Appendix 2: Funding and activity levels

Introduction to Appendix 2

Provides tables detailing the modelled budgets for 2019–20, as well as the activity tables that detail the 2019–20 targets for a range of programs across the health system.

A note on terminology

The term 'funded organisations' relates to all entities that receive departmental funding to deliver services. Aspects of these guidelines referring to funded organisations are applicable to all department-funded entities.

For the purposes of these guidelines, the term 'health services' relates to public health services, denominational hospitals, public hospitals and multipurpose services, as defined by the *Health Services Act 1988*, regarding services provided within a hospital or a hospital-equivalent setting. Aspects of these guidelines that refer specifically to 'health services' are only applicable to these entities.

The term 'community service organisations' refers to registered community health centres, local government authorities and non-government organisations that are not health services.

These guidelines are also relevant for Ambulance Victoria, Health Purchasing Victoria, Mildura Base Hospital and the Victorian Institute of Forensic Mental Health. The guidelines specify where aspects of the guidelines are relevant for these organisations.

2.1 Budget tables

2.1.1 Health service modelled budgets 2018–19 and 2019–20

Notes:

i. Please see Table 2.3 for details on funding flowing through the National Health Funding Pool.

ii. Please see Table 2.4 for details on mental health expenditure.

iii. 2018–19 numbers may differ from the *Department of Health and Human Services policy and funding guidelines, Volume 2: Health operations 2018–19* due to changes in classification and funding commitments made during 2018.

iv. Subtotals and totals may not add up due to rounding.

Table 2.1: Expenditure budgets 2018–19 and 2019–20

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	Public health $'000s	2019–20 Total $'000s
Metropolitan and regional														
Albury Wodonga Health	210,718	765	740	37,583	4,266		**254,072**	221,402	770	755	43,509	4,276		**270,711**
Alfred Health	800,740	6,203	607	62,306	2,035	9,033	**880,924**	822,707	6,328	623	77,019	2,070	8,479	**917,225**
Austin Health	633,245	1,130	1,728	59,657	5	51	**695,815**	651,701	1,129	1,775	72,647		17	**727,270**
Ballarat Health Services	244,645	11,158	138	38,450	1,104	13	**295,509**	255,677	11,342	141	46,192	1,123		**314,475**
Barwon Health	489,307	13,328	2,420	42,701	4,931	133	**552,819**	503,361	13,503	2,486	54,252	5,004	108	**578,714**
Bendigo Health Care Group	246,746	13,037	2,058	55,097	1,122		**318,060**	260,245	13,594	2,104	65,036	1,137		**342,116**
Calvary Health Care Bethlehem Limited	21,279	86					**21,365**	22,168	88					**22,256**
Eastern Health	715,005	8,062	12,278	108,286	3,975	533	**848,140**	741,873	8,073	15,247	130,251	4,032		**899,476**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	Public health $'000s	2019–20 Total $'000s
Goulburn Valley Health	165,741	3,991	1,891	25,153	1,682		**198,457**	174,603	4,035	2,715	30,773	1,665		**213,791**
Latrobe Regional Hospital	171,922		138	46,449	1,433	277	**220,220**	179,861		141	54,676	1,471	273	**236,423**
Melbourne Health	639,801	6,124	371	212,636		15,629	**874,561**	661,076	6,232	303	246,998		15,584	**930,192**
Mercy Public Hospitals Inc.	307,748		138	57,952	84		**365,922**	326,319		141	65,170	85		**391,715**
Monash Health	1,249,449	11,878	1,828	167,924	13,347	1,055	**1,445,481**	1,302,236	12,086	4,317	200,704	13,262	700	**1,533,304**
Northern Health	483,630	4,150	138		10	13	**487,940**	516,876	4,200	140				**521,217**
Peninsula Health	433,913	6,327	2,504	49,663	7,160	139	**499,706**	452,908	6,362	2,597	59,814	6,931	115	**528,727**
Peter MacCallum Cancer Centre	196,855			71		17	**196,942**	210,166			72			**210,238**
St Vincent's Hospital Melbourne Limited	452,059	3,679	1,159	59,770	304	181	**517,153**	467,920	3,658	3,092	69,091	299	187	**544,247**
The Royal Children's Hospital	445,120	19		7,962	331	961	**454,392**	458,145	20		22,138	479	596	**481,377**
The Royal Victorian Eye and Ear Hospital	93,198					16	**93,214**	96,608						**96,608**
The Royal Women's Hospital	202,128		968	664	273	108	**204,141**	214,171		996	674	277	58	**216,177**
Western Health	653,129	3,580	9,989	173	5	1,015	**667,891**	686,918	3,605	13,561	175		903	**705,162**
Total	**8,856,376**	**93,517**	**39,094**	**1,032,497**	**42,068**	**29,174**	**10,092,725**	**9,226,941**	**95,025**	**51,135**	**1,239,193**	**42,111**	**27,020**	**10,681,421**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	Public health $'000s	2019–20 Total $'000s
Subregional and local														
Bairnsdale Regional Health Service	65,303	1,321	136		213		**66,973**	68,476	1,341	334		216		**70,368**
Bass Coast Health	49,953	1,647	81		1,657		**53,338**	54,855	1,672	83		1,874		**58,484**
Benalla Health	18,703	1,182			1,469		**21,354**	20,915	1,190			1,147		**23,252**
Castlemaine Health	24,312	2,908					**27,220**	26,292	3,031					**29,322**
Central Gippsland Health Service	61,004	3,910	136		904		**65,954**	63,957	3,965	465		1,627		**70,014**
Colac Area Health	25,338	1,982	8		623		**27,951**	27,720	2,012	8		633		**30,374**
Djerriwarrh Health Services	42,801	2,343			2,547		**47,690**	45,659	2,377			2,584		**50,620**
East Grampians Health Service	19,627	1,660			839		**22,126**	20,864	1,687			853		**23,404**
Echuca Regional Health	54,872	1,932			955		**57,758**	62,502	1,961			967		**65,430**
Gippsland Southern Health Service	19,792	2,367			458		**22,616**	21,807	2,402	195		395		**24,800**
Kyabram and District Health Services	15,151	1,381			1,130		**17,662**	15,677	1,432			1,145		**18,255**
Maryborough District Health Service	20,446	2,591			737		**23,774**	21,997	2,584			746		**25,327**
Northeast Health Wangaratta	105,295	1,980	136		754	13	**108,178**	112,235	2,009	139		746		**115,130**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	Public health $'000s	2019–20 Total $'000s
Portland District Health	25,312	1,182	8		1,828		**28,331**	26,734	1,195	8		1,858		**29,795**
Ramsay Health Care Limited	100,017		138	16,344	5		**116,505**	103,808		394	19,864			**124,066**
South West Healthcare	121,000	1,534	399	21,865	1,817	18	**146,633**	133,567	1,555	409	25,880	1,847		**163,259**
Stawell Regional Health	14,711	1,095		240	1,196		**17,241**	15,493	1,109		244	1,216		**18,061**
Swan Hill District Health	36,089	2,017			1,815		**39,921**	41,258	2,047			1,520		**44,826**
West Gippsland Health Care Group	75,626	2,868			978		**79,471**	80,956	2,919			994		**84,869**
Western District Health Service	43,549	3,487		111	876		**48,023**	48,444	3,546		113	656		**52,758**
Wimmera Health Care Group	59,894	3,038	136		1,254		**64,322**	62,881	3,074	139		1,275		**67,368**
Total	**998,795**	**42,423**	**1,180**	**38,560**	**22,054**	**31**	**1,103,043**	**1,076,097**	**43,109**	**2,175**	**46,100**	**22,301**		**1,189,782**
Grand total	**9,855,171**	**135,940**	**40,274**	**1,071,056**	**64,122**	**29,205**	**11,195,767**	**10,303,038**	**138,133**	**53,310**	**1,285,293**	**64,412**	**27,020**	**11,871,203**

2.1.2 Small rural health services expenditure budgets 2018–19 and 2019–20

Notes:

i. 2018–19 numbers may differ from the *Department of Health and Human Services policy and funding guidelines, Volume 2: Health operations 2018–19* due to changes in classification and funding commitments made during 2018–19.

ii. The expenditure budget for the Coleraine campus is reported as part of the Western District Health Service.

iii. Subtotals and totals may not add up due to rounding.

Table 2.2: Small rural health services expenditure budgets 2018–19 and 2019–20

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Total $'000s
Alexandra District Health	6,661	146		442	**7,249**	6,886	149		449	**7,485**
Alpine Health	11,797	1,778		305	**13,880**	12,352	2,010		310	**14,672**
Beaufort and Skipton Health Service	4,751	994		149	**5,894**	5,550	1,010		151	**6,711**
Beechworth Health Service	5,021	1,059		344	**6,424**	5,038	1,155		350	**6,543**
Boort District Health	2,608	374			**2,982**	2,918	380			**3,298**
Casterton Memorial Hospital	3,989	991		38	**5,018**	4,260	1,006		38	**5,305**
Cohuna District Hospital	6,422	560			**6,982**	6,883	568			**7,452**
Corryong Health	4,128	779		120	**5,027**	4,425	836		122	**5,383**
East Wimmera Health Service	12,930	2,611		609	**16,150**	13,970	2,734		619	**17,323**
Edenhope and District Memorial Hospital	3,779	614		67	**4,460**	4,070	637		68	**4,774**
Great Ocean Road Health	5,589	1,016		208	**6,813**	6,220	1,017		211	**7,448**
Heathcote Health	2,973	517		127	**3,617**	3,212	525		129	**3,866**
Hepburn Health Service	9,707	2,248		1,052	**13,007**	10,394	2,282		1,071	**13,747**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Total $'000s
Hesse Rural Health Service	2,254	768		580	**3,602**	2,504	779		589	**3,873**
Heywood Rural Health	2,753	490			**3,243**	3,056	497			**3,553**
Inglewood and Districts Health Service	2,287	560		544	**3,391**	2,570	561		553	**3,684**
Kerang and District Health	6,700	1,106		5	**7,811**	7,178	1,109			**8,288**
Kilmore and District Hospital	14,468	1,047			**15,515**	16,237	1,048			**17,285**
Kooweerup Regional Health Services	5,291	915			**6,206**	5,572	918			**6,490**
Kyneton District Health Service	10,726	177			**10,903**	11,277	94			**11,371**
Maldon Hospital	1,775	558			**2,333**	1,863	558			**2,422**
Mallee Track Health and Community Service	4,257	1,668			**5,925**	4,717	1,670			**6,387**
Mansfield District Hospital	7,579	1,076		392	**9,047**	8,262	1,077		398	**9,737**
Moyne Health Services	4,086	1,208		7	**5,301**	4,675	1,290		7	**5,973**
NCN Health	19,310	2,752		379	**22,441**	20,639	2,770		385	**23,794**
Omeo District Health	1,940	398			**2,338**	2,125	399			**2,523**
Orbost Regional Health	6,220	629		499	**7,348**	6,675	631		551	**7,857**
Robinvale District Health Services	6,074	945		232	**7,251**	6,219	947		236	**7,402**
Rochester and Elmore District Health Service	5,989	1,007			**6,996**	6,296	1,055			**7,351**
Rural Northwest Health	9,422	1,585		581	**11,588**	9,905	1,643		591	**12,138**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Total $'000s
Seymour District Memorial Hospital	12,968	1,052		88	**14,108**	13,620	1,054		89	**14,763**
South Gippsland Hospital	5,944	46		142	**6,132**	6,644	47		82	**6,772**
Tallangatta Health Service	3,773	575		228	**4,576**	4,566	600		227	**5,393**
Terang and Mortlake Health Service	5,569	534		1,236	**7,339**	5,882	656		1,255	**7,793**
Timboon and District Healthcare Service	3,879	292		288	**4,459**	4,094	342		293	**4,729**
West Wimmera Health Service	15,284	3,063	259	2,414	**21,020**	16,125	3,222	263	2,725	**22,335**
Yarram and District Health Service	5,653	837		406	**6,896**	6,199	841		484	**7,524**
Yarrawonga District Health Service	9,706	1,351		644	**11,701**	10,326	1,351		655	**12,333**
Yea and District Memorial Hospital	2,694	379		363	**3,436**	3,066	379		370	**3,815**
Total	**256,958**	**38,705**	**259**	**12,489**	**308,411**	**276,471**	**39,845**	**263**	**13,011**	**329,592**

2.1.3 Activity-based funding: Health service expenditure budgets 2018–19 and 2019–20 by service category

Notes:

i. This table shows (state and Commonwealth) funding flowed through the National Health Funding Pool to activity-based funding funded hospitals by the National Health Reform Agreement (NHRA) service (refer to Chapter 1, section 1.4.1 'Pricing and funding framework') and out-of-scope funding.

ii. This table does not include public hospital services provided by small rural health services or non-health service organisations.

iii. 2018–19 numbers may differ from the *Department of Health and Human Services policy and funding guidelines, Volume 2: Health operations 2018–19* due to changes in classification and funding commitments made during 2018–19.

iv. Subtotals and totals may not add up due to rounding.

Table 2.3: Activity-based funding: Health service expenditure budgets 2018–19 and 2019–20 by service category

Health service	Total 2018–19 $'000s	Acute admitted $'000s	Acute non-admitted patients $'000s	Emergency $'000s	Subacute $'000s	Subacute non-admitted $'000s	Non-admitted home ventilation $'000s	Teaching, training and research $'000s	Mental health admitted $'000s	Non-admitted mental health $'000s	Non-admitted CAMHS $'000s	Other non-admitted services $'000s	Other public hospital programs $'000s	Out-of-scope funding $'000s	Total 2019–20 $'000s
Metropolitan and regional															
Albury Wodonga Health	**254,072**	92,736	5,828	13,770	4,201	6,020	–	3,457	7,743	19,800	3,198	–	–	113,958	**270,711**
Alfred Health	**880,924**	562,176	52,253	36,350	60,280	25,018	–	19,650	24,751	39,617	8,400	–	–	88,730	**917,225**
Austin Health	**695,815**	453,572	46,095	32,586	44,369	18,210	8,546	19,616	29,708	23,233	9,492	–	–	41,843	**727,270**
Ballarat Health Services	**295,509**	156,376	15,484	24,720	18,394	9,889	–	8,933	15,698	23,446	4,747	–	–	36,788	**314,475**
Barwon Health	**552,819**	333,054	30,003	28,016	25,266	19,684	–	12,921	12,742	35,412	5,238	5	37,150	39,223	**578,714**
Bendigo Health Care Group	**318,060**	179,708	18,225	21,471	22,788	16,394	–	10,266	23,235	34,718	5,805	–	–	9,506	**342,116**
Calvary Health Care Bethlehem Limited	**21,365**	1,967	146	–	7,639	10,964	–	809	–	–	–	–	–	731	**22,256**
Eastern Health	**848,140**	526,229	42,087	59,970	54,827	29,946	–	19,114	39,741	81,607	11,794	–	–	34,161	**899,476**
Goulburn Valley Health	**198,457**	112,506	12,344	19,232	12,739	6,884	–	6,154	7,149	21,009	2,868	–	–	12,906	**213,791**
Latrobe Regional Hospital	**220,220**	132,058	7,974	12,637	11,891	7,901	–	5,589	16,561	31,318	4,399	–	–	6,095	**236,423**

Health service	Total 2018–19 $'000s	Acute admitted $'000s	Acute non-admitted patients $'000s	Emergency $'000s	Subacute $'000s	Subacute non-admitted $'000s	Non-admitted home ventilation $'000s	Teaching, training and research $'000s	Mental health admitted $'000s	Non-admitted mental health $'000s	Non-admitted CAMHS $'000s	Other non-admitted services $'000s	Other public hospital programs $'000s	Out-of-scope funding $'000s	Total 2019–20 $'000s
Melbourne Health	**874,561**	457,512	53,924	26,705	36,175	25,404	–	25,593	84,446	140,355	9,616	–	–	70,462	**930,192**
Mercy Hospitals Victoria Limited	**365,922**	256,592	33,627	17,306	7,057	3,346	–	5,429	28,676	33,257	704	–	–	5,721	**391,715**
Monash Health	**1,445,481**	900,782	89,492	67,271	61,975	39,231	–	32,797	79,233	102,336	14,083	–	103,126	42,978	**1,533,304**
Northern Health	**487,940**	367,855	32,889	36,682	36,628	24,269	–	11,381	12	140	–	–	–	11,361	**521,217**
Peninsula Health	**499,706**	320,370	15,542	36,772	42,305	19,982	–	10,001	16,384	39,775	2,008	–	–	25,588	**528,727**
Peter MacCallum Cancer Institute	**196,942**	121,113	25,318	–	–	–	–	3,441	–	–	–	–	–	60,366	**210,238**
St Vincent's Hospital Melbourne Limited	**517,153**	309,046	37,637	24,539	33,159	17,624	–	20,172	22,044	43,113	1,690	–	–	35,223	**544,247**
The Royal Children's Hospital	**454,392**	340,546	41,316	34,288	5,671	15,917	2,327	9,682	5,266	4,212	13,195	–	–	8,957	**481,377**
The Royal Victorian Eye and Ear Hospital	**93,214**	62,422	24,797	6,482	–	–	–	1,838	–	–	–	–	–	1,069	**96,608**
The Royal Women's Hospital	**204,141**	169,029	39,376	2,459	–	–	–	4,638	381	294	–	–	–	–5,574	**216,177**
Western Health	**667,891**	422,482	50,509	56,754	38,362	24,675	–	14,186	2	10,856	–	–	71,387	15,949	**705,162**
Metropolitan and regional total	**10,092,725**	**6,283,710**	**674,864**	**558,009**	**523,724**	**321,357**	**10,873**	**245,666**	**413,773**	**684,500**	**97,238**	**5**	**211,662**	**656,040**	**10,681,421**
Subregional and local															
Bairnsdale Regional Health Service	**66,973**	43,552	3,889	8,390	3,919	4,422		2,315	–	334	–	0		3,546	**70,367**
Bass Coast Health	**53,338**	30,633	2,470	8,398	4,629	3,761		1,420	–	–	–	–		7,172	**58,483**

Health service	Total 2018–19 $'000s	Acute admitted $'000s	Acute non-admitted patients $'000s	Emergency $'000s	Subacute $'000s	Subacute non-admitted $'000s	Non-admitted home ventilation $'000s	Teaching, training and research $'000s	Mental health admitted $'000s	Non-admitted mental health $'000s	Non-admitted CAMHS $'000s	Other non-admitted services $'000s	Other public hospital programs $'000s	Out-of-scope funding $'000s	Total 2019–20 $'000s
Benalla Health	**21,354**	17,011	651	–	471	1,769		294	–	–	–	–		3,056	**23,252**
Castlemaine Health	**27,220**	17,516	468	–	4,141	2,912		367	–	–	–	–		3,917	**29,321**
Central Gippsland Health Service	**65,954**	42,879	6,116	7,266	2,793	2,684		2,076	–	465	–	–		5,735	**70,014**
Colac Area Health	**27,951**	23,102	1,851	–	625	1,366		349	–	–	–	–		3,080	**30,373**
Djerriwarrh Health Services	**47,690**	34,583	8,033	–	693	1,487		562	–	–	–	–		5,262	**50,620**
East Grampians Health Service	**22,126**	17,411	487	–	616	803		1,235	–	–	–	–		2,852	**23,404**
Echuca Regional Health	**57,758**	38,507	4,906	9,054	3,807	2,607		2,495	–	–	–	–		4,054	**65,430**
Gippsland Southern Health Service	**22,616**	17,539	2,097	–	966	415		352	–	195	–	–		3,236	**24,800**
Kyabram and District Health Services	**17,662**	14,246	346	–	779	–		98	–	–	–	–		2,786	**18,255**
Maryborough District Health Service	**23,774**	18,863	1,284	–	165	685		546	–	–	–	–		3,785	**25,328**
Northeast Health Wangaratta	**108,178**	79,378	5,544	10,369	5,711	5,771		3,115	13	139	–	–		5,090	**115,130**
Portland District Health	**28,331**	21,574	1,856	–	935	1,196		350	–	–	–	2		3,881	**29,794**
Ramsay Health Care Limited	**116,505**	75,730	4,425	10,411	3,729	2,782		3,781	4,647	11,686	1,799	–		5,075	**124,065**
South West Healthcare	**146,633**	91,725	9,299	11,147	9,373	4,915		4,808	7,376	14,916	2,070	4		7,625	**163,258**
Stawell Regional Health	**17,241**	12,632	791	–	144	1,416		218	–	225	–	–		2,635	**18,061**

Health service	Total 2018–19 $'000s	Acute admitted $'000s	Acute non-admitted patients $'000s	Emergency $'000s	Subacute $'000s	Subacute non-admitted $'000s	Non-admitted home ventilation $'000s	Teaching, training and research $'000s	Mental health admitted $'000s	Non-admitted mental health $'000s	Non-admitted CAMHS $'000s	Other non-admitted services $'000s	Other public hospital programs $'000s	Out-of-scope funding $'000s	Total 2019–20 $'000s
Swan Hill District Health	**39,921**	23,651	2,190	7,142	3,595	2,855		816	–	–	–	–		4,576	**44,825**
West Gippsland Health Care Group	**79,471**	58,155	4,427	9,037	1,771	3,325		2,712	–	–	–	–		5,441	**84,868**
Western District Health Service	**48,023**	34,060	3,177	4,669	1,914	2,230		823	–	113	–	2		5,769	**52,757**
Wimmera Health Care Group	**64,322**	42,077	5,028	5,929	3,317	2,986		1,650	–	139	–	7		6,235	**67,368**
Subregional and local total	**1,103,043**	**754,824**	**69,337**	**91,813**	**54,093**	**50,388**		**30,384**	**12,036**	**28,212**	**3,870**	**16**		**94,808**	**1,189,781**
Grand total	**11,195,767**	**7,038,534**	**744,201**	**649,822**	**577,817**	**371,745**	**10,873**	**276,050**	**425,809**	**712,712**	**101,108**	**21**	**211,662**	**750,848**	**11,871,202**

2.1.4 Mental health expenditure budgets 2018–19 and 2019–20 by service type

Notes:

i. 2018–19 numbers may differ from the *Department of Health and Human Services policy and funding guidelines, Volume 2: Health operations 2018–19* due to changes in classification and funding commitments made during 2018–19.

ii. Subtotals and totals may not add up due to rounding.

