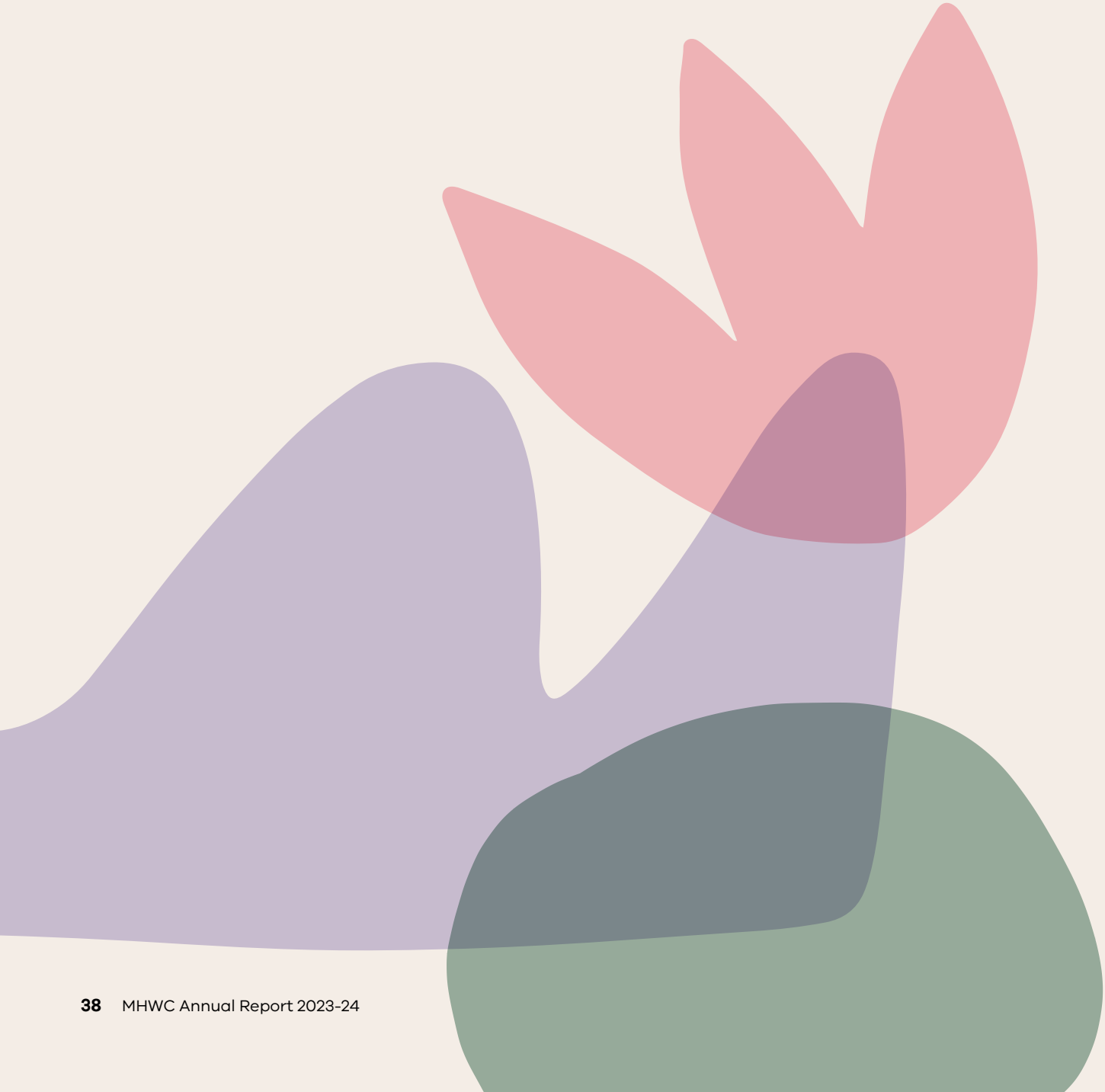
What we've seen

The Commission is required to report on the safety, quality, and performance of the system, as well as progress towards improving mental health and wellbeing outcomes in the Victorian community.



Mental health and wellbeing system review

The Mental Health and Wellbeing Commission (the Commission) has a wide range of statutory objectives and functions. These include contributing to system governance via monitoring and reporting, as well as functions to promote the improvement, awareness and understanding of mental health and wellbeing across government, business and the wider community.

The Commission is required to report on the safety, quality, and performance of the system, as well as progress towards improving mental health and wellbeing outcomes in the Victorian community. This Annual Report represents the first round of system reporting undertaken by the Commission, and it is intended to provide an analysis of the current state and recent trends in mental health and wellbeing in Victoria.

The Commission is required to report on the incidence of gender-based violence at bed-based mental health and wellbeing services in each Annual Report. In the 2023-24 reporting year, we requested access to relevant sources of data but have not been provided with these data. The Commission understands that there are definitional issues that are being examined by the Department of Health. These issues must be resolved so the Commission can meet its legislative reporting requirements in future annual reports.

Our approach to system review and reporting

As outlined in the Commission's Monitoring and Reporting Plan (to be published in 2024), the Commission's approach to reviewing mental health and wellbeing outcomes in the community includes examination of several factors, ranging from social determinants of mental health, through to psychological distress, service outcomes, and suicide and self-harm. These are dimensions broadly used in other mental health and wellbeing outcomes frameworks, for example, the Productivity Commission's Report on Government Services.

Some of the factors explored in this report are beyond the control of the Victorian government, but they help provide important context in which the Victorian system operates. For example, social determinants of mental health and psychological distress contribute to the underlying level of need for mental health supports.

Where the Commission feels there is sufficient evidence to make commentary in the form of a hypothesis or view, we have done so. However, we note that many of the issues outlined are complex and we will seek to understand these in greater detail over time.

The work here provides both a starting point for meeting our reporting obligations for how mental health and wellbeing is tracking within the community and informs our future work and plans as outlined in our Monitoring and Reporting Plan.

It is also important to recognise that state-funded services are not the only services accessible to consumers. This necessitates consideration of non-state government-funded supports, such as services via the Medicare Benefits Schedule or medications on the Pharmaceutical Benefits Scheme.

The reporting is organised as follows:

1. **Mental health and wellbeing in the Victorian community –** including social determinants and prevalence of mental ill-health to assess the extent of community need for service delivery
2. **System performance, quality and safety –** including levels of access and investment, as well as whether the quality and safety of the system is improving in aggregate
3. **System and broader outcomes –** to examine whether the system is helping consumers, families, carers and supporters to recover, and the overall outcomes for community.

The Commission intends to supplement this analysis with a deep-dive report into the safety, quality, and performance of the system, drawing on detailed data from the Victorian Department of Health. We aim to provide a more detailed examination of the performance, quality and safety of the system by location and for specific cohorts, with key measures to be incorporated into future annual reports. This report will be released prior to the 2024-25 Annual Report.

The following section provides a brief summary of our assessment of the state of the Victorian community's mental health, as well as the Commission's view of the performance, quality, and safety of the mental health system. More information is provided in the subsequent sections.

Some notes on data used in this report

At the time of writing the Victorian government has not released its Outcomes and Performance Framework (the OPF). The Commission will continue to scan and review emerging trends and issues affecting the wellbeing of the Victorian community. We will review our approach following release of the framework. At present the analysis is focused on public data, including from the Department of Health's Mental Health Services Annual Report, the Productivity Commission's Report on Government Services and associated data sources, the Australian Institute of Health and Welfare, the Australian Bureau of Statistics, and several other sources.

Over time we will work with government to assist in addressing any gaps in the measures available, and ensuring the OPF is measuring what matters most to consumers, their families, carers and supporters in the broader Victorian community.

The Commission has not been able to report as comprehensively as we would like in relation to some aspects of system performance, quality and safety. We will continue to work with the Department of Health to address data issues. These include definitional issues, matters of timing, and data that enables a finer granularity of analysis or reporting than is included in this report.

The Act requires the Commission to report on the incidence of gender-based violence at bed-based mental health and wellbeing services in each annual report. We endeavoured to fulfil this requirement. The Commission understands that there are definitional issues around these measures that are being examined by the Department and will continue to work with them to ensure the issues are resolved so we can meet our obligations in future annual reports.

The Commission is confident the data issues will be resolved and therefore intends to augment this annual report by undertaking a deep dive analysis of data relating to restrictive practices and compulsory treatment across consumer groups in different services in 2024-25.

