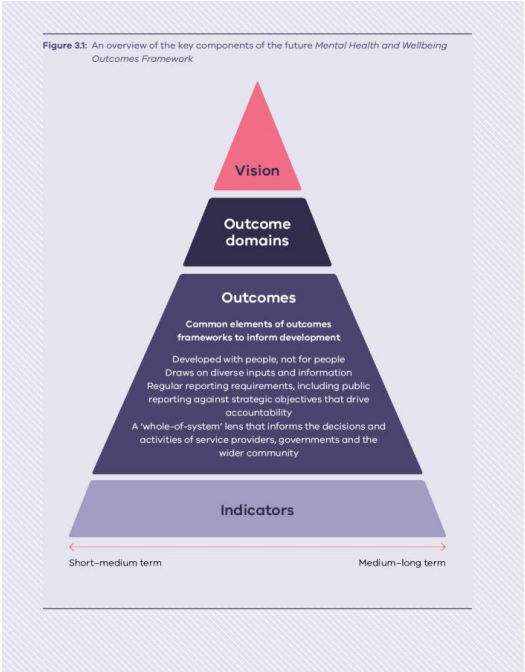
Results for all indicators are set out in full in Appendix 1, with key indicators to note this year discussed below. The most recently available data has been included. Clinical data from November 2020 may have been affected by protected industrial activity affecting the collection of non-clinical

and administrative data and recording of ambulatory mental health service activity and consumer measures. Affected data reported from November 2020 should be interpreted with this in mind.

The Victorian Population Health Survey (VPHS) runs annually and provides a wide range of information about the health, lifestyle and wellbeing of Victorians aged 18 years and older. For the 2020 survey, people being asked about chronic illnesses such as heart disease, asthma or depression also had the option to say (for the first time) that they had been told by a doctor that they had either bipolar disorder or schizophrenia. A relatively small sample of people with bipolar disorder or schizophrenia was obtained; however, it permits some useful insights into the health and wellbeing of Victorians with serious mental illness. Caution should be applied in interpreting some results, but in future, it is hoped a larger sample will be obtained. Where appropriate, information from the VPHS has been included below to illuminate outcomes for Victorians with severe mental illness.

The Royal Commission's final report recommended developing a new mental health and wellbeing outcomes framework to drive collective responsibility and accountability for mental health and wellbeing outcomes. Work on the framework will take place in the second half of 2021. It will be developed in a collaborative process and will draw on existing approaches as well as new ones. The 2020 VPHS results may assist in developing the new framework and new potential indicators for measuring outcomes.

Figure 2: Key components of the future mental health and wellbeing outcomes framework



Source: Royal Commission into Victoria's Mental Health System: final report, Vol. 1, Figure 3.1

Table 3: Outcomes framework – domains and their outcomes

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

Domain 1: Victorians have good mental health and wellbeing

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

Data on selected key indicators

Mental health and wellbeing of vulnerable Victorians

Outcome indicators show that Aboriginal Victorians continue to be over-represented in clinical mental health services. Aboriginal people form about 0.7 per cent of Victoria's population, with 3.3 per cent receiving clinical mental health care compared with 1.12 per cent of the Victorian population overall. This has been trending upwards over the past five years.

Data from the VPHS on levels of psychological distress shows that the proportion of adults with high or very high levels of psychological distress was significantly higher in the Aboriginal population compared with the proportion in all adults, at 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, and very high levels of psychological distress may signify a need for professional help and provide an estimate of the need for mental health services.

For Victorian Aboriginal children, the proportion at high risk of clinically significant problems related to behaviour and emotional wellbeing at school entry rose slightly to 19.7 per cent. However, it remains far higher than the proportion for all Victorian children, which is substantially lower at 7.4 per cent.[3]

There is strong evidence that people who are targets of racism are at greater risk of developing a range of mental health problems such as anxiety and depression. Racism is a key determinant of the health of Aboriginal Australians that may explain the unremitting gap in health and socioeconomic outcomes between Aboriginal and non-Aboriginal Australians.[4] Racism against Aboriginal Victorians is a significant problem. Aboriginal communities are particularly vulnerable to the effects of the pandemic because Aboriginal people have disproportionately high levels of chronic health problems. Although case numbers have been low for Aboriginal Victorians, social and economic disparities may have exacerbated psychological distress related to the pandemic and measures taken to control its spread.

Many LGBTIQ+ Victorians also experience health inequalities, discrimination and economic disadvantage. It is possible that relative economic disadvantage in the LGBTIQ+ community may have been exacerbated 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.

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

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)	2020	14.8%	15.4%	15.0%	18.1%	23.5%
1.2 Proportion of Victorian population receiving clinical mental health care	2020–21	1.05%	1.13%	1.13%	1.14%	1.12%
2.3 Proportion of Victorian population who identify as LGBTIQ+ with high or very high	2020	n/a	22.1%	Not available	Not available	36.6%

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

[4] Markwick A, et al. 2019, 'Experiences of racism among Aboriginal and Torres Strait Islander adults living in the Australian state of Victoria: a cross-sectional population-based study', *BMC Public Health*, 19(1):309.

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
psychological distress (adults)						
3.1 Proportion of Victorian Aboriginal population who are receiving clinical mental health care	2020–21	2.8%	2.8%	3.0%	3.2%	3.3%
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%

Suicide rate

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 and is lower than the national rate of 12.1. Victoria's rate has remained 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 pandemic. Data released by the State Coroner indicates that the year-to-date number of suicide deaths in Victoria at the end of August 2021 is substantially less than for the same period in 2020.

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

Progressing the Balit Murrup social and emotional wellbeing framework

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

Balit Murrup was developed alongside *Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027* – the overarching framework for action to improve the health, wellbeing and safety of Aboriginal Victorians now and over the next 10 years.

Balit Murrup will also provide a policy framework to help guide the planning, co-design and delivery of the royal commission's Aboriginal social and emotional wellbeing recommendations.

Improving mental health outcomes for Aboriginal people

Under *Balit Murrup*, the Victorian Government allocated $20.2 million ($7.7 million in 2016–17, $4 million in 2018–19 and $8.5 million in 2019–20 over two years) to four demonstration projects delivering holistic, integrated and culturally safe social and emotional wellbeing services to Aboriginal people with moderate to severe mental illness. The four demonstration projects are engaging Aboriginal clients and their families for extended periods to support resilience, healing and recovery.

To support integrated care, the demonstration sites, led by ACCOs, partner with local public health services. The four demonstration sites are:

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

During pandemic restrictions, the demonstration projects used telehealth services to continue to engage with their clients and to maintain integrated service delivery. The demonstration sites also adopted the pandemic's safety procedures to ensure outreach services could be maintained.

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

In 2020, more than 650 Aboriginal people received support across the four demonstration projects. For example, since the launch of the Ballarat and District Aboriginal Co-operative Keela Borron program in 2017, 23 children have reunified with their families as a direct result of the program. While family reunification is the ultimate goal, the Keela Borron program has also been instrumental in building parental and caregiver capacity. In providing wraparound supports for parents and caregivers including counselling, psychology, culture groups, men's and women's groups and other ACCO-based health programs, the Keela Borron program is helping prevent and minimise harm while also getting children and young people home to a safe and nurturing environment.[5]

Aboriginal Mental Health Traineeship Program

The 2020–21 Victorian State Budget committed $1.35 million to further support the Aboriginal Mental Health Traineeship Program (established in 2017–18 with $3.5 million over three years).

The Aboriginal Mental Health Traineeship Program is a key workforce program under *Balit Murrup* that is training Aboriginal people to become mental health professionals. Trainees work as part of a multidisciplinary team to provide culturally safe and inclusive mental health care for Aboriginal people in Victoria.

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

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

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

Another key workforce initiative under *Balit Murrup* is the 10 clinical and therapeutic mental health positions employed in ACCOs across regional and metropolitan Victoria since 2017–18. The

[5] Number of active clients across the four demonstration project sites at the end of June 2020 and reunified data reported by Ballarat and Districts Aboriginal Cooperative.

positions have continued in 2020–21 and deliver culturally responsive and trauma-informed services to Aboriginal people, families and communities. The clinical and therapeutic positions subscribe to the concept of self-determination for Aboriginal people. The aim is to empower community and clients to manage their mental health, as well as develop resilience, connect to culture, connect to community, and live a healthy lifestyle.

During pandemic restrictions, the clinical and therapeutic mental health positions continued to provide social and emotional wellbeing services through telehealth and by adopting COVIDSafe procedures to ensure outreach services could be maintained.

The clinical and therapeutic mental health positions are highly skilled and come from a broad range of roles such as mental health nurses, occupational therapists, psychiatrists, psychologists and social workers.

Initiatives under the Victorian suicide prevention framework

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

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

Hospital Outreach Post-Suicide Engagement program

The HOPE program offers assertive, tailored outreach support for a three-month period to people who are at significant risk of suicide following hospital discharge for a suicide attempt.

The objectives of the HOPE program are to improve recovery outcomes, to provide community-based support to help build self-resilience and capacity to self-manage distress and other risk factors for suicidality, and to improve workforce capacity and capability. The program was designed to fill a gap in the mental health system where people sometimes had little or no follow-up care after presenting to an ED with suicidal concerns.

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

The 2020–21 State Budget provided $27.3 million to expand HOPE from the initial 12 sites to all 21 area mental health services as recommended in the Royal Commission into Victoria's Mental Health System's interim report. Six of these new HOPE sites are operational and providing much-needed support following a suicide attempt, with a further three due to begin in August and September 2021.

The new funding also helped improve the program's design including broader referral pathways into the service, extended hours of services, and a new HOPE service for children and young people, in partnership with four health providers. The new child and youth HOPE services will be informed by the experiences of children and young people, and their carers and families. HOPE's expanded pathways, extended service hours and the new child and youth HOPE services are expected to be operational by the end of 2021.

In May 2021, Victoria entered into an expanded bilateral agreement for aftercare following a suicide attempt with the Commonwealth Government under which the Commonwealth matched Victorian investments in HOPE with another four Way Back support services. This builds on the four Way

Back sites the Commonwealth funded when the bilateral agreements began in June 2019, expanding suicide aftercare to 29 sites across Victoria.

In 2021, KPMG completed an evaluation of the first 12 HOPE sites that showed positive outcomes and impacts were achieved for individuals and their support networks. The program is filling a key gap in the system and is supporting people at a transition point between an acute issue and returning to community-based support.

> I'm excited. I've managed to change my whole life … I used to react by getting down. [HOPE staff member] has given me tools, strength and coping mechanisms to deal with situations.
>
> – Client

Place-based suicide prevention trials

Place-based suicide prevention trials continue to be delivered through partnerships and co-investment with Primary Health Networks in 12 locations across Victoria. Victorian Government funding to the sites is due to conclude in June 2022. The new Mental Health and Wellbeing Division in the Department of Health is working with Primary Health Networks and other stakeholders to ensure the achievements and lessons from the trials are shared with mental health services and the community, and to drive sustainability of suicide prevention strategies in the sector and the community.

Using a community development model, each trial uses a range of evidence-based suicide prevention strategies to recognise and respond to signs of suicidality.

Several Primary Health Networks are implementing geographic expansions of trial sites in their catchments based on achievements in their trial sites.

The trials are undergoing an independent, external evaluation, which is still underway. Preliminary findings from the evaluation are positive and suggest improvement over time in local suicide prevention systems and capacity. Systems improvements have occurred in relation to:

- partnerships and collaboration
- care integration and coordination
- prioritising suicide prevention.

Healthy Equal Youth project and grants

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

In 2020-21, the Victorian Government allocated $1.9 million through the HEY project to 16 organisations to undertake mental health promotion and community engagement activities with a focus on LGBTIQ+ young people aged up to 25 years and their families.

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

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

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

People with severe mental illness have poorer physical health yet receive less and lower quality health care than the rest of the population.[6] The VPHS found a statistically significant higher proportion (14.2 per cent) of adults with schizophrenia who were also told by their doctor that they had type 2 diabetes, compared with all adults (5.8 per cent).[7] Many commonly prescribed medications for schizophrenia can cause weight gain, increasing the risk of type 2 diabetes.

There was a statistically significantly higher proportion (38.8 per cent) of adults with a severe mental illness who were obese compared with all adults (20.1 per cent). Conversely, there was a statistically significantly lower proportion of adults with a severe mental illness who were of normal weight compared with all adults. This is consistent with the finding of a higher prevalence of type 2 diabetes.

In relation to smoking, the VPHS found a statistically significantly higher proportion (40.9 per cent) of adults with a severe mental illness who were current smokers compared with all adults (16.8 per cent). Conversely, there was a statistically significantly lower proportion of adults with a severe mental illness who were non-smokers compared with all adults.

Data on selected key indicators

Our outcomes framework indicators for physical health are tobacco use (as a risk factor) and type 2 diabetes (as a preventable illness). Results this year have improved slightly with a decrease in both the proportion of admitted clients who used tobacco and registered clients with type 2 diabetes. However, as discussed in appendix one, and consistent with the VPHS, the indicators show a much higher proportion of clients with tobacco use or a diagnosis of type 2 diabetes than the general population.

Mental health conditions are associated with reduced life expectancy. A range of factors contribute to this mortality gap, including disadvantage, increased prevalence of chronic illness, reduced help-seeking and the accessibility and quality of health care[8].

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	2020-21	38.2%	37.1%	36.5%	36.5%		32.7%

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

[7] The relative standard error associated with the estimate for those with schizophrenia was high, indicating that this estimate must be interpreted with caution.