Table 2.4: Mental health expenditure budgets 2018–19 and 2019–20 by service type

Health service	2018–19 Total $'000s	2019–20 Acute $'000s	2019–20 Non-acute $'000s	2019–20 Ambulatory $'000s	2019–20 Psychosocial rehabilitation and support $'000s	2019–20 Residential $'000s	2019–20 Service system capacity $'000s	2019–20 Subacute $'000s	2019–20 Total $'000s
Metropolitan and regional									
Albury Wodonga Health	**37,583**	17,989	–	16,603	1,105	1,443	486	5,883	**43,509**
Alfred Health	**62,306**	23,697	–	43,030	1,817	–	2,645	5,829	**77,018**
Austin Health	**59,657**	30,114	5,297	25,976	1,166	–	2,434	7,661	**72,648**
Ballarat Health Services	**38,450**	12,813	2,543	26,441	1,369	750	814	1,463	**46,193**
Barwon Health	**42,701**	11,579	636	33,928	1,314	1,688	1,280	3,828	**54,253**
Bendigo Health Care Group	**55,097**	18,542	4,238	31,815	1,421	1,301	1,828	5,890	**65,035**
Eastern Health	**108,286**	38,813	–	71,850	3,257	2,567	3,126	10,639	**130,252**
Goulburn Valley Health	**25,153**	6,845	–	18,159	1,045	750	626	3,347	**30,772**
Latrobe Regional Hospital	**46,449**	14,813	1,272	31,745	1,045	375	1,494	3,933	**54,677**
Melbourne Health	**212,636**	76,475	5,509	130,223	4,571	2,191	6,829	21,200	**246,998**
Mercy Public Hospitals Inc.	**57,952**	27,837	–	28,710	1,568	–	1,226	5,829	**65,170**
Monash Health	**167,924**	66,608	10,587	93,221	3,135	3,564	3,950	19,639	**200,704**
Peninsula Health	**49,663**	15,778	–	31,624	1,646	1,286	1,400	8,080	**59,814**
Peter MacCallum Cancer Centre	**71**	–	–	–	–	–	72	–	**72**

Health service	2018–19 Total $'000s	2019–20 Acute $'000s	2019–20 Non-acute $'000s	2019–20 Ambulatory $'000s	2019–20 Psychosocial rehabilitation and support $'000s	2019–20 Residential $'000s	2019–20 Service system capacity $'000s	2019–20 Subacute $'000s	2019–20 Total $'000s
St Vincent's Hospital Melbourne Limited	**59,770**	21,022	–	34,148	1,689	2,720	3,684	5,829	**69,092**
The Royal Children's Hospital	**7,962**	5,201	–	15,833	135	–	968	–	**22,137**
Victorian Institute of Forensic Mental Health	**64,525**	54,135	–	12,511	–	–	1,793	–	**68,575**
The Royal Women's Hospital	**664**	–	–	587	–	–	87	–	**674**
Western Health	**173**	–	–	–	–	–	175	–	**175**
Metropolitan and regional total	**1,097,022**	**442,261**	**30,081**	**646,403**	**26,282**	**18,634**	**34,918**	**109,050**	**1,307,768**
Subregional and local									
Ramsay Health Care Limited	**16,334**	4,274	–	11,523	1,045	–	1,136	1,885	**19,864**
South West Healthcare	**21,865**	6,384	636	14,863	1,105	–	715	2,178	**25,880**
Stawell Regional Health	**240**	–	–	–	–	244	–	–	**244**
Western District Health Service	**111**	–	–	–	–	113	–	–	**113**
Subregional and local total	**38,560**	**10,658**	**636**	**26,386**	**2,150**	**356**	**1,851**	**4,063**	**46,100**
Small rural health service									
West Wimmera Health Service	**259**	–	–	–	–	263	–	–	**263**
Small rural health service total	**259**					**263**			**263**
Other									
La Trobe University	**1,943**	–	–	1,270	–	–	810	–	**2,080**
Lyndoch Living Inc.	**369**	–	–	–	–	375	–	–	**375**

Health service	2018–19 Total $'000s	2019–20 Acute $'000s	2019–20 Non-acute $'000s	2019–20 Ambulatory $'000s	2019–20 Psychosocial rehabilitation and support $'000s	2019–20 Residential $'000s	2019–20 Service system capacity $'000s	2019–20 Subacute $'000s	2019–20 Total $'000s
Tweddle Child and Family Health Service	**136**	–	–	–	–	–	138	–	**138**
The Queen Elizabeth Centre	**132**	–	–	–	–	–	134	–	**134**
The University of Melbourne	**369**	–	–	–	–	–	349	–	**349**
Other total	**2,949**			**1,270**		**375**	**1,431**		**3,076**
Grand total	**1,138,790**	**452,919**	**30,718**	**674,059**	**28,433**	**19,628**	**38,200**	**113,114**	**1,357,207**

2.1.5 Registered community health centres budgets 2018–19 and 2019–20

Note:

i. 2018–19 numbers may differ from the *Department of Health and Human Services policy and funding guidelines, Volume 2: Health operations 2018–19* due to changes in classification and funding commitments made during 2018–19.

Table 2.5: Registered community expenditure budgets 2018–19 and 2019–20

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Access Health and Community		388			3,251		**3,640**		919			3,332		**4,251**
Ballarat Community Health	69	174	2,325	700	2,885	244	**6,397**	70	437	3,031	711	3,002	250	**7,499**
Banyule Community Health		317			3,328		**3,645**		597			3,420		**4,017**
Bellarine Community Health Ltd	448	399			2,307		**3,154**	456	463			2,415		**3,334**
Bendigo Community Health Services Limited	139	134	4,349		3,682	301	**8,606**	142	186	4,467	136	3,910	308	**9,149**
Bentleigh Bayside Community Health		411			2,279		**2,690**		419			2,335		**2,754**
Castlemaine District Community Health Limited		142			863		**1,006**		147			892		**1,038**
Central Bayside Community Health Services Limited		693	13		3,464		**4,170**		705			3,560		**4,266**
Cohealth Limited		6,689	3,678	11,742	10,003	113	**32,226**		6,944	2,901	10,629	11,167	115	**31,756**
Darebin Community Health Service		505	507		5,521		**6,533**		666	521		5,620		**6,807**
Dpv Health		1,949		2	9,063		**11,014**		2,293		2	10,066		**12,361**
Eastern Access Community Health Inc.		1,781	8,829	7,827	6,729		**25,166**		2,628	8,388	6,959	8,432	112	**26,519**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Gateway Health Limited		1,592	2,474		2,592	306	**6,964**		2,063	2,541	136	2,760	320	**7,820**
Gippsland Lakes Community Health	385	801	158	34	2,977		**4,354**	392	1,212	82	35	3,784	112	**5,617**
Grampians Community Health		481	249	79	1,323		**2,131**		531	256	81	1,358		**2,225**
Ipc Health		4,036	18		9,308		**13,362**		4,105			9,414		**13,519**
Latrobe Community Health Service Limited	1,233	6,313	5,119	765	5,699	98	**19,228**	1,255	7,773	5,756	779	6,335	100	**21,998**
Link Health and Community Limited		96			2,682		**2,778**		454			2,761		**3,215**
Merri Community Health Services Limited		5,624		70	4,303		**9,998**		5,875		72	4,466		**10,413**
Nexus Primary Health		1,526	194		1,857		**3,576**		2,242	199		1,907		**4,348**
Nillumbik Community Health Service Ltd		349	519		4,622		**5,490**	20	906	534		4,721		**6,181**
North Richmond Community Health Limited	1,633	56	4,078		2,393	1,115	**9,273**	1,657	86	4,148		2,465	1,146	**9,501**
Primary Care Connect			1,242		1,115		**2,357**			1,188		1,128		**2,316**
Ranges Community Health		48			2,476		**2,524**		245			2,557		**2,802**
Star Health Group	1,887	3,620	3,377	3,640	4,405	701	**17,630**	1,911	3,709	3,239	3,636	4,567	721	**17,781**
Sunbury Community Health Centre Limited		713			2,121		**2,834**		755			2,178		**2,933**
Sunraysia Community Health Services Limited	1,323	1,514	579		3,404	114	**6,935**	1,125	1,539	956		3,600	118	**7,338**
Total	**7,115**	**40,353**	**37,709**	**24,859**	**104,653**	**2,992**	**217,682**	**7,027**	**47,898**	**38,205**	**23,175**	**112,153**	**3,302**	**231,760**

2.1.6 Local government authorities 2018–19 and 2019–20

Notes:

i. 2018–19 numbers may differ from the *Department of Health and Human Services policy and funding guidelines, Volume 2: Health operations 2018–19* due to changes in classification and funding commitments made during 2018–19.

ii. This table shows the health funding to local government authorities that receive > $1 million from specific health outputs.

iii. The Primary and dental health column includes the impact of machinery of government changes for Maternal and child health services.

iv. Subtotals and totals may not add up due to rounding.

Table 2.6: Local government authorities 2018–19 and 2019–20

Health service	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Banyule City Council	498				**498**	1,121		1,078		**2,198**
Baw Baw Shire Council	252				**252**	814		742		**1,556**
Bayside City Council	233				**233**	1,357		599		**1,956**
Brimbank City Council	483				**483**	1,644		2,600		**4,243**
Campaspe Shire Council	267		282		**549**	474		750		**1,224**
Cardinia Shire Council	52				**52**	56		1,425		**1,480**
Casey City Council	3,730		85		**3,815**	4,873		4,734		**9,607**
City of Ballarat	233				**233**	1,058		1,170		**2,228**
City of Boroondara	184				**184**	838		886		**1,724**
City of Darebin	662		43		**705**	1,422		1,301		**2,723**
City of Greater Geelong	900			59	**959**	2,277		2,394	60	**4,731**
City of Kingston	1,520				**1,520**	3,521		1,247		**4,768**
City of Manningham	299				**299**	907		770		**1,676**
City of Port Phillip	1,217				**1,217**	1,683		839		**2,522**
City of Stonnington	138				**138**	1,006		640		**1,645**

Health service	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Frankston City Council	289				**289**	1,561		1,532		**3,092**
Glen Eira City Council	229				**229**	1,793		1,090		**2,883**
Golden Plains Shire Council	189		460		**649**	348		743		**1,092**
Greater Bendigo City Council	288				**288**	771		1,304		**2,075**
Greater Shepparton City Council	446				**446**	572		936		**1,508**
Hobsons Bay City Council	363				**363**	1,496		925		**2,421**
Hume City Council	2,041				**2,041**	2,924		3,707		**6,630**
Knox City Council	153				**153**	787		1,277		**2,064**
Latrobe City Council	515		31		**546**	1,661		1,153		**2,814**
Maribyrnong City Council	300				**300**	1,101		892		**1,994**
Maroondah City Council	291				**291**	539		1,061		**1,600**
Melbourne City Council	221				**221**	1,115		803		**1,918**
Melton City Council	1,161				**1,161**	1,775		2,219		**3,994**
Mildura Rural City Council	181		347		**529**	892		1,252		**2,145**
Monash City Council						1,288		1,236		**2,524**
Moonee Valley City Council	1,167				**1,167**	1,677		932		**2,608**
Moreland City Council	230				**230**	1,426		1,731		**3,157**
Mornington Peninsula Shire Council	404				**404**	2,246		1,505		**3,751**
Municipal Association of Victoria	173			1,819	**1,992**	323		175	1,843	**2,341**
Nillumbik Shire Council	377				**377**	566		496		**1,061**
The City of Greater Dandenong	454	54			**508**	2,270		2,046		**4,316**
Warrnambool City Council	343				**343**	729		372		**1,102**
Whitehorse City Council	227				**227**	1,253		1,133		**2,386**
Whittlesea City Council	1,061				**1,061**	1,970		3,113		**5,082**

Health service	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Wyndham City Council	455				**455**	2,004		4,061		**6,064**
Yarra City Council	578				**578**	761		707		**1,468**
Yarra Ranges Shire Council	448				**448**	1,758		1,685		**3,443**
All other local government organisations (< $1 million)	3,427		351		**3,779**	8,983		9,834		**18,817**
Total	**26,678**	**54**	**1,599**	**1,878**	**30,210**	**67,635**		**69,095**	**1,903**	**138,633**

2.1.7 Non-government providers 2018–19 and 2019–20

Notes:

i. 2018–19 numbers may differ from the *Department of Health and Human Services policy and funding guidelines, Volume 2: Health operations 2018–19* due to changes in classification and funding commitments made during 2018–19.

ii. This table shows the health funding to non-government organisations that receive > $1 million from specific health outputs.

iii. Subtotals and totals may not add up due to rounding.