Summary of the Commission's analysis

Available data shows that the Victorian community has experienced increasing levels of psychological distress in recent years. Rates of high or very high psychological distress reported in the Victorian Public Health Survey were increasing prior to the pandemic, from 15 per cent in 2018 to 18 per cent of adults in 2019. In 2020, rates of high or very high psychological distress increased to 23.5 per cent and have remained at these levels to 2022. Our review of mental health determinants in recent years suggests the community is still experiencing significant challenges.

This reinforces the need for continued investment in the mental health and wellbeing system as well as a need to address the factors contributing to mental illness and psychological distress in the community.

The number of people accessing mental health and wellbeing services has increased in recent years. This has been supported by substantial funding by the Victorian government but also affected by the withdrawal of other supports, such as the additional funded psychology services made available by the Australian government during the COVID-19 pandemic under the Better Access initiative. National data shows there has been an increase in the use of medication to treat mental illness, reinforcing that the community is requiring additional support.

In Victoria, there has been a growth in Victorian government-funded clinical mental health services delivered in the community since the reform commenced, while the number of consumers accessing bed-based services has remained steady. This may be indicative of the successful targeted investment in earlier intervention by government. However, further work is needed to confirm whether additional bed-based service delivery is needed, and whether there has been a net increase in service accessibility in the community.

There appears to be improvement in some elements of safety in bed-based service settings. The rate of seclusion has decreased, and stronger targets for further reductions in the use of seclusion have been set by government for 2024-25. The use of compulsory treatment appears to be steady.

Outcomes reported from mental health and wellbeing services also appear to be stable. These are measures of mental health on exit from a service, as assessed by consumers and clinicians. Noting that these are direct measures of service impact, further data and analysis are required to monitor improvements in the outcomes produced by the system as a whole.

The rate of Victorians taking their own lives is increasing, with data from the Victorian Coroner's Court indicating 11.7 deaths by suicide per 100,000 population at the end of 2023 (801 deaths). This trend has continued into 2024, with 453 deaths to July, compared to 434 at the same time in 2023. The Commission notes the multi-factorial nature of suicide, and the need for coordinated and comprehensive work by government to address the drivers alongside improving the performance, quality, and safety of services.

This difficult outcome reflects the scale of the challenge facing the Victorian government at a time where there is increased budgetary pressure. While we note there are workforce constraints factored into recent budgetary decisions regarding the pace of reform, the data indicate that there are significant challenges facing the Victorian community, reflected by increased rates of distress in recent years, additional demand for support, and increased levels of suicide.

Figure 9: Summary data from our analysis of the mental health and wellbeing system

1. Community mental health and wellbeing

What are the long and short-term trends in mental illness and distress?

Mental illness and psychological distress in Victoria are increasing over the long-term and escalated significantly during 2020-2022. The Victorian Population Health Survey (VPHS) shows distress increased by over half in two years – from 15 per cent in 2018 to 18.1 per cent in 2019 and 23.4 per cent in 2020.

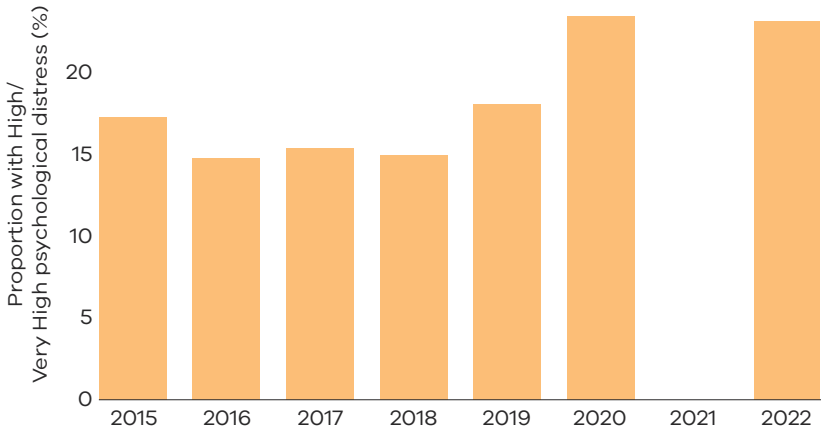
While circumstances of the pandemic are a likely explanation for the increased level of distress in 2020, the rate of distress remained persistently high in 2022, at 23.2 per cent. The primary contributor to this is unclear; it may be caused by residual issues from the pandemic or non-pandemic factors, as discussed later in this analysis.

At the time of writing the 2024 VPHS is underway. The outcomes of this survey will be important for understanding whether levels of psychological distress have since decreased back to longer-term trends or remain elevated at levels observed through the pandemic.

The VPHS data also reflect that different degrees of mental health challenges are experienced by different groups of people. For example, the data show that over 40 per cent of women under 24, and 33 per cent of women between 25 and 34 were experiencing high levels of psychological distress in 2022. In contrast, the highest rate for men is among the 25 to 34 years age group, with one in four men reporting high psychological distress.

Figure 10: Proportion of adult population with High/Very high psychological distress (K10 score≥22)

Source: VPHS and Victoria's mental health services annual reports[1]
Please note that data from 2021 is not available.



The increasing rate of psychological distress is consistent with increasing rates of mental disorders. Data from the National Study of Mental Health and Wellbeing, 2020-2022 show that the proportion of people reporting symptoms of a mental disorder in the previous 12 months rose from 19.5 per cent in 2007 to 21.5 per cent nationally in 2020-22, with similar trends in Victoria. This suggests a longer-term trend of increasing levels of mental illness in the community.

The following section explores some of the drivers of psychological distress and mental illness in more detail, to provide the Commission and the Victorian community with some understanding of what sits behind the broad increases described above.

1 https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey and https://www.health.vic.gov.au/publications/victorias-mental-health-services-annual-report

What factors may have contributed to the long-term changes in mental illness in the Victorian community?

While there is minimal causal data on what broad social, economic, and cultural changes are driving mental illness and psychological distress, the determinants of mental health more broadly are relatively well known. The Royal Commission into Victoria's Mental Health System identified many factors that may be protective or add risk across different life stages , including:

- family functioning and childhood experiences
- housing security
- financial stability and employment
- physical activity
- social support and connection
- physical health conditions
- use of drugs and alcohol.

Some of these drivers are harder to shift or may take some time to materially impact mental health at the community level. These are discussed below to provide an indication of the longer-term trend in many of these determinants. Overall, there are some key trends of concern in these drivers, although several of them have been addressed over the past decade and are moving in a positive direction or remain steady.

Figure 11: Factors that may be contributing to long term changes in mental illness in the Victorian community

Risky consumption of alcohol

Source: Alcohol, tobacco & other drugs in Australia, AIHW[3]

↓ Proportion of people engaging in risky drinking has **fallen** from around 38 per cent in the early 2000s, to around 26 per cent in 2022-23.

↑ Similar trend for tobacco smoking, although e-cigarette and illicit drug use has **increased**.

Drug and alcohol-related ambulance attendance

Source: Alcohol, tobacco & other drugs in Australia, AIHW

↓ Rates of attendances increased to 2019 but then trended **downward** to 2023.

Estimates of rates of homelessness

Source: ABS Census[4]

↑ **Increased** from 2006 to 2021, rising from 35 to 47 per 10,000 population.

Home ownership by age group

Source: Australian Institute of Health and Welfare, Home ownership and housing tenure, 2023

↓ Steady **downward** trend in home ownership over time across all age groups.[5]

Family violence

Source: Crime Statistics Victoria[6]

↑ **Increase** in family violence incidents from 1,265 per 100,000 population in 2018-19 to 1,378 in 2022-23.

Youth resilience

Source: Victorian public health and wellbeing outcomes dashboard[7]

↓ **Reduction** in resilience from 2014 (70.1 per cent resilient) to 2018 (67.3 per cent).

Family functioning

Source: Victorian public health and wellbeing outcomes dashboard

↓ **Decrease** in children living in families with unhealthy functioning from 2013 (7.6 per cent) to 2021 (6.7 per cent).

Developmentally vulnerable children

Source: Australian Early Childhood Census[8]

→ The proportion of developmentally vulnerable children has remained relatively **steady**, with around 20 per cent of Victorian children vulnerable on at least one domain in 2021; similar proportions to 2009.