[8] Sara G, Chen W, Large M, Ramanuj P, Curtis J, McMillan F, Mulder CL, Currow D, Burgess P (2021). Potentially preventable hospitalisations for physical health conditions in community mental health service users: a population-wide linkage study. Epidemiology and Psychiatric Sciences 30, e22, 1–10. https://doi.org/10.1017/S204579602100007X

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior		Most current data
5.2 Proportion of registered mental health clients with a type 2 diabetes diagnosis	2020–21	9.8%	9.9%	10.0%	10.1%		9.3%

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

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

Establishing outcome indicators for domain 3 under the 10-year mental health plan proved challenging. Data linkage is one mechanism, but it can be difficult to arrange the relevant information sharing and can require substantial resources, including expertise to analyse linked data. Some questions from the VPHS, however, are directly relevant to this domain.

Wellbeing includes both objective and subjective measures. Objective measures include measures such as life expectancy. Subjective wellbeing incorporates both a person's emotions and their information-based appraisal of how their life is measuring up to their expectations.[9] High subjective wellbeing (such as life satisfaction, absence of negative emotions, optimism and positive emotions) causes better health and longevity.

The survey found statistically significantly higher proportions of adults with a severe mental illness who reported low (23.8 per cent) and medium (29.8 per cent) satisfaction with life compared with all adults (6.7 per cent and 16.9 per cent respectively). Conversely, there was a statistically significantly lower proportion of adults with a severe mental illness who reported high satisfaction with life compared with all adults.

In addition, there was a statistically significantly higher proportion (30.7 per cent) of adults with a severe mental illness (bipolar disorder and/or schizophrenia) who never or not often felt valued by society compared with all adults (10.8 per cent). Conversely, there was a significantly lower proportion (26.9 per cent) of adults with a severe mental illness who felt valued by society compared with all adults (52.0 per cent).

Domain 3 includes the outcomes related to Victorians with mental illness participating in and contributing to the economy, and Victorians with mental illness having financial security. In previous years, discussion has occurred with the Department of Social Security to link data in order to assess income support. This type of approach may be explored further in future, as linkage becomes more accepted and routine.

There is a well-established link between employment status and health, with unemployment being associated with poorer health. The VPHS looked at the employment status of respondents, finding a

[9] Victorian Agency for Health Information 2021, *Victorian Population Health Survey 2019: summary of results*, State of Victoria, Melbourne.

statistically significantly higher proportion (22.6 per cent) of adults with a severe mental illness who were unemployed compared with all adults (9.2 per cent). Conversely there was a statistically significantly lower proportion (45.1 per cent) of adults with a severe mental illness who were employed compared with all adults (61.6 per cent). There was no difference in the proportions of adults who were not in the labour force.

There was a statistically significantly higher proportion (45.6 per cent) of adults with a severe mental illness who said they could not raise $2,000 within two days in an emergency, indicating that they were financially stressed compared with all adults (16.1 per cent). Financial stress is a health risk factor.

Another outcome under this domain is that Victorians with mental illness are socially engaged and live in inclusive communities. The VPHS asked questions to measure the level of social and emotional support that an individual has. There was a statistically significantly lower proportion (88.9 per cent) of adults with a severe mental illness who had close friends or family with whom they talked regularly compared with all adults (94.9 per cent).

Data on selected key indicators

Psychological risk rating for prisoners

In 2020–21, there was a significant increase in people allocated a psychiatric risk rating (P-rating) on reception to prison (within one week). 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 pandemic-related restrictions on Victorians. Measures required to reduce the risk of transmitting the pandemic in prisons (including protective quarantine and suspension of face-to-face visits) may also play a role, though these are less likely to have had 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	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%

Registered clients living in stable housing

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

are in stable housing, the proportion with unstable housing is large in comparison with the general population and is increasing.

A recent review of the evidence on housing and mental health[10] found a lack of affordable, safe and appropriate housing for people with mental ill health, and that secure tenure allows people to focus on mental health treatment and rehabilitation. Housing, homelessness and mental health are interrelated, and the health and mental health of Victorians relies in part on access to housing.

Victoria is making a substantial effort to increase the amount of social housing through the Big Housing Build. This initiative includes building safe, secure and stable housing for more than 2,000 Victorians with mental illness.

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	2020–21	81%	80%	80%	79%	80%

Early Intervention Psychosocial Support Response

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

In 2020–21, this statewide service provided psychosocial supports to approximately 2,673 people. During this period 588 people living with a significant, enduring psychosocial disability were supported while they completed the NDIS access process and became an NDIS participant. More than 40 per cent of these clients require intensive support, which is defined as requiring support at least five times a week or multiple times a day. A further 40 per cent require moderate-level support, defined as one to five episodes of support each week.

The Victorian Government committed further funding of more than $50 million over two years, until early to mid-2023, to 16 health services across Victoria to deliver this service in partnership with non-government organisations. The initiative began in January 2019. Health services and community-managed mental health providers are working together to provide people with a psychosocial disability with integrated treatment and psychosocial recovery care in the community. This will reduce the impact that mental illness can have on people's ability to self-manage their mental illness, form meaningful relationships and take part in community life.

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

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

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

Data on selected key indicators

Consumer experience

The Your Experience of Service (YES) survey did not run in 2020 owing to the pandemic, but it was run in the first half of 2021. 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 (18.7 per cent) or always (69.7 per cent) respected. This was followed by the proportion of consumers who reported they usually (22.7 per cent) or always (58.0 per cent) had opportunities for family and carers to be involved in their treatment or care if they wanted. 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 (33.8 per cent) and a further quarter as very good (25.4 per cent). While a further substantial proportion rated their experience of care as good (22.8 per cent), there is clear room for improvement for some consumers.

The survey provides input from a consumer perspective on how mental health services are performing. Consumer-reported measures help to build a more person-centred view of mental health service performance. The introduction of the Carer Experience Survey provides another important source of data for how families, carers and supporters experience Victorian mental health services.

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
14.6 Proportion of consumers who reported they usually (22.7%) or always (58.0%) had opportunities for family and carers to be involved in their treatment or care if they wanted	2020–21	82.5%	83.8%	82.5%	n/a[11]	80.7%
15.1 Proportion of consumers reporting their individuality and values were usually (18.7%) or always (69.7) respected	2020–21	88.0%	88.7%	90.1%	n/a	88.4%
16.6 Proportion of consumers who rated their experience of care with a service in the last three months as very good (25.4%) or excellent (33.8%)	2020–21	65.1%	65.4%	65.5%	n/a	61.2%

Compulsory treatment and restrictive interventions

The proportion of compulsory inpatient admissions has decreased, as has the duration of compulsory treatment. The rate of seclusion episodes has risen slightly. These results are explored in detail later in this report.

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
16.1 Rate of seclusion episodes per 1,000 occupied bed days (inpatient)	2020–21	10.0	9.7	8.6	9.7	10.0
16.4 Proportion of inpatient admissions that are compulsory	2020–21	51.4%	50.3%	49.7%	51.0%	50.2%
16.5 Average duration of compulsory orders (days)	2020–21	64.1	76.6	75.6	82.9	78.2

[11] Because of the pandemic, the YES survey was not conducted in 2019–20 as planned.

Progressing the mental health workforce strategy

The Royal Commission into Victoria's Mental Health System noted that positive outcomes for people living with mental illness, their families and carers, are related to the composition, values and skills of the workforce. Victoria's *Mental health workforce strategy*, released in 2016, was developed to strengthen the mental health workforce in a rapidly changing environment characterised by growing demand, increasingly diverse and complex consumer circumstances and an ageing population. Initiatives related to the royal commission have completed the strategy's implementation. The Royal Commission final report recommended a new mental health and wellbeing workforce strategy be developed by the end of 2021.

Attraction, retention and workforce supply

Workforce Strengthening Project

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

In 2020–21, the Workforce Strengthening Project has delivered funding for 126.5 fulltime-equivalent (FTE) mental health positions. Positions supported in 2020–21 include:

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

Following an implementation evaluation in 2019–20, the department engaged St Vincent's Hospital Melbourne to lead a research and evaluation project that will evaluate the impact of the Workforce Strengthening Project positions. St Vincent's will also undertake research into workforce attraction and retention in public specialist mental health services.

Recovery Workforce Package

The $235 million Recovery Workforce Package, provided in the 2020–21 Victorian State Budget, has increased support for frontline workers across mental health, family violence, health and child protection, creating better pathways to roles in these vital sectors, and recruiting to new positions. Within this, $12.7 million was allocated to positions in mental health services for the following positions:

- *Child and adolescent psychiatry (CAP) rotations in public specialist mental health services*. Mental health services were asked to take part in an expression of interest process to increase the number of training positions. Overall, 43 additional mandatory CAP rotations and capacity for seven FTE supervision positions were supported. Eighteen rotations will occur at regional mental health services.
- *Mental health prequalification employment positions*. These positions provide allied health, nursing, medical and psychology undergraduates with work experience opportunities and attract future candidates to mental health roles. The funding provides employment for 52 prequalification nursing students and 68 prequalification allied health and medicine students. The positions are placed across eight services, five of which are establishing new prequalification employment programs.

- *Transition to mental health nursing positions*. These positions provide support for experienced registered nurses to transition into mental health nursing. A pilot program was established to place ED nurses from Sunshine Hospital into the North Western Mental Health transition-to-mental-health nursing program. The purpose of this project is to increase the capacity and capability of staff in EDs to respond to consumers and their families or carers when presenting with mental health issues. Further transition nurse positions are to be allocated to Victorian mental health services in 2021–22.

Regional workforce relocation grants pilot

Regional mental health services were offered access to grants in 2020–21 to support worker relocation through Rural Workforce Agency Victoria. At the time of the report the grants were still open to services.

Mental health workforce attraction and recruitment – communication strategy

In 2020–21, the department engaged a marketing agency to develop a communication strategy to support mental health workforce attraction and recruitment. Consumers, carers, mental health services and target discipline groups have been engaged in developing the strategy, this was delivered in September 2021.

Workforce development

In addition to the broad learning and development offerings through the Centre for Mental Health Learning's training calendar, a number of discipline-specific initiatives were supported in 2020–21.

Lived experience workforce initiatives

Several initiatives focused on practice support. Development opportunities for lived experience workforces also continued in 2020–21. These included:

- access to supervision for lived experience workers – a pilot project led by the Centre for Mental Health Learning in partnership with VMIAC and Tandem
- consumer perspective supervision training
- the *Family carer lived experience workforce supervision framework* and funding for training development
- Intentional Peer Support five-day core training and two-day training for managers of peer support workers.

Psychiatry Leadership Development Program

Following the Psychiatry Leadership Development Grants offered in 2020–21, the department funded a program to further support psychiatry leadership 2020–21.

The Psychiatry Leadership Program is being designed to build the leadership capabilities for the future mental health system as envisaged by the Royal Commission into Victoria's Mental Health System's final report. The program will build Victorian psychiatrist's leadership capabilities in:

- co-leadership with consumers, carers and their families
- change management
- quality improvement and safety management
- other priority areas as determined through a co-production process.

The program is being developed by the Royal Australian and New Zealand College of Psychiatrists (Victoria Branch) in collaboration with VMIAC, Tandem, the Victorian Aboriginal Community

Controlled Health Organisation, Victorian Transcultural Mental Health and the Centre for Mental Health Learning Victoria.

Lived Experience Workforce Advisory Group

The department established the Lived Experience Workforce Advisory Group (LEWAG) in July 2020. The LEWAG Provides guidance for reform activity and new investment related to lived experience workforce, and the implementation of strategic projects across the Mental Health and Wellbeing Division. The group comprises lived experience workers from various roles across community and clinical mental health and AOD services, and agencies that have a role in providing supports and development to lived experience workforce, including HASCU, Mental Health Victoria, Centre for Mental Health Learning, Harm Reduction Victoria; SHARC; VMIAC and Tandem.

Consumers, families and carers as partners

Safe, high-quality mental health services depend on effective partnerships with consumers, families and carers. Positive participation by consumers and carers, as well as clinicians and other people from the community, is based on mutual respect and recognition of the specific knowledge, expertise and experience that each brings.

The recommendations from the Royal Commission emphasise the variety of ways in which people with a lived experience of mental ill health and their families and carers will take part in transforming the mental health system. This includes consultation with the community, co-designing solutions and introducing numerous new leadership roles to elevate the voices of people with lived experience in service design and delivery.

Within the department's Mental Health and Wellbeing Division, this includes establishing a Lived Experience Branch and an Executive Director, Lived Experience. This team will include several new designated lived experience roles in both mental health and alcohol and other drugs to build on existing lived expertise within the division and in Safer Care Victoria.

Lived Experience Advisory Group

The Lived Experience Advisory Group (LEAG) brings together consumers, families and carers, safeguarding agencies and the department's Mental Health and Wellbeing Division to embed lived experience perspectives across the division, and to support safe, appropriate and authentic lived experience engagement to inform the division's work. The LEAG is key to ensuring lived experience perspectives inform the reform agenda set out by the royal commission.

The LEAG is co-chaired by the CEOs of VMIAC and Tandem and an executive director from the Mental Health and Wellbeing Division. The group is informed by the principles outlined in the department's *Lived experience engagement framework*. It provides expert advice on lived experience perspectives in a range of areas such as increasing supported decision making and supporting the lived experience workforce (including consumer and carer consultants).

The LEAG is a key strategic partner in implementing the Royal Commission's recommendations, providing expert advice from lived experience and rights-safeguarding perspectives across the transformation agenda.

The group played a significant role in providing advice on the impact of the pandemic on consumers, families and carers, and in developing strategies to support Victorians during this unprecedented time.