Table 2.7: Non-government providers 2018–19 and 2019–20

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Alzheimer's Australia Vic Inc.		2,494					**2,494**							
Anglicare Victoria			997	1,926	36		**2,959**			1,105	1,621			**2,726**
Australian Centre for Grief and Bereavement Inc.	1,843						**1,843**	1,880						**1,880**
Australian College of Optometry		6,660					**6,660**		6,794					**6,794**
Australian Community Support Organisation Inc.			16,392	3,253			**19,645**			13,624	3,228			**16,852**
Australian Drug Foundation Inc.			1,424				**1,424**			1,463				**1,463**
Australian Red Cross Blood Service	12,333						**12,333**	13,505						**13,505**
Ballan and District Soldiers Memorial Bush Nursing Hospital and Hostel Inc.	108	90					**198**	130	135					**265**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Ballarat Hospice Care Inc.	2,082						**2,082**	2,083						**2,083**
Banksia Palliative Care Service Inc.	3,914						**3,914**	3,197						**3,197**
Beyond Blue Limited				2,200			**2,200**				2,200			**2,200**
Break Thru People Solutions				1,463			**1,463**				955			**955**
Breastscreen Victoria Inc.						39,617	**39,617**						48,458	**48,458**
Brotherhood of St Laurence		2,321					**2,321**		2,362					**2,362**
Cancer Council Victoria	2,492					4,750	**7,243**	523					2,387	**2,910**
Caraniche Pty Ltd			1,961				**1,961**			2,011				**2,011**
Care Connect Limited		744		477			**1,221**		1,265		475			**1,741**
Carers Victoria Inc.		3,625		251	596		**4,472**		3,726		258	605		**4,589**
Centacare, Catholic Diocese of Ballarat Inc.		1,842		148			**1,990**		1,886		152			**2,038**
Cobaw Community Health Services Limited	35	106		42	1,309		**1,492**	71	227		216	1,348		**1,862**
Council on the Ageing (Victoria) Inc.		1,001					**1,001**		1,308					**1,308**
Darlingford Upper Goulburn Nursing Home Inc.		1,223					**1,223**		1,254					**1,254**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Diabetes Australia – Victoria					1,137		**1,137**					1,154		**1,154**
Eastern Palliative Care Association Inc.	12,111						**12,111**	10,776						**10,776**
Ermha Limited		2,718		1,875			**4,593**		2,783		1,189			**3,972**
Family Planning Victoria Inc					4,125	195	**4,320**					4,195	200	**4,395**
Gegac	196	166	1,230	35	144		**1,771**	201	171	1,506	36	147		**2,061**
Gippsland Health Network Limited					15	1,614	**1,629**					16	971	**986**
Goulburn Valley Family Care Inc		989		89	365		**1,443**		1,092		92	371		**1,554**
Gunditjmara Aboriginal Co-Operative Limited	241	50	280	364	144		**1,079**	247	114	288	370	147		**1,166**
Harm Reduction Victoria Inc.			392			664	**1,056**			487			683	**1,169**
Hepatitis Victoria Inc.						1,369	**1,369**						1,408	**1,408**
Indigo North Health Inc.		1,121			544		**1,665**		1,186			553		**1,739**
Integrated Clinical Oncology Network Pty Ltd	1,712						**1,712**							
La Trobe University	3,612	880		1,949	705	536	**7,683**	3,815	896		2,289	716	524	**8,242**
Loddon Mallee Housing Services Limited		1,556					**1,556**		1,595					**1,595**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Mcauley Community Services for Women		349		892			**1,241**		356		918			**1,274**
Mdas Limited	443	52	1,041	733	321		**2,591**	454	53	1,322	330	328		**2,488**
Mecwa		4,785					**4,785**		8,587					**8,587**
Melbourne City Mission	6,448	185					**6,633**	5,591	190					**5,780**
Melbourne Primary Care Network Limited	1,269				15	655	**1,940**					16	610	**626**
Mentis Assist Limited		115		1,190			**1,305**		117		724			**841**
Mercy Palliative Care Ltd	8,162						**8,162**	7,070						**7,070**
Merri Outreach Support Service Inc.		1,434					**1,434**		1,473					**1,473**
Mind Australia				9,150			**9,150**				8,010			**8,010**
Moira Inc.		1,111					**1,111**		1,135					**1,135**
Monash University	5,005		962			161	**6,127**	1,078		557			767	**2,402**
Murdoch Childrens Research Institute	908					602	**1,510**	150					7,548	**7,698**
National Ageing Research Institute Ltd	368	800					**1,169**	374	814				188	**1,376**
Neami Limited				14,823			**14,823**				13,657			**13,657**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Ngwala Willumbong Limited		103	1,356		85		**1,545**		106	1,382		87		**1,575**
Njernda Aboriginal Corporation	248	161	603	64			**1,077**	254	166	620	66			**1,105**
Northern District Community Health Service		119			1,329		**1,448**		121			1,399		**1,519**
Odyssey House, Victoria			16,185				**16,185**			15,201				**15,201**
Peninsula Home Hospice	4,284						**4,284**	3,713						**3,713**
People Living with HIV/AIDS Victoria Inc.						1,657	**1,657**						1,704	**1,704**
Red Cliffs and Community Aged Care Services Inc.		1,069					**1,069**		1,125					**1,125**
Royal District Nursing Service Limited		25,664			108	699	**26,470**		26,086			109	719	**26,914**
Rumbalara Aboriginal Co-Operative Limited	197	189	522	65	204		**1,177**	202	274	796	67	209		**1,547**
Rural Workforce Agency, Victoria Limited	5,770						**5,770**	5,419						**5,419**
Sacred Heart Mission Inc.		433		1,322			**1,754**		444		1,360			**1,804**
Spiritual Health Victoria Incorporated	1,190			124			**1,314**	1,208						**1,208**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Tandem Inc.				2,130			**2,130**				2,165			**2,165**
Task Force Community Agency Inc.			3,146				**3,146**			3,245				**3,245**
The Goulburn Valley Hospice Care Service Inc.	1,491						**1,491**	1,482						**1,482**
The Salvation Army (Victoria) Property Trust		2,816	10,607		81		**13,504**		2,889	10,362		83		**13,334**
The University of Melbourne	4,037			2,375	255	8,001	**14,668**	3,140			2,378	259	8,132	**13,909**
The Victorian Foundation for Survivors of Torture Inc.				1,831	2,105		**3,937**				1,886	2,140		**4,026**
Very Special Kids	2,090						**2,090**	2,131						**2,131**
Victoria Legal Aid				2,796			**2,796**				2,838			**2,838**
Victorian Aboriginal Community Controlled Health Organisation Inc.	599	145	303	355	676	1,182	**3,259**	614	149	392	365	611	1,129	**3,260**
Victorian Aboriginal Health Service Co-Operative Limited	246	179	661	2,245	144	180	**3,655**	253	184	674	1,947	384	185	**3,626**
Victorian Aids Council Inc.			441			6,041	**6,481**			452	84		6,212	**6,749**
Victorian Clinical Genetics Services Limited	4,671					1,956	**6,627**	5,017					1,995	**7,012**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Victorian Cytology Service Limited						15,668	**15,668**	56					15,654	**15,710**
Victorian Health Promotion Foundation						40,223	**40,223**						41,027	**41,027**
Villa Maria Catholic Homes Limited		3,627		98			**3,725**		3,762		100			**3,863**
Vincentcare Victoria		1,000					**1,000**		1,024					**1,024**
Wellways Australia Limited		75		10,406			**10,482**		77		9,365			**9,442**
Wesley Mission Victoria		2,627	16,801	7,770	852		**28,050**		3,287	18,193	7,014	866		**29,361**
Western Region Alcohol and Drug Centre Inc.			1,953				**1,953**			2,296				**2,296**
Western Victoria Primary Health Network Limited			550		15	546	**1,111**			565		16	514	**1,094**
Windana Drug and Alcohol Recovery Inc.			12,781				**12,781**			12,304				**12,304**
Within Australia Incorporated				1,590			**1,590**				1,408			**1,408**
Women's Health Victoria Inc.	687				1,765		**2,452**	697				1,393		**2,090**
Women's Health West Inc.		114			1,133		**1,247**		117			1,159		**1,276**
Yooralla	1,118						**1,118**		327					**327**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Youth Projects Limited			1,871				**1,871**			1,418				**1,418**
Ysas Pty Ltd			15,185		21		**15,205**			17,125	136			**17,261**
All other organisations (< $1 million)	11,963	22,726	5,413	10,633	11,541	3,398	**65,674**	11,357	29,258	5,128	10,791	11,678	12,736	**80,947**
Total	**101,874**	**97,468**	**113,056**	**84,662**	**29,772**	**129,715**	**556,548**	**86,686**	**108,914**	**112,515**	**78,691**	**29,989**	**153,750**	**570,545**

2.1.8 Other funded organisations 2018–19 and 2019–20

Note:

i. 2018–19 numbers may differ from the *Department of Health and Human Services policy and funding guidelines, Volume 2: Health operations 2018–19* due to changes in classification and funding commitments made during 2018–19.

Table 2.8: Other funded organisations expenditure budgets 2018–19 and 2019–20

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Ambulance services $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Ambulance services $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Ambulance Victoria	29,843		744,711	338				**774,892**	18,276		768,209					**786,485**
Childrens Health Partnership Pty Ltd	161,070							**161,070**	138,432							**138,432**
Dental Health Services Victoria	–1					159,311	256	**159,565**	–3					161,494	261	**161,752**
Exemplar Health Partnership	74,147							**74,147**	54,814							**54,814**
Health Purchasing Victoria	14,905							**14,905**	15,148							**15,148**
Karingal St Laurence Limited		2,150			221			**2,371**		2,203			227			**2,430**
Lyndoch Living Inc.	1,981	3,876			369			**6,226**	2,099	4,671			375			**7,146**
National Blood Authority	106,456							**106,456**	108,053							**108,053**
Plenary Health Casey Pty Ltd	13,769							**13,769**	16,296							**16,296**

Health service	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Ambulance services $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Ambulance services $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Plenary Health (CCC) Pty Ltd	170,792							**170,792**	66,042							**66,042**
Postgraduate Medical Council of Victoria	1,943							**1,943**	1,596							**1,596**
Rw Health Partnerships Pty Ltd	45,241					10		**45,251**	45,205							**45,205**
South East Palliative Care Ltd	5,609							**5,609**	4,691							**4,691**
The Florey Institute of Neuroscience and Mental Health	342				1,669		360	**2,371**	281				1,582		4,467	**6,330**
The NSW Ministry of Health	9,600							**9,600**								
Victorian Comprehensive Cancer Centre Ltd	8,517							**8,517**	4,519							**4,519**
Victorian Institute of Forensic Mental Health	516				62,471			**62,987**	292				70,794			**71,086**
All other organisations (< $1 million)	5,296	446		65	486	873	708	**7,874**	6,399	266		66	475	881	15,206	**23,295**
Total	**650,025**	**6,472**	**744,711**	**403**	**65,216**	**160,194**	**1,323**	**1,628,345**	**482,140**	**7,140**	**768,209**	**66**	**73,453**	**162,376**	**19,934**	**1,513,318**

2.1.9 Health operations 2018–19 and 2019–20

Notes:

i. 2018–19 numbers may differ from the *Department of Health and Human Services policy and funding guidelines, Volume 2: Health operations 2018–19* due to changes in classification and funding commitments made during 2018–19.

ii. Acute and subacute category includes ambulance services.

iii. Subtotals and totals may not add up due to rounding.

Table 2.9: Health operations expenditure budgets 2018–19 and 2019–20

Provider type	2018–19 Acute health services $'000s	2018–19 Ageing, aged and home care $'000s	2018–19 Ambulance services $'000s	2018–19 Drugs services $'000s	2018–19 Mental health $'000s	2018–19 Primary and dental health $'000s	2018–19 Public health $'000s	2018–19 Total $'000s	2019–20 Acute health services $'000s	2019–20 Ageing, aged and home care $'000s	2019–20 Ambulance services $'000s	2019–20 Drugs services $'000s	2019–20 Mental health $'000s	2019–20 Primary and dental health $'000s	2019–20 Public health $'000s	2019–20 Total $'000s
Health service	9,855,171	135,940	–	40,274	1,071,056	64,122	29,205	**11,195,767**	10,303,038	138,133	–	53,310	1,285,293	64,412	27,020	**11,871,203**
Small rural health service	256,958	38,705	–	–	259	12,489	–	**308,411**	276,471	39,845	–	–	263	13,011	–	**329,590**
Community health centre	7,115	40,353	–	37,709	24,859	104,653	2,992	**217,682**	7,027	47,898	–	38,205	23,175	112,153	3,302	**231,760**
Health consortium	–	7	–	157	184	2,499	–	**2,847**	–	8	–	161	188	2,508	–	**2,864**
Local government	–	26,678	–	54	–	1,599	1,878	**30,210**	–	67,635	–	–	–	69,095	1,903	**138,633**
Non-government provider	101,874	97,468	–	113,056	84,662	29,772	129,715	**556,548**	86,686	108,914	–	112,515	78,691	29,989	153,750	**570,545**
Other	650,025	6,472	744,711	403	65,216	160,194	1,323	**1,628,345**	482,140	7,140	768,209	66	73,453	162,376	19,934	**1,513,318**
Total	**10,871,143**	**345,623**	**744,711**	**191,653**	**1,246,236**	**375,328**	**165,113**	**13,939,810**	**11,155,362**	**409,574**	**768,209**	**204,257**	**1,461,062**	**453,543**	**205,907**	**14,657,913**

2.2 Activity target tables

2.2.1 Victorian acute admitted activity targets (WIES26) 2019–20

Notes:

i. NBCSP WIES refers to the National Bowel Cancer Screen Program colonoscopy WIES, which is an expansion of the program to all Victorian public hospitals providing colonoscopy in 2019–20.

ii. Note that changes to weighted ambulatory service event (WASE) prices will be implemented during 2019–20 to reflect continued development of the specialist clinics funding model, which continues to be shadowed in 2019–20. No impact to funding will arise from these changes.

Table 2.10: Victorian acute admitted activity targets (WIES26) 2019–20

Health service	Public/private WIES (including elective surgery)	National Bowel Screening WIES	WIES DVA	WIES TAC	Total WIES
Albury Wodonga Health	27,688	14	117	15	27,834
Alfred Health	103,894	34	473	6,164	110,564
Austin Health	84,218	182	677	583	85,660
Bairnsdale Regional Health Service	7,839	67	146	25	8,077
Ballarat Health Services	32,835	75	124	224	33,257
Barwon Health	61,566	47	343	584	62,541
Bass Coast Health	5,264	14	50	5	5,333
Benalla Health	2,734	8	86	–	2,828
Bendigo Health Care Group	33,877	53	340	231	34,501
Castlemaine Health	2,887	12	25	1	2,925
Central Gippsland Health Service	7,403	44	73	34	7,554
Colac Area Health	3,621	12	40	9	3,682
Djerriwarrh Health Services	5,134	13	16		5,163
East Grampians Health Serv	2,884	13	27	1	2,925
Eastern Health	102,066	205	566	485	103,321
Echuca Regional Health	7,043	46	81	43	7,213
Gippsland Southern Health Service	2,483	28	27	8	2,546
Goulburn Valley Health	21,538	66	151	139	21,894
Kyabram District Health Services	2,486	8	31	0	2,525
Latrobe Regional Hospital	25,317	52	217	128	25,715
Maryborough District Health Service	2,809	10	49	1	2,868
Melbourne Health	90,027	47	411	5,596	96,081
Mercy Hospitals Victoria Limited	49,334	58	360	9	49,760
Monash Health	166,114	116		592	166,822
Northeast Health Wangaratta	14,793	44	201	97	15,135
Northern Health	71,356	190	257	308	72,111
Peninsula Health	63,121	29	456	306	63,912
Peter MacCallum Cancer Institute	23,074		129		23,203
Portland District Health	3,232	15	39	11	3,297
Ramsay Health Care Limited	13,203	44	153	47	13,447

Health service	Public/private WIES (including elective surgery)	National Bowel Screening WIES	WIES DVA	WIES TAC	Total WIES
Royal Victorian Eye & Ear Hospital	12,130		46	6	12,181
South West Healthcare	16,607	57	145	71	16,880
St Vincents Hospital Melbourne Limited	57,222	63	203	184	57,671
Stawell Regional Health	2,110	4	25	6	2,146
Swan Hill District Health	4,245	20	71	31	4,367
The Royal Childrens Hospital	59,758			514	60,272
The Royal Womens Hospital	32,783			5	32,788
West Gippsland Healthcare Group	10,117	0	68	50	10,235
Western District Health Service	5,331	83	79		5,493
Western Health	79,746	144	389	266	80,545
Wimmera Health Care Group	7,645	44	129	41	7,858
Total	**1,327,533**	**1,961**	**6,820**	**16,820**	**1,353,130**

2.2.2 Victorian small rural health service acute admitted activity targets 2019–20

Notes:

i. Recall is not applied on notional public/private WIES targets for small rural health services.

ii. NBCSP WIES refers to National Bowel Cancer Screen Program colonoscopy WIES, which is an expansion of the program to all Victorian public hospitals providing colonoscopy in 2019–20.

iii. NBCSP WIES is paid to actual activity. Targets shown in the table are estimated activity volumes only.

Table 2.11: Victorian small rural health service notional acute admitted activity targets 2019–20

Health service	National Bowel Screening WIES	WIES DVA	WIES TAC	WIES renal	Total
Small rural health service					
Alexandra District Health	5.66	27.77	2		35.43
Alpine Health	0.36	42.15	2	68.9	113.41
Beaufort and Skipton Health Service		13.84	0		13.84
Beechworth Health Service		9.99	–3		6.99
Boort District Health		1.67			1.67
Casterton Memorial Hospital	3.54	10.77	–4	16.55	26.86
Cohuna District Hospital	3.22	9.82	1	45.06	59.1
Corryong Health	0	14.8		30.75	45.55
East Wimmera Health Service		23.94		49.32	73.26
Edenhope and District Memorial Hospital		3.24	1	9.31	13.55
Great Ocean Road Health		0.63		19.74	20.37
Heathcote Health		1.86	0		1.86
Hepburn Health Service	10.26	27.61	2	57.06	96.93
Hesse Rural Health Service		1.27	2		3.27
Heywood Rural Health		3.95	0		3.95
Inglewood and Districts Health Service		3.66	0		3.66
Kerang and District Health	6.17	15.34			21.51
Kilmore and District Hospital	0.36	15.06			15.42
Kooweerup Regional Health Services		7.99	–1		6.99
Kyneton District Health Service	14.75	14.16	0	75.37	104.28
Maldon Hospital		1.7			1.7
Mansfield District Hospital	0.71	10.22	3	48.33	62.26
Moyne Health Services		36.9			36.9
NCN Health	4.18	42.36	1		47.54
Orbost Regional Health		6.92	2	45.17	54.09
Robinvale District Health Services		5.77	0	47.74	53.51
Rochester and Elmore District Health Service	3.53	5.1	–2		6.63
Rural Northwest Health		56.88	0		56.88
Seymour District Memorial Hospital	13.37	40.28		115.02	168.67
South Gippsland Hospital	10.02	16.45	0		26.47
Tallangatta Health Service		15.51	0		15.51

Health service	National Bowel Screening WIES	WIES DVA	WIES TAC	WIES renal	Total
Terang and Mortlake Health Service	4.44	16.66		6.72	27.82
Timboon and District Healthcare Service	0.71	6.51	0		7.22
West Wimmera Health Service	0	49.89	9	0.37	59.26
Yarram and District Health Service		13.81	1	24.59	39.4
Yarrawonga District Health Service	10.55	39.77	0	167.32	217.64
Yea and District Memorial Hospital		7.17	3		10.17
Total	**91.83**	**621.42**	**19**	**827.32**	**1559.57**

2.2.3 Victorian acute non-admitted activity targets 2019–20

Note:

i. Total WASE includes public and private activity.

ii. Note that changes to WASE targets will be implemented during 2019–20 to reflect continued development of the specialist clinics funding model, which continues to be shadowed in 2019–20. No impact to funding will arise from these changes.

Table 2.12: Victorian acute non-admitted activity targets 2019–20

Health service	Total Weighted Ambulatory Service Events
Albury Wodonga Health	20,423
Alfred Health	186,801
Austin Health	166,910
Ballarat Health Services	61,402
Barwon Health	106,161
Bendigo Health Care Group	61,756
Eastern Health	152,197
Goulburn Valley Health	47,296
Latrobe Regional Hospital	27,246
Melbourne Health	164,429
Mercy Hospitals Victoria Limited	126,172
Monash Health	289,269
Northern Health	127,230
Peninsula Health	63,240
Peter MacCallum Cancer Institute	88,325
Royal Victorian Eye and Ear Hospital	93,814
St Vincent's Hospital Melbourne Limited	119,314
The Royal Children's Hospital	154,726
The Royal Women's Hospital	138,286
Western Health	182,416
Bairnsdale Regional Health Service	14,904
Bass Coast Health	8,250
Benalla Health	2,256
Castlemaine Health	1,650
Central Gippsland Health Service	22,903
Colac Area Health	6,526
Djerriwarrh Health Services	27,612
East Grampians Health Service	1,674
Echuca Regional Health	16,858
Gippsland Southern Health Service	7,370
Kyabram District Health Services	1,219
Maryborough District Health Service	4,512
Northeast Health Wangaratta	19,149
Portland District Health	7,309

Health service	Total Weighted Ambulatory Service Events
Ramsay Health Care Limited	14,950
South West Healthcare	32,594
Stawell Regional Health	2,745
Swan Hill District Health	7,223
West Gippsland Healthcare Group	17,204
Western District Health Service	10,765
Wimmera Health Care Group	17,224
Total	**2,622,311**

2.2.4 Non-admitted radiotherapy activity (WAU) targets 2019–20

Table 2.13: Non-admitted radiotherapy activity targets 2019–20

Health service	Radiotherapy base variable WAU	Radiotherapy DVA base variable WAU	Total
Alfred Health	80,160	648	80,808
Austin Health	71,390	731	72,121
Barwon Health	40,463	551	41,014
Peter MacCallum Cancer Institute	292,068	2,092	294,160
Total	**484,080**	**4,022**	**488,103**

Table 2.14: Shared-care radiotherapy activity targets 2019–20

Health service	Radiotherapy non-admitted shared care
Monash Health	153
Northern Health	209
Peninsula Health	165
Western Health	17
Total	**545**

2.2.5 Admitted subacute and non-acute targets (subacute WIES4) 2019–20

Table 2.15: Admitted subacute and non-acute targets (subacute WIES4) 2019–20

Health service	Palliative care public/private	Rehabilitation public/private	GEM public/private	Maintenance public	Total public/private	Total Department of Veterans' Affairs	Total Admitted subacute
Albury Wodonga Health	15	460	199		673	13	685
Alfred Health	–	2,018	2,231		4,249	55	4,304
Austin Health	489	1,852	1,712		4,053	125	4,178
Ballarat Health Services	284	708	670		1,661	34	1,695
Barwon Health	384	1,058	837		2,279	71	2,350
Bendigo Health Care Group	178	1,141	743		2,061	58	2,119
Calvary Health Care Bethlehem Limited	301	420	–		721	–	721
Eastern Health	940	1,804	2,475		5,219	128	5,347
Goulburn Valley Health	161	533	457		1,151	22	1,173
Latrobe Regional Hospital	89	598	346		1,033	47	1,080
Melbourne Health	258	977	2,104		3,339	42	3,381
Mercy Hospitals Victoria Limited	288	76	292		656	19	675
Monash Health	472	2,871	2,479		5,822	25	5,846
Northern Health	535	639	2,272		3,446	41	3,487
Peninsula Health	401	1,562	2,058		4,021	146	4,167
Peter MacCallum Cancer Institute	–	–	–		–	–	–
St Vincent's Hospital Melbourne Limited	627	1,331	1,190		3,148	48	3,197
The Royal Children's Hospital	–	365	–		365	–	365
Western Health	365	897	2,341		3,603	79	3,682
Bairnsdale Regional Health Service	39	202	129	–	370	17	387
Bass Coast Health	35	247	151	–	432	16	449