Physical health

Source: Report on Government Services, Mental Health Services – Productivity Commission[9]

↑ People with a mental illness are estimated to be 86 per cent **more** likely to have asthma, 76 per cent **more** likely to have cardiovascular disease, and 69 per cent **more** likely to have arthritis. They are also 65 per cent **more** likely to be daily smokers, although they are marginally less likely to be overweight or obese, or at risk of long-term harm from alcohol.

2 RCVMHS Volume 1, pages 158, 159

3 https://www.aihw.gov.au/reports/illicit-use-of-drugs/state-alcohol-drug-use

4 Table 3. Rates(a) of people experiencing homelessness by state/territory, 2006 to 2021, https://www.abs.gov.au/statistics/people/housing/estimating-homelessness-census/latest-release#state-and-territories

5 For detail, see https://www.aihw.gov.au/reports/australias-welfare/home-ownership-and-housing-tenure#ownership

6 https://www.crimestatistics.vic.gov.au/family-violence-data/family-violence-data-tables, Victoria Police Data Tables (2024).xlsx

7 https://www.health.vic.gov.au/victorian-public-health-and-wellbeing-outcomes-dashboard

8 https://www.aedc.gov.au/data-explorer/

9 Data tables 13A.58 and 13A.59, accessed via https://www.pc.gov.au/ongoing/report-on-government-services/2023/health/services-for-mental-health

Causality is difficult to assess in some of these longer-term measures. For example, poor mental health may limit physical recovery, and vice versa, or there may be external factors that influence both mental and physical health. In addition, changes in reported rates of family violence may be due to changing rates of reporting, rather than changes in the underlying level of violence. The important finding is that over the longer-term many of the factors that are protective of mental health and wellbeing appear to be deteriorating.

There are additional factors that are more difficult to measure and may be examined by the Commission in the coming years. Use of technology, changing methods of connecting with others, social cohesion, and global events such as wars and terrorism are broad issues that are noted in the media and within research and policy releases as impacting mental health.

What about the factors affecting mental health and wellbeing more recently?

At the time of writing, most of the evidence on levels of psychological distress in the Victorian community is available until around 2022. As noted above, the prevalence of mental illness and distress at that time may have been affected by factors related to COVID-19 as well as other issues.

The 2024 VPHS is being collected at the time of writing, and the Commission views this as a critical piece to understanding whether some of the psychological distress observed over 2020 to 2022 has subsided.

In the meantime, the Commission has sought to understand several of the key drivers that may be influencing community distress at present. Some of the themes and drivers identified by the Commission at this time include:

- Workplace mental health – there have been increases in the rates of mental health Workcover claims up to 2022-23[10]
- School refusal – estimated to be up by 50 per cent to 2021[11]
- Wellbeing of Aboriginal and Torres Strait Islander peoples – particularly following the unsuccessful referendum on the national voice to parliament.

Transitioning away from the supports and approaches that underpinned government and the community's response to the pandemic have also raised challenges. These include:

- the withdrawal of programs developed through the pandemic such as the Homeless to Home program[12]
- withdrawal of financial supports developed to support people through lockdowns
- the use of working from home arrangements, and current discourse around in what form this continues.

In parallel to these issues is a particularly tough economic environment, with substantial cost-of-living challenges, and restraint in Victorian government spending. The VPHS shows 57 per cent of respondents that experienced food insecurity also experienced high or very high levels of distress, indicating that access to such essentials is correlated with psychological distress. Noting this, consumer price index data for Melbourne shows that some of the fastest growing prices from December 2021 to June 2024 were for essential household items such as oils (42 per cent), gas and household fuels (36 per cent), beverages and drinks (around 28 per cent), bread (25 per cent), eggs (25 per cent), and milk (23 per cent).[13]

The evidence above, while not comprehensive by any means, suggests a continuing need for the Victorian government to prioritise the mental health and wellbeing of the community, despite the difficult budgetary environment. Over the coming year, the Commission expects to be informed of and to review, the government's approach to ensuring a coordinated and outcomes-focused approach across government to address community determinants of mental health, as envisioned by the Royal Commission into Victoria's Mental Health System.

These trends in distress and illness impact the demand for mental health and wellbeing services. These impacts as well as the safety, quality, and performance of the Victorian mental health and wellbeing system are described below.

10 Worker's compensation claims data on https://data.safeworkaustralia.gov.au/interactive-data/topic/workers-compensation (accessed 25 September 2024) shows an increase in mental health claims in Victoria from 2,195 in 2017-18 to 3,844 in 2022-23.

11 https://www.orygen.org.au/About/News-And-Events/2024/Orygen-launches-new-toolkit-to-address-rising-rate

12 https://www.homes.vic.gov.au/sites/default/files/documents/202407/05246%20H2H%20Outcomes%20Evaluation%20Snapshot%20Report%20REV%205-7-24_accessible.pdf The Homeless to Home program was developed in the pandemic using and saw 72 per cent of clients report improvements in their mental health.

13 ABS catalogue 6401.0 Consumer Price Index, Australia, TABLE 9. CPI: Group, Sub-group and Expenditure Class, Index Numbers by Capital City

2. System performance, quality and safety

The increased levels of distress in the Victorian community outlined above have several flow-on effects on demand for mental health and wellbeing services. While the focus of the Commission's work is on Victorian publicly funded services, which are within the scope of the Act, it is important to note that these are often not the first support sought by members of the community. As outlined by the Royal Commission into Victoria's Mental Health System; Services – including Local, Area, and Statewide services – sit on a scale of responses, which start with informal supports, and include non mental health services, as well as primary and secondary service that may be funded by others, such as the Commonwealth.

As such, we have reviewed trends in the level of support provided by General Practitioners (GPs) and private psychologists as context for Victorian service use and may consider measures of other early interventions in future reporting.

Primary and secondary mental health access

The Medicare Benefits Schedule data below show that there has been increased usage of GPs and psychologists, including private psychological services subsidised by Medicare, over the past decade.

There was a substantial jump in service delivery in 2020-21, in line with COVID-19 and a doubling of the number of Medicare-subsidised psychological sessions available to people to 20, although this eased back to 2022-23.

Figure 12: Six levels in a responsive and integrated system

Source: Royal Commission into Victoria's Mental Health System, Volume 1, page 226

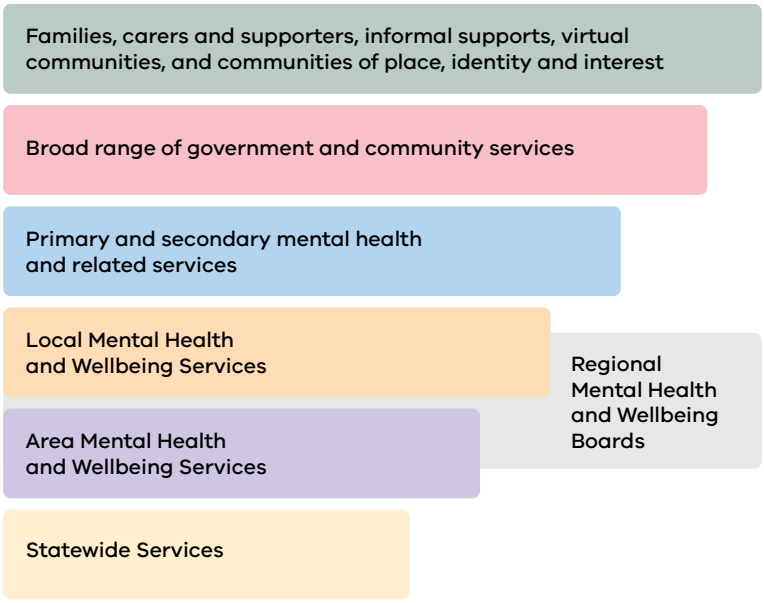
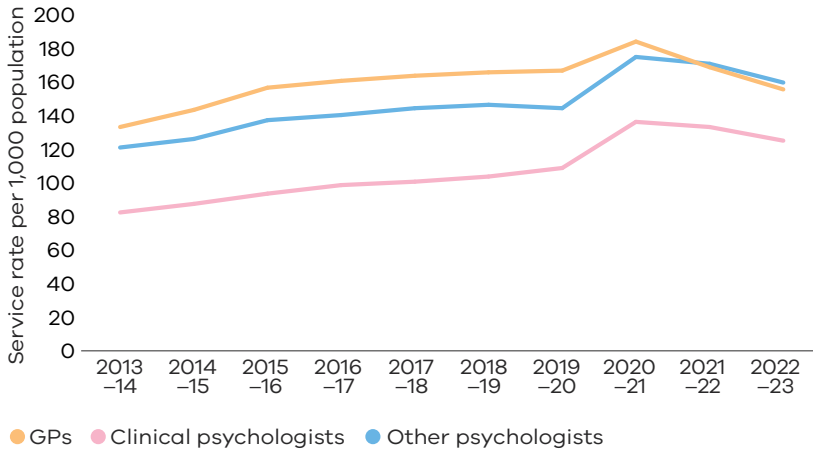


Figure 13: MH service rates per 1,000 persons – GPs and psychologists



In contrast, the rate of prescriptions to treat mental health conditions increased substantially during 2020-21 and 2021-22 and continued to be high in 2022-23. These trends indicate that while direct access to GPs and psychologists may have subsided to reflect longer-term trends, there remains a residual level of mental illness that is being treated by medication at a significantly higher rate than previously.