Consumer profile – Flick Grey

Consumer member of the Lived Experience Advisory Group
Mental health researcher

When I had my first experience framed as a 'mental health problem', I was already an academic, voraciously engaging with social theory. Like the American author and social activist bell hooks, 'I came to theory because I was hurting – the pain within me was so intense that I could not go on living … I saw in theory then a location for healing'. While I have met many kind individuals working in the mental health system, the structures of meaning-making kept hurting. I discovered the consumer/survivor movement and new possibilities began to emerge. Over the past 15 years I've been privileged to have incredible conversations locally, nationally and internationally with some brilliant thinkers in the consumer/survivor movement and beyond.

Currently, I'm a consumer member of the Lived Experience Advisory Group, alongside freelance work training, supervising, offering Open Dialogue and consultancy. I'm also passionately involved in Mad Studies. Previously, I've worked as a consumer consultant, academic, peer manager and resource coordinator.

I'm especially committed to what Miranda Fricker calls 'hermeneutical justice', expanding collective hermeneutical resources (ways of thinking). The ways we currently understand human experiences of distress and extreme states are limited by the dominance of psychiatric framings, and I believe other ways of understanding these experiences are foundational to system-wide change. I'm often described as 'a spanner' (because what I offer disrupts thinking-as-usual), but I prefer wilder metaphors, like being a theoretical magpie, picking up and offering various juicy morsels of possibilities.

It's taken me a while to figure out my place in this collective grappling, around questions of how to best support people in distress or experiencing extreme states. Being part of the LEAG has been really generative – a living example of what's possible when people with different perspectives come together in a dialogic structure that explicitly redresses existing power differentials. I don't feel like I need to come with pre-formed answers but trust that collectively we will find ways forward.

Participation registers

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

The registers allow a consistent approach to engaging a diverse range of consumers, families and carers. The registers are managed by VMIAC and Tandem and are used by the Mental Health and Wellbeing Division and other Victorian government agencies. Register participants are inducted by peers at VMIAC and Tandem and are supported and remunerated during participation activities. While there are challenges both for participants and divisional staff in learning how to work together, there is a growing understanding of how to do this work safely and effectively. Working with registered participants allows unique and valuable perspectives to be incorporated into the Division's work and ensures work is grounded in the lived experiences of those who use services, and their families and carers.

Consumer and carer consultants

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

Consultants work from either a consumer or family/carer perspective. A consumer consultant has a lived experience of mental health challenges and an understanding of the public mental health service system. Family/carer consultants have a lived experience of supporting someone with mental health challenges or psychological distress. Consultants draw on personal experience as well as feedback from other consumers, family and carers to contribute to system improvements. They aim to promote lived experience perspective in all levels of decision making and are placed at the centre of policy and practice change, as partners in co-design and co-production. This includes representing consumer or carer perspectives at meetings, advising on policy, designing and delivering training, and promoting consumer-focused, recovery-oriented service delivery. Consultants are employed in each area mental health service across Victoria, having local influence and working together across services to ensure higher level mental health reform.

The Statewide Consumer Consultant Council was established in 2019 to provide an opportunity for consumer consultants to connect and develop the role and related work priorities. The department supports this group as key partners in helping ensure services meet the needs of those who use them. The council has become a highly valued group for the department to connect with consumers for advice on a range of reform and policy issues. Tandem Time, hosted by Tandem, provides support and an opportunity for the family and carer workforce, including consultants and peer workers, to share information, best practice and emerging research, and identify system issues and advocacy opportunities. Work is also being undertaken to support the family and carer workforce in partnership with the carer lived experience workforce, the Centre for Mental Health Learning and the Bouverie Centre.

Profile: Monash Health Mental Health Program – consumer and family/carer service

The Monash Health Mental Health Program has a long history of employing lived experience staff. The current senior consumer consultant has worked at Monash Health for more than 22 years, and the senior family/carer consultant for more than 12. Lived experience consultants have played an essential role for many years at Monash Health in promoting the consumer and family/carer voice within the mental health program. Their work includes representation on committees and working groups (including Quality and Safety and National Standards committees), participating in staff recruitment and selection, staff training and education, and supporting the design and review of mental health services.

The lived experience consultants also support a number of community advisors, who are community members with both consumer and family/carer lived experience. This group meets once a month as a Lived Experience Advisory Forum, followed by the Advisory Committee, which is also attended by the mental health program director and general manager.

Over the past 18 months or so, work has been undertaken to formalise and record all lived experience participation and engagement activities within the mental health program. Processes are now in place for managing requests for lived experience participation, including processing

payments for community advisors. All policies and procedures and patient information is reviewed from a lived experience perspective.

The lived experience consultants also take the lead on the YES (consumer) and, most recently, the CES (carer) experience surveys, from administering the surveys to helping the program understand the results and develop improvement plans.

From 2018, Monash Health has also employed consumer and family/carer peer workers on four adult inpatient units. From the outset, Monash established peer work team leader positions to provide lived experience leadership and to support the peer workers alongside the nurse unit managers. In 2020, Monash expanded the peer workforce to the ED at Monash Medical Centre, the youth community teams, and most recently one of the adult community teams in Casey. In a relatively short space of time, the peer workforce has proved to be valued members of multidisciplinary teams, providing invaluable support to consumers, their family members and carers. Peer workers are also great champions for consumer choice, recovery and family-inclusive practice.

Given the size of the mental health program at Monash Health, with nine inpatient units, eight community bed-based services and more than 30 community-based teams, it is essential that the lived experience workforce continues to grow to support all service areas. Monash looks forward to seeing an expansion in the lived experience leadership structure and consultant workforce to support the review and co-design of services following the recommendations from the royal commission. Monash will expand the consumer and family/carer peer workforce across all service areas in its mental health program.

Coronavirus (COVID-19) impact on consumers, carers and families

The pandemic has changed the way we live and will continue to do so. The virus and its associated restrictions have challenged the mental health and wellbeing of all Victorians.

For many people who were already experiencing psychological and emotional distress, this was heightened due to the compounding effects of lockdown. A VMIAC survey found that most respondents reported poorer mental health during the pandemic compared with their previous situation. Seclusion, physical distancing and not being able to go outside or exercise were noted as the biggest contributing factors to worsening mental health.

Consumers experienced reduced access to mental health services and formal supports, as well as informal support networks such as friends and family. Mental health inpatient units suspended visits from families and friends, as well as restricting leave for consumers.

For families, carers and supporters, many people took on increased caring responsibilities while trying to manage their own wellbeing. The department increased the funding available to support carers through the Mental Health Carer Support Fund, which provides respite and hardship assistance to support people in their caring role.

Both VMIAC and Tandem provided much-needed support to consumers and their families and carers during the pandemic. The department continues to work closely with the peak bodies to respond to the continuing impacts of the pandemic.

Victorian Mental Illness Awareness Council projects

VMIAC is the peak Victorian non-government organisation for people with lived experience of mental health issues or emotional distress. It provides advocacy, education, consultation and information to promote the rights of people using, or wanting to use, mental health services.

During the pandemic, and particularly in periods of lockdown, VMIAC received a substantial increase in the number of calls from consumers experiencing heightened distress. In response to this, the department funded VMIAC to establish the 'Check-In' service, offering a peer-based connection and support program for people with a lived experience of mental or emotional distress. The program included:

- a six-week program offering weekly sessions with a peer support worker over Zoom or telephone
- an eight-week program offering weekly sessions of art making, meditative practice, yoga, Wayapa Wuurrk and reflection practices over Zoom (or in person when available).

VMIAC also played a key role in advising on and supporting engagement with consumers to provide submissions to the royal commission. This included support with consumers' submissions, hosting roundtables with the Commissioners, and working directly with Mental Health Reform Victoria as part of implementation. Since the release of the royal commission's final report, VMIAC has continued to engage with consumers and has provided response reports on aspects of report, including on developing the new Mental Health and Wellbeing Act.

Tandem projects

Tandem is the peak Victorian not-for-profit body for carers of people with mental health issues and organisations with a mental health carer-support focus. Tandem's role is to provide leadership, coordination and information for the organisations and individuals advocating for family and friends of people living with mental health issues.

To support carers with the increased pressure and hardship brought about by the pandemic, Tandem received increased funding for the Carer Support Fund and introduced cash payments to facilitate easier and faster access to hardship support for carers engaged with mental health services. Tandem reported a significant increase in the number of applications since the pandemic began, with the cash payments making up most requests.

In addition to increased hardship support, Tandem extended its support and referral line and ran weekly meditation sessions for families and carers. Their CRAFT program encouraged families, carers and supporters to contribute to a wall hanging that will be launched when the pandemic-related restrictions allow.

Tandem was instrumental in supporting families and carers to engage with the royal commission, facilitating roundtables across the state for families and carers to share their views and stories with the Commissioners. Tandem supported carers with individual submissions and submitted its own response, which called for a compassionate mental health and wellbeing system that is fair, funded, inclusive and safe.

Measuring experience of service

Your Experience of Service survey

The YES survey is a national tool that provides an annual snapshot of consumers' experiences using clinical mental health and psychosocial rehabilitation support services. The survey currently consists of two questionnaires, both of which were developed with mental health consumers. The questionnaires are based on the recovery principles in the National Standards for Mental Health Services.

There are separate questions for users of clinical (hospital and community-based) services and community-managed organisations. Run annually since 2016, the YES survey covers a number of

domains including: dignity and respect; evaluating recovery; uniqueness and the individual; partnership and communication; attitudes and rights; and providing real choices.

Since 2019, six new questions have been included in Victoria's clinical questionnaire. These were developed with consumers and refined with feedback from the Chief Psychiatrist and mental health services. The questions explore more specific areas of service experience, including restrictive interventions, advance statements, personal safety and physical health.

In 2020, concerns were raised about whether the survey could safely be administered during the pandemic. In consultation with YES champions in services, including the lived experience workforce, a decision was taken to not conduct the survey.

In 2021, the pandemic continued to affect the survey. Unfortunately, the survey fieldwork period coincided with a lockdown and related restrictions in mental health services. Several strategies were introduced to mitigate this and ensure consumers were provided with an opportunity to complete the survey. This included extending the fieldwork period, piloting innovations in delivering the survey and more frequent forums for YES champions to collectively problem-solve. As a result of these efforts and the ongoing flexibility of services, 2,367 surveys were returned (2,760 in 2019 and 2,532 in 2018).

Carer Experience Survey

The CES was implemented across Victoria for the first time in 2020. Like the YES survey, the CES is a national tool that provides an annual snapshot of people's experience of mental health services, except the CES focuses on carers' experiences.

A steering group was established that included mental health carers, carer consultants, Tandem and VMIAC to co-design the CES for Victoria. A mailout methodology was endorsed to maximise reach and access, given that many carers are not frequently onsite at services. Five additional questions were co-designed by the group and added to the Victorian survey.

The survey consists of 28 questions, which include closed-coded and open-ended questions across seven domains: providing information and support, valuing individuality, supporting active participation, showing respect, making a difference, safety, and discharge.

Implementation was delayed due to the pandemic, and the fieldwork period ran between December 2020 and March 2021, which surveyed carers' experiences between April and October 2020. As such, results reflect carers' experiences during lockdown and its associated restrictions. In all, 1,098 surveys were completed, representing a 12 per cent return rate.

Some services declined to take part due to a paucity of carer details. However, it is expected that all services will take part in future surveys, and this will be a focus of the 2021 implementation to support statewide involvement.

Results suggest significant room for improvement across all domains. Overall, 20 per cent of carers reported their experience with the service as excellent. Carers reported a lack of family-inclusive practice, particularly around involvement in treatment, care and discharge planning. Additionally, carers reported a perceived lack of support in their caring role, as well as gaps in service and system orientation, participation and mental health literacy. Areas that performed well included carers receiving a number they could call after hours (71 per cent), feeling their opinion was respected (54 per cent) and feeling safe while using the service (53 per cent). Feedback from family/carer consultants indicate that the CES results are consistent with anecdotal understanding of carers' experiences with Victorian mental health services. Formalising these insights provide a valuable baseline for continuous improvement, and the department is working with services to embed the CES in local outcomes frameworks.

Grampians Prevention and Recovery Care (PARC) Opening

The Grampians PARC opened in early August 2020 and has been working at close to full capacity since then. The service provides early intervention support and clinical treatment for people who are unwell, or who are recovering from an acute illness and need a period of extra support.

The PARC is located in central Ballarat and provides a safe and supportive 12-bed residential setting close to public transport, shops and Ballarat Health Service. This allows consumers to receive treatment while still having access to their existing support networks and community. The PARC is helping to fill a service gap between community and hospital-based care, for people who are at a stage where they may find it difficult to cope at home.

The service model offers both short-term (up to 28 days) and longer term (up to three months) placements, depending on the needs of the consumer. It is open to people aged between 16 and 64 years, and many of the consumers who have used the PARC to date have been young people aged under 25 years.

The Grampians PARC was designed to blend in with the neighbourhood's character. The building connects three existing heritage buildings, with a series of courtyard spaces, including two functional outdoor areas (a quiet courtyard and an active one). Wide eaves and sheltered outdoor activity spaces make the building more sustainable and resilient to changing climates.

All of the 12 bedrooms have ensuites, and swipe cards for added privacy. There are three wings, which each have four bedrooms and a separate lounge area with TV. This ensures the service can manage gender safety concerns when required. The PARC has a large communal kitchen dining and living space, where consumers can socialise; make meals and engage with the activities program.

PARCs provide recovery-oriented services, which offer consumers autonomy and social inclusion, together with clinical mental health care. Individual and group programs offer practical assistance, therapeutic activities, and socialisation opportunities that take into account consumer preferences.