Health service	Palliative care public/private	Rehabilitation public/private	GEM public/private	Maintenance public	Total public/private	Total Department of Veterans' Affairs	Total Admitted subacute
Benalla Health	–	–	–	44	44	5	49
Castlemaine Health	–	266	129	–	395	23	418
Central Gippsland Health Service	71	62	128	–	261	8	269
Colac Area Health	21	–	–	37	58	–	58
Djerriwarrh Health Services	44	–	–	–	44	–0	44
East Grampians Health Serv	9	–	–	46	55	–	55
Echuca Regional Health	40	183	136	–	358	3	362
Gippsland Southern Health Service	33	–	–	57	90	7	97
Kyabram District Health Services	–	–	–	73	73	–	73
Maryborough District Health Service	–	–	–	15	15	0	16
Northeast Health Wangaratta	43	252	248	–	542	28	570
Portland District Health	42	–	–	45	87	0	88
Ramsay Health Care Limited	40	284	23	–	347	20	368
South West Healthcare	170	347	316	–	832	9	842
Stawell Regional Health	–	–	–	13	13	–	13
Swan Hill District Health	–	26	250	60	336	4	340
West Gippsland Healthcare Group	36	–	106	–	142	1	142
Western District Health Service	36	113	31	–	180	25	205
Wimmera Health Care Group	19	143	153	–	315	24	339
Total	**6,464**	**21,433**	**24,205**	**390**	**52,493**	**1,142**	**53,635**

2.2.6 Transition Care Program targets 2019–20

Table 2.16: Transition Care Program targets 2019–20

Health service	Bed days	Home days	Total
Metropolitan and regional			
Alfred Health	27,010	5,110	32,120
Austin Health	7,652	10,617	18,270
Ballarat Health Services	13,847	9,153	23,000
Barwon Health	12,390	6,590	18,980
Bendigo Health Care Group	18,220	12,814	31,034
Eastern Health	26,237	8,054	34,291
Goulburn Valley Health	13,118	13,546	26,665
Latrobe Regional Hospital	8,381	6,956	15,337
Melbourne Health	10,568	12,448	23,015
Mercy Hospitals Victoria Limited	2,186	1,464	3,651
Monash Health	17,491	10,983	28,475
Northern Health	8,746	15,743	24,488
Peninsula Health	16,762	5,492	22,254
St Vincent's Hospital Melbourne Limited	10,932	11,349	22,281
Western Health	12,390	10,983	23,373
Subregional and local			
Portland District Health	1,458	732	2,190
Ramsay Health Care Limited	2,551	3,295	5,846
South West Healthcare	3,645	3,663	7,309
Western District Health Service	1,093	1,464	2,558
Total	**214,678**	**150,458**	**365,136**

2.2.7 Health Independence Program contact targets 2019–20

Note: Seymour, Yarram and NCN Health are small rural health services.

Table 2.17: Health Independence Program contact targets 2019–20

Health service	Public contacts target
Metropolitan and regional	
Albury Wodonga Health	26,926
Alfred Health	94,170
Austin Health	75,016
Ballarat Health Services	41,898
Barwon Health	75,393
Bendigo Health Care Group	60,592
Calvary Health Care Bethlehem	14,826
Eastern Health	134,496
Goulburn Valley Health	30,814
Inner South Community Health Service	13,830
Latrobe Regional Hospital	32,567
Melbourne Health	100,866
Mercy Public Hospitals Inc.	13,792
Monash Health	170,618
North Richmond Community Health Service	11,994
Northern Health	105,316
Peninsula Health	87,636
The Royal Children's Hospital	23,628
St Vincent's Hospital	66,263
Western Health	99,451
Subregional and local	
Bairnsdale Regional Health Service	25,792
Bass Coast Regional Health	19,531
Benalla and District Memorial Hospital	7,474
Castlemaine Health	17,052
Central Gippsland Health Service	11,841
NCN Health	4,148
Colac Area Health	6,649
Djerriwarrh Health Services	9,062
East Grampians Health Service	1,134
Echuca Regional Health	12,578
Lyndoch Living Inc.	7,720
Maryborough District Health Service	1,503
Mildura Base Hospital	14,410
Northeast Health Wangaratta	31,574
Portland District Health	5,911
Seymour Health	12,806

Health service	Public contacts target
South West Healthcare – Warrnambool	24,942
Stawell Regional Health	9,030
Swan Hill District Hospital	13,921
West Gippsland Healthcare Group	17,341
Western District Health Service	12,118
Wimmera Health Care Group	13,761
Yarram and District Health Service	3,248
Total	**1,544,284**

2.2.8 Total parenteral nutrition service event targets 2019–20

Table 2.18: Total parenteral nutrition service event targets 2019–20

Health service	Service event target
Austin Health	123
Melbourne Health	147
Monash Health	200
St Vincent's Hospital Melbourne Limited	76
The Royal Children's Hospital	95
Total	**641**

2.2.9 Home enteral nutrition service event targets 2019–20

Table 2.19: Home enteral nutrition service event targets 2019–20

Health service	Service event target
Metropolitan and regional	
Albury Wodonga Health	336
Alfred Health	947
Austin Health	1,405
Ballarat Health Services	553
Barwon Health	1,232
Bendigo Health Care Group	360
Calvary Health Care Bethlehem Limited	677
Eastern Health	473
Goulburn Valley Health	415
Latrobe Regional Hospital	208
Melbourne Health	928
Monash Health	4,479
Northern Health	420
Peninsula Health	551
Peter MacCallum Cancer Institute	1,282
St Vincent's Hospital Melbourne Limited	1,667
The Royal Children's Hospital	7,047
Western Health	877
Subregional and local	
Bairnsdale Regional Health Service	88
Bass Coast Health	36
Benalla Health	47
Central Gippsland Health Service	95
Colac Area Health	62
East Grampians Health Service	55
Gippsland Southern Health Service	21
Maryborough District Health Service	12
Northeast Health Wangaratta	80
Portland District Health	7
Ramsay Health Care Limited	281
South West Healthcare	213
Stawell Regional Health	57
Swan Hill District Health	89
West Gippsland Healthcare Group	122
Western District Health Service	–
Wimmera Health Care Group	82
Total	**25,204**

2.2.10 Home renal dialysis targets 2019–20

Table 2.20 Home renal dialysis targets 2019–20

Health service	Annual target
Alfred Health	98
Austin Health	72
Barwon Health	51
Bendigo Health Care Group	29
Eastern Health	64
Melbourne Health	104
Monash Health	168
Northern Health	33
St Vincent's Hospital Melbourne Limited	83
The Royal Children's Hospital	7
Western Health	84
Total	**793**

2.2.11 Nationally Funded Centres program 2019–20

Notes:

i. Targets are subject to approval by the Nationally Funded Centres Reference Group and the Australian Health Ministers' Advisory Council.

ii. Prices are subject to approval by the Nationally Funded Centres Reference Group and the Australian Health Ministers' Advisory Council.

iii. Paediatric liver transplantation – 55 per cent for The Royal Children's Hospital and 45 per cent for Austin Health.

iv. Paediatric lung/heart-lung transplantation – 97 per cent for Alfred Health and 3 per cent for The Royal Children's Hospital.

Table 2.21: Nationally Funded Centres program targets 2019–20

Nationally Funded Centres program	Funded organisation	Annual target
NFC – Islet Cell Transplantation	St Vincent's Hospital Melbourne Limited	6.00
NFC – Paediatric Heart no VAD	The Royal Children's Hospital	3.00
NFC – Paediatric Heart VAD	The Royal Children's Hospital	6.00
NFC – Paediatric Lung Transplantation	Alfred Health	4.85
	The Royal Children's Hospital	0.15
NFC – Pancreas Transplants	Monash Health	20.00
NFC – Transplants – Paediatric Liver	Austin Health	4.95
NFC – Transplants – Paediatric Liver	The Royal Children's Hospital	6.05
Total		**51.00**

2.2.12 Mental health acute, non-acute, subacute and residential available beds 2019–20

Note for the following three tables:

i. Mental health funded bed days – total reflects part-year effect for beds scheduled to open in 2019–20.

ii. Increased capacity will occur across five mental health services. Further capital developments during 2019–20 will create additional capacity throughout the year.

iii. Increased capacity through the purchase of public beds from private hospitals is *not* included in the table.

Table 2.22: Mental health acute available beds 2019–20

Health service	Mental health funded bed – acute specialist	Mental health funded bed – acute adult	Mental health funded bed – acute aged	Mental health funded bed – acute child and adolescent	Total Mental health funded acute bed	Total Mental health funded acute bed days
Metropolitan and regional						
Albury Wodonga Health		15	5		20	7,305
Alfred Health	4	54	15		73	26,663
Austin Health	11	53		23	87	31,777
Ballarat Health Services	5	23	10	2	40	14,610
Barwon Health		28	6		34	12,419
Bendigo Health Care Group	5	35	20		60	21,915
Eastern Health		88	30	12	130	45,564
Goulburn Valley Health		15	5		20	7,305
Latrobe Regional	5	29	10	2	46	16,802
Melbourne Health	16	152	54		222	81,085
Mercy Health	8	70			78	28,490
Monash Health	8	111	40	23	182	66,476
Peninsula Health		35	15		50	18,263
St Vincent's Hospital		44	20		64	23,376
The Royal Children's Hospital				17	17	6,209
Victorian Institute of Forensic Mental Health	54				54	
Subregional and rural						
Mildura Base Hospital		10	2	2	14	5,114
South West Healthcare		15	5		20	7,305
Total	**116**	**777**	**237**	**81**	**1,211**	**420,678**

Table 2.23: Mental health non-acute, subacute and residential available beds 2019–20

Health service	Mental health funded bed – non-acute	Mental health funded bed – subacute CCU	Mental health funded bed – subacute PARC	Mental health funded bed – residential	Total Mental health funded subacute and residential bed	Total Mental health funded subacute and residential bed days
Metropolitan and regional						
Albury Wodonga Health		26	10	15	51	18,628
Alfred Health		20	10		30	10,958
Austin Health	38	22	10	20	90	32,873
Ballarat Health Services	12	10		32	54	19,724
Barwon Health	3	12	12	45	72	25,933
Bendigo Health Care Group	20	12	20	30	82	29,951
Eastern Health		40	20	64	124	45,291
Goulburn Valley Health		10	10	20	40	14,610
Latrobe Regional	6	14	10	10	40	14,610
Melbourne Health	26	80	40	62	208	75,972
Mercy Health		20	10		30	10,958
Monash Health	60	40	50	94	244	89,121
Peninsula Health		20	20	30	70	25,568
St Vincent's Hospital		20	10	60	90	32,873
The Royal Children's Hospital						
Victorian Institute of Forensic Mental Health	82				82	
Subregional and local						
Mildura Base Hospital			10		10	3,653
South West Health	3	2	10	13	28	10,227
Total	**250**	**348**	**252**	**495**	**1,345**	**460,950**

Table 2.24: Mental health total acute, non-acute, subacute and residential available beds and available bed days 2019–20

Health service	Mental health funded acute bed	Mental health funded acute bed days	Mental health funded non-acute, subacute and residential bed	Mental health funded non-acute, subacute and residential bed days	Mental health beds	Mental health beds
Metropolitan and regional						
Albury Wodonga Health	20	7,305	51	18,628	71	25,933
Alfred Health	73	26,663	30	10,958	103	37,621
Austin Health	87	31,777	90	32,873	177	64,650
Ballarat Health Services	40	14,610	54	19,724	94	34,334
Barwon Health	34	12,419	72	25,933	106	38,352
Bendigo Health Care Group	60	21,915	82	29,951	142	51,866
Eastern Health	130	45,564	124	45,291	254	90,855
Goulburn Valley Health	20	7,305	40	14,610	60	21,915
Latrobe Regional Hospital	46	16,802	40	14,610	86	31,412
Melbourne Health	222	81,085	208	75,972	430	157,057
Mercy Health	78	28,490	30	10,958	108	39,448
Monash Health	182	66,476	244	89,121	426	155,597
Peninsula Health	50	18,263	70	25,568	120	43,831
St Vincent's Hospital	64	23,376	90	32,873	154	56,249
The Royal Children's Hospital	17	6,209	–	–	17	6,209
Victorian Institute of Forensic Mental Health	54		82		136	
Subregional and local						
Mildura Base Hospital	14	5,114	10	3,653	24	8,767
South West Health	20	7,305	28	10,227	48	17,532
Total	**1,211**	**420,678**	**1,345**	**460,950**	**2,556**	**881,628**

2.2.13 Mental health ambulatory targets 2019–20

Table 2.25: Mental health acute, non-acute, subacute and residential service hour targets 2019–20

Health service	Ambulatory contacts
Metropolitan and regional	
Albury Wodonga Health	37,754
Alfred Health	92,271
Austin Health	62,332
Ballarat Health Services	61,208
Barwon Health	72,115
Bendigo Health Care Group	73,500
Eastern Health	166,096
Goulburn Valley Health	42,009
Latrobe Regional Hospital	73,138
Melbourne Health	271,244
Mercy Health	65,644
Monash Health	195,861
Peninsula Health	61,104
St Vincent's Hospital	70,952
The Royal Children's Hospital	37,584
The Royal Women's Hospital	505
Victorian Institute of Forensic Mental Health	0
Subregional and local	
Mildura Base Hospital	27,037
South West Healthcare	35,629
Total	**1,445,983**

2.2.14 Alcohol and other drugs output targets 2019–20

Table 2.26: Alcohol and other drugs output targets 2019–20

Health service	DTAU– residential drug withdrawal	DTAU – residential rehabilitation	DTAU - Assessment	DTAU – care and recovery coordination	DTAU- counselling	DTAU - Intake	Episodes of care – mobile overdose response	DTAU – non-residential withdrawal	Episodes of care - Pharmacotherapy	DTAU – therapeutic day rehabilitation	Episodes of care – youth A&D supported accommo-dation	Episodes of care – youth outreach	DTAU – youth residential drug withdrawal	Total
Metropolitan and regional														
Alfred Health									140					**140**
Austin Health									140					**140**
Barwon Health			280	263	669	424		304			5	55		**2,000**
Bendigo Health Care Group		2,391												**2,391**
Eastern Health	3,441	1,598	701	562	1,786	545	19	669	170					**9,491**
Goulburn Valley Health	933		237	196	622			226						**2,213**
Monash Health	3,113										32	28		**3,173**
Peninsula Health			222	140	562	294		253			8	109		**1,589**
St Vincent's Hospital Melbourne Ltd	2,769													**2,769**
Western Health	2,765	6,041	497	392	1,583			578	140	660		220	1,597	**14,472**
Subregional and local														
Bairnsdale Regional Health Services	238													**238**
Central Gippsland Health Service	396													**396**
Colac Area Health											1			**1**
Gippsland Southern Health Service	238													**238**
Portland District Health											1			**1**

Health service	DTAU– residential drug withdrawal	DTAU – residential rehabilitation	DTAU - Assessment	DTAU – care and recovery coordination	DTAU- counselling	DTAU - Intake	Episodes of care – mobile overdose response	DTAU – non-residential withdrawal	Episodes of care - Pharmacothe rapy	DTAU – therapeutic day rehabilitation	Episodes of care – youth A&D supported accommo-dation	Episodes of care – youth outreach	DTAU – youth residential drug withdrawal	Total
Ramsay Health Care Limited	308													**308**
South West Healthcare									12					**12**
Total	**14,200**	**10,029**	**1,936**	**1,554**	**5,222**	**1,263**	**19**	**2,029**	**602**	**660**	**47**	**412**	**1,597**	**39,571**

List of figures, tables and boxes

Policy guide

Appendices – Funding rules

Acronyms and abbreviations

ABO	blood group system
ACCO	Aboriginal community-controlled organisations
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standard
AIDS	acquired immune deficiency syndrome
AIMS	Agency Information Management System
ALOS	average length of stay
AN-SNAP	Australian National Subacute and Non-Acute Patient
AOD	alcohol and other drugs
AR-DRG	Australian Refined Diagnosis Related Groups
ASD	atrial septal defect
CCU	Critical Care Unit
CORE	Centre for Outcome and Resource Evaluation
CSO	Community service organisation
DRG	diagnosis-related group
EBA	enterprise bargaining agreements
ECT	electroconvulsive treatment
ED	emergency department
F1	Financial Data
FCP	Family Choice Program
FIM™	Functional Independence Measure
GEM	geriatric evaluation and management
HACC	Home and Community Care
HARP	Hospital admission risk program
HBPCCT	Hospital based palliative care consultancy team
HEN	Home Enteral Nutrition
HITH	Hospital in the Home
HIV	human immunodeficiency virus
ICT	information communication technology
ICU	intensive care unit
IHPA	Independent Hospital Pricing Authority
LOS	length of stay
MDS	Hospital Minimum Payroll and Workforce Employee Dataset
MHCSS	mental health community support services
MICA	Mobile Intensive Care Ambulance
NBCSP	National Bowel Cancer Screening Program
NGO	non-government organisation
NHT	nursing home type
NFC	Nationally Funded Centres
NHRA	National Health Reform Agreement
OP	Specialist (Outpatient) Clinics

PAC	post-acute care
PARC	prevention and recovery care
PC	palliative care
PSRACS	public sector residential aged care service
RIR	residential in-reach
SACS	Subacute ambulatory care services
SMF	State managed fund
SOP	Statement of Priorities
STI	sexually transmissible infections
TAC	Transport Accident Commission
TCP	Transition Care Program
TPN	total parenteral nutrition
VACS	Victorian Ambulatory Classification and Funding System
VAED	Victorian Admitted Episodes Dataset
VCDC	Victorian Cost Data Collection
VIC-DRG	Victorian-modified Diagnosis Related Group
ViCTOR	Victorian Children's Tool for Observation and Response
VINAH	Victorian Integrated Non-Admitted Health
VRSS	Victorian Respiratory Support Service
WASE	Weighted Ambulatory Service Event
WAU	weighted activity unit
WIES	weighted inlier equivalent separation

Royal Commission into
Victoria's Mental Health System

ATTACHMENT NC-4

This is the attachment marked 'NC-4' referred to in the witness statement of Dr Neil Coventry dated 29 July 2020.

Reportable Deaths
Chief Psychiatrist's Guideline

Summary Version

The Reportable Death notification process allows the Chief Psychiatrist to monitor adverse outcomes for consumers of mental health services.

This advisory note presents the current *Chief Psychiatrist's Guidelines: Reportable Deaths* document in a shorter, simpler format. Two new points are highlighted.

Inpatients

For the purposes of this policy, an inpatient is defined by the Chief Psychiatrist as *any person, regardless of legal status*, who:

- has been admitted to a mental health inpatient unit
- is on approved leave from an inpatient unit
- has absconded from an inpatient unit
- has been transferred to a non-psychiatric ward during a mental health admission
- has been discharged from a mental health inpatient unit within the previous 24 hours.

All deaths of inpatients, including expected deaths, must be notified to the Chief Psychiatrist within 24 hours. Notifications can be made by telephone (9096-7571), fax (9096-7697) or email (ocp@dhhs.vic.gov.au).