Access to the Victorian mental health system

Data from the Victorian Department of Health shows that the delivery of funded mental health services has increased. From 2019-20 to 2023-24:

- the number of consumers accessing clinical mental health services increased by 21 per cent
- growth was highest in specialist (71 per cent) and child and adolescent mental health services (41 per cent), and lowest in aged mental health services (12.3 per cent)
- forensic mental health service access spiked in 2021-22 but fell again in 2022-23
- adult mental health services strongly reflect the overall trend in access, with 80 per cent of mental health consumers accessing an adult mental health service in 2023-24.

In addition, the number of consumers who are 'new', or have not accessed services in the previous five years, increased by 32.6 per cent over this period. The Commission will seek to understand whether this reflects increases in psychological distress in the community, or greater access for people who previously were not able to access services.

Figure 14: Prescription rate per 1,000 persons – all MH prescriptions, Victoria

Source: Medicare mental health services 2022–23 data tables and Data tables: Mental health-related prescriptions 2022–23, Australian Institute of Health and Welfare

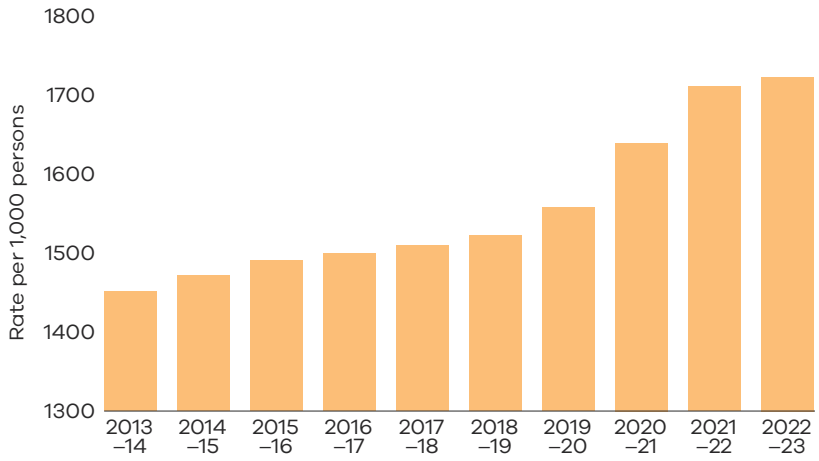
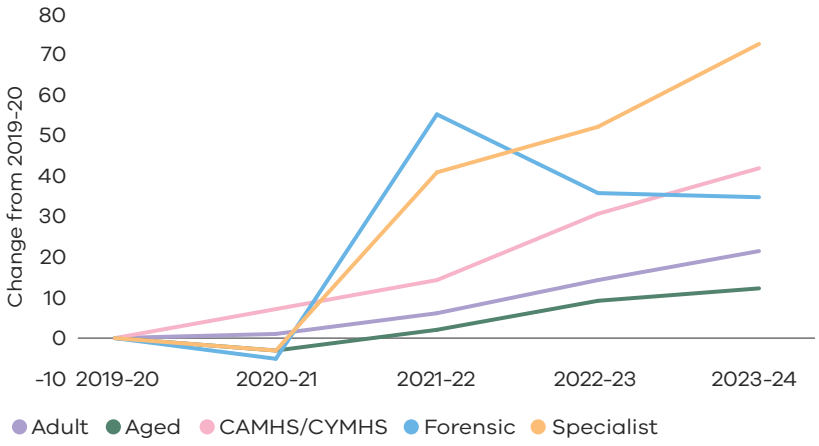


Figure 15: Change in consumers accessing clinical services from 2019-20 by cohort

Source: Service data provided by the Department of Health



The growth in access has been primarily in community-based clinical services, while bed-based service activity has remained stable over time. Key trends include that:

- the number of acute admitted patient separations (discharge) has changed from 26,660 in 2019-20 to 26,108 in 2023-24
- total bed-based separations increased only from 31,073 to 31,315
- clinical community service contacts increased from 2.6 million to 3.1 million over the same period
- mental health presentations at emergency departments increased from 101,049 in 2019-20 to 108,696 in 2023-24, (although they dropped to 95,245 in 2022-23, there was then a particular increase to 108,696 in 2023-24). Overall, this suggests a possible rise in the numbers of people in crisis.
- the number of consumers accessing mental health community support services (which are affected by service delivery transferring to the National Disability Insurance Scheme (NDIS)) declined from 5,818 in 2019-20 to 2,535 by 2021-22. Since then, the number of consumers accessing these services has increased to 3,658 in 2023-24.

These trends indicate that increased access to services has come predominantly from community-based clinical service delivery. While this may indicate an increase in earlier intervention, and more appropriate service usage and availability, the Commission has been unable to confirm whether this reflects a net increase in access, or whether it primarily reflects substitution from other community-based services into funded services.

Systemic impacts of the implementation of mental health and wellbeing Locals, and whether funding for community services is delivering a net increase in service access are factors that the Commission will be seeking to understand over the coming years as new Locals are funded.

The Commission has also considered complaints in its review of system access. The rate of complaints made to the Commission regarding access, including refusal to assess or treat consumers, has increased in 2023-24, indicating that some consumers are still facing barriers to accessing services even with increased non-admission service delivery.

Insights from complaints – access issues

The Commission received 140 in-scope complaints relating to accessing services over this reporting period. Of these, 57 were related to refusal [of services] to assess or treat consumers, which represents an increase of two complaints per month on the previous 14 months (from July 2022 to August 2023).

How has funding aligned with service delivery?

The level of funding for clinical and community mental health services has increased substantially over the past five years.

Figure 16 shows total investment documented in State Budget papers. Mental Health Clinical Care and Mental Health Community Care increased from around $1.5 billion prior to the Royal Commission, to a budgeted amount of almost $3 billion in 2024-25.

The increase in funding reflects recurrent funding in mental health and wellbeing services, as well as budget initiatives in each year, which are announced with a four-year budget horizon. Page 28 (and elsewhere) in the 2024-25 Budget Overview references the $6 billion of investment that government has made into Victoria's mental health system to deliver on the recommendations of the Royal Commission. This amount appears to refer to budget initiatives linked to the reforms relating to the Royal Commission, mental health, and (in some years) alcohol and other drugs.

The Commission has reviewed budget paper initiatives from 2016-17 and onwards related to mental health and wellbeing as well as others linked to the Royal Commission. Figure 17 shows the expenditure announced through initiatives in previous budgets, mapped to the years that the expenditure was budgeted to occur.[14] This analysis shows that a significant portion of government funding of mental health and wellbeing initiatives ($3.8 billion) was announced in 2021-22, responding to the final report of the Royal Commission. Budget paper initiatives typically provide for a four-year horizon, therefore the funding included in the forward estimates for initiatives announced in the 2021-22 budget extends to 2024-25.

Figure 16: Total output funding – mental health

Source: Budget Paper 3 total output funding tables.

Notes: 2023-24 is the revised estimate and 2024-25 is the budgeted value in the 2024-25 budget papers. Other values are 'actual' amounts from previous years in each budget. Values include MH Clinical Care, and MH Community Care line items.