Programs at Grampians PARC are co-facilitated with peer workers and include a morning session focussed on mind and body, followed by a mutual help group. Afternoon activities might include a drum beat session run by Catholic Care or physical activities run by Reclink. Volunteers come in to run art and craft sessions as well as gardening (some of the produce is used in the cooking at PARC). Shopping, cooking and cleaning are also part of the agenda, and help people prepare to go home.

The new service is helping some consumers avoid a hospital admission, and for others Grampians PARC is part of their pathway out of hospital and back home.

Home › Mental health › **Community-based care**

Grampians Prevention and Recovery Care centre

4. Public mental health services in 2020–21

Key statistics for 2020–21:
Total service hours: 1,309,614
Emergency department presentations: 105,741

Overview

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

The pandemic took hold in early 2020 and has changed the way Victorians of all ages have lived their lives in the past 18 months. This has affected people in many ways, including our mental health and how public mental health services have been delivered. There has been a disproportionate impact on the mental health of children and young people.

The Australian Bureau of Statistics (ABS) found in June 2021 that almost one in three (30 per cent) younger Australians aged 18 to 34 years experienced high or very high levels of psychological distress.[12] In comparison, 18 per cent of people aged 35 to 64 years and 10 per cent of people aged 65 or older experienced high or very high levels of psychological distress. The ABS found that more people living in Victoria in June 2021 (27 per cent) experienced high or very high levels of psychological distress compared with the rest of Australia (18 per cent). For consent reasons, children are often excluded from population health surveys, so data on children and young people aged under 18 is less available than data for adults. However, the survey found that around half (48 per cent) of all people who reported having a mental health condition experienced high or very high levels of psychological distress compared with 16 per cent who did not have such a condition.

One source of data on young people is Mission Australia's large annual survey of people aged 15 to 19 years conducted between April and August 2020.[13] Nationally, more than four in 10 (42.6 per cent) young people felt stressed either all of the time or most of the time. Double the proportion of female respondents felt stressed all the time or most of the time (53.9 per cent compared with 26.8 per cent of males). The top three issues of personal concern for young people from Victoria were coping with stress, body image and mental health. Nationally, young people who identified the pandemic as a personal concern reported being worried about a range of issues, including the impact of the pandemic on education, isolation and mental health.

Measures taken to control the pandemic, such as restrictions on movement and activity, 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.[14] This may be exacerbated by excessive use of electronic and social media. Loss of

[12] Household Impacts of COVID-19 Survey <https://www.abs.gov.au/statistics/people/people-and-communities/household-impacts-covid-19-survey/latest-release>

[13] Tiller E, et al. 2020, *Youth Survey Report 2020*, Mission Australia, Sydney.

[14] 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.

predictable structure and routines, and lack of social connectedness with friends, can be substantial issues for young people.[15] Consequent loneliness cannot necessarily be mitigated by using phones or other forms of communication.[16] Loneliness is a risk factor for mental ill health, as well as being distressing in its own right.[17]

In looking at clinical mental health data for the year, the effects of the pandemic are evident. 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 2020–21 compared with the previous year. On 30 June 2020, a return to stage 3 Stay at Home restrictions was announced, so 2020–21 began with restrictions in place in Victoria. Restrictions, which became more severe, stayed in place for months, and were eased on 28 October 2020 and again on 8 November 2020. Subsequently there were other outbreaks of coronavirus (COVID-19), resulting in further periods of restrictions.

The total number of mental health ED presentations was higher in each quarter of 2020–21 than it had been the previous year. The proportion of total ED presentations that were mental health–related rose slightly (Table 4).

Table 4: Mental health–related ED presentations as a proportion of all ED presentations during the coronavirus (COVID-19) pandemic

Measure	Q1	Q2	Q3	Q4	Total
Mental health ED presentations 2019–20	24,585	26,489	25,840	24,031	100,945
Mental health ED presentations 2020–21	25,775	27,679	26,365	25,922	105,741
Mental health–related ED presentations as a percentage of total presentations 2019–20	5.24%	5.62%	5.64%	6.86%	5.77%
Mental health–related ED presentations as a percentage of total presentations 2020–21	7.25%	6.31%	5.59%	5.51%	6.09%

Published reports suggest that the pandemic has had a negative effect on children's mental health, and EDs are often the first point of care. In America, the proportion of mental health–related ED visits for young people aged 12 to 17 years increased by 31 per cent in the period from March to October 2020 compared with the same period in 2019. The proportion of mental health–related ED visits was higher among girls and young women aged under 18 years.[18]

[15] Nearchou F, et al. 2020, 'Exploring the impact of COVID-19 on mental health outcomes in children and adolescents: a systematic review', *International Journal of Environmental Research and Public Health*, 17(22):8479.

[16] Ellis WE, et al. 2020, 'Physically isolated but socially connected: psychological adjustment and stress among adolescents during the initial COVID-19 crisis', *Canadian Journal of Behavioural Science*, 52:177–187.

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

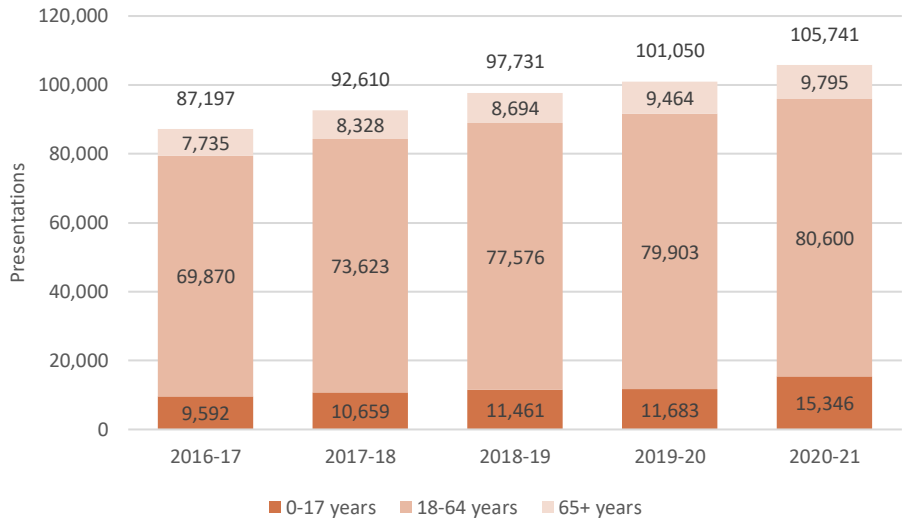
[18] Leeb R, et al. 2020, 'Mental health–related emergency department visits among children aged under 18 years during the COVID-19 pandemic – United States, January 1 – October 17 2020', *The Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report*, 69(45):1675–1680.

In recent years the number of young people presenting to Victorian EDs with mental health concerns has steadily increased.[19] The pandemic appears to have accelerated an existing trend. Although some effects of the virus and its related restrictions are emerging, 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).[20]

As discussed above, the social and educational impacts of the pandemic on children and young people have been substantial. Compared with older age groups, young people have experienced high rates of psychological distress, loneliness, educational disruption, unemployment, housing stress and domestic violence.[21] Young people are also concerned about their lack of voice in decision making, and in being negatively stereotyped. Among young people aged 13 to 17 years, in July–August 2020, the proportion who thought there was no clear way for children and young people to feed into the national discussion rose from 26 per cent in April to 65 per cent in July–August.[22]

The number of mental health–related ED presentations among children and young people had been slowly increasing in recent years but jumped sharply from 11,683 in 2019–20 to 15,346 in 2020–21. Presentations by adults and older people rose slightly but were similar to the levels of the previous year (Figure 3).

Figure 3: Emergency department presentations, by age, 2016–17 to 2020–21



Data source: VEMD

In relation to acute inpatient and bed-based care, and services in the community, the pandemic also had effects. The number of hospitalisations during each quarter of 2020–21 for mental illness was less than the comparable quarter the previous year.

[19] Hiscock H, et al. 2018, 'Paediatric mental and physical health presentations to emergency departments, Victoria, 2008–15', *Medical Journal of Australia*, 208(8):343-348.

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

[21] Ibid.

[22] UNICEF (United Nations International Children's Emergency Fund) Australia <https://www.unicef.org.au/about-us/publications> (August 2020)

Services took a range of actions to protect the health and wellbeing of consumers, carers and staff, including implementing contingency plans and reducing admissions to prevention and recovery care (PARC) services to create alternative treatment settings for a pandemic outbreak. Some services with rooms where there are shared facilities had to reduce available bed numbers. At times services had bed closures for a week or more across multiple campuses due to outbreaks. Overall, there was a reduction in the number of acute mental health separations in comparison with the previous year (Table 5).

Table 5: Mental health acute separations (excluding same days) for each quarter, 2019–20 and 2020–21

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4
2019–20	7,905	8,074	7,888	7,183
2020–21	6,664	6,780	6,529	6,911

Bed occupancy was substantially reduced in acute admitted care, as shown in Table 6. Occupancy levels returned to slightly above desirable maximum occupancy for acute inpatient settings in non-pandemic conditions but remain well under pre-pandemic levels.

Table 6: Quarterly bed occupancy levels, 2020–21

Setting	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Admitted – acute	82.6%	83.1%	83.1%	83.9%
Admitted – non-acute	91.0%	89.9%	88.4%	88.1%
Non-admitted – bed-based	83.4%	85.0%	85.7%	83.8%
Non-admitted – subacute (CCU)	77.1%	79.2%	81.1%	82.1%
Non-admitted – subacute (PARC)	59.6%	71.0%	73.4%	74.1%
Total	**80.6%**	**82.4%**	**82.9%**	**83.1%**

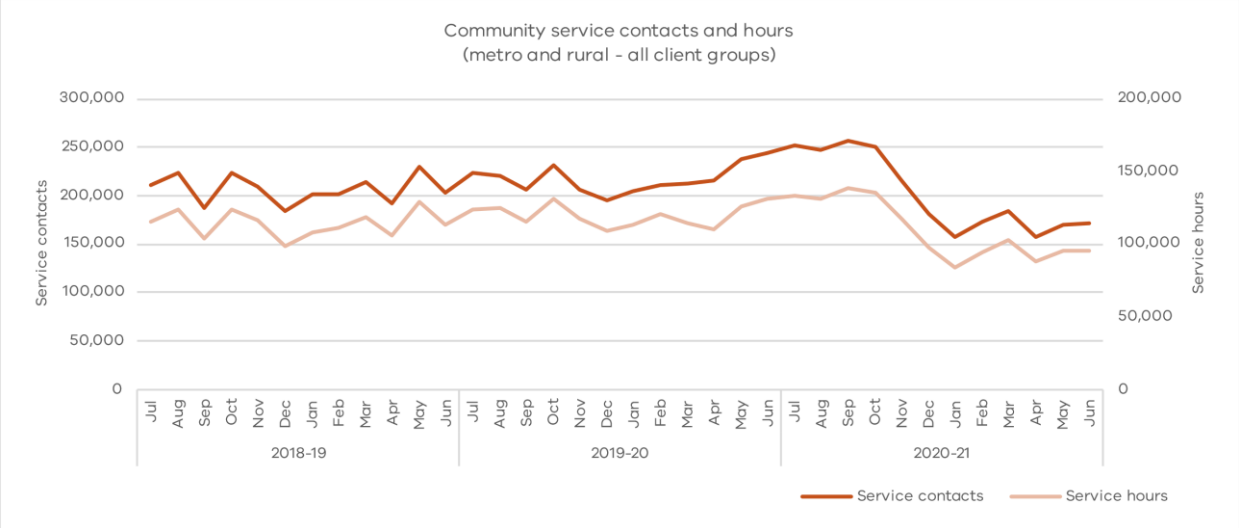
Community contact data shows changes with an apparent substantial decrease across the year. Table 7 shows the increase in adult community contacts during the first quarter of 2021 compared with 2020. Figure 4 shows the drop in recorded contacts from November 2020 that reflects under-reporting of service activity. From this time, data for community mental health services in particular is less complete. The mode of contacts changed substantially during the pandemic away from face-to-face service delivery and towards phone and videoconferencing. For 2020–21, 51.7 per cent of all contacts occurred by phone, 29.2 per cent were direct, 10.7 per cent were classed 'other asynchronous'[23] and 5.9 per cent involved videoconference or teleconference.

[23] Asynchronous electronic communication devices include answering machines, email, SMS, text messaging and voicemail. The information exchange is 'asynchronous' where the participant/recipient can read and respond as their availability permits.

Table 7: Adult community service contacts, 2018–19 to 2020–21

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4
2018–19	466,015	463,752	467,620	466,335
2019–20	481,900	472,910	473,617	524,083
2020–21	566,848	483,088	376,149	358,560

Figure 4: Community service contacts and hours, 2018–19 to 2020–21



Data source: CMI/ODS. Date extracted: 13 August 2021

The majority of people who use clinical mental health services are adults, therefore utilising adult mental health services. The number of consumers who are children, younger people, and older people, is smaller. Specialist services and forensic services have the smallest client populations. The overall number of consumers in 2020–21 was stable; however, this masks changes between different groups. There was a large increase in child and adolescent mental health services (CAMHS) consumers of 7.0 per cent. For adults, numbers remained static, with a slight increase of 1.0 per cent. For aged, specialist and forensic services, consumer numbers decreased slightly.

Service contacts decreased overall (−7.4 per cent); however, the data is incomplete. The largest percentage decrease is for consumers using aged persons mental health services (−13.0 per cent). Data from CYMHS shows a small increase in service contacts overall of 2.9 per cent. Forensic consumer contacts reportedly decreased by 12.2 per cent, and contacts from specialist mental health services decreased by 5.7 per cent.

Total service hours are also incomplete and reportedly decreased by 8.8 per cent overall, but the impact varied across different groups. The only reported increase was for CYMHS service hours (2.2 per cent). Other groups reportedly decreased: −17.0 per cent in aged, −10.2 per cent in adult services, −6.8 per cent in forensic services and −11.7 per cent for specialist hours.