The Chief Psychiatrist now requires that the deaths must also be reported of persons who have been detained in an emergency department or non-psychiatric ward under the Mental Health Act, including section 351 (Apprehension by Police).

In addition, all unexpected, unnatural or violent deaths of mental health consumers on non-psychiatric wards must be reported.

Community patients

The Chief Psychiatrist must be notified in writing of:

- all unexpected, unnatural or violent deaths (including suspected suicides) of community-resident persons who were registered as mental health consumers within the previous three months or who had sought service from a mental health provider within that period and not been provided with service
- all deaths of community-resident patients under the Mental Health Act (including forensic orders).

People are considered to be mental health consumers until their case is closed and they have been notified of this closure (or the service has made all reasonable efforts to do so).

If a person was receiving service from a mental health community support service, that service must also notify the Chief Psychiatrist.

Deaths due to natural causes of persons not under the Mental Health Act are not reportable.

Notification process

The *MHA 125 Notice of Death* form must be submitted within three days of a reportable death, either by email or fax. Typed forms are preferred and an electronic template is now available. If clinicians prefer to complete the form by hand, they can add extra pages if necessary. Information is required concerning:

- the circumstances of death
- the person's last known mental status
- identified risks and measures taken to address them
- treatments provided including psychotropic medications
- known medical conditions
- contact made with carers
- contact made with the Coroner where applicable

Forensicare must also submit a report for patients on non-custodial supervision orders.

A more detailed clinical report must be submitted within 14 days if requested by the Chief Psychiatrist.

Other reporting systems

The **Coroner** requires notification of all deaths that appear to have been unexpected, unnatural or violent, or to have resulted directly or indirectly from an accident or injury, regardless of the person's legal status or location.

The Coroner must also be notified of all deaths of inpatients and community patients under the Mental Health Act. See coronerscourt.vic.gov.au for more information.

Inpatient suicides (including suicides on non-psychiatric wards) are one of eight nationally defined sentinel event categories that must be notified to the Victorian Department of Health and Human Service's **Sentinel Event Program**. See www2.health.vic.gov.au for more information.

September 2016

Royal Commission into
Victoria's Mental Health System

ATTACHMENT NC-5

This is the attachment marked 'NC-5' referred to in the witness statement of Dr Neil Coventry dated 29 July 2020.

Victorian Agency for Health Information

Victorian Health Incident Management System

Victorian Health Incident Management System

Minimum Dataset

VICTORIA State Government

Background

Over 2018–19, the Victorian Agency for Health Information (VAHI) has developed a new Victorian Health Incident Management System Minimum Dataset (VHIMS MDS) for the collection of clinical, occupational health and safety (OH&S) incidents, near misses and hazards.

The new VHIMS MDS comprises the data items that Victorian public health services will be required to collect and submit to VAHI to support statewide reporting.

VAHI developed the minimum dataset through consultation with Safer Care Victoria, the Department of Health and Human Services (the Department), the Australian Nursing and Midwifery Federation, the Mental Health Complaints Commissioner, the Office of the Chief Psychiatrist, the Victorian Managed Insurance Agency and WorkSafe. VAHI also carried out a review of what is currently being collected in other jurisdictions across Australia.

The VHIMS Analytics Working Group, an advisory group comprised of representatives from Victorian public health services, the Department and Safer Care Victoria also assisted in the development of the VHIMS MDS.

What will this mean for Victorian public health services?

Victorian public health and community services covered by VHIMS Central arrangements will commence reporting the new VHIMS MDS at the start of the 2019–20 financial year.

A statewide tender is underway to establish a panel of suppliers of incident management and feedback systems for those Victorian public health services not covered by VHIMS Central arrangements, with the panel anticipated to be in place by November 2019.

Health services impacted by the tender arrangements will be required to collect and submit the new VHIMS MDS after they transition to their preferred incident and feedback management systems. This will support VAHI's routine reporting of VHIMS data.

In the interim, until Victorian public health services transition to their new system providers, VAHI will continue to receive the current quarterly VHIMS data extract through the Department's secure data exchange.

Development of the VHIMS MDS

The purpose of the VHIMS MDS is to improve quality and safety in Victorian public health services through statewide reporting, supporting the roles of the Department and Safer Care Victoria.

A set of guiding principles was used to develop the VHIMS MDS, which looked for relevance, utility, collectability, reliability, applicability and being evidence-based. The starting points for the VHIMS MDS were the 20 fields currently being collected through interim reporting arrangements and fields from the VHIMS2 dataset.

VAHI followed recommendations from stakeholders and the advisory group that requested a strong focus on data items required to monitor trends and support statewide reporting, rather than data items required for individual incident investigation and management.

The VHIMS MDS covers clinical and OH&S incidents. Collection of feedback information will come later.

Once the VHIMS MDS is adopted, it will enable collection of meaningful statewide incident data that will be reported to Victorian public health services. The reports will identify statewide patterns and trends. These data will also inform Safer Care Victoria and the Department in their oversight and monitoring roles. Safer Care Victoria and the Department will work closely with Victorian public health services in considering learnings and areas for improvement.

The VHIMS MDS

The data items in the VHIMS MDS can be grouped into the following broad categories:

- General incident information
- Who was involved?
- When did it happen?
- Where did it happen?
- What happened?
- Why and how did it happen?
- Actions

Additional fields are required depending on the notification type: clinical incident, occupational health and safety (OH&S) incident, or hazard (non-clinical/non-OH&S incidents) (see Table 1). Data elements are only mandatory where they are relevant for that incident.

Table 1: Data Elements in the Victorian Health Incident Management System Minimum Dataset (VHIMS MDS)

The following table contains an overview of VHIMS MDS data elements.

Data element	Field type	Rationale for inclusion
Data elements applicable to all incidents		
General incident information		
Incident ID	Number (calculated field)	Unique identifier for each incident. Allows counting of incidents and updating of existing incidents.
Notification type	Calculated field	Calculated based on questions in the 'Who was involved?' section below. Enables clear identification of the type of incident: clinical, OH&S or hazard.
Grouping key	Calculated field	The grouping key will identify related incidents where multiple incident reports were entered on the same incident (e.g. an incident where both a staff member and patient were affected). Enables analysis where multiple people are impacted by a single incident.
Date closed	Date	Enables analysis of how long different groups of incidents are taking to close, potentially showing areas with incomplete investigations or barriers that prevent closing investigations.
Status of incident	Calculated field	Enables monitoring of trends in review and management of incidents.
Who was involved?		
Was a patient/client/resident, staff or visitor harmed either physically or psychologically?	Yes/No	To enable identification of who was harmed by the incident. To enable clear identification of who was injured or harmed by the incident and enable the identification of trends to see how many incidents involved more than one person.
If yes, please indicate who was involved	Multiple value list	
Was a patient/client/resident, staff or visitor **nearly** harmed either physically or psychologically (i.e. is this a near miss incident)?	Yes/No	Enables identification of a near miss.
If yes, please indicate who was involved (patient/staff/visitor)	Multiple value list	Enables clear identification of who was nearly injured or harmed by the incident and enables identification of trends to see how many incidents involved more than one person.
Does this relate to a hazard or a non-person related event, e.g. medication discrepancies, hazards, IT system/building issues?	Yes/No	To enable identification of hazards and non-person related events.

Table 1: Data Elements in the Victorian Health Incident Management System Minimum Dataset (VHIMS MDS) (con't)

Data element	Field type	Rationale for inclusion
Data elements applicable to all incidents		
When did it happen?		
Incident date	Date	Enables time series reporting and supports analysis of when incidents are occurring.
Incident time	Time	Support analysis of what time of day incidents are occurring.
Where did it happen?		
Organisation	Single value list	Enables identification of the organisation reporting the incident and supports regional analysis of incidents.
Campus	Single value list	Enables identification of the campus where the incident occurred. This will enable analysis at a finer level than health service.
Ward/location	Single value list	Enables assessment of whether there are trends across different locations in health services.
Speciality/Unit	Single value list	Allows grouping of specialities across health services to look for trends relating to specialities not apparent in health service analysis, e.g. statewide investigation into mental health services or aged care.
What happened?		
Brief summary	Free text box	Enables thematic analysis of what happened.
Details	Free text box	Enables thematic analysis of what happened.
Incident type/Event type	Multiple value list	Enables more reliable and accurate analysis using incident type. The VHIMS2 taxonomy for incident classification will be used (25 clinical incident types, 13 OH&S incident types, and 79 non-person or hazard event types). Multiple incident types can be selected but there is no longer a distinction between primary and related incident types.
Incident type sub-categories. For example: • Type • Process • Problem	Single value list	Enables more detailed investigation of specific incident types, such as PINCH medications or cytotoxic procedures. For example, if the incident type was 'skin integrity', the type should be captured from the following: • Pressure injury • Skin tear • Wound
Was an emergency response called	Yes/No	Enables identification of how many incidents resulted in an emergency response.
If yes, type of emergency response	Single value list	Enables identification of what type of emergency responses are called where there is an incident, e.g. analysis of code greys.

Table 1: Data Elements in the Victorian Health Incident Management System Minimum Dataset (VHIMS MDS) (con't)

Data element	Field type	Rationale for inclusion
Data elements applicable to all incidents		
Why and how did it happen?		
External notifications	Multiple value list	Enables identification of how many incidents resulted in a notification to another organisation and which organisations are being notified.
Is this incident related to care provided by this organisation? (this question was previously 'Is this a valid clinical incident?')	Yes/No	Allows services to mark incidents that do not relate to care provided by their organisation. This field will enable these clinical incidents to be excluded from analysis.
Is VMIA notifiable?	Yes/No	Enables identification of how many incidents resulted in a VMIA notifiable event, and aligns with the inclusion of the data item 'Is this a WorkSafe notifiable event?'
Actions		
Review type	Multiple value list	Enables monitoring of trends in review and management of incidents.
Review status	Single value list	Enables monitoring of trends in review and management of incidents.

Table 1: Data Elements in the Victorian Health Incident Management System Minimum Dataset (VHIMS MDS) (con't)

Data element	Field type	Rationale for inclusion
Additional data elements for clinical incidents only		
Client ID/UR Number	Free text box	
Age	Calculated field	Enables demographic analysis of incidents. Age will be calculated from date of birth, but date of birth will not be viewable as part of the VHIMS MDS.
Gender	Single value list	Enables demographic analysis of incidents.
Level of harm sustained (this field was previously 'Degree of impact')	Single value list	These fields determine the clinical incident severity rating (ISR). ISR is used to group incidents with similar levels of harm and to assess the degree of investigation needed.
Required level of care (this field was previously 'Level of care')	Single value list	
Level of treatment required	Single value list	
Contributing factors	Multiple value list	Allows for the collection of multiple contributing factors. This will enable more reliable reporting on contributing factors, create more insights in root causes and enable identification of trends for both clinical and OH&S incidents.
Was open disclosure conducted?	Single value list	Enables analysis of open disclosure..
Related National Safety and Quality Health Service Standard	Multiple value list	Enables analysis of if incidents related to National Safety and Quality Health Service Standards
Is this one of the following sentinel events? If other, describe other sentinel event.	Single value list Free text box	Enables analysis of sentinel events, for cross referencing with SCV notifications.

Table 1: Data Elements in the Victorian Health Incident Management System Minimum Dataset (VHIMS MDS) (con't)

Data element	Field type	Rationale for inclusion
Additional data elements for OH&S incidents only		
Reporter role	Single value list	Enables demographic analysis of incidents.
Where did the incident occur?	Single value list	Enables analysis of where OH&S incidents are occurring, e.g. at the workplace, when travelling as part of the job, etc.
Level of harm sustained (this field was previously 'Degree of impact')	Single value list	These fields determine the OH&S incident severity rating (ISR). ISR is used to group incidents with similar levels of harm and to assess the degree of investigation needed.
Required level of care (this field was previously 'Level of care')	Single value list	
Actions required (this field was previously 'Level of treatment')	Single value list	
Type of injury	Multiple value list	Where someone was harmed, enables analysis of the type and location of injury.
Body part	Multiple value list	
If other body part, specify	Free text box	
Is this a WorkSafe notifiable event?	Yes/No	Enables identification of how many incidents resulted in a WorkSafe notifiable event.
Preventative/corrective action	Multiple value list	Enables monitoring of trends in review and management of incidents.
Status of preventative/ corrective action	Single value list	Monitors the extent to which health services have implemented their intended strategies.
Completion date of preventative/ corrective action	Date	Monitors the extent to which health services have implemented their intended strategies.
Reason why preventative/ corrective action was not achievable	Free text box	Monitors the extent to which health services have implemented their intended strategies.

Data element	Field type	Rationale for inclusion
Additional data elements for hazards (non-clinical/non-OH&S incidents) only		
Level of impact	Single value list	These fields determine the hazard incident severity rating. ISR is used to group hazards with similar levels of impact and to assess the degree of investigation needed.
Level of disruption to services	Single value list	
Level of intervention required	Single value list	

Royal Commission into
Victoria's Mental Health System

ATTACHMENT NC-6

This is the attachment marked 'NC-6' referred to in the witness statement of Dr Neil Coventry dated 29 July 2020.

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health

Restrictive interventions in designated mental health services

Chief Psychiatrist's guideline

Introduction

Achieving the best health and wellbeing for all Victorians is a key priority for the Victorian Government. In the Victorian public mental health system, this will be achieved through recovery-oriented practice that minimises the use and duration of compulsory treatment; safeguards the rights and dignity of people with a mental illness; and enhances oversight while encouraging innovation and service improvement.

Consistent with these objectives, the Department of Health, the Chief Psychiatrist and mental health services share a commitment to reducing and where possible eliminating restrictive interventions in mental health services. The aim is to achieve a safe environment through a systematic approach that involves consumers, carers, the mental health workforce and mental health management.

Restrictive interventions are not therapeutic. They are intrusive practices used as a last resort to prevent serious and imminent harm to a consumer or another person. In Victoria, the Department of Health, the Chief Psychiatrist and public mental health services have undertaken a number of activities to promote the reduction of restrictive interventions. Restrictive interventions should only be used after all possible preventative practices have been tried or considered and have been found to be unsuitable. The use of restrictive interventions has been linked to re-traumatision of past experiences, serious injuries and even death. When used, restrictive intervention needs to be approached by a registered nurse or registered medical practitioner in a way that maximises the physical and psychological well-being of all involved, given the risks involved.

Reducing restrictive interventions is underpinned by the following principles (Department of Health, ***Providing a safe environment for all: Framework for reducing restrictive interventions, 2013*** (http://docs.health.vic.gov.au/docs/doc/Providing-a-safe-environment-for-all:-Framework-for-reducing-restrictive-interventions)

- All key stakeholders (consumers, carers, mental health service staff, management and the government) have a role in the design and implementation of safe environments.
- Consumers, carers and mental health staff are treated with respect and dignity; their rights and responsibilities are central to promoting safety.
- The service environment is organised to ensure the safety and wellbeing of consumers, carers, and mental health staff.
- Difficult and challenging behaviour is managed in ways that show decency, humanity and respect for individual rights, while effectively managing risk.
- Restrictive interventions are used as a last resort and for the briefest duration after all other less restrictive options reasonably available have been tried or considered and found to be unsuitable in the circumstances.
- Programs to reduce restrictive interventions require effective governance and ongoing monitoring of local strategies and initiatives to ensure effective implementation.
- Recovery-oriented practice, trauma-informed care, supported decision making and family/carer inclusive practice inform workforce practices and are necessary to create positive clinical cultures and to prevent cultures that are coercive or create conflict.

Using this guideline

The use of restrictive interventions must follow both the legal requirements of the Mental Health Act 2014 (the Act) and best practice requirements as indicated in the evidence based literature. In this guideline, these requirements are arranged into three parts surrounding the use of a restrictive intervention (leading up to the use of a restrictive intervention; during the actual use; and following the use of the intervention).

All Victorian designated mental health services are required to have in place local policies, procedures and clinical practices that reduce, and where possible, eliminate the use of restrictive practices. Such processes should align with associated legislation including the Victorian Occupational Health and Safety Act 2004. This guideline sets out the expectations of what services are to consider in establishing policies and procedures in the use of restrictive interventions. However, local policies and procedures are required to consider the particular service setting, populations served and any other relevant local factors. Some of these specific considerations are addressed at the end of the guideline.

A designated mental health service under the Act includes those services that have an intake role for mental health consumers (for example emergency departments) Collaborative clinical governance arrangements between such services and mainstream mental health services need to be in place to ensure the legislative and best practice requirements are met. Such arrangements should ensure that:

- Consumers have a right to safe, high quality health care and to the provision of the information they need to participate in decisions about their care.
- Consumers have the right to openness and honesty of communication and to be cared for in an environment that fosters trust in those providing care.
- Clinicians and clinical teams have access to robust systems and processes to support them in providing safe, high quality care to consumers.
  (http://www.health.vic.gov.au/clinrisk/publications/clinical_gov_policy.htm)

Key definitions

There are a number of terms employed throughout international mental health policy, legislation and literature to refer to people accessing mental health services. In this guideline, the terms 'person', and 'consumer' are used to reflect the language of recovery. Similarly, this document uses the term 'carer', which encapsulates relevant third parties including 'a support person', 'family', 'guardians', 'parents' or 'a nominated person'[1].

The Act closely regulates the use of **'restrictive interventions'**. Part 6 of the Act outlines when restrictive interventions can be used, who can authorize them and the monitoring of restrictive interventions when used. Section 3 of the Act defines 'restrictive interventions' as 'bodily restraint or seclusion'.

'Bodily restraint' is defined in the Act as 'a form of physical or mechanical restraint that prevents a person having free movement of his or her limbs, but does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's ability to get off the furniture' (s. 3).

While not considered contemporary practice, if cot sides or table tops are used with the intent to restrain, then this does constitute restraint and should be treated and recorded as such.

- '**Physical restraint**' involves the skilled[2], hands-on immobilisation or physical restriction of a person.
- '**Mechanical restraint**' involves the application of devices (including belts, harnesses, manacles, sheets and straps) to restrict a person's movement.

'**Seclusion**' is defined by the Act as the 'sole confinement of a person to a room or any other enclosed space, from which it is not within the control of the person confined to leave' (s. 3). Any confinement of a person that meets this definition is seclusion, even if the person agrees to, or requests, such confinement.

The Act applies to the use of restrictive interventions on all persons, regardless of age and legal status, who are receiving mental health services in a 'designated mental health service'[3] (s. 3). These services are listed in the Mental Health Regulations 2014. The designated mental health services may provide mental health services in mental health in-patient services, community mental health services, some emergency departments and specialist mental health services for children, adolescents and older adults.

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[1] A person nominated by the consumer to receive information and to support them while the consumer is under the Mental Health Act 2014. The nominated person assists a consumer to exercise their rights, and communicate their views and preferences. The nominated person is consulted at critical points during the consumer's treatment such as when a person enters and leaves a service (s.23).

[2] A person suitably trained and recognised by the organisation as such.

[3] A 'designated mental health service' is a prescribed public hospital, a prescribed public health service, a prescribed denominational hospital or a prescribed privately-operated hospital, all within the meaning of section 3(1) of the Health Services Act 1988. It also includes a prescribed private hospital within the meaning of section 3(1) of the Health Services Act 1988 that is registered as a health service establishment under Part 4 of that Act and the Victorian Institute of Forensic Mental Health.

Prior to the use of restrictive interventions

Legal requirements

When can restrictive interventions be used?

Restrictive interventions may only be used on a person after all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable (s. 105).