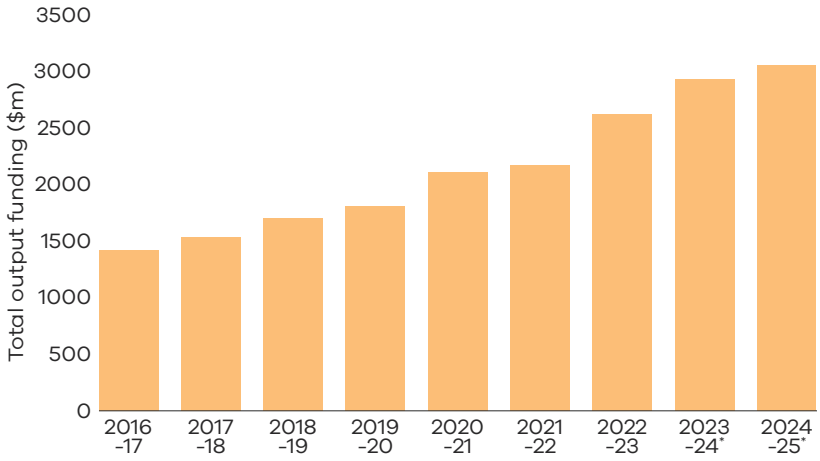
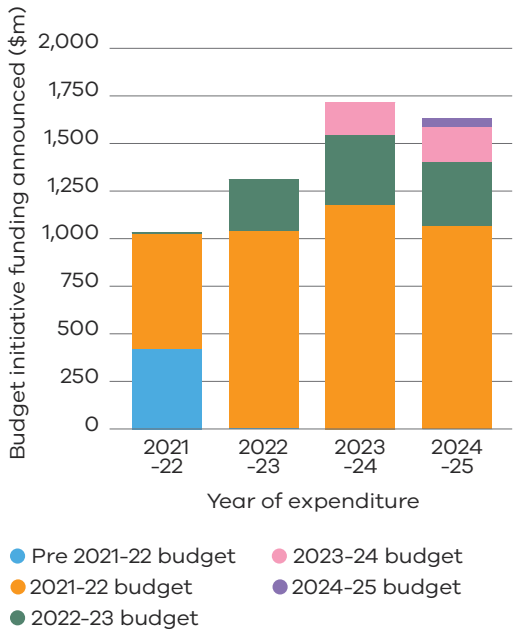


Figure 17: Previously announced mental health initiatives by budget and planned expenditure year (excludes recurrent funding)[15]



It's important to note that some budgeted initiatives might be reasonably expected to continue, however, budgets from 2025-2026 are not yet announced. We strongly encourage government to announce a revised implementation plan and associated funding to reduce any impact uncertainty might have.

14 These include output initiatives, which are initiatives intended to achieve particular outputs, as well as capital investments, for example in health infrastructure.

15 Includes all budget initiatives recorded under clinical or community mental health, or in other areas but noted as being linked to the implementation of recommendations from the Royal Commission into Victoria's Mental Health System.

How safe is the system?

As mentioned previously, our first year of monitoring is limited primarily to publicly available information, including the appendices of Victoria's mental health services annual report 2023-24. The tables underpinning the following safety, quality, and performance information are available in the appendix of that report.

Overall, there are positive signs of improvements in safety, with rates of seclusion and restraint decreasing. However, the use of compulsory treatment continues to be relatively consistent, with little change from 2021-22. Key trends include:

- The proportion of open cases in community-based clinical services where consumers are on treatment orders remained steady at 11.2 per cent
- The proportion of inpatient consumers admitted on compulsory treatment orders dropped slightly from 47.9 per cent in 2021-22 to 47.5 per cent in 2023-24.
- There has been a relatively steady decrease in the use of compulsory treatment for specialist and aged services, but other settings are somewhat more variable over time.
- The duration of compulsory treatment increased, from 87.1 days on average in 2021-22 to 102.6 days in 2023-24.

Insights from complaints – compulsory treatment

The Commission received 91 complaints relating to consumers disagreeing with treatment orders in the current reporting period. The rate of complaints received in relation to these issues fell from 13.6 per month in July 2022 to August 2023 to 9.1 per month from September 2023 to June 2024.

Some of the factors raised in consumer complaints about compulsory treatment include the financial impacts of compulsory treatment, and disagreement about the clinical diagnosis of their mental illness.

Complaints related to communication about compulsory status increased in this reporting period, with 4.6 complaints received per month, up from 2.9 per month from July 2022 to August 2023.

Restrictive practices including seclusion and restraint, are reported by services via the Client Management Interface/Operational Data Store (CMI/ODS). Key trends from those data on the use of seclusion are as follows:

- Use of seclusion has decreased, from 9.8 episodes per 1,000 days in 2021-22 to 6.3 episodes per 1,000 occupied bed days in 2023-24.
  - This is below the target for adult and forensic services (8 episodes per 1,000 days), but above the target for child, youth, and aged care services (5 episodes per 1,000 days).
- Seclusion is being used for longer on average per episode, rising from 18.6 hours in 2021-22 to 21.8 hours in 2023-24.

There are positive signs of improvement with changes to targets set by government. The target for seclusion has been revised downwards for 2024-25: 6 per 1,000 days for adult and forensic, 3 per 1,000 days for other services.

Reported bodily restraint episodes are also decreasing.

- Bodily restraint is down from 19.8 episodes per 1,000 occupied bed days in 2021-22 to 15.2 episodes in 2023-24.
- The average duration of restraint is at the lowest it has been over the past five years, lasting 0.1 hours per episode on average. Given the low average duration and variability in restraint duration from previous years, it is unclear whether this constitutes a trend.

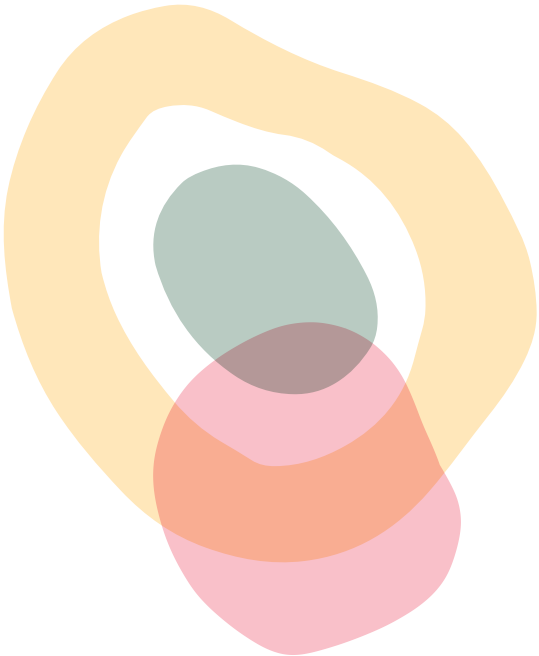
The Commission has been informed that there have been two suspected suicides on the premises of mental health inpatient units in 2023-24.

Insights from complaints – restrictive practices

The Commission received 57 complaints from consumers involving possible use of restrictive practices in the current reporting period. This reflects an increase of 1.9 complaints per month from the previous 14 months, from July 2022.

The use of security guards was a theme identified in some of the complaints received by the Commission over the past year. In addition, several complainants indicated they would like to see more personal support being offered to consumers after removal of restrictive practices, and to be involved in experience of care reviews.

The Commission also started receiving complaints related to possible chemical restraint for the first time in this reporting period, with a total of 12 complaints received.



Involvement and experiences of carers, families and supporters

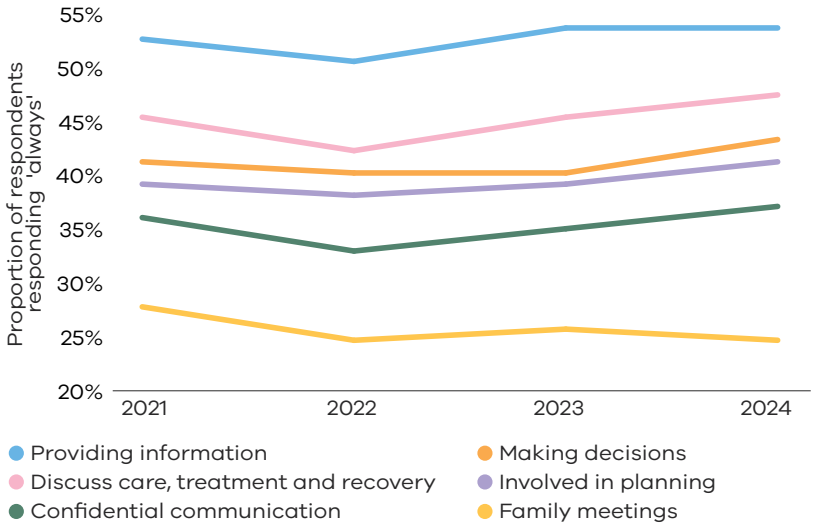
Data from the Department of Health's Carer Experience Survey indicate that there has been improvement in the experiences of carers from 2021-22 to 2023-24, following a drop from 2020-21 to 2021-22. However, the overall level of respondents reporting that they 'always' had positive involvement and experiences remains relatively low, with less than half of respondents reporting this way for all but one question.