The data shows higher demand for CAMHS during 2020–21. Adult inpatient services have historically been under pressure to meet demand. The number of adult inpatient admissions for mental illness has shown a slight reduction in each of the last two years due to the pandemic. Adult services have very high occupancy levels, and the trimmed average length of stay is under 10 days and has been since before 2015–16 (Table 8). Forensic services for compulsory treatment are also under pressure, with very high bed occupancy and only a small number of separations.

Table 8: Trimmed average length of stay (≤ 35 days), 2016–17 to 2020–21

Population	2016–17	2017–18	2018–19	2019–20	2020–21
Adult	9.5	9.1	9.2	9.5	9.4
Aged	15.7	15.5	15.1	15.4	15.7
CYMHS	6.9	6.6	6.5	6.3	5.8
Forensic	20.5	21.7	24.0	21.8	19.1
Specialist	15.8	15.3	16.0	15.6	15.0
Total	**10.0**	**9.6**	**9.6**	**9.8**	**9.7**

Who accessed public mental health services in 2020–21?

Key statistic for 2020–21:
76,832 registered consumers, similar to last year

There was an increase in the number of children and young people, and adult consumers, accessing public mental health services in 2020–21. The total number of people accessing services was 76,832, similar to the previous year. Adult and aged persons consumer numbers dropped across the four quarters. Child and adolescent consumer numbers were higher in the first half of the year. A drop in the number of specialist consumers was evident in quarters 2 and 3. Forensic services are a relatively small part of the service system, and the number of consumers was fairly steady across the year.

About two-thirds of adult, aged and specialist consumers, and more than half of children and young people, previously had contact with mental health services during the past five years. Just over half of registered consumers (52.0 per cent) were women or girls and a third (33.2 per cent) lived in rural areas.

How were people referred to clinical services in 2020–21?

Most people were referred to clinical mental health services by hospitals, as shown in Table 9. About a quarter of referrals were from EDs (24.4 per cent), and Table 10 shows that the proportion of referrals from EDs has generally been increasing over time – from 21.9 per cent in 2016–17. A further 23.0 per cent of referrals came from acute health. The latter group may include people who were admitted with a physical illness or injury and were subsequently referred for mental health treatment. General practitioners continued to be a key source of referrals (9.8 per cent), as did families (6.8 per cent).

A small proportion of consumers (7.7 per cent) were taken to an ED by police or protective services officers under s. 351 of the Mental Health Act. This occurs if a police officer or protective services officer is satisfied that a person appears to have a mental health issue and, because of the apparent issue, the person needs to be apprehended to prevent serious and imminent harm to themselves or another person. The purpose of the apprehension is to facilitate examination of the person by a doctor or assessment by a mental health practitioner.

During 2020–21, there were 8,113 presentations to EDs under s. 351, a 24 per cent increase on the previous year. The vast majority (81.6 per cent or 6,622 people) related to adults aged 18 to 65 years. This was followed by people aged under 18, who accounted for 1,262 or 15.6 per cent of these presentations. The number of these presentations involving young people under 18 years

increased by 65.4 per cent, up from 763 in 2019–20. Numbers also increased for adults, from 5,566 to 6,622.

There were 105,741 mental health–related ED presentations in 2020–21, a 4.6 per cent increase from the previous year, spread across all age groups (Table 11). Across the age spectrum, there were 26,874 separations in mental health acute inpatient units in 2020–21, which was very similar to 2019–20. There has been a slight decrease in the proportion of compulsory admissions this year, with fluctuation in a narrow range over the past five years. In 2020–21, 50.2 per cent of admissions were compulsory. The increase may relate to the impact of the pandemic and the lower number of admissions overall.

Table 9: Source of mental health referrals, 2020–21

Referral source	2020–21
Emergency department	24.6%
Acute health	23.0%
General practitioner	9.8%
Family	6.8%
Consumer/self	4.7%
Community health services	4.0%
Police	3.9%
Others and unknown	23.2%

Table 10: Source of referrals (newly referred consumers only), 2016–17 to 2020–21

Setting	2016–17	2017–18	2018–19	2019–20	2020–21
Acute health	22.1%	21.5%	21.6%	22.1%	23.1%
Emergency department	21.9%	24.1%	27.3%	25.9%	24.4%
General practitioner	11.6%	11.5%	10.3%	9.8%	9.8%
Family	7.9%	7.2%	6.5%	6.7%	6.8%
Client/self	4.6%	4.7%	4.3%	4.7%	4.7%
Community health services	4.7%	4.9%	4.1%	4.3%	4.1%
Police	3.5%	3.7%	3.6%	3.7%	3.9%
Others and unknown	23.8%	22.2%	22.4%	22.7%	23.1%

Table 11: Mental health–related emergency department presentations, 2016–17 to 2020–21

Population	2016–17	2017–18	2018–19	2019–20	2020–21
Adult	69,870	73,623	77,576	79,903	80,600
Aged	7,735	8,328	8,694	9,464	9,795
CYMHS	9,592	10,659	11,461	11,683	15,346
Total	**87,197**	**92,610**	**97,731**	**101,050**	**105,741**

How did people experience our services?

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

Many results for the YES survey dropped slightly this year, with the fieldwork period coinciding with a lockdown and related restrictions. The results show that one-third of consumers rated their experience of care with a service in the preceding three months as excellent (33.8 per cent) and a further quarter as very good (25.4 per cent). While a substantial proportion rated their experience of care as good (22.8 per cent), there is clear room for improvement for some consumers. For Victorian inpatients during lockdown periods, experiences may have been negatively affected by bans on visitors, leave and other restrictions to prevent the spread of coronavirus (COVID-19). For consumers in the community, many services were delivered by phone to reduce the risk of infection, and for consumers who prefer face-to-face contact, this may not have been ideal.

Despite the pandemic, the CES was implemented across Victoria for the first time in 2020. This is an important new source of information about our services and the experience of families, carers and supporters. The CES implementation also occurred during lockdown and associated restrictions, and results suggest significant room for improvement. Overall, 20 per cent of carers reported their experience with a service as excellent. 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 2020–21:

12,566 CAMHS consumers, an increase of 7.0 per cent

2,623 separations [24]

There was an increase in both inpatient and community clinical mental health service activity in 2020–21. Most children and young people receive clinical treatment in the community. In 2020–21, a higher proportion of service hours (18.5 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

[24] The term 'separations' is a way of describing the number of times people receive an episode of bed-based care. A consumer is separated at the time the hospital ceases to be responsible for the person's care, and they are discharged from hospital accommodation. One consumer can have several separations over the course of a year.

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 2020–21, there were 12,566 registered CAMHS consumers, an substantial increase of 7.0 per cent.

Some children and young people in Victoria require inpatient treatment for mental illness. During the year, there were 2,623 separations of children and young people for mental illness, an increase of 15.1 per cent over the previous year. Compulsory admissions were at 21.6 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 fell substantially to 19.1 days in 2020–21, a drop of almost 22 per cent from the previous year. The proportion of children and young people receiving treatment in the community on a community treatment order remained low and stable at 1.0 per cent.

The trimmed average length of stay (< 35 days) for CYMHS is experiencing a slight downward trend and was 5.8 days in 2020–21 (Table 8). The long-term trend for length of stay has been downwards since 2008–09 when it was 10.3 days. Children and young people who stayed longer than 35 days accounted for 10.5 per cent of all CAMHS bed days. The bed occupancy rate rose substantially to 66.4 per cent for the year (Table 12). There was a steady rise in bed occupancy from 60.6 per cent in quarter 1 to 70.6 per cent in quarter 4. The readmission rate for CAMHS rose this year. It is high in comparison with other age groups, at 23.4 per cent in 2020–21. 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 2020–21, there were 357,791 reported contacts, an increase of 2.9 per cent, which continues the pattern of an increase in service activity over the past five years.

Table 12: CYMHS bed occupancy rate (including leave, excluding same days), 2015–16 to 2020–21

Setting	2016–17	2017–18	2018–19	2019–20	2020–21
Admitted – acute	60.9%	62.6%	60.4%	60.9%	66.4%

Adult mental health services

Key statistics for 2020–21:
62,095 adult consumers[25]
20,857 separations

Inpatient services

In 2020–21, there were 20,857 separations of adults for mental illness, very similar to last year. Hospitalisations fluctuated during the year, rising in the first six months of 2020–21. 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 steady at 55.5 per cent.

Bed occupancy for adult inpatient services was high at 86.9 per cent (Table 13), but this is lower than usual levels because of the pandemic. Occupancy levels of around 95 per cent have been sustained for several years and present significant ongoing challenges for services. The trimmed length of stay for adults is steady at 9.4 days.

Of the adults who were admitted as inpatients, 58.9 per cent had contact with a community service before admission. The post-discharge follow-up rate was 84.9 per cent, but the data is incomplete. In 2020–21, 15.1 per cent of people were readmitted to hospital within 28 days of discharge compared with 14.6 per cent in 2019–20. 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 13: Adult bed occupancy rates (including leave, excluding same day), 2016–17 to 2020–21

Setting	2016–17	2017–18	2018–19	2019–20	2020–21
Admitted – acute	95.0%	94.6%	94.6%	92.5%	86.9%
Admitted – non-acute	88.5%	82.7%	83.4%	87.6%	86.4%
Non-admitted – subacute (CCU)	78.6%	80.1%	80.9%	80.3%	79.9%
Non-admitted – subacute (PARC)	80.7%	75.7%	79.0%	71.3%	69.5%
Total	**87.9%**	**86.7%**	**87.6%**	**85.8%**	**82.4%**

Clinical mental health services delivered in the community

Key statistics for 2020–21:
1,784,646 contacts
934,113 service hours

The number of recorded community contacts for adults in 2020–21 was 1,784,646, an apparent decrease of 8.5 per cent over the previous year. Service hours show an apparent decrease of 10.2

[25] 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.

per cent. The mode of service delivery changed substantially with the impact of the pandemic. Face-to-face contacts reduced substantially from March 2020 and were increasingly replaced by phone and videoconference contacts. Consistent with the previous four years, 14.9 per cent of adult consumers receiving treatment in the community were on community treatment orders.

Prevention and recovery care

Key statistics for 2020–21:
3,668 separations
69.5 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 three youth PARCs for young people aged 16 to 25 years in Bendigo, Frankston and Dandenong. A fourth youth PARC is due to open in Parkville in early 2022. Young people may also attend an adult PARC; however, it is rare for 16 to 18-year-olds to do so.

Service activity in PARCs fluctuated due to the pandemic. Separations increased by 8.7 per cent to 3,668, with more separations after quarter 1. Occupied bed days increased this year by 2.5 per cent and bed occupancy was at 69.5 per cent, substantially down from the usual level of 75–80 per cent. Occupancy varies between services and tends to be higher in urban areas. During the pandemic, admissions for some PARCs were limited to step-down care from inpatient units to ensure greater infection control and to meet workplace physical distancing requirements. Some consumers chose their home environment rather than a PARC because of concerns about infection. Additionally, some PARCs scaled down service delivery as part of a strategy to potentially use PARCs as extension services for inpatient units if required.

Aged persons mental health services

Key statistics for 2019–20:
8,019 aged consumers[26]
217,506 community contacts

The number of aged consumers using public mental health services decreased slightly by 3.3 per cent in 2020–21 to 8,019. Most of this group had previous contact with mental health services, with 35.1 per cent being new consumers. During the year, there were 2,246 separations of Victorians aged 65 years or older. Bed occupancy decreased this year (Table 14), but there were slightly more mental health ED presentations of older people than in 2019–20.

The trimmed average length of stay remained steady at 15.7 days. This is much longer than the adult length of stay. The longer length of stay partly reflects the time that is sometimes required to find safe, appropriate accommodation, or to put in place appropriate discharge supports for unwell elderly people. Sometimes a consumer cannot be discharged to return home, or a nursing home may decline to have them return to that service. It may be necessary to find alternative

[26] 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.

accommodation and undertake processes such as applications to VCAT for guardianship and administration orders.

The preadmission contact rate was 60.9 per cent. Half of all admissions were compulsory, and this has been fairly stable over the past four years. The post-discharge follow-up rate was 89.4 per cent, a drop from previous years, but the data may be incomplete. Readmissions within 28 days were relatively low at 7.1 per cent and reduced from the year prior. There are good reasons during the 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 homelike 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 172 separations in 2020–21, a small increase from last year, although the bed occupancy rate was steady at 85.0 per cent. They provided 146,161 occupied bed days, slightly up from last year. Aged care bed-based facilities have faced particular risks from the coronavirus (COVID-19) pandemic, and it is not surprising to see some reductions in this part of the sector.

There were 217,506 community contacts in 2019–20, an apparent decrease of 13.0 per cent. Service hours also showed an apparent reduction at 107,164 hours (a reported decrease of 17.0 per cent).

Table 14: Aged persons bed occupancy rates (including leave, excluding same day), 2016–17 to 2020–21

Setting	2016–17	2017–18	2018–19	2019–20	2020–21
Admitted – acute	85.2%	87.0%	87.7%	80.9%	79.8%
Non-admitted – bed-based	86.9%	87.3%	86.9%	83.9%	85.0%
Total	**86.4%**	**87.2%**	**87.2%**	**82.9%**	**83.3%**

Forensic mental health services

Key statistics for 2020–21:
1,177 consumers
183 separations
20,877 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 decreased by 4.9 per cent following a substantial increase in each of the four previous years. Overall, there were 183 separations of people from acute forensic mental health inpatient units during the year, an increase of 46 from 2019–20. Forensic mental health service provision has increased in recent years. The number of forensic consumers has risen

steadily, and a higher number of separations is consistent with this increase in service use and provision. Pressure on forensic inpatient beds remains high, with a bed occupancy rate of 96.8 per cent (Table 15).