Each clinician has a responsibility to first use practices to prevent the use of restrictive interventions. Such practices rely on reducing the risk factors for harm as well as enhancing protective factors that promote a safe, secure, understanding and accepting environment. Internationally, initiatives to reduce the use of restrictive intervention have included developing leadership for organisational change; the use of data to inform practice; the involvement of a consumer and carer peer support workforce; the use of preventative interventions such as sensory modulation; workforce development; and debriefing (for an overview of evidence-based preventative practices see *Reducing restrictive interventions: Literature review and document analysis, 2013* http://docs.health.vic.gov.au/docs/doc/Reducing-restrictive-interventions:-Literature-review-and-document-analysis).

Restrictive interventions may only be used if it is 'necessary to prevent imminent and serious harm to the person or to another person' (s. 110 and s. 113).

The determination of 'serious and imminent harm' is based on clinical judgment, clinical knowledge and the assessment of a person and their behaviour using evidenced based assessment tools. Clinical staff must assess and document that there is a high probability that the person will (or within the near future will) seriously harm themselves or another person and cite their rationale for this judgement.

In a matter of urgency, restrictive interventions may be applied to any person receiving services in a designated mental health service, regardless of legal status, under duty of care. Although such events are out of the scope of this guideline, the principles for reducing restrictive interventions (see pp. 5-6) still apply. However, if the person is a voluntary consumer, consideration must be given as to whether the person meets the criteria for compulsory status under the Act. If at any point an Assessment Order (s.28) is made, then the requirements of the Act apply as outlined in the legal requirements sections throughout this guideline.

Bodily restraint may also be used to 'administer treatment' or 'medical treatment' to a person (s. 113). Treatment is defined in s.6 of the Act and medical treatment in s. 7 of the Act.

Where are restrictive interventions regulated?

Part 6 of the Mental Health Act regulates the use of restrictive interventions (bodily restraint and seclusion) on a person receiving mental health services in a designated mental health service.

For the purpose of determining whether a person is receiving services 'in' a designated mental health service and whether Part 6 of the Mental Health Act applies, it will be those places or premises where people with mental illness are taken and detained for compulsory assessment or treatment in accordance with the Act. This will include acute mental health inpatient units and secure extended care units operated by the designated mental health service. It will also include emergency departments where the person is subject to an Order under the Mental Health Act (excluding people apprehended by police under section 351).

It also includes other medical and surgical inpatient facilities, whenever concurrent medical and mental health treatment is being provided.

Restrictive interventions in emergency departments

- A person may be brought into the ED under s. 351 of the Act (apprehension of the person by the police) if the person appears to have a mental illness and the action is required to prevent serious and imminent risk to the person or another person.
- If a restrictive intervention is used while the person is on a s.351, then its use is not regulated under the Act.
- If the person is assessed by a registered medical practitioner or a mental health practitioner and an Assessment Order is made (s.28), then from this point the requirements of the Act apply, which are outlined in the legal requirements sections throughout this guideline.

Advance statements

Division 3 of Part 3 of the Act allows for the writing of advance statements by consumers. These set out the person's preferences to treatment, strategies for avoiding the use of restrictive interventions. They may also include preferences about what should occur if the use of a restrictive intervention is required (s. 19). Advanced statements4 are a significant strategy in de-escalating the potential use of a restrictive intervention. Consumers should be asked whether they have made a statement and if not, be given the option of developing one.

How are restrictive interventions authorised?

- The use of restrictive interventions must be authorised by an 'authorised psychiatrist', or a 'delegate'[5] determined by the authorised psychiatrist by written instruction.
- If an authorised psychiatrist or delegate is not immediately available, a registered medical practitioner or the senior registered nurse on duty may authorise a restrictive intervention (s. 111(1)(b) and s. 114(1)(b)). This covers the use of a restrictive intervention in an emergency department or a general area of the hospital where mental health services are being carried out.
- A registered medical practitioner or senior registered nurse must notify the authorised psychiatrist, or delegate, about the use of a restrictive intervention as soon as practicable[6].
- An authorised psychiatrist, or delegate, must examine the person as soon as is practicable (s. 111(3) and s. 114(3)). This examination must involve an assessment of the person's mental health status and physical health status, a risk assessment and an assessment of the need to continue the restrictive intervention.
- If the authorised psychiatrist or delegate is not available to examine the person, he or she must arrange for a registered medical practitioner to examine the person as soon as practicable to decide whether continued use of the restrictive intervention is necessary, unless the practice has been ceased in the meantime.
- A registered nurse may approve the use of **physical restraint** if it is necessary as a matter of urgency to prevent imminent and serious harm to the person or another person; and an authorised psychiatrist, a registered medical practitioner or the senior registered nurse on duty is not immediately available to authorise the use (s. 115(1)).

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4 These statements must be in writing, signed and witnessed by 'an authorised witness' (s. 20). An authorised witness includes a registered medical practitioner, mental health practitioner or a person who may witness the signing of a statutory declaration under section 107A of the Evidence (Miscellaneous Provisions) Act 1958 (s.3).

5 A 'delegate' may be a psychiatrist; a person to whom limited registration has been granted under section 66 of the Health Practitioner Regulation National Law to enable the person to undertake a period of postgraduate training or supervised practice in psychiatry or to undertake assessment or sit an examination approved by the Medical Board in relation to psychiatry; or a person to whom limited registration has been granted to enable the person to practice in psychiatry in an area of need under section 67 of the Health Practitioner Regulation National Law (s. 151 (1)).

6 "As soon as practicable" is frequently used in the Act but not defined. Clinically it would reflect a response that needs to occur almost immediately.

- The registered nurse must seek the authorisation of an authorised psychiatrist, a registered medical practitioner or the senior registered nurse on duty as soon as practicable (s. 115(2).
- If a registered medical practitioner or senior registered nurse on duty authorises the use of physical restraint, that person must notify an authorised psychiatrist, or delegate, about the use of urgent physical restraint as soon as practicable (s. 114(2)).
- The registered nurse who has approved the use of a physical restraint on a person must immediately stop the use of physical restraint, if the registered nurse is satisfied that the continued use of the physical restraint is no longer necessary (s. 115(3)). This may well occur before the person is assessed by a medical practitioner but does not reduce the urgency for this to occur.

An 'Authority for use of restrictive interventions' form (MHA 140) needs to be completed by the person authorizing the use of a restrictive intervention. The registered nurse who approves the urgent use of physical restraint must complete the 'Approval for urgent physical restraint' form (MHA 141).

Best practice

Engagement with consumers and carers

The use of restrictive interventions needs to reflect trauma-informed care principles. Experiences of trauma are common among consumers and the use of restrictive interventions has the potential to be experienced as a traumatic event and/or trigger previous traumatic experiences. Responses may be extreme and may include symptoms such as flashbacks, hallucinations, dissociation, aggression, self-injury and depression. Advance statements and safety plans should be used to ensure care is trauma-informed. Carers can provide valuable and useful insights to assist mental health staff in this regard.

There is a greater chance of avoiding the use of restrictive interventions when there is the full and informed inclusion of consumers and carers in discussions about the use of restrictive interventions. Every effort must be made to routinely provide information sensitively to consumers and carers about the use of restrictive interventions. It is important for staff to listen, and respond to consumer and carer concerns about the use of restrictive interventions.

While it is appropriate to provide information about these interventions to carers in general terms, it is only where the consumer consents to the disclosure of specific planning involving the potential use of a restrictive intervention, that the details can be discussed with carers.

Medical assessment

Restrictive interventions should not be initiated in a designated mental health service unless a thorough medical assessment of the consumer has occurred. This should include identifying and documenting any substance use, recent medical procedures, surgical procedures, or conditions. However, if restrictive interventions have been applied to prevent serious and imminent harm prior to a medical assessment, a medical examination must be conducted as soon as practicable after the restrictive intervention has commenced. If the restrictive intervention was authorised by a registered practitioner or the senior registered nurse, s. 111(3) and s. 114(3) require the authorised psychiatrist to examine the person as soon as practicable after being notified.(for detail see **How are restrictive interventions authorised** on page 5)

Occasionally during a medical assessment a consumer is profoundly mentally unwell, unable or unwilling to give coherent responses to questions and violently opposed to being examined. While this makes adequate assessment difficult, as thorough an assessment as possible under the circumstances must take place.

Use of medication

The decision to prescribe medication before or during the use of a restrictive intervention is a medical decision. The use of medication to target symptoms of mental illness and reduce acute arousal and agitation (ie acute sedation) is appropriate. The use of medication to restrict movement (analogous to physical and mechanical restraint) is potentially hazardous and has no defined place in the Act or practice. Acute sedation and pharmacological treatments need to be very carefully considered with clear criteria for use determined by the

service, to guide judicious use of medications to relieve distress. Services need to ensure acute sedation policies are developed.

Nursing care planning

A collaborative nursing care plan that takes into consideration individual consumer needs, preferences and experiences, and carer views, of what interventions are most effective should be in place for all consumers. This should include the consumer consultant or peer worker if the current consumer approves of their involvement.

In some services consumer safety needs will be addressed in an integrated care plan. In others a specific "safety plan" may be developed. The extent to which planning can occur will vary depending on the individual. In an emergency, the opportunity to plan will be more limited, but a plan should be developed as soon as possible.

It is very unlikely that a nursing plan should include the care or intention to use a restrictive practice as it can only apply in emergency situations or after all possible interventions have been tried to reduce its need. If restrictive interventions are planned then care planning must include consideration or trial of all reasonable and less restrictive interventions (s. 105) and strategies to inform the person sensitively of the decision for the restrictive intervention (including why this decision has been made and how the consumer will be observed, managed and reviewed).

Staff training and education

Services will ensure there are a number of suitably trained registered nurses, registered medical practitioners and security staff available and trained in the service approved approach to restrict interventions. This would include all direct care staff and security staff. This should occur with new staff at orientation and all staff through refresher training, to ensure staff are familiar with the required practices.

Training must develop:-

- Proficiency in the use of evidence based preventative strategies (such as de-escalation techniques and the use of sensory modulation) to ensure restrictive interventions are used minimally.
- Proficiency in using approved techniques.
- An understanding of part 6 of the Act governing the use of restrictive interventions.
- An awareness of the consumer experiences of compulsory treatment and restrictive interventions.
- An understanding of the causes of aggressive or threatening behaviour.
- An awareness of the impact of staff behaviours and attitudes on consumers.
- Proficiency in undertaking observation and monitoring requirements.
- Proficiency in recognising signs of physical distress during the use of restrictive interventions.
- Proficiency in responding to escalating emergency responses and basic life support skills (CPR).
- An understanding of the standards set out in this guideline, and local policies and procedures.
- An understanding of the need to consider the use of restrictive interventions within a framework that promotes recovery-oriented practice and trauma-informed care.
- An understanding of how medication can be used to prevent and support a person who is acutely agitated.

Note that services should have in place policies that recognise that training requirements vary across disciplines depending on their functions and roles.

During the use of restrictive interventions

Legal requirements

Notification of the use of a restrictive intervention

After commencement of the use of a restrictive intervention, an authorised psychiatrist must take reasonable steps to notify relevant persons regarding the use of the restrictive intervention, the nature of the restrictive intervention and the reason for using it. The following persons should be notified where appropriate (s.107):-

- The nominated person
- A guardian;
- A carer, (if the authorised psychiatrist believes that the use of the restrictive intervention will affect the carer and the care relationship)
- A parent (if the person is under the age of 16 years)
- The Secretary to the Department of Human Services (if the person is the subject of a custody to Secretary order or a guardianship to Secretary order) (s. 107).

Monitoring the use of a restrictive intervention

An authorised psychiatrist must **examine** the person at least every four hours during the use of a **restrictive intervention** (s. 112(3) and s.116(4)). The time interval cannot be more than four hours. If the examination indicates the need for a greater frequency than every four hours, then this must occur. Each examination should be as thorough as the circumstances permit, and should cover the person's mental health status, physical health status, risk assessment and an assessment of the need to continue the restrictive intervention or if the use of the restrictive intervention can be ceased.

If it is not practicable for an authorised psychiatrist or delegate to conduct an examination at the frequency determined, then the examination can be delegated to a registered medical practitioner (s. 112(4) and s. 116(5)).

During the use of **seclusion,** a registered nurse or registered medical practitioner must undertake an assessment to determine the clinical observation frequency, but this should not occur less than every 15 minutes (s. 112(2)). If the observation indicates the need for more frequent observations (than every 15 minutes), then this must occur.

Clinical observation during seclusion is the purposeful gathering of information to inform clinical decision making. It is not passive surveillance. It involves gathering both objective and subjective information about the person from direct contact with the person (Nursing Observation Through Engagement in Psychiatric Inpatient Care: Department of Health Guideline, 2013,

http://docs.health.vic.gov.au/docs/doc/Nursing-observation-through-engagement-in-psychiatric-inpatient-care).

These observations should include but are not limited to the assessment of:

- breathing
- level of movement
- alertness and responsiveness
- levels of agitation
- the need to continue seclusion

Clinical decision making from this information may require more detailed physical health assessment, mental health status assessment or risk assessment; more frequent observations; or reporting of findings to a medical practitioner, authorised psychiatrist or delegate. The detail of what is required during purposeful observations should be outlined in the consumer's care plan.

During **bodily restraint**, a registered nurse or registered medical practitioner must clinically **review** the person every 15 minutes (s. 116(3)). The frequency must not be less than every 15 minutes. If the clinical review indicates the need for more frequent review (than every 15 minutes), then this must occur.

Clinical review is the purposeful gathering of information to inform clinical decision making. It involves gathering both objective and subjective information about the person from direct contact with the person. Registered nurses have specific responsibilities for the physical monitoring of bodily restraint. This involves monitoring vital signs and physical integrity. It includes but is not limited to:

- pulse
- temperature
- movement
- breathing
- skin integrity
- hydration, nutrition and elimination needs
- neurovascular observations of the restrained limb(s) (pulse, colour, warmth, sensation, movement and the experience of pain)
- alertness and responsiveness
- levels of agitation
- the need to continue bodily restraint

A person on whom a **bodily restraint** is used must be under **continuous observation** by a registered nurse or registered medical practitioner (s. 116(2)). This level of observation reflects the seriousness of the intervention and the potential for injury and death. The focus of attention during observation must be on the person's safety, dignity and any change in the person's physical, risk or mental health status. Continuous observations can involve two approaches.

- Constant (arm's length) observations occur with the person being in arm's length of a registered nurse or registered medical practitioner at all times:
- Constant (visual) observations occur with the person being within the vision of a registered nurse or registered medical practitioner at all times.

A collaborative decision of which continuous observation to use should be made by the registered nurse and/or registered medical practitioner concerned and documented in the nursing care plan. The person being observed should be made aware of the observation type, purpose and duration. Where possible they should be involved in the decision making about observations.

The 'Restrictive interventions observation form' (MHA 152) needs to be completed to maintain a record of clinical observations or reviews. This form must be completed by a registered nurse or registered medical practitioner undertaking the observations or reviews. A form must be completed for each type of restrictive intervention, to record the date and time that each type of restrictive intervention starts and ends, and the detail of the observations or reviews.

Meeting the needs of the person

The clinician who authorises[7] the use of a restrictive intervention must ensure that the person's needs are met and the person's dignity is protected by the provision of appropriate facilities and supplies (s. 106). This should include:-

- Engaging with the person and providing explanation and reassurance.
- Protecting the person's self-respect and dignity.

[7] Refer to section 'How are restrictive interventions authorised'.

- Meeting individual needs (based on culture, language, age, disability, religion, gender, sexuality, trauma history, vulnerability).
- Checking body alignment and that positioning remains appropriate.
- Reviewing vital signs.
- Preventing the development of adverse effects (e.g. pressure sores, abrasions, tissue damage, injury from immobilization, etc).
- Ensuring hydration and meeting nutritional needs. A fluid balance chart should be immediately commenced for a person who has been subject to a restrictive intervention.
- Providing adequate arrangements and assistance relating to elimination needs and personal hygiene.
- Ensuring the prescription and administration of medications.
- Providing the opportunity for physical exercise as appropriate.
- Ensuring clothing is comfortable and appropriate.
- Negotiating the removal of potentially dangerous items in a respectful manner and storing the items appropriately.

Best practice

Restrictive intervention[8] techniques

Known adverse events associated with the use of restrictive interventions include

- death
- positional asphyxia
- compromised airway due to aspiration or choking
- neck or chest compression
- bruising
- dehydration
- loss of muscle strength and mobility
- incontinence
- needle stick injury
- deep vein thrombosis
- increase in psychological distress

Staff involved in restrictive interventions should be aware of the likelihood of increased agitation when a restrictive intervention is applied.

In considering **physical restraint:**

- Only physical restraint techniques approved by the designated mental health service should be used.
- The least restrictive physical intervention techniques required for the situation should always be applied.
- There is no physical restraint position that is absolutely safe.
- Physical restraint techniques which apply direct pressure to the neck, thorax, abdomen, back or pelvic area

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[8] Section 3 of the Act defines **'restrictive interventions'** as 'bodily restraint or seclusion'.

'Bodily restraint' is defined as 'a form of physical or mechanical restraint that prevents a person having free movement of his or her limbs, but does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's ability to get off the furniture' (s. 3).

'Physical restraint' involves the skilled, hands-on immobilisation or physical restriction of a person.

'Mechanical restraint' involves the application of devices (including belts, harnesses, manacles, sheets and straps) to restrict a person's movement.

are especially unsafe and should not be used under any circumstances.
- Whatever position is used there must be vigilant monitoring and managing of the risks.
- A senior registered nurse or registered medical practitioner as defined by the health service procedures needs to assume the responsibility for leading the team through the restraint process, and for ensuring that the airway and breathing are not compromised, and that vital signs are monitored for any physical deterioration.
- Physical restraint of consumers on the floor should be avoided.
- If the floor is used then this should be for the shortest period of time and for the purpose of gaining control of the situation.
- Prone (face down) restraint on the floor poses a risk of serious injury and should not be used (see Chief Psychiatrist Clinical Practice Advisory Notice: Practice of Prone Restraint, 2013 http://docs.health.vic.gov.au/docs/doc/Chief-Psychiatrist-Clinical-Practice-Advisory-Notice:-Practice-of-Prone-Restraint
- If prone restraint is used, the registered nurse will ensure the person is not in a prone position for longer than 3 minutes.
- There is no completely safe time limit for the duration of any physical restraint technique. Physical restraint must be ceased as soon as possible.
- Physical restraint techniques that deliberately inflict pain must not be used.
- If the consumer experiences pain during the use of physical restraint, the technique should be altered immediately to achieve a pain free experience.
- Health services should ensure executive oversight is present over all restraint practice and policy development.
- All staff involved in restrictive interventions should be educated in the use of restraint and the risks associated with restraints.
- All restraints should be treated as an incident, reviewed and documented accordingly.

In considering **mechanical restraint**;-

- Only mechanical restraint devices approved by the designated mental health service should be used.
- Furniture (including beds with cot sides and chairs with tables fitted on their arms) should not be used with the intent to restrain a person.
- The device must be applied for the minimum amount of time required. Release of limbs from mechanical restraint must occur at least once per hour to prevent injury from immobilisation and to allow repositioning.
- If the restraint devices are not being used, remove them from the environment.

The use of restrictive interventions is clinically led. Security staff involved in the use of a restrictive intervention must act as directed by the senior registered nurse on duty or medical practitioner present, at all stages. The techniques used by security staff must comply with the practices stipulated in these guidelines and in local policies and procedures. Where there are concerns about the individual practices of staff involved, this must be reported to the appropriate manager responsible for the service.

A medical review must take place after the restrictive intervention has been ceased.