Questions asked of respondents to the Carer Experience Survey included questions related to active participation. These included:

- In the last six months, how often did the following occur?
  - You were given the opportunity to provide relevant information about your family member, partner or friend
  - You were involved in decisions affecting your family member, partner or friend
  - You were given opportunities to discuss the care, treatment and recovery of your family member, partner or friend (even, if for reasons of confidentiality, you could not be told specific information)
  - You were involved in planning for the ongoing care, treatment and recovery of your family member, partner or friend
  - You had opportunities to communicate confidentially with the treating doctor if you needed (such as by phone, email or in person)
- In the last six months how often were you invited to a family meeting with the treating team? This includes face-to-face, telephone or video meetings.

Involvement in family meetings is the only of these elements that has not shown improvement over that period.

Figure 18: Proportion of CES respondents reporting opportunities to actively participate in treatment decisions



The Commission recognises that the inclusion and involvement in decision-making of the lived experience workforce are real measures of the quality, safety, and performance of the mental health and wellbeing system.

In establishment year, the Commission has been developing a framework for understanding how lived experience workforces operate across the mental health and wellbeing system. In addition to understanding how these staff operate in clinical settings, for example as peer workers, there is also a strong focus on system roles. These include lived experience managers and executive officers. It also includes understanding how these staff are involved in all organisational processes such as planning, evaluation, recruitment, quality and safety and community engagement.

We intend to conduct a deep-dive report into measures of quality, safety, and performance of the system which will be used in future annual reports. As part of this report, we will consider measures relating to lived experience involvement within services and across the system.

This is something that is difficult to quantify, but we intend to share best-practice examples where lived experience has been embedded in organisations in an inclusive and systemic manner, across all roles, levels and teams.

3. System and broader outcomes

Is the system helping people recover?

Measures of good system performance and the recovery of consumers should be carefully considered and not limited to clinical measures of mental health on exit from a tertiary service. The Commission expects that, within a system context, consumer outcomes should reflect measures that are important to consumers, which are often non-clinical outcomes. This includes whether consumers receive appropriate support following service access, and in subsequent mental health episodes are able to access services to intervene earlier and in settings that maximise their wellbeing, enabling them to live the lives they want to live.

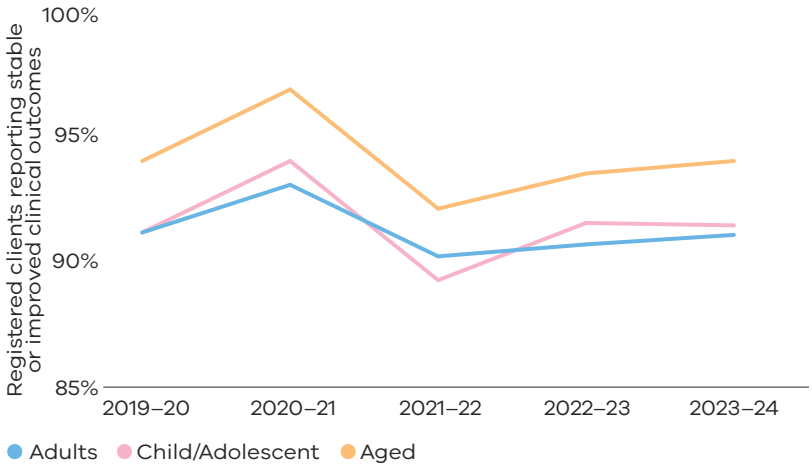
While this is the aspiration, service outcomes data at present are primarily related to experiences and impacts of clinical services. These data indicate relatively similar outcomes over time. Clinician-reported rates of improvement in community mental health cases at closure were at 53.5 per cent in 2023-24. This was up from 52.0 per cent in 2021-22, but similar to the 53.4 per cent recorded in 2019-20.

Assessments of outcomes from consumers have shown similar trends to clinical assessments. The proportion of registered clients experiencing stable or improved clinical outcomes in adult, child and adolescent, or aged mental health services increased slightly from 2021-22 to 2023-24, but these 2023-24 outcomes were similar to 2019-20.

Rates of follow-up after discharge are relatively high, with 90.9 per cent of inpatient consumers experiencing follow-up within seven days. Rates are lower in Forensic and Specialist services, at around 80 per cent, while aged consumers have the highest rates of follow-up, at 94.3 per cent.

Figure 19: Proportion of consumers reporting improved clinical outcomes from services

Source: Your Experience Survey (YES) data provided by the Department of Health



Are suicides and self-harm changing?

Suicides and self-harm are tragic outcomes that are a multifactorial issue. In considering the data on these elements, we are mindful that the mental health and wellbeing system plays only a part in this picture. For example, disconnection from culture and Country, intergenerational trauma, relationship breakdown and family violence are important factors, as are other mental health determinants, psychological distress and illness, access, quality and safety of all parts of the mental health system (including those not funded by the Victorian Government) and the effectiveness of those supports in helping people. Within the system it's also important to balance avoidance of potential self-harm or suicide with dignity of risk.

Suicide remained the leading cause of death in Victoria for people aged 18 to 44 in 2022, and the second leading cause of death behind heart disease for people aged 45-54. It accounted for 10 per cent of life-years lost to all causes.

Data from the Victorian Suicide Register (VSR), established by the Victorian Coroner's Court, were examined to identify recent trends in suicide. It is important to note that Victoria's suicide frequency can vary substantially from month to month and annually. This is not unique to Victoria – it is a feature of suicide data around Australia and the world. The deaths included in the Victorian Suicide Register (VSR) are regularly reviewed as coroners' investigations progress and more is learned about the circumstances in which they occurred.

Deaths may be removed from the VSR if investigation establishes they are likely not to be suicides; likewise, deaths initially missed may be added to the VSR as new evidence consistent with suicide is gathered. This is why some data reported here may be different to what was reported in other places. The majority of deaths that occurred in 2023 are currently under investigation by coroners to determine the circumstances. For these reasons, it is important to note that conclusions regarding trends in suicide may change as the data are updated.

Data from the Victorian Coroner's Court to the end of 2023 show:

- There was an increase in the number of suicides from below 700 in 2019 to 2021, to 761 in 2022, and 801 in 2023.
  - This rate of growth (around 15 per cent over the five years) is over three times the rate of population growth (around 4.3 per cent from 2019 to 2023).
- From 2019 to 2021 three times as many men died from suicide than women.
- In 2022 and 2023, women accounted for a higher proportion of suicides, with the ratio falling to 2.6 men dying from suicide per woman.
- One third of suicides occur in regional locations.

Figure 20: Annual suicides in Victoria

Source: Coroners Court 2023 Annual Suicide Data Report

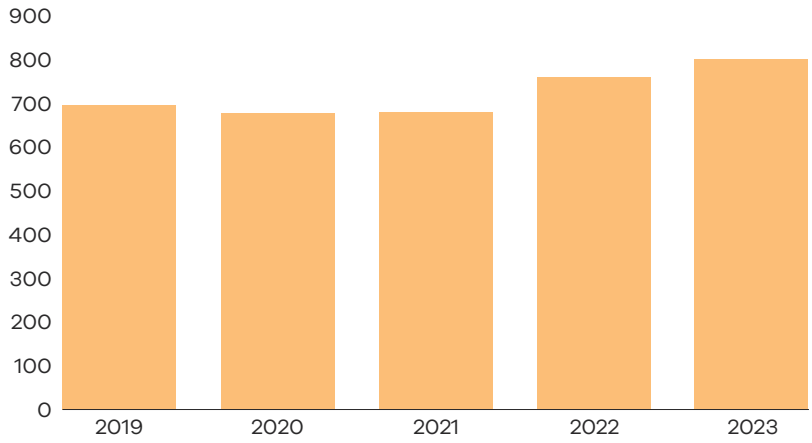
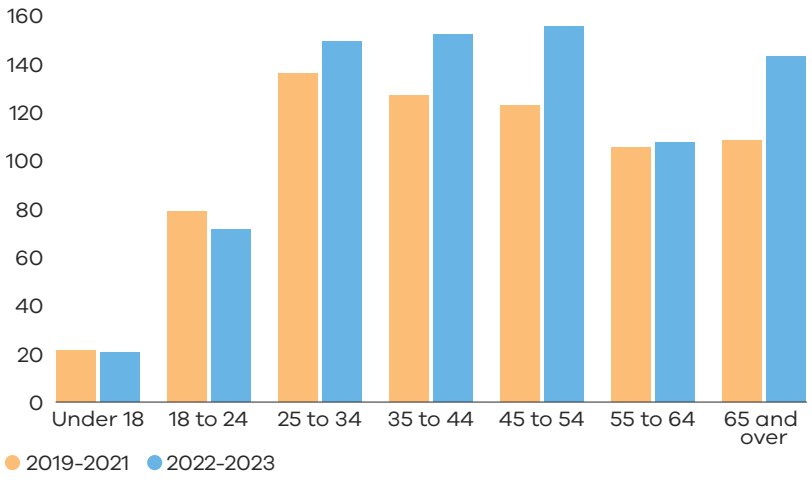