Forensic consumers had the longest average duration of compulsory treatment, at 105.9 days. This part of the service system had the lowest proportion of new consumers at 18.1 per cent – most had some engagement with services in the preceding five years.

Table 15: Forensic bed occupancy rates (including leave, excluding same day), 2016–17 to 2020–21

Setting	2016–17	2017–18	2018–19	2019–20	2020–21
Admitted – acute	95.0%	96.6%	95.5%	95.0%	96.8%
Admitted – non-acute	94.4%	93.1%	94.5%	96.4%	95.7%
Total	**94.6%**	**94.3%**	**94.8%**	**95.9%**	**96.1%**

Specialist mental health services

Key statistics for 2020–21:
1,922 consumers
975 separations
33,248 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 an apparent 5.7 per cent decrease in service contacts in 2020–21, and a slight decrease in the number of consumers receiving specialist services. Some bed-based services in this category were temporarily delivered in the community to reduce the risks of the pandemic to consumers, carers and the workforce.

There were 975 separations from specialist services, 1.6 per cent fewer than last year. The trimmed average length of stay (≤ 35 days) was similar to the past three years at 15.0 days and was substantially longer than the comparable figure for adults not receiving specialist services. People who stayed longer than 35 days accounted for 19.4 per cent of occupied bed days. The preadmission contact rate improved, and post-discharge follow-up continued a substantial upward trend from 2016–17. However, both rates remained relatively low at 43.5 per cent and 68.3 per cent respectively. Readmissions within 28 days are unusual, with a rate of 1.9 per cent in 2020–21.

Admitted acute occupied bed days rose slightly to 23,453, and the bed occupancy rate, which is variable, was 67.1 per cent. There are a small number of specialist bed-based services, and bed occupancy for these services dropped a little to 72.2 per cent from 79.2 per cent.

Compulsory treatment

The new Mental Health and Wellbeing Act recommended by the Royal Commission into Victoria's Mental Health System will specify measures to reduce rates and negative impacts of compulsory assessment and treatment, seclusion and restraint. The Royal Commission recommended that the government acts immediately to ensure compulsory treatment is only used as a last resort. The

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.[27]

The proportion of consumers on a community treatment order has been steady over time. For adults, there has been a range of 14.4–14.9 per cent over the past four years, and the current rate is 14.9 per cent. Very few CAMHS consumers are on community treatment orders, with a steady rate of 1.0–1.1 per cent. Community orders are also relatively unusual for aged persons and specialist services clients, with rates in 2020–21 of 5.0 and 7.7 per cent respectively. Orders are more common for forensic consumers, but the rate remains steady at 13.7 per cent.

The average duration of compulsory treatment in the service system has been trending upwards over time, as shown in Table 16. However, for adults, by far the largest group, there has been a reduction this year. There has also been a reduction for CAMHS and specialist consumers. Steady increases continue for aged and forensic clients.

Table 16: Average duration (days) of a period of compulsory treatment by cohort, 2016–17 to 2020–21

Population	2016–17	2017–18	2018–19	2019–20	2020–21
Adult	64.5	76.7	75.7	83.1	77.4
Aged	50.5	61.5	66.1	70.3	75.4
CAMHS	23.8	21.8	24.8	24.4	19.1
Forensic	79.5	87.3	91.5	100.6	105.9
Specialist	39.7	49.6	54.2	69	47.1
Total	**64.13**	**76.6**	**75.6**	**82.9**	**78.2**

Seclusion and restraint

Key statistics for 2020–21:

Seclusion rate – 9.4 per 1,000 occupied bed days (adults)

Average inpatient seclusion duration – 7.3 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 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.[28]

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

The rate of seclusion rose to 10.0 episodes per 1,000 occupied bed days in 2020–21, from a rate of 9.7 in 2019–20 (Table 17). This rate was across all services, which masks the frequency of the

[27] Recommendation 55

[28] Recommendation 54

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 41.1 per 1,000 occupied bed days. This year the rate for children and young people decreased to 10.1.

Table 17: Seclusion episodes per 1,000 occupied bed days, 2016–17 to 2020–21

Population	2016–17	2017–18	2018–19	2019–20	2020–21
Adult	11.3	10.5	9.5	10	9.4
Aged	1.8	1.2	0.7	0.6	0.6
CAMHS	5.4	8.8	12	14.4	10.1
Forensic	28.7	34.3	26.8	33	41.1
Specialist	3.1	0.6	0.4	0.5	2.9
Total	**10.0**	**9.7**	**8.6**	**9.7**	**10.0**

Work is underway with all services to reduce the use of restrictive interventions, including work with CAMHS. For 2020–21, 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 because it is rare for an older person to be secluded, and that rate is already low. Nonetheless, there are differences between services and targets assist in moving all services towards reduced use of restrictive interventions.

The highest rate of seclusion occurs in forensic services, as can been seen in Table 17, with adults and CAMHS services having similar seclusion rates this year. The target for seclusion for children, young people, and adults is 10.0 per 1,000 occupied bed days. For older people it is 5.0 and for forensic services the target is 15.0 per 1,000 occupied bed days. 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 show a welcome decline this year. 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 2020–21, developing tailored behavioural programs and intensifying staffing efforts.

The average duration of seclusion has increased from 13.8 hours in 2019–20 to 15.3 hours (Table 18) following a substantial reduction from 20.0 hours in 2018–19. This figure includes consumers with a forensic background for whom the average duration of seclusion was 34.5 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.

Table 18: Average inpatient seclusion duration (hours), 2016–17 to 2020–21

Population	2016–17	2017–18	2018–19	2019–20	2020–21
Adult	9.6	8.9	6.3	6	7.3
Aged	5	5.5	4.4	6.5	2.9
CAMHS	1.1	1.5	1	3.2	2.5
Forensic	52.2	48.5	81.4	40.5	34.5
Specialist	94.6	9.4	2.3	3.8	27.4

Population	2016–17	2017–18	2018–19	2019–20	2020–21
Total	**17.4**	**16.7**	**20.0**	**13.8**	**15.3**

The corresponding figure for adults was 7.3 hours, an increase from last year's figure of six hours. For children and young people, the average duration of seclusion decreased this year to 2.5 hours from 3.2 hours the previous year.

The bodily restraint rate was steady this year at 21.1 compared with 21.0 per 1,000 occupied bed days in 2019–20. The rate varied from 1.0 for specialist consumers to 76.5 per 1,000 occupied bed days for consumers with a forensic background, reducing from 90.3 in 2019–20 and 162.1 in 2018–19. The average duration of restraint reduced to 12 minutes in 2020–21, from 18 minutes the previous year.

Appendix 1: Mental health reporting based on the outcomes framework

The outcomes framework, and its indicators, measure and monitor how our programs and services are contributing to improved outcomes for people with mental illness. The pandemic has affected the delivery of some surveys, and the capacity of departments and services to undertake new developmental work on indicators has been reduced.

Domain 1: Victorians have good mental health and wellbeing

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

Data for outcomes 1 and 2 is drawn from the 2020 Victorian Population Health Survey and other sources and reflects the wellbeing of Victorians during the 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.[29] From March 2020, widespread restrictions of movement, physical distancing measures and physical isolation or lockdowns were 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 (23.5 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.

During the pandemic, the Australian Bureau of Statistics and several universities have conducted surveys to examine the impact of coronavirus (COVID-19) on the mental health of Australians. These surveys have shown changes over time in the levels of distress in the population. This is not surprising; at times case numbers have dropped and people's lives and occupations have begun to return to normal. There is some evidence that rates of mental distress have had a similar pattern to financial stress over the course of the pandemic.[30]

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.

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

[30] Melbourne Institute 2020, *Coping with COVID-19: rethinking Australia*. Chapter 4: Heightened mental distress: Can addressing financial stress help?

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)	2020	14.8%	15.4%	15.0%	18.1%	23.5%
1.2 Proportion of Victorian population receiving clinical mental health care	2020–21	1.05%	1.13%	1.13%	1.14%	1.12%
1.3 Proportion of Victorian young people with positive psychological development[31]	2018	68.8%	n/a	67.3%	n/a	67.3%
1.4 Proportion of Victorian older persons (65 years or older) with high or very high psychological distress	2020	8.5%	10.0%	9.2%	11.9%	14.2%
1.5 Proportion of children at school entry at high risk of clinically significant problems related to behaviour and emotional wellbeing	2020	4.8%	4.9%	5.6%	6.7%	7.4%

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	2020	17.2%	17.3%	13.8%	19.6%	23.3%

[31] 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
high psychological distress (adults)						
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%

This is 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.[32] Mental health and general physical health are poorer for LGBTIQ+ adults compared with non-LGBTIQ+ adults, and a higher proportion have two or more chronic illnesses.[33] 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 inexperience food insecurity.[34] It is possible that relative economic disadvantage in the LGBTIQ+ community may have been exacerbated 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 0.7 per cent of Victoria's population, yet the proportion of the Aboriginal population receiving clinical mental health care sits at 3.3 per cent and has been trending upwards over the past five years.

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

[33] 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

[34] Ibid., Table 7.

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, and very high levels of psychological distress may signify a need for professional help and provide an estimate of the need for mental health services. Levels for Aboriginal Victorians showed substantial and 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.[35]

Aboriginal communities are especially vulnerable to the effects of the pandemic, as people have disproportionately high levels of chronic health conditions.[36] The low incidence of cases in Victoria's Aboriginal communities is a credit to Aboriginal health services and leaders, and to health experts and health services. However, social and economic disparities may have exacerbated psychological distress related to the pandemic and measures taken to control its spread. Additional stress, loss and uncertainty associated with the pandemic, physical and social isolation and restricted practices combined with increasing rates of unemployment and financial distress may have had a larger impact on a subpopulation that was already vulnerable.

The proportion of Victorian Aboriginal children at school entry at high risk of clinically significant problems related to behaviour and emotional wellbeing rose slightly this year to 19.7 per cent. Although the proportion for all Victorian children rose in 2019, at 7.4 per cent, it is substantially lower than the proportion for Victorian Aboriginal children.[37]

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.

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	2020–21	2.8%	2.8%	3.0%	3.2%	3.3%

[35] 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.

[36] Victorian Aboriginal Community Controlled Health Organisation submission to Victorian Government's Response to the COVID-19 pandemic <https://www.parliament.vic.gov.au/images/stories/committees/paec/COVID-19_Inquiry/Submissions/77._Victorian_Aboriginal_Community_Controlled_Health_Organisation.pdf>

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

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
receiving clinical mental health care						
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 pandemic. Data released by the State Coroner indicates that the year-to-date number of suicide deaths in Victoria at the end of August 2021 is substantially less than the number at the same time in 2020.[12]

Studies have consistently found that the pandemic has had a negative impact on the mental health of Victorians and Australians, but to date, there has been no evidence of an accompanying increase in suicides. Analysis of Victorian data found that the pandemic has been a factor in some suicide deaths but that the pandemics does not appear to be a discrete stressor in its own right.[13] The pandemic, for some people, is a context that produces stress across domains of people's lives by precipitating negative life events such as job loss and isolation, straining relationships, and frustrating people's efforts to improve their lot.

Supporting people's mental health is important, and for Victorians experiencing stress related to the pandemic, access to housing, welfare, employment and other services relevant to their situation may help. Financial support for businesses and individuals during the pandemic; prohibitions on evictions; and efforts to support social connectedness may all have contributed to the small reduction in the suicide rate.

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. Data quality for this year may therefore be affected by changed patterns of admission due to the pandemic.

Nonetheless there is a reduction in tobacco use, which is trending down. Tobacco smoking is Australia's leading cause of preventable death and disease, and 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%).[38]

The proportion of registered clients with a type 2 diabetes diagnosis is slightly reduced this year, however, 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	2020-21	38.2%	37.1%	36.5%	36.5%	32.7%
5.2 Proportion of registered mental health clients with a type 2 diabetes diagnosis	2020–21	9.8%	9.9%	10.0%	10.1%	9.3%

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

Indicators yet to be developed.

[38] Tobacco smoking snapshot https://www.aihw.gov.au/reports/australias-health/tobacco-smoking

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 2021, therefore the results relating to children and young people with mental illness and NAPLAN in the outcomes framework are unchanged from last year's report, and date back to 2018. NAPLAN was not carried out in 2020, because of the pandemic. Although provisional NAPLAN results for 2021 for Victoria have been released, the national report by the Australian Curriculum, Assessment and Reporting Authority (which provides comparison points) will not be available until December 2021. Had analysis proceeded this year, it would have used 2019 NAPLAN data.

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. It is anticipated that comparable data will be available next year. 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 minimum standard for numeracy	2018	n/a	n/a	67.9%	66.0%	64.8%
7.3 Proportion of Year 9 students receiving clinical	2018	n/a	n/a	59.2%	52.5%	49.1%

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
mental health care at or above the national minimum standard for reading						
7.4 Proportion of Year 9 students receiving clinical mental health care at or above the national minimum standard for numeracy	2018	n/a	n/a	60.1%	56.3%	50.3%

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

Indicators yet to be developed.

Outcome 9: Victorians with mental illness have financial security

Indicators yet to be developed.

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

Indicators yet to be developed.