Communication

Information about the restrictive intervention must be provided to the consumer at the time the intervention is in use,including providing explanations and reassurance to the consumer. Consideration needs to be given to the involvement and support of a consumer consultant or peer support worker.

Staff must offer information on restrictive interventions to visitors and to other people (including other consumers) who have witnessed the use of a restrictive intervention, and provide an opportunity to discuss any

concerns they may have from witnessing the use. The privacy and confidentiality of persons involved should be maintained at all times.

Clinical documentation

The person's clinical record should demonstrate that the requirements of Part 6 of the Act, this guideline, and local policies and procedures have been met. This includes:-

- A description of the person's condition at the commencement of the intervention.
- The rationale for the use of restrictive interventions.
- Details arising from the nursing observations or review.
- Any medication or treatment provided and the response to treatment.
- The outcome of the initial and four-hourly medical examinations.
- Details of second opinions and/or case conference reviews.
- The nursing care plan.
- A copy of the MHA 152 observation form.
- Confirmation relevant persons have been notified of the use of the restrictive intervention under section 107

Case conference and second opinion

Where the restrictive intervention is used for extended periods of time or on a recurrent basis, it is good clinical practice to undertake a case conference. Consumers who repeatedly behave in a manner that threatens themselves or others and whose symptoms fail to respond to a full range of clinical interventions pose particular clinical challenges that require careful consideration and management. The reasons for the repeated behaviour should be explored and understood with the consumer. A thorough review of the person's history, treatments attempted and their duration, medication administered and responses, as well as the impact of contextual factors (e.g. organisational factors, the environment and team functioning) should be undertaken by the treating team (inclusive of consumer consultant involvement) and may be the subject of a case conference. This should include the consumer and carer directly involved where possible.

It is also good clinical practice to obtain a second opinion to review the consumer's management with prolonged or recurrent use of a restrictive intervention. This should be a second opinion external to the treating team.

In both instances a detailed care plan should be developed that:-

- Describes the behaviour in question.
- Identifies the precipitating and exacerbating factors.
- Outlines strategies aimed at reducing the behaviour and the need for a restrictive intervention.
- Outlines a graded series of responses.

After the use of restrictive interventions

Legal requirements

Release from restrictive interventions

If a clinician, who is able to authorise the use of a restrictive intervention, is satisfied that the continued use of the restrictive intervention is no longer necessary, then he or she must take immediate steps to release the person from the restrictive intervention (s. 109). This decision must be based on decision making stemming from active assessment of, and in collaboration with, the consumer.

If the use of a restrictive intervention needs to be reapplied, this marks the commencement of a new period of use and requires a new approval and/or authorisation process.

Reporting to the Chief Psychiatrist

An authorised psychiatrist must give a written report to the Chief Psychiatrist on the use of any restrictive intervention (s. 108(1)). This report must contain the details required by the Chief Psychiatrist and be given to the Chief Psychiatrist within the time stipulated (s. 108). In practice, this information is entered monthly onto the Client Management Interface (CMI) database in each service.

Best practice

Post restrictive intervention consumer support

- It is a priority to review the use of a restrictive intervention and to plan collaboratively with the consumer to minimise the future need for a restrictive intervention. The consumer's understanding and experience of the incident should be explored, once the person is able and willing to discuss the incident leading to the use of a restrictive intervention, at a time of their choosing.
- A restrictive intervention is a potentially traumatic experience that requires sensitivity and skill in discussing. The consumer needs to be asked if they would like to discuss his or her experience of the restrictive intervention.
- The purpose of a post restrictive intervention consumer support session is to provide an opportunity for the person's experience of the episode to be acknowledged and heard. Attempts to justify the decision to use a restrictive intervention may be counter-productive and should be avoided.
- The consumer should be given a choice as to who he or she would like to discuss their experience with, wherever possible. This may include access to an available peer support network.
- A post restrictive intervention support session should also be offered to other persons, as appropriate, including carers and other consumers who witnessed the event.

Experience of care review

Following the use of a restrictive intervention, a formal systemic review should occur as soon as possible with input from a range of staff including the unit manager, senior registered nurses, a consultant psychiatrist, any staff involved and carer/consumer consultants from the service concerned. Wherever possible, the consumer and their carer should be supported and encouraged to participate in the review.

The aim of the experience of care review is to:-

- Involve the consumer considering what else might have been done to prevent or minimise the use of a restrictive intervention.
- Review the use of the restrictive intervention in relationship to the factors that precipitated its use.
- Identify preventative strategies trialled to prevent the restrictive intervention and the reasons for failure.
- Review compliance with the Act.

- Review system-wide management issues that may need addressing to prevent further use of restrictive interventions.
- Ensure that any systemic issues that would ordinarily generate an incident report are appropriately documented and escalated for a) information and b) remedial action.

Any systemic issues identified need to be forwarded to the relevant safety and quality improvement committee for attention. Restrictive intervention monitoring should be included in the ongoing quality assurance program of the designated mental health service. Findings from this review should inform the development of training programs.

Other quality-improvement activities should include local clinical audits based on the knowledge and application of Part 6 of the Act, local policies and procedures, and this guideline (see health service self-assessment suggestion below[9]). These are leadership activities to enhance strategies to reduce the use of restrictive interventions.

[9] Health service self-assessment of restrictive interventions

Standard 1: Compliance with statutory requirements

There are established documented procedures to ensure compliance with the requirements specified in this guideline.

Policies and procedures are reviewed by the service to ensure compliance with the above requirements.

Standard 2: Restrictive interventions are comprehensively reviewed

There is an established procedure for reviewing restrictive interventions used in the service.

Practice improvements are made in light of reviewing restrictive interventions via the health service clinical governance framework.

Developing local policies and procedures

All services should have local policies and procedures which take into account the particular service setting, populations served and any other relevant local factors. Specific considerations should be given to the following.

Gender safety and sensitivity

Sensitivity to gender-specific needs is crucial. Consumers may have different preferences about the gender of staff involved in prevention and early intervention, as well as the use of a restrictive intervention. The consumer's preferences should be sought and responded to. Arrangements for clothing, searches for dangerous objects, toileting and review should also be undertaken in regard to gender sensitivity. Consideration should also be given to the possibility of pregnancy in female consumers and the implications of this, especially if medications contraindicated during pregnancy are being considered.

It is important to remember a key component of providing gender sensitive care is to understand trauma and how it manifests in people when they are in acute distress.

Intellectual disability or acquired brain injury

Where a person has an intellectual disability or acquired brain injury, his or her behaviour may be the principal means of communication, particularly where his or her ability to communicate may also be impaired by mental illness. Problematic behaviour, where possible, should be assessed for meaning before making decisions to use a restrictive intervention.

It should be anticipated that it is not uncommon for these consumers to demonstrate a low frustration tolerance and at times poor impulse control. People with cognitive impairment often have difficulty in understanding the rationale for the use of a restrictive intervention and may react with an escalation in agitation during this process. Carers' views should be taken into account regarding the use of a restrictive intervention and their preferences regarding notification of such events.

It is important, wherever possible, for the nature of the intervention and the reasons for it to be explained at a level the person is able to comprehend. All the above points should be outlined in a detailed care plan.

Older persons

Consideration should be given to the ramifications of the use of a restrictive intervention for this age group. There is a marked increase of bone fractures and loss of skin integrity when applying and maintaining a restrictive intervention for older persons, as well as exacerbation of underlying confusion and agitation. Special consideration should be given to the assessment for underlying or emerging medical conditions impacting on the person's mental state and behaviour.

Carers views should also be taken into account regarding the use of a restrictive intervention and their preferences regarding notification of such events. Wherever possible, older adults should receive one-to-one nursing care in preference to using a restrictive intervention. All the above points should be outlined in a detailed care plan.

Children and adolescents

The developmental status of a young person should be a consideration in any decision to use a restrictive intervention. The use of a restrictive intervention with children under the age of 12 years should be avoided. Restrictive interventions must be used with caution when they involve adolescents because in most cases their musculoskeletal systems are immature, which elevates the risk of injury.

The carer, of a young person must be informed of the use of a restrictive intervention as soon as practicable. A decision to involve a carer, or other relevant third parties in the debriefing process must take into account the young person's capacity to consent to their involvement.

Aboriginal consumers

Aboriginal consumers may perceive or interpret the use of a restrictive intervention differently depending on their cultural backgrounds and personal experiences of colonisation.

Special care must be taken to achieve effective communication, first to avert the use of the restrictive intervention if possible, and second to minimise the trauma of the intervention to the consumer, both during and after the intervention. It is important to be aware that communication problems in themselves may lead to unnecessary restrictive interventions. Cultural advisors should be used, if possible, as a means to minimise the potential for miscommunication and misunderstanding.

Culturally and linguistically diverse (CALD) consumers

Restrictive interventions may be more traumatic and potentially more dangerous for people who are unable to understand what is happening or unable to communicate their questions or concerns. Consumers may perceive or interpret the use of a restrictive intervention differently depending on their cultural backgrounds and personal experiences such as being a refugee or being a survivor of abuse or torture.

Special care must be taken to achieve effective communication, first to avert the use of the restrictive intervention if possible, and second to minimise the trauma of the intervention to the consumer, both during and after the intervention. It is important to be aware that communication problems in themselves may lead to unnecessary restrictive interventions. Interpreters should be used (telephone or face-face) or cultural advisors, if possible, as a means to minimise the potential for miscommunication and misunderstanding.

Consumers with sensory impairment

The use of a restrictive intervention may also be more traumatic and potentially more dangerous for those who are unable to fully understand what is happening or unable to communicate their questions or concerns due to sensory impairment. Specific interventions, such as the physical restraint of an auditory impaired person's hands, may also prevent effective communication.

Special care must be taken in these situations to achieve effective communication. The use of carers who are familiar with the communication needs of the consumer should be considered in these situations.

Related guidelines and resources

Framework for recovery-oriented practice, 2011

http://docs.health.vic.gov.au/docs/doc/Framework-for-Recovery-oriented-Practice

Creating Safety, project documents and report, 2009

http://www.health.vic.gov.au/chiefpsychiatrist/documents/creatingsafety/creating_safety_project_report.pdf

http://www.health.vic.gov.au/chiefpsychiatrist/creatingsafety/index.htm

Creating safety, seclusion literature review, 2007

http://www.health.vic.gov.au/chiefpsychiatrist/documents/creatingsafety/litreview.pdf

Chief Psychiatrist Clinical Practice Advisory Notice: Practice of Prone Restraint, 2013

http://docs.health.vic.gov.au/docs/doc/Chief-Psychiatrist-Clinical-Practice-Advisory-Notice:-Practice-of-Prone-Restraint

Department of Human Services, Senior Practitioner Physical Restraint Direction Paper, 2011

http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/reports-publications/physical-restraint-direction-paper-senior-practitioner

National Safety Priorities in Mental Health: a National Plan for Reducing Harm, 2005

http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-safety

The Royal Australian and New Zealand College of Psychiatrists, Minimising the use of seclusion and restraint in people with mental illness, 2010

https://www.ranzcp.org/Files/ranzcpattachments/Resources/College_Statements/Position_Statements/ps61-pdf.aspx

Providing a safe environment for all: Framework for reducing restrictive interventions, 2013

http://docs.health.vic.gov.au/docs/doc/Providing-a-safe-environment-for-all:-Framework-for-reducing-restrictive-interventions

Reducing restrictive interventions: Literature review and document analysis, 2013

http://docs.health.vic.gov.au/docs/doc/Reducing-restrictive-interventions:-Literature-review-and-document-analysis

Chief Psychiatrist's guidelines

http://www.health.vic.gov.au/mentalhealth/cpg/

About Chief Psychiatrist's guidelines

The information provided in this guideline is intended as general information and not as legal advice. Service providers should obtain independent legal advice if they have queries about individual cases or their obligations under the Mental Health Act 2014.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT NC-7

This is the attachment marked 'NC-7' referred to in the witness statement of Dr Neil Coventry dated 29 July 2020.

Chief Psychiatrist's annual report 2018–19

VICTORIA State Government | Health and Human Services

Chief Psychiatrist's annual report 2018–19

To receive this publication in an accessible format phone 1300 767 299, using the National Relay Service 13 36 77 if required, or email the Office of the Chief Psychiatrist <ocp@dhhs.vic.gov.au>.

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Available on the Chief Psychiatrist's webpage <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist>.

Chief Psychiatrist's message

I am pleased to present the Office of the Chief Psychiatrist's annual report for 2018–19.

This year, my office has responded to challenges and complexity in the Victorian mental health system like never before. Demand for advice and support from my office has been unprecedented and the need to be constantly mindful of promoting the human rights of consumers paramount.

We welcomed the commencement of the Royal Commission into Victoria's Mental Health Services and have been pleased to be asked to contribute to its knowledge-gathering and policy assessment activities. We look forward to the generational change that is required to provide the quality and safe mental health treatment Victorian mental health consumers and carers are seeking. The impact on mental health awareness has already been profound and I have been moved by the increasing contacts and the very personal and distressing accounts of experiences my office is receiving from people who are seeking support.

In 2018–19 the National Disability Insurance Scheme (NDIS) rollout was finalised across Victoria. While there are challenges involved with implementing a substantial reform of this nature, the NDIS will provide access to a broader range of life long supports to an estimated 15,000 Victorians with a psychosocial disability. Already my office has worked across the department and with the sector to ensure equity of access and appropriate support for consumers with mental illness through the NDIS, particularly for individuals with complex and often dual disability, such as intellectual impairment. My office's work on these matters to push for appropriate solutions and deliver high-quality services for consumers and carers is increasing exponentially. We also continue to experience increasing numbers of direct contacts from mental health service providers seeking advice and assistance – demonstrating our strong relationships with services and the value of our collaborative approach to clinical leadership. Sustained effort will be required as new partnerships and ways of working together are built between the clinical mental health system and the NDIS. That is why we will continue to collaborate with health services to the build the capability of clinicians and the relationships with the National Disability Insurance Agency to resolve individual cases as the scheme matures. A key development has been the establishment of NDIS funded Hospital Liaison Officers to help staff in hospitals to resolve NDIS related discharge delays.

My office is privileged to have strong links and daily contact with mental health clinicians, as well as staff of agencies such as the Mental Health Tribunal, the Office of the Public Advocate and Safer Care Victoria. This gives us access to a wealth of 'frontline' knowledge that informs our policy and quality assurance activities. I thank the clinicians, service leaders, consumers and carers who have shared their expertise and experiences with us. I acknowledge the very high levels of demand in Victoria's mental health services during 2018–19 and the impact this has on everyone who comes into contact with the system. At times during this very busy year I have reflected that my office is in some ways like a microcosm of the larger system, and when it is under pressure we can see that paralleled in the issues that are surfacing for our attention.

While the role of the Office of the Chief Psychiatrist as stated in the *Mental Health Act 2014* includes clinical leadership and quality and safety improvements across the Victorian public mental health system, we do not do this alone. We acknowledge the work of other bodies and agencies who advocate for patients and carers in the mental health system. Their work in helping to identify opportunities for improvement within the system provides further support to the work undertaken by the Office of the Chief Psychiatrist.

This year we established a committee to focus on important work to promote sexual safety in acute mental health settings. These initiatives are in addition to our daily work, including: monitoring restrictive interventions in mental health services; investigating serious clinical incidents; undertaking

reviews and supporting mental health services to address issues of concern; liaising with mental health and other services to improve outcomes for individual consumers; and responding to calls, letters and emails from consumers and carers seeking assistance and advice regarding access to mental health services.

I am fortunate to lead a multidisciplinary team of skilled and compassionate people who are dedicated to improving Victoria's mental health system. I acknowledge and thank the Chief Mental Health Nurse, my deputies, the OCP manager and the clinical advisors, project officers and administrative staff in my team for their unflagging commitment and support.

Dr Neil Coventry
Chief Psychiatrist

Contents

Overview

Aims of the report

The aims of this annual report are to:

- inform mental health consumers, carers, service providers and members of the public about the activities of the Office of the Chief Psychiatrist (OCP) in the 2018–19 financial year
- provide information about specific clinical practices that must be reported by health services to the Chief Psychiatrist under the *Mental Health Act 2014*
- contribute to ongoing improvement in the quality and safety of Victoria's mental health services.

Statutory framework and role of the Chief Psychiatrist

The Mental Health Act aims to improve the treatment experiences of people with a mental illness by actively involving and supporting them, and their families and carers, in making decisions about their treatment and exercising their rights.

The Act has a number of core principles and objectives including that:

- assessment and treatment are provided in the least intrusive and restrictive way
- people are supported to make and participate in decisions about their assessment, treatment and recovery
- individuals' rights, dignity and autonomy are protected and promoted at all times
- priority is given to holistic care and support options that are responsive to individual needs
- the wellbeing and safety of children and young people are protected and prioritised
- carers are recognised and supported in decisions about treatment and care.

Under s. 119 of the Act, the Secretary to the Department of Health and Human Services ('the department') can appoint a Chief Psychiatrist. The role of the Chief Psychiatrist, as described in s. 120 of the Act, is to:

- provide clinical leadership and expert clinical advice to mental health service providers in Victoria
- promote continuous improvement in the quality and safety of mental health services
- promote the rights of people receiving mental health services
- provide advice to the designated minister and the departmental Secretary about mental health services.

Under the Act, 'mental health service providers' are designated mental health services (often public or denominational hospitals) and publicly funded mental health community support services. Often referred to jointly as 'public mental health services', these services include a range of hospital and community-based clinical mental health services and the Victorian Institute of Forensic Mental Health (known as 'Forensicare').

More information about the Mental Health Act and how it relates to the role of the Chief Psychiatrist can be found on the department's website <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist>.

Functions of the Chief Psychiatrist

The Chief Psychiatrist provides system-wide oversight of Victoria's public mental health services. Supported by the OCP, the role promotes quality and safety in services provided to some of Victoria's most vulnerable people. The functions of the Chief Psychiatrist, as summarised under s. 121 of the Act, are to:

- develop, communicate and assist mental health service providers to comply with standards, guidelines and practice directions
- develop and provide information or training, and monitor service provision, to promote quality and safety
- assist mental health services to comply with the Act, regulations made under the Act and codes of practice
- conduct clinical practice audits and clinical reviews of mental health service providers, and investigations in relation to service provision
- analyse data, undertake research and publish information about Victoria's mental health services
- publish an annual report
- give directions to mental health service providers regarding service provision
- promote cooperation and coordination between mental health services and providers of health, disability and community support services.

The Office of the Chief Psychiatrist and the Department of Health and Human Services

The Act defines the statutory role of the Chief Psychiatrist, who also holds an executive officer role in the department, as leading the OCP.

As the department's quality and safety 'arm' in the stewardship of clinical mental health services, the OCP supports the Chief Psychiatrist's responsibility to provide clinical leadership to the sector. The OCP undertakes a wide range of activities including:

- monitoring restrictive and invasive interventions, which include seclusion, restraint and electroconvulsive treatment (ECT)
- responding to serious clinical incidents
- working with mental health and other service providers to improve care for individual consumers
- helping to embed new practices and models of care.

The OCP incorporates the work of the Office of the Chief Mental Health Nurse (OCMHN). The Chief Mental Health Nurse provides nursing leadership and supports mental health nursing through education/training, through promoting best practice and through workforce planning and development. The OCMHN supports the practical implementation of the OCP's work with policy, procedures and workforce development initiatives.

Structure of the report

This annual report outlines the OCP's activities from 1 July 2018 to 30 June 2019 and has been divided into two sections.

Section 1 relates to leadership and quality and safety improvement across Victoria's mental health system. These activities include: providing advice to services and ministers; clinical leadership; and reviews, audits and investigations to promote continuous improvement in quality and safety.