Figure 21: Average annual suicides by age group

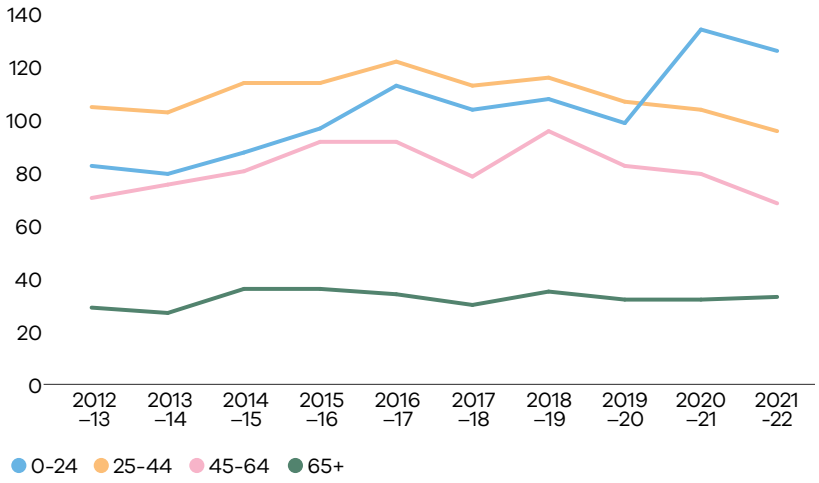
Source: Coroners Court 2023 Annual Suicide Data Report



A key factor in the increase in suicides in 2022 and 2023 reported by the Victorian Coroner's Court is an increase in suicides for those aged 35-54, and those aged 65 and over. The chart above compared the profile of annual average suicides by age group, over the periods 2019 to 2021 and 2022 to 2023.

Figure 22: Intentional self-harm hospitalisations per 100,000 population

Source: Admitted Patient Care National Minimum Dataset



While suicides among young people have remained relatively stable, intentional self-harm among young people in Victoria surged in 2020-21 and 2021-22. Data from the Australian Institute of Health and Welfare based on the Admitted Patient Care National Minimum Dataset shows:

- the rate of intentional self-harm hospitalisations per 100,000 people increased from around 100 in 2019-20 to 120 in 2021-22
- rates of intentional self-harm among people aged 25 to 64 have been falling over the past five years, after rising from 2012-13 to 2016-17
- rates among those over 65 have remained relatively stable and are the lowest across the age cohorts.

Next steps

Following this review, the Commission has identified the following key actions to inform our approach for the next year.

We will:

- review whether psychological distress in the community changes significantly in the 2024 VPHS
- consider whether to adjust our monitoring of community outcomes and determinants, based on a review of government's Outcomes and Performance Framework
- develop a framework to monitor lived experience leadership and representation across the mental health and wellbeing system
- continue to monitor government's investment in mental health and wellbeing and ensure mental health is a priority for government
- seek evidence on whether there is a net increase in access to services accessible to the community
- undertake a deep dive into measures of quality, safety, and performance of the system, which will:
  - examine trends across locations, providers, and cohorts
  - seek to explore the reasons behind aggregate changes (e.g. the increase in the average length of compulsory treatment)
  - potentially identify additional measures for reporting in future annual reports
- review government's revised implementation plan for the Royal Commission recommendations, including to seek input from government on:
  - assessment of whether initiatives put in place to address workforce constraints are having an effect
  - whether reform work that is less dependent on workforce is being considered and commenced where it is appropriate to do so.

"We need to lay solid foundations if we are to perform our role effectively. This means getting the right people, having a clear understanding of how we contribute to change, and feasible plans that don't duplicate the work of others. This can be painstaking work, but it is an essential part of being impactful."

Commissioner Annabel Brebner

Progress on the Royal Commission recommendations

The final report of the Royal Commission into Victoria's Mental Health System was tabled in a special sitting of the Victorian Parliament on 2 March 2021.

The final report included 65 recommendations in addition to the nine interim report recommendations. The recommendations set out a 10-year vision for a future mental health system where people can access treatment close to their homes and in their communities.

The Victorian government committed to implementing all recommendations.

Our role

The Commission is charged with monitoring and reporting on the progress of implementing the recommendations made by the Royal Commission.

As outlined in the Commission's Monitoring and Reporting Plan, our role includes:

- Independent oversight of the implementation of the Royal Commission recommendations.
- to identify concerns with implementation progress and approach to alert government, the sector, and the community to any emerging risks and problems.
- to elevate the status of mental health across government, to ensure the recommendations remain a priority.

Our approach

The Commission remains committed to understanding progress towards achieving the outcomes of the recommendations.

Our initial approach is focused on understanding government's approach to date, including prioritisation, implementation planning, and timelines.

While we understand that implementation may be impacted by many factors, and changing circumstances may necessitate changes in how the recommendations are implemented, what we seek to understand is whether any changes are ultimately in pursuit of the objectives and outcomes set out by of the Royal Commission.

We are currently in a dialogue with government to better understand progress on the recommendations. The Department of Health has provided a summary of recommendation progress as at 30 June, which updates a previous update provided to the Public Accounts and Estimates Committee (PAEC) on 31 May, 2024.

The summary includes the implementation progress status of each of the recommendations, as well as the implementation completion date as outlined by the Royal Commission. We note that government has indicated it has reviewed and recast the implementation of the reform program through its Phase 2 Reform Plan, which is set to be released in late 2024. As a result, the Commission understands that both the acquittal approach and the associated timeframes for the Royal Commission recommendations will be updated throughout the course of 2024-25.

The Commission has committed, through its Monitoring and Reporting Plan, to an independent program of consultative work to validate the implementation of recommendations and identify key issues. This will help to inform the Commission's approach to reporting progress against the recommendations in future years.

Through 2023-24, the Commission has also been made aware of community concerns around the timing and funding for recommendations and put questions to the Victorian government about the future of mental health reforms. We look forward to the release of the Phase 2 Reform Plan, and to being informed of how government will seek to address those issues through that plan.

Figure 23: Royal Commission recommendation progress and original timelines outlined by the Royal Commission on Victoria's Mental Health System as 30 June 2024

Source: Victorian Department of Health

Rec	Title	Implementation to be completed by (as set by Royal Commission)	Implementation progress
1	Supporting good mental health and wellbeing	1.1 End 2022 1.2-1.4 End 2031	In progress
2	Governance arrangements for promoting good mental health and preventing mental illness	End 2022	In progress
3	Establishing a responsive and integrated mental health and wellbeing system	3.1 & 3.2a End 2026 3.2b. & 3.2c End 2022 3.2d. End 2026 3.3 End 2022 3.4 & 3.5 End 2024	In progress
4	Towards integrated regional governance	4.1 Mid 2021 4.2 End 2023 4.3 End 2026 4.4 End 2023 4.5 End 2022	In progress
5	Core functions of community mental health and wellbeing services	End 2026	In progress
6	Helping people find and access treatment, care and support	6.1 & 6.2 End 2026 6.3-6.5 End 2022	In progress
7	Identifying needs and providing initial support in mental health and wellbeing services	End 2026	In progress
8	Responding to mental health crises	End 2024 8.3.c End 2022	In progress
9	Developing 'safe spaces' and crisis respite facilities	End 2026	In progress
10	Supporting responses from emergency services to mental health crises	10.1 End 2024 10.2 End 2022 10.3 End 2024	In progress