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

This indicator reports on the percentage of prisoners receiving a psychiatric risk rating (P-rating) on entry to prison. 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 pandemic restrictions on Victorians in the community, consistent with other data in this report. Measures required to reduce the risk of transmitting the pandemics 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 to 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 prior to 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[14]	2020–21	81%	80%	80%	79%	80%

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 dropped a little, but this reflects in part under-reporting. Follow-up soon after discharge enhances continuity of care at a time when consumers often require additional supports. The number of new registered clients is trending slightly downwards. This may reflect difficulty in accessing services.

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

The duration of compulsory treatment has dropped a little, with the proportion of people receiving compulsory community or inpatient treatment fairly stable. This is 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 (18.7 per cent) or always (69.7 per cent) respected. This was followed by the proportion of consumers who reported they usually (22.7 per cent) or always (58.0 per cent) had opportunities for family and carers to be involved in their treatment or care if they wanted. In Victoria, New South Wales and Queensland, a higher proportion of consumers in ambulatory care report a positive experience of service than consumers in inpatient care.[39] For Victorian inpatients during lockdown periods, experiences may have been negatively affected by bans on visitors, leave and other restrictions to prevent the spread of the pandemic.

Results for the YES survey show, for example, that one-third of consumers rated their experience of care with a service in the preceding three months as excellent (33.8 per cent) and a further quarter as very good (25.4 per cent). While a further substantial proportion rated their experience of care as good (22.8 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 pre-admission contact	2020–21	51.8%	59.4%	58.6%	60.6%	58.5%

[39] Mental health services in Australia <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/consumer-perspectives-of-mental-health-care/consumers-in-ambulatory-care>

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
13.2 Rate of readmission within 28 days	2020–21	13.4%	13.8%	13.2%	14.2%	14.8%
13.3 Rate of post-discharge follow-up	2020–21	77.6%	86.9%	88.0%	89.4%	84.5%
13.4 New registered clients accessing public mental health services (no access in last five years)	2020–21	36.6%	36.8%	36.0%	35.3%	34.8%
13.5 Proportion of consumers reporting the effect the service had on their ability to manage their day-to-day life was very good (26.2%) or excellent (25.3%)	2020–21	53.6%	55.2%	56.1%	n/a	51.5%

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)	2020–21	91.1%	91.2%	91.3%	91.1%	91.5%
14.2 Proportion of registered clients experiencing stable or improved clinical outcomes (CAMHS)	2020–21	91.3%	90.7%	91.0%	91.2%	91.0%
14.3 Proportion of registered clients experiencing stable or improved clinical outcomes (aged persons)	2020–21	92.3%	92.5%	93.6%	93.6%	94.3%
14.4 Proportion of registered clients experiencing stable or improved clinical outcomes (forensic)[40]	2020–21	n/a	n/a	n/a	n/a	n/a

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

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
14.5 Proportion of registered clients experiencing stable or improved clinical outcomes (specialist)[41]	2020–21	n/a	n/a	n/a	n/a	n/a
14.6 Proportion of consumers who reported they usually (22.7%) or always (58.0%) had opportunities for family and carers to be involved in their treatment or care if they wanted	2020–21	82.5%	83.8%	82.5%	n/a[42]	80.7%

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 (18.7%) or always (69.7%) respected	2020–21	88.0%	88.7%	90.1%	n/a	88.4%
15.2 Proportion of people with a mental illness reporting a care plan was developed with them that considered all their needs as very good (23.9%) or excellent (37.5%)	2020–21	63.0%	62.5%	63.4%	n/a	61.4%

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)	2020–21	10.0	9.7	8.6	9.7	10.0

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

[42] Because of the pandemic, the YES survey was not conducted in 2019–20 as planned.

Indicator	Reference year	Four years prior	Three years prior	Two years prior	One year prior	Most current data
16.2 Rate of bodily restraint episodes per 1,000 occupied bed days (inpatient)	2020–21	19.1	22.8	26.1	21.0	21.1
16.3 Proportion of community cases with client on a treatment order	2020–21	11.1%	11.4%	11.0%	11.2%	11.3%
16.4 Proportion of inpatient admissions that are compulsory	2020–21	51.4%	50.3%	49.7%	51.0%	50.2%
16.5 Average duration of compulsory orders (days)	2020–21	64.1	76.6	75.6	82.9	78.2
16.6 Proportion of consumers who rated their experience of care with a service in the last three months as very good (25.4%) or excellent (33.8%)	2020–21	65.1%	65.4%	65.5%	n/a	61.2%
16.7 Proportion of consumers reporting the effect the service had on their overall wellbeing was very good (28.2%) or excellent (30.0%)	2020–21	56.3%	57.8%	58.1%	n/a	54.8%

Appendix 2: Public mental health service data

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

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

Data source: CMI/ODS, or as footnoted otherwise

Date extracted: 21 August 2020, or as footnoted otherwise

Date generated: 17 September 2020

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	2016–17	2017–18	2018–19	2019–20	2020–21
Total estimated residential population in Victoria ('000)[43]	6,322	6,461	6,596	6,730	6,862

People accessing mental health services

Measure	2016–17	2017–18	2018–19	2019–20	2020–21
Mental health–related emergency department presentations	87,197	92,610	97,731	100,945	105,741
Emergency department presentations that were mental health–related (%)	5.14%	5.27%	5.36%	5.78%	6.09%

People accessing clinical mental health services

Measure	2016–17	2017–18	2018–19	2019–20	2020–21
Consumers accessing clinical mental health services[44]	66,488	72,905	74,830	74,492	76,832
Proportion of population receiving clinical care (%)[45]	1.05%	1.13%	1.13%	1.14%	1.12%

[43] Population estimate is based on Victoria in Future 2019 estimated residential population at 30 June. Refer to Victoria in Future projections <https://www.planning.vic.gov.au/land-use-and-population-research/victoria-in-future> for more information.

[44] Sum of rows will not equal total because one consumer can access multiple services. 2015–16, 2016–17 and 2020–21 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 2015–16 and 2016–17 began in May 2016 and was resolved by February 2017. Industrial activity in 2020–21 began in November 2020. Affected data reported during this period should be interpreted with caution.

[45] Population estimate is based on Victoria in Future 2019 estimated residential population at 30 June.

Consumer location	Area	2016–17	2017–18	2018–19	2019–20	2020–21
Consumer residential location (%)	Metro	64.35%	64.0%	63.9%	63.5%	63.6%
	Rural	32.7%	32.9%	32.8%	33.0%	33.2%
	Unknown/other	3.0%	3.0%	3.3%	3.4%	3.2%

Consumer demographics	Description	2016–17	2017–18	2018–19	2019–20	2020–21
Gender (%)	Female	50.4%	50.3%	50.4%	50.5%	50.0%
	Male	49.5%	49.6%	49.4%	49.3%	47.7%
	Other/unknown	0.1%	0.2%	0.2%	0.2%	0.3%
Age group (%)	0–4	0.8%	0.8%	0.8%	0.7%	0.6%
	5–14	8.2%	8.2%	8.5%	8.0%	8.6%
	15–24	19.1%	19.3%	19.6%	19.8%	20.2%
	25–34	17.9%	17.6%	18.0%	18.3%	18.6%
	35–44	18.2%	18.0%	17.3%	17.4%	16.8%
	45–54	14.6%	14.8%	15.1%	14.1%	14.6%
	55–64	8.8%	8.7%	8.8%	9.0%	9.0%
	65–74	6.1%	6.2%	6.1%	6.1%	6.0%
	75–84	4.3%	4.2%	4.0%	4.1%	3.9%
	85–94	1.9%	1.8%	1.7%	1.7%	1.6%
	95+	0.2%	0.2%	0.2%	0.1%	0.1%
Consumers of culturally diverse backgrounds (%)	Culturally diverse	13.6%	13.8%	13.9%	14.1%	14.0%
Aboriginal or Torres Strait Islander status (%)	Indigenous	2.8%	2.8%	3.0%	3.2%	3.3%
Country of birth (top 10 non-English speaking) (%)	Italy	1.1%	1.0%	0.9%	0.8%	0.7%
	Vietnam	0.8%	0.9%	0.8%	0.8%	0.8%
	India	0.7%	0.8%	0.9%	1.0%	1.0%
	Greece	0.8%	0.8%	0.7%	0.7%	0.7%
	China (excludes SARs and Taiwan)	0.6%	0.7%	0.7%	0.7%	0.7%
	Sri Lanka	0.5%	0.5%	0.5%	0.5%	0.6%
	Turkey	0.4%	0.4%	0.4%	0.4%	0.4%
	Philippines	0.4%	0.5%	0.4%	0.4%	0.5%
	Sudan	0.3%	0.4%	0.4%	0.4%	0.4%
	Iran	0.4%	0.4%	0.4%	0.4%	0.4%
	Vietnamese	0.5%	0.5%	0.5%	0.5%	0.5%

Consumer demographics	Description	2016–17	2017–18	2018–19	2019–20	2020–21
Preferred language other than English (top 10) (%)	Italian	0.5%	0.5%	0.4%	0.4%	0.3%
	Greek	0.4%	0.5%	0.4%	0.4%	0.4%
	Arabic	0.3%	0.3%	0.3%	0.4%	0.3%
	Mandarin	0.3%	0.3%	0.3%	0.4%	0.4%
	Persian (excluding Dari)	0.2%	0.2%	0.2%	0.2%	0.2%
	Turkish	0.2%	0.2%	0.2%	0.2%	0.2%
	Macedonian	0.1%	0.1%	0.2%	0.2%	0.1%
	Cantonese	0.1%	0.1%	0.1%	0.1%	0.1%
	Croatian	0.1%	0.1%	0.1%	0.1%	0.1%

Treatment	Cohort	2016–17	2017–18	2018–19	2019–20	2020–21
Consumers accessing clinical mental health services[46]	Adult	51,790	57,643	59,771	61,443	62,095
	Aged	7,373	8,269	8,096	8,290	8,019
	CAMHS	10,714	11,678	11,799	11,745	12,566
	Forensic	752	875	988	1,237	1,177
	Specialist	1,821	2,188	2,166	1,954	1,922
Diagnosis (%)	Schizophrenia, paranoia and acute psychotic disorders	24.2%	23.3%	22.9%	22.9%	22.5%
	Mood disorders	20.2%	19.7%	19.1%	18.8%	18.3%
	Stress and adjustment disorders	8.5%	8.7%	9.1%	8.8%	9.0%
	Personality disorders	6.0%	6.3%	6.6%	6.6%	6.5%
	Anxiety disorders	5.3%	5.7%	5.8%	6.1%	6.2%
	Substance abuse disorders	3.5%	3.5%	3.3%	3.3%	3.3%
	Organic disorders	2.7%	2.6%	2.2%	2.1%	2.0%
	Disorders of psychological development	1.9%	1.9%	2.2%	2.0%	2.0%
	Disorders of childhood and adolescence	2.0%	1.9%	1.9%	1.9%	1.9%
	Eating disorders	1.5%	1.5%	1.6%	1.6%	2.0%

[46] Sum of rows will not equal total because one consumer can access multiple services. 2015–16, 2016–17 and 2020–21 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 2015–16 and 2016–17 began in May 2016 and was resolved by February 2017. Industrial activity in 2020–21 began in November 2020. Affected data reported during this period should be interpreted with caution.

Treatment	Cohort	2016–17	2017–18	2018–19	2019–20	2020–21
	Other	1.0%	1.0%	1.0%	1.0%	1.0%
	Obsessive compulsive disorders	0.5%	0.5%	0.5%	0.6%	0.6%
	No mental health diagnosis recorded	22.5%	23.3%	23.9%	24.3%	24.7%
Referral source (newly referred consumers only) (%)	Acute health	22.1%	21.5%	21.6%	22.1%	23.1%
	Emergency department	21.9%	24.1%	27.3%	25.9%	24.4%
	General practitioner	11.6%	11.5%	10.3%	9.8%	9.8%
	Family	7.9%	7.2%	652%	6.7%	6.8%
	Client/self	4.6%	4.7%	4.3%	4.7%	4.7%
	Community health services	4.7%	4.9%	4.1%	4.3%	4.1%
	Police	3.5%	3.7%	3.6%	3.7%	3.9%
	Other/unknown	23.8%	22.2%	22.4%	22.7%	23.1%
New consumers accessing services (no access in the prior 5 years)[47] (%)	Total	36.6%	36.8%	36.0%	35.3%	34.8%
Consumers accessing services during each of the previous 5 years[48] (%)	Total	141%	13.5%	13.4%	13.5%	13.7%

Service activity – bed-based	Setting	2016–17	2017–18	2018–19	2019–20	2020–21
Total number of separations (excluding same days)	Admitted – acute	24,334	26,124	26,692	26,658	26,884
	Admitted – non-acute	219	222	274	245	263
	Non-admitted – bed-based	239	247	205	229	178
	Non-admitted – subacute (CCU)	682	650	545	565	620
	Non-admitted – subacute (PARC)	3,406	3,460	3,547	3,373	3,668
	Total	**28,880**	**30,703**	**31,263**	**31,070**	**31,613**

[47] 2015–16, 2016–17 and 2020–21 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 2015–16 and 2016–17 began in May 2016 and was resolved by February 2017. Industrial activity in 2020–21 began in November 2020. Affected data reported during this period should be interpreted with caution.

[48] Ibid.