Section 2 covers the OCP's statutory reporting requirements under the Mental Health Act including monitoring ECT, restrictive interventions (use of seclusion and restraint) and reportable deaths.

Section 1: Leadership and quality and safety improvement

The year in review

Activity in the OCP

In 2018–19 the OCP experienced unprecedented demand over 2017–18 levels, including a:

- 23 per cent increase in the number of contacts received
- 27 per cent increase in the number of ministerial matters requiring a response
- 31 per cent increase in the number of contacts from carers
- 45 per cent increase in requests for clinical advice
- 97 per cent increase in the number of contacts from departmental staff regarding consumers requiring multiple service system responses.

Since 2015–16 this equates to a:

- 99 per cent increase in the number of contacts received
- 182 per cent increase in the number of ministerial matters requiring a response
- 94 per cent increase in the number of contacts from carers
- 121 per cent increase in the number of contacts from Area Mental Health Service staff
- 52 per cent increase in requests for clinical advice
- 850 per cent increase in the number of contacts from the department regarding consumers requiring multiple service system responses.

In 2018–19 we also:

- finalised two major Chief Psychiatrist investigations
- undertook nine ECT audits
- undertook 23 site visits
- hosted four quality and safety forums, four authorised psychiatrist forums, nine senior mental health nurse specialty forums and nine committee meetings for the ECT committee, Restrictive Interventions committee, Morbidity and Mortality committee and Sexual Safety committee
- implemented a new case management system.

Highlights of 2018–19

Personality disorder initiative

The Victorian Government committed to supporting consumers of public clinical mental health services who have complex, high-risk presentations resulting from severe personality disorders to access high-quality, evidence-based assessment and clinical treatment. The Victorian State Budget committed $9.16 million over four years for the Personality Disorder Initiative.

This exciting initiative will build the expertise and capability of the clinical mental health workforce to assess, treat and support people with severe personality disorders who are at high risk of suicide, high-lethality self-harm and/or violent or aggressive behaviours and improve outcomes for this cohort.

The Chief Psychiatrist is the department's sponsor for the Personality Disorder Initiative and led development of the service framework and expressions of interest process during 2018–19. After a highly competitive process, six health services have been selected to deliver the initiative in partnership with Victoria's statewide specialist personality disorder service Spectrum Personality Service for Victoria (Spectrum). Work to roll out the program will continue in 2019–20.

Workforce initiatives

In 2018–19 a range of workforce initiatives were implemented to support the delivery of safe, high-quality mental health care.

In 2018 the Centre for Mental Health Learning (CMHL) Victoria was established. The CMHL centralises and supports learning and development for mental health workforce development in Victoria, including for the lived experience workforce. This centralised approach reduces duplication and assists in disseminating information, tools, resources and expertise across the mental health sector. The CMHL is focusing its work on four pillars: engagement and communication; alignment and coordination; innovation and systems change; and evidence and quality.

CMHL activity in 2018–19 has included data collection, model development and engagement and communication, with more than 55 consultation sessions with public mental health services and other key stakeholders around learning and development and future workforce support needs. The CMHL has also co-produced a Victorian strategy for the lived experience workforce in partnership with members of the lived experience workforce, peak bodies, employers and other agencies. This strategy will support the future of the lived experience workforce and will be launched in July 2019.

The OCMHN supported 18 mental health services across the state to roll out 63 new positions funded in the 2018–19 Victorian State Budget. These new positions included transition to practice positions for mental health nursing, community mental health engagement worker roles and clinical nurse consultant roles. These new positions will better support consumers to access primary care, employment, housing and other community services.

The workforce team also awarded innovation grants to nine consumer-led and family/carer-led projects focusing on workforce development through the Workforce Innovation Grant Program.

The *Consumer perspective supervision framework* for consumer workers was released in November 2018. The framework was co-produced in a partnership led by the Victorian Mental Illness Awareness Council (VMIAC), the Centre for Psychiatric Nursing and the department.

Finally, two pilot Psychotherapy Essentials in Mental Health Nursing workshops were held for staff from Barwon Health, Mercy Health and Goulburn Valley Health. The workshops are targeted at community mental health nurses to build their psychotherapy skills and to support consumer recovery.

Physical health framework

In March 2019 the department released *Equally well in Victoria: Physical health framework for specialist mental health services*. This document is the first of its kind in Victoria. It describes a range of initiatives for organisations and clinicians to work in partnership with consumers and carers to discuss physical health in the context of a recovery plan. This framework provides information to help mental health services and clinicians to think about how to tailor treatment and strategies to the realities of the daily lives of consumers.

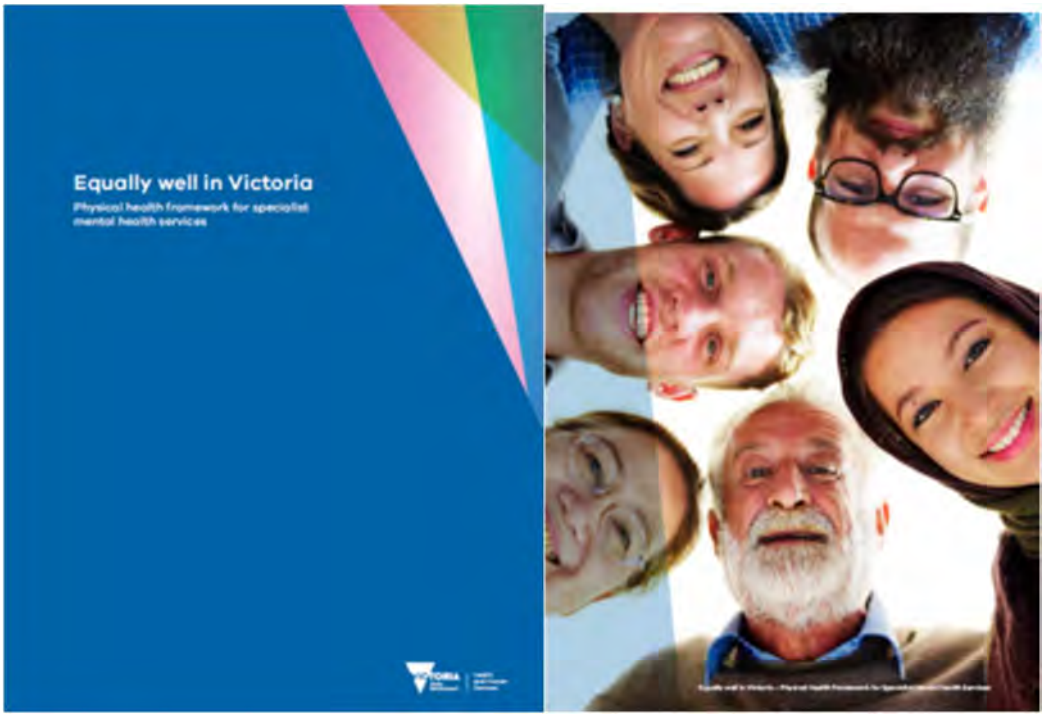
Under the leadership of Victoria's Chief Mental Health Nurse and in partnership with VMIAC and Tandem, the framework was developed as Victoria's response to the Equally Well National Consensus Statement. The framework describes consumers', carers' and clinicians' perspectives on how mental health services can address physical health issues.

An expert reference group comprising mental health consumers and carers, experts from mental health, general practice, community health and peak health organisations guided the approach and content of this document.

Five interconnected domains support physical health care in Victorian specialist mental health services:

- consumer physical health needs
- collaborative planning and therapeutic interventions
- healthcare setting
- workforce considerations
- supporting safety.

The framework describes the necessary elements at the organisation and clinical practice levels to guide implementation of physical health in a consistent way across Victoria. It asks services and clinicians to use a recovery approach to physical health and offer help to consumers that extends beyond biomedical screening, diagnosis and treatment. It also asks clinicians to work in an interprofessional way to understand each person's recovery journey and, using collaborative recovery plans, to enquire about the person's physical health, appreciating the complex interplay with mental illness and how this operates in the context of the person's life. The framework is an important first step for Victorian mental health services.



Safewards in Victorian emergency departments

Mental health services experience high levels of conflict events such as aggression, violence and absconding. Often, in response to these events, restrictive practice may be used. Safewards is a model designed to improve safety for patients and staff. Safewards Victoria is now a recognised resource in the National Safety and Quality Health Standards and can be used as evidence in meeting accreditation.

The OCMHN oversees Victoria's Safewards program and was formally launched for statewide implementation to all mental health services in 2016. The Safewards model is currently being trialled in emergency departments at Peninsula Health and Bendigo Health, with a further trial of Safewards in general settings to begin in 2020.

Safewards in Emergency Departments is a world first. The pilot is well underway, with planning and training phases completed and implementation of interventions currently occurring. The University of Melbourne is evaluating the trial project, and this is due for completion in December 2020.

The emergency department trial has adapted some of the interventions and included two new interventions. There are nine interventions that will be trialled for suitability in emergency departments: soft words, talk through, positive words, delivering bad news, know each other, calming methods, reassurance, senior safety round, and perception and awareness.

Continued interstate and global interest has established Safewards Victoria as a best practice framework for conflict reduction and increased safety.

Further to the evidence from the trial, staff have reported increased feelings of safety and cooperation. Safewards is providing services with a best practice model and framework that promotes therapeutic environments to support recovery. The program continues to show a growing evidence of not only therapeutic support but also culture change improvements in services that have keenly taken up Safewards.

The key focus of the Safewards model is to reduce conflict and containment within mental health services. The model attempts to identify and address the flashpoints/triggers in staff and patients that may result in harm, such as violence, self-harm or absconding, and reduce the likelihood of this occurring.

Conflicts that threaten people's safety in mental health settings, and subsequent negative outcomes for staff and patients, is complex. Safewards provides a model for engaging with this complexity and provides practical options in the form of interventions to enable staff and patients to work together to address this. Safewards is effective in improving the quality of interactions between staff and patients, as well as enhancing the support that staff and patients provide each other, resulting in better experiences of care and supporting the safety and wellbeing of patients and staff.

Safewards provides an understanding of the factors contributing to conflict and restrictive interventions and explores the relationship between restrictive interventions and occupational violence. The model highlights four themes: providing a framework for best practice; reducing restrictive interventions and conflict reduction; supporting culture change and improvements; and promoting recovery principles. The model has been designed to enhance safety and promote therapeutic environments to support recovery, increasing patient and staff engagement and communication in health settings.

The Safewards model examines six originating domains (patient community, patient characteristics, regulatory framework, staff team, physical environment and outside hospital), which can give rise to potential 'flashpoints' – that is, situations where conflict could arise. The flashpoints can trigger conflict, which can lead to containment. The flashpoints are practically addressed with 10 evidence-based interventions. The 10 interventions in mental health are: clear mutual expectations, soft words, talk through, positive words, bad news mitigation, know each other, mutual help meeting, calm down methods, reassurance, and discharge messages.

Sexual safety practice improvements

Sexual safety in mental health services remains one of the Chief Psychiatrist's highest priorities.

In January 2019 the OCP established the Sexual Safety Committee. The committee aims to promote the rights of people receiving mental health care from mental health service providers and continuous improvement in relation to sexual safety in designated mental health services. More specifically, it works to:

- advise on information collection regarding sexual safety to be reported to the Chief Psychiatrist
- review and analyse information from sexual safety notifications and the Victorian Health Incident Management System in designated mental health services
- provide advice and recommendations to the Chief Psychiatrist concerning sexual safety in designated mental health services
- provide advice to the Chief Psychiatrist in relation to clinical practice audits and clinical reviews that relate to sexual safety
- identify and promote best practice in mental health service delivery regarding sexual safety
- provide advice on or contribute to conducting research on issues about sexual safety
- help develop and review standards, guidelines or practice directions to address systemic issues relating to sexual safety for the Chief Psychiatrist
- oversee of a workplan determined by the committee.

Human rights project

The team has completed the first phase of consultation for an important project on promoting consumer rights within the mental health sector, showcased in the Mental Health Branch's 2018–19

annual report. This work will focus on reducing restrictive interventions and promoting gender and sexual safety.

New Chief Psychiatrist guidelines and advisory notices

Electronic communication and privacy in designated mental health services

This year the Chief Psychiatrist published a new guideline: *Electronic communication and privacy in designated mental health services*. Development of this guideline demonstrates the range of factors that need to be reflected in such guidelines and the legislative frameworks that dictate health services' responsibilities. Extensive consultation was undertaken with consumers, legal experts and the Mental Health Complaints Commissioner to get it right. The guideline is gradually being implemented across Victorian mental health services.

The guideline demonstrates that the Chief Psychiatrist recognises the importance of personal electronic communication devices such as mobile phones, tablets and computers, and the role such devices can play in promoting recovery and maintaining connection and communication with social networks. Personal devices are everywhere in society and can provide therapeutic benefit through enabling communication, recreation, research, addressing daily needs and maintaining dignity. However, such devices may also present a risk to the user or others – for example, through unlawful use (such as stalking, harassment or breaching personal privacy), disinhibited behaviour creating risk for the user (such as online gambling or shopping) or through personal preference as expressed through an advance statement.

The principles presented in this guideline are informed by legislation including the *Charter of Human Rights and Responsibilities Act 2001*, the Mental Health Act, the *Health Records Act 2001* and the *Surveillance Devices Act 1999*:

- Every patient has the right to enjoy his or her human rights, without discrimination (Charter of Human Rights and Responsibilities Act).
- Patients have the right to privately communicate information of all kinds (including audio and visual) and to communicate lawfully with any person (Mental Health Act).
- A patient must not be deprived of his or her property other than in accordance with law (Charter of Human Rights and Responsibilities Act).
- An authorised psychiatrist may direct staff, in writing, to restrict communication if this is needed to protect health, safety and wellbeing (conditions and exceptions are provided in the Mental Health Act).
- If a patient's right to communicate is restricted, this must be effected in the least restrictive way possible, within the context of a patient-centred, recovery-focused approach, with due consideration to alternative options to communicate. Restrictions needs to be reviewed regularly and ceased immediately when no longer necessary (Mental Health Act).
- Recording of 'health information' using an electronic communication device is subject to health privacy principles (Health Records Act and Surveillance Devices Act).

The psychiatrist's first assessment of new inpatients

The Chief Psychiatrist also published the *Advisory notice: The psychiatrist's first assessment of new inpatients*. The note aims to set a standard of practice that can be checked as part of services' ongoing quality and safety audits. It was compiled with the assistance of clinicians with medical and nursing expertise.

The advisory notice documents that the psychiatrist's first assessment of a new inpatient is of critical importance. A current mental status examination, diagnostic formulation and risk review all contribute

to an informed, well-directed and collaborative treatment plan. It clearly articulates that oversight by a consultant at the time of admission or shortly afterwards helps all members of the multidisciplinary team to identify consumers' needs and respond to them quickly and effectively. An admission process that starts well will deliver a better outcome in a shorter period of time.

Community deaths audit

In 2018–19 the OCP finalised the audit report *An analysis of deaths in 2015 of community-resident consumers of Victorian mental health services*. The report describes the causes and circumstances of deaths of mental health consumers living in the community in 2015. This timeframe was chosen to ensure that all coroners' findings were available.

The findings make interesting reading. The 110 suicides of mental health consumers represented 18 per cent of all suicides in Victoria in that period. Interpersonal conflict was thought to be the trigger more commonly than serious, persistent mental illness. One-fifth of the individuals concerned had inflicted self-harm in the three months before death, and a similar proportion had abused alcohol or other drugs.

Of deaths due to accidental overdose, approximately one-third were due solely or in part to prescribed or illicit opioids. Deaths due to medical causes were mostly due to cardiac or respiratory conditions, often at strikingly young ages. Rates of infection with hepatitis C were many times higher than in the general population.

These findings emphasise the value of current initiatives to improve consumers' physical wellbeing, to offer support to people leaving emergency departments or medical wards after attempted suicide and to develop local suicide prevention initiatives.

Section 2: Statutory reports

Under the Mental Health Act, services must report to the Chief Psychiatrist about ECT use, the use of restrictive interventions such as seclusion and bodily restraint, and reportable deaths. Gathering information in this way offers the opportunity to monitor trends, identify issues and improve clinical practices to enhance the safety and quality of mental health services. This section of the report provides data and analysis specific to each area for 2018–19.

Electroconvulsive treatment

ECT induces modified seizures for therapeutic purposes under the protection of general anaesthesia and muscle relaxation. It is an effective treatment for a range of mental illnesses including severe depression, mania, schizophrenia and catatonia. It may be recommended when other treatments have not worked, or take too long to work, or cannot be undertaken safely. ECT might also be recommended to people for whom the treatment worked well previously.

This evidence-based treatment is individually tailored to maximise benefit and reduce adverse effects including memory deficits. Side effects are minimised by applying stimulation to one side of the head (unilateral ECT) with the smallest possible dose of electrical stimulation. Treatments are typically administered on two or three occasions per week over a period of two or more weeks. A small proportion of people benefit from ongoing episodic treatments to prevent relapse.

The Chief Psychiatrist and the Mental Health Tribunal oversee the use of ECT. Services must inform the Chief Psychiatrist of each treatment, stipulating the type of treatment and the reason for its use.

Electroconvulsive treatment in public mental health services

In relation to ECT, the Chief Psychiatrist's special responsibilities include:

- receiving reports from public mental health services about ECT use
- reporting on the number of young people (under 18 years of age) who receive ECT.

The number of people who receive ECT has remained relatively static since 2014–15 (see Table 1) despite a 20 per cent increase over this period in admissions to adult and aged persons' inpatient units.

Table 1: Number of treatments and people treated by ECT, 2014–15 to 2018–19

Measure	2014–15	2015–16	2016–17	2017–18	2018–19
Number of treatments	11,509	11,975	12,296	13,291	12,965
Number of people treated	1,025	934	1,031	1,030	972

Mood disorders accounted for nearly two-thirds of treatments in 2018–19, followed by schizophrenia and other psychoses (Table 2).

Table 2: Percentage of ECT treatments by diagnosis, 2014–15 to 2018–19

Diagnosis	2014–15	2015–16	2016–17	2017–18	2018–19
Mood disorders	54%	63%	66%	62%	60%
Schizophrenia and other psychoses	34%	33%	30%	34%	34%

Diagnosis	2014–15	2015–16	2016–17	2017–18	2018–19
Other conditions	6%	2%	2%	2%	2%
Not reported	6%	1%	2%	2%	4%

Table 3 shows that, overall, more women than men were treated with ECT across the life span. This is consistent with community-wide gender-based differences in the prevalence of mood disorders.

Table 3: Number of ECT treatments by age group and gender, 2018–19

Gender	18–29	30–39	40–49	50–59	60–69	70–79	80+
Men	497	927	1,097	1,148	843	804	222
Women	721	798	1,240	927	1,440	1,396	816

Electroconvulsive treatment and young people

The Chief Psychiatrist must collect data on the number of people aged under 18 years who receive ECT and their clinical outcomes. A subcommittee of the ECT Committee oversees this work. In 2018–19, six people who received ECT were aged under 18 years. This increase from one in the previous year has been reviewed and is not believed to be attributable to any specific reason.

In late 2019 the Chief Psychiatrist will submit a written report to the Minister for Mental Health on young persons who received ECT between 1 July 2014 and 30 June 2019, since the introduction of the revised Mental Health Act. This report will be tabled in Victorian Parliament.

Deaths of people receiving mental health treatment

The death of a person receiving treatment or support for a mental illness is a tragic event. The Chief Psychiatrist collects data from mental health services to learn from