Rec	Title	Implementation to be completed by (as set by Royal Commission)	Implementation progress
11	New models of care for bed based services	11.1 End 2026 11.2 End 2022 11.3 End 2026 11.4 End 2031	In progress
12	Developing new bed-based rehabilitation services	12.1 & 12.2 End 2026 12.3 End 2031	To be commenced
13	Addressing gender-based violence in mental health facilities	13.1 End 2031 13.2 Mid 2022 13.3 End 2026 13.4 End 2031	In progress
14	Supporting mental health consultation liaison services	End 2024	In progress
15	Supporting good mental health and wellbeing in local communities	15.1 & 15.2 End 2024 15.3 End 2026 15.4 End 2022	In progress
16	Establishing mentally healthy workplaces	16.1 End 2022 16.2 End 2023	In progress
17	Supporting social and emotional wellbeing in schools	17.1 End 2031 17.2 End 2022 17.3 End 2031	In progress
18	Supporting the mental health and wellbeing of prospective and new parents	18.1 End 2026 18.2 End 2022	In progress
19	Supporting infant, child and family mental health and wellbeing	19.1-19.4 End 2022 19.5 End 2026	In progress
20	Supporting the mental health and wellbeing of young people	20.1 End 2022 20.2 End 2024 20.3 End 2026 20.4 End 2022	In progress

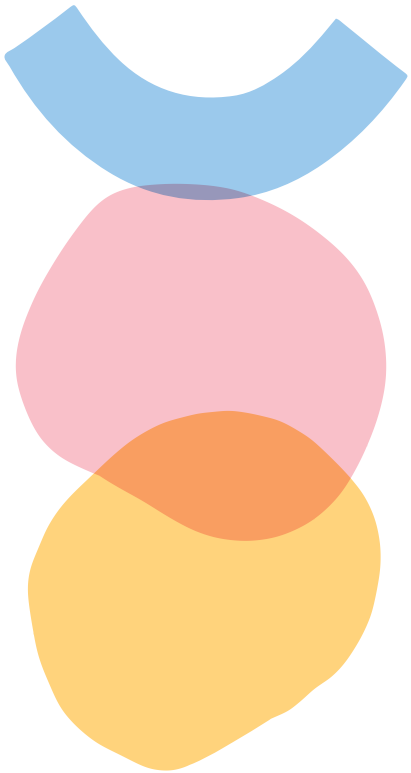
Rec	Title	Implementation to be completed by (as set by Royal Commission)	Implementation progress
21	Redesigning bed-based services for young people	21.1 & 21.2 End 2026 21.3 End 2022	In progress
22	Supporting the mental health and wellbeing of older Victorians	22.1 End 2022 22.2 & 22.3 End 2024	To be commenced
23	Establishing a new Statewide Trauma Service	End 2022	In progress
24	A new approach to addressing trauma	End 2026	In progress
25	Supported housing for adults and young people living with mental illness	25.1 End 2031 25.2 End 2022 25.3 End 2024 25.4 End 2026 25.5 End 2022 25.6 End 2031	In progress
26	Governance arrangements for suicide prevention and response efforts	26.1 End 2022 26.2 End 2031	In progress
27	Facilitating suicide prevention and response initiatives	27.1 & 27.2 End 2024 27.3 End 2022	In progress
28	Developing system-wide roles for the full and effective participation of people with lived experience of mental illness or psychological distress	End 2031	In progress
29	A new agency led by people with lived experience of mental illness or psychological distress	End 2024	In progress
30	Developing system wide involvement of family members and carers	End 2031	In progress
31	Supporting families, carers and supporters	31.1 & 31.2 End 2022 31.3 End 2024	In progress
32	Supporting young carers	End 2022	In progress
33	Supporting Aboriginal social and emotional wellbeing	33.1-33.3 End 2022 33.4 End 2024	In progress

Rec	Title	Implementation to be completed by (as set by Royal Commission)	Implementation progress
34	Working in partnership with and improving accessibility for diverse communities	34.1 End 2031 34.2 End 2022 34.3 End 2031 34.4 End 2021 34.5 End 2024	In progress
35	Improving outcomes for people living with mental illness and substance use or addiction	End 2022	In progress
36	A new statewide service for people living with mental illness and substance use or addiction	36.1 End 2024 36.2 End 2026 36.3 End 2022	In progress
37	Supporting the mental health and wellbeing of people in contact with, or at risk of coming into contact with, the criminal and youth justice systems	37.1 End 2026 37.2 & 37.3 End 2022 37.4 End 2024	In progress
38	Providing safe and appropriate mental health treatment, care and support at Thomas Embling Hospital	38.1 End 2026 38.2 End 2031	In progress
39	Supporting the mental health and wellbeing of people in rural and regional Victoria	39.1.a. End 2026 39.1.b. End 2022	In progress
40	Providing incentives for the mental health and wellbeing workforce in rural and regional areas	End 2031	In progress
41	Addressing stigma and discrimination	41.1 End 2031 41.2 End 2024 41.3 End 2031 41.4 End 2031	In progress
42	A new Mental Health and Wellbeing Act	Mid 2022	Completed
43	Future review of mental health laws	End 2031	To be commenced
44	A new Mental Health and Wellbeing Commission	44.1 & 44.2 Mid 2022 44.3 End 2031	In progress

Rec	Title	Implementation to be completed by (as set by Royal Commission)	Implementation progress
45	Effective leadership of and accountability for the mental health and wellbeing system	45.1 Mid 2022 45.2 End 2031 45.3 Mid 2021 45.4 End 2031	Completed
46	Facilitating government wide efforts	Mid 2022	Completed
47	Planning the new mental health and wellbeing system	47.1 End 2022 47.2 End 2023 47.3 End 2031 47.4 End 2026	In progress
48	Selecting providers and resourcing services	48.1 & 48.2 End 2031 48.3 End 2022	In progress
49	Monitoring and improving mental health and wellbeing service provision	End 2022	In progress
50	Encouraging national partnerships	End 2022	Completed
51	Commissioning for integration	End 2031	To be commenced
52	Improving the quality and safety of mental health and wellbeing services	52.1 End 2021 52.2 End 2031	In progress
53	Strong oversight of the quality and safety of mental health and wellbeing services	End 2031	Completed
54	Towards the elimination of seclusion and restraint	54.1 End 2031 54.2 End 2022 54.3 & 54.4 End 2031	In progress
55	Ensuring compulsory treatment is only used as a last resort	55.1 End 2031 55.2 End 2022 55.3 & 55.4 End 2031	In progress
56	Supporting consumers to exercise their rights	56.1 End 2031 56.2 End 2022 56.3 End 2024 56.4 End 2031	In progress

Rec	Title	Implementation to be completed by (as set by Royal Commission)	Implementation progress
57	Workforce strategy, planning and structural reform	57.1 End 2031 57.2 End 2023 57.3 End 2021	In progress
58	Workforce capabilities and professional development	58.1 End 2021 58.2 & 58.3 End 2022 58.4 End 2031	In progress
59	Workforce safety and wellbeing	59.1 End 2021 59.2 End 2026 59.3 End 2021	In progress
60	Building a contemporary system through digital technology	60.1 End 2022 60.2 End 2026 60.3 End 2024	To be commenced
61	Sharing mental health and wellbeing information	End 2022	In progress
62	Contemporary information architecture	End 2024	In progress
63	Facilitating translational research and its dissemination	63.1 End 2023 63.2 End 2024	In progress
64	Driving innovation in mental health treatment, care and support	End 2031	To be commenced
65	Evaluating mental health and wellbeing programs, initiatives and innovations	65.1 End 2022 65.2 End 2026 65.3 End 2031	In progress
IR1	Victorian Collaborative Centre for Mental Health and Wellbeing	Not specified	Completed
IR2	Targeted acute mental health service expansion	Mid 2022	Completed
IR3	Suicide prevention	Not specified	Completed
IR4	Aboriginal social and emotional wellbeing	End 2026	Completed

Rec	Title	Implementation to be completed by (as set by Royal Commission)	Implementation progress
IR5	A service designed and delivered by people with lived experience	Not specified	In progress
IR6	Lived experience workforces	Not specified	In progress
IR7	Workforce readiness	Junior Medical Officers by End 2023, otherwise not specified	In progress
IR8	New approach to mental health investment	Not specified	Completed
IR9	The Mental Health Implementation Office	Not specified	Completed



> “My aspiration for the future of the Commission is that we will prove to be effective; to truly progress the vision of the Royal Commission’s Final Report; to carry meaning for people with lived experience; and to be enabling and supportive to services.”
>
> **Danilo Di Giacomo, General Manager, Lived Experience**