Service activity – bed-based	Setting	2016–17	2017–18	2018–19	2019–20	2020–21
Occupied bed days (including leave, excluding same days)	Admitted – acute	364,468	375,273	388,440	385,789	385,049
	Admitted – non-acute	71,470	74,409	78,148	81,575	81,231
	Non-admitted – bed-based	157,508	156,890	154,823	150,705	151,432
	Non-admitted – subacute (CCU)	104,625	105,072	104,852	103,634	100,591
	Non-admitted – subacute (PARC)	65,915	65,712	70,063	63,430	64,997
	Total	**763,988**	**777,358**	**796,328**	**785,135**	**783,302**
Bed occupancy rate (including leave, excluding same days)	Admitted – acute	88.7%	88.6%	88.9%	86.4%	83.2%
	Admitted – non-acute	90.5%	85.7%	86.9%	89.9%	89.4%
	Non-admitted – bed-based	87.1%	87.4%	86.2%	83.7%	84.5%
	Non-admitted – subacute (CCU)	78.6%	80.1%	80.9%	80.3%	79.9%
	Non-admitted – subacute (PARC)	80.7%	75.5%	79.0%	71.3%	69.6%
	Total	**86.3%**	**85.6%**	**86.1%**	**83.9%**	**82.2%**

Service activity – community	Population	2016–17	2017–18	2018–19	2019–20	2020–21
Total service contacts, by sector[49]	Adult	1,189,771	1,791,352	1,861,977	1,951,031	1,784,646
	Aged	168,748	243,537	232,202	249,918	217,506
	CAMHS	278,784	329,172	334,118	347,641	357,791
	Forensic	17,265	19,648	23,797	23,772	20,877
	Specialist	21,189	22,791	27,894	35,271	33,248
	Total	**1,615,759**	**2,406,502**	**2,479,989**	**2,607,635**	**2,414,070**
Total service hours, by sector[50]	Adult	585,322	909,805	979,228	1,309,878	934,113
	Aged	86,138	125,676	124,716	129,045	107,164
	CAMHS	180,005	217,735	223,850	227,101	232,172
	Forensic	10,652	12,189	16,403	15,278	14,239
	Specialist	19,778	20,821	25,317	27,247	24,063
	Total	**881,897**	**1,286,228**	**1,369,516**	**1,438,552**	**1,311,752**

[49] Ibid.

[50] Ibid.

Service activity – community	Population	2016–17	2017–18	2018–19	2019–20	2020–21
Unregistered consumer service hours[51]	**Total**	**15.7%**	**15.6%**	**16.0%**	**15.5%**	**16.0%**

Service performance	Population	2016–17	2017–18	2018–19	2019–20	2020–21
Readmission to inpatient rate 28 day (lagged 1 month)	Adult	14.3%	14.4%	13.7%	14.6%	15.1%
	Aged	6.8%	8.5%	7.6%	9.0%	7.1%
	CAMHS	17.6%	19.3%	19.9%	21.7%	23.4%
	Forensic	12.3%	7.8%	6.0%	7.5%	5.0%
	Specialist	2.0%	1.2%	1.9%	2.1%	1.9%
	Total	**13.4%**	**13.8%**	**13.2%**	**14.2%**	**14.8%**
Preadmission contact rate, all consumers[52]	Adult	53.1%	60.2%	59.7%	61.7%	58.9%
	Aged	54.0%	65.0%	65.7%	63.6%	60.9%
	CAMHS	49.5%	58.1%	57.0%	60.8%	64.2%
	Forensic	17.6%	21.6%	26.8%	16.0%	16.2%
	Specialist	30.6%	38.5%	30.9%	39.5%	43.5%
	Total	**51.8%**	**59.4%**	**58.6%**	**60.6%**	**58.5%**
Post-discharge follow-up rate (lagged 7 days)[53]	Adult	79.3%	88.4%	89.1%	90.9%	84.9%
	Aged	74.6%	93.2%	94.5%	94.9%	89.4%
	CAMHS	83.9%	86.2%	87.0%	86.6%	86.1%
	Forensic	31.2%	26.4%	28.4%	28.6%	37.6%
	Specialist	41.1%	53.3%	60.9%	65.4%	68.3%
	Total	**77.6%**	**86.9%**	**88.0%**	**89.4%**	**84.6%**
Trimmed average length of stay ≤ 35 days – inpatient	Adult	9.5	9.1	9.2	9.5	9.4
	Aged	15.7	15.5	15.1	15.4	15.7
	CAMHS	6.9	6.6	6.5	6.3	5.8
	Forensic	20.5	21.7	24.0	21.8	19.1
	Specialist	15.8	15.3	16.0	15.6	15.0
	Total	**10.0**	**9.6**	**9.6**	**9.8**	**9.7**

[51] Ibid.

[52] Ibid.

[53] Ibid.

Compulsory treatment	Population	2016–17	2017–18	2018–19	2019–20	2020–21
Community cases with consumers on treatment order (%)	Adult	14.6%	14.9%	14.4%	14.9%	14.9%
	Aged	4.5%	5.1%	5.4%	5.0%	5.0%
	CAMHS	1.1%	1.1%	1.1%	1.0%	1.0%
	Forensic	15.8%	13.1%	14.1%	13.5%	13.7%
	Specialist	2.2%	5.7%	4.9%	5.0%	7.7%
	Total	**11.1%**	**11.4%**	**11.0%**	**11.2%**	**11.3%**
Compulsory admissions – inpatient (%)	Adult	56.9%	55.3%	54.3%	56.0%	55.5%
	Aged	48.2%	46.8%	46.7%	50.1%	48.6%
	CAMHS	17.0%	20.2%	21.9%	20.5%	21.6%
	Forensic	100.0%	100.0%	100.0%	100.0%	100.0%
	Specialist	8.8%	8.9%	11.2%	9.5%	8.4%
	Total	**51.4%**	**50.3%**	**49.7%**	**51.0%**	**50.2%**
The average duration (days) of a period of compulsory treatment	All	64.1	76.6	75.6	82.9	78.2
Consumers on an order for more than 12 months (%)	All	12.4%	13.0%	12.9%	13.1%	13.4%
Adult (18+) consumers who have an advance statement recorded (%)	All	2.39%	2.61%	2.85%	2.95%	3.18%
Adult (18+) consumers who have a nominated person recorded (%)	All	2.39%	2.43%	2.59%	2.53%	2.53%

Restrictive practice	Population	2016–17	2017–18	2018–19	2019–20	2020–21
Seclusion episodes per 1,000 occupied bed days – inpatient	**Total**	10.0	9.7	8.6	9.7	10.0
Average inpatient seclusion duration (hours)	**Total**	17.4	16.7	20.0	13.8	15.3
Bodily restraint episodes per 1,000 occupied bed days – inpatient	**Total**	19.1	22.8	26.1	21.0	21.1
Average inpatient bodily restraint duration (hours)	**Total**	0.4	0.3	0.2	0.3	0.2

Clinician-reported outcome	Population	2016–17	2017–18	2018–19	2019–20	2020–21
Community cases with significant improvement at case closure[54] (%)	Adult	53.3%	52.7%	51.7%	53.6%	55.1%
	Aged	54.5%	56.3%	59.0%	59.8%	60.6%
	CAMHS	48.1%	44.8%	43.9%	47.0%	45.5%
	Specialist	20.5%	24.1%	32.3%	61.9%	58.1%
	Total	**52.2%**	**51.6%**	**51.2%**	**53.4%**	**54.1%**
Community cases stable at case closure[55] (%)	Adult	37.8%	38.5%	39.6%	37.5%	36.4%
	Aged	37.8%	36.2%	34.6%	33.8%	33.7%
	CAMHS	43.2%	45.9%	47.1%	44.2%	45.5%
	Specialist	75.0%	72.4%	67.1%	28.6%	27.9%
	Total	**39.2%**	**39.7%**	**40.4%**	**38.0%**	**37.7%**
Community cases with significant deterioration at case closure[56] (%)	Adult	8.9%	8.8%	8.8%	9.0%	8.5%
	Aged	7.7%	7.5%	6.4%	6.4%	6.5%
	CAMHS	8.7%	9.3%	9.0%	8.8%	9.1%
	Specialist	4.5%	3.5%	0.6%	9.5%	14.0%
	Total	**8.6%**	**8.7%**	**8.4%**	**8.6%**	**8.4%**

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		2016–17	2017–18	2018–19	2019–20	2020–21
Total output cost - actual (as published in Budget paper No. 3) ($ million)[57]	Clinical mental health	1,258.2	1,372.7	1,542.1	1,650.0	1,937.6
	Mental health community support services	124.8	120.0	118.5	111.0	121.8

Service inputs		2016–17	2017–18	2018–19	2019–20	2020–21
Specialist mental health beds (from policy and funding guidelines)	Admitted – acute	1,162	1,174	1,205	1,211	1,212
	Admitted – non-acute	244	244	250	250	250
	Admitted total	1,406	1,418	1,455	1,461	1,462
	Non-admitted – bed-based	525	495	495	495	491
	Non-admitted – subacute (CCU)	358	358	348	348	338

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

[55] Ibid.

[56] Ibid.

[57] Impacted by the reduction in mental health community support services progressively transferring to the NDIS.

Service inputs		2016–17	2017–18	2018–19	2019–20	2020–21
	Non-admitted – subacute (PARC)	230	250	250	252	264
	Non-admitted total	1,113	1,103	1,093	1,095	1,093
	Total	**2,519**	**2,521**	**2,548**	**2,556**	**2,555**
Fulltime-equivalent staff by workforce type[58]	Administrative and clerical staff	571	440	451	711	n/a
	Allied health and diagnostic professionals	1,500	1,590	1,636	1,800	n/a
	Carer workers	18	35	31	34	n/a
	Consumer workers	18	42	39	40	n/a
	Domestic staff	174	158	118	151	n/a
	Medical officers	848	871	915	985	n/a
	Nurses	4,180	4,260	4,548	4,909	n/a
	Other personal care staff	239	195	248	190	n/a

People accessing mental health community support services

Consumers	2016–17	2017–18	2018–19	2019–20	2020–21
Total consumers accessing mental health community support services[59]	10,051	8,605	5,732	5,818	3,180

Consumer demographics	Description	2016–17	2017–18	2018–19	2019–20	2020–21
Gender (%)	Female	56.2%	57.3%	57.3%	54.3%	54.7%
	Male	43.2%	41.9%	41.8%	44.2%	43.7%
	Other/unknown	0.6%	0.7%	0.8%	1.5%	1.5%
Age group (%)	0–4	0.3%	0.3%	0.2%	0.3%	0.1%
	5–14	1.7%	2.1%	3.4%	6.2%	0.3%
	15–24	13.6%	13.1%	13.9%	19.2%	20.4%
	25–34	19.3%	18.8%	17.2%	14.9%	16.3%
	35–44	23.3%	22.6%	20.6%	17.7%	18.4%
	45–54	23.5%	24.7%	25.3%	20.9%	21.7%
	55–64	14.0%	14.9%	16.3%	15.4%	17.4%
	65–74	1.9%	1.9%	2.6%	4.5%	4.3%
	75–84	0.3%	0.3%	0.4%	0.8%	0.9%
	85–94	0.0%	0.0%	0.0%	0.0%	0.1%

[58] Sourced from the Mental Health Establishments National Minimum Dataset.

[59] Impacted by the reduction in mental health community support services progressively transferring to the NDIS.

Consumer demographics	Description	2016–17	2017–18	2018–19	2019–20	2020–21
	95+	1.6%	0.9%	0.0%	0.1%	0.1%
	Unknown	0.5%	0.5%	0.0%	0.0%	0.1%
Aboriginal or Torres Strait Islander (%)	Indigenous	2.3%	1.9%	2.2%	2.8%	2.9%
Culturally diverse status (%)	Yes	4.3%	3.9%	4.8%	5.4%	7.2%

Service activity	2016–17	2017–18	2018–19	2019–20	2020–21
Community service units	767,261	635,040	338,835	128,007	2,703
Bed-based rehabilitation bed days	82,322	81,435	62,417	51,029	46,542

Service input	Population	2016–17	2017–18	2018–19	2019–20	2020–21
Bed-based rehabilitation beds	Other[60]	101	102	22	0	0
	Youth	159	159	159	159	159
	Total	260	261	181	159	159

[60] Residential rehabilitation beds transitioned to the NDIS from 2018–19 to 2019–20.

Appendix 3: Victoria's public mental health system

Area-based clinical services[61]

Child and adolescent services/child and youth services[62]

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

Adult services

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

Aged persons services (65+ years)

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

Statewide specialist services

- Aboriginal services
- Brain disorder services

[61] 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.

[62] 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).

- 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 2 and 3

Figure 3

Age	2016–17	2017–18	2018–19	2019–20	2020–21
Total	87,197	92,610	97,731	101,050	105,741
0–17 years	9,592	10,659	11,461	11,683	15,346
18–64 years	69,870	73,623	77,576	79,903	80,600
65+ years	7,735	8,328	8,694	9,464	9,795

Data source: VEMD

Figure 4

Raw data: 2018–19

Month	Service hours	Service contacts
July	115,334	211,480
August	124,211	223,529
September	104,165	187,848
October	124,186	222,793
November	116,943	209,326
December	99,040	183,461
January	107,583	201,219
February	111,631	201,550
March	118,564	213,499
April	105,648	192,673
May	129,465	229,768
June	112,744	202,839

Raw data: 2019–20

Month	Service hours	Service contacts
July	124,194	223,140
August	124,772	220,675
September	115,742	206,232
October	130,981	230,937
November	117,966	206,652
December	109,330	194,639
January	112,857	203,897
February	121,042	210,959

Month	Service hours	Service contacts
March	114,360	212,756
April	110,237	215,702
May	126,387	238,273
June	130,682	243,770

Raw data: 2019–20

Month	Service hours	Service contacts
July	132,774	251,231
August	131,035	246,854
September	138,581	256,994
October	135,666	250,897
November	117,977	215,757
December	97,427	180,444
January	83,346	156,539
February	93,940	172,661
March	102,492	183,599
April	88,005	157,921
May	95,493	169,801
June	95,016	171,368

Data source: CMI/ODS. Date extracted: 13 August 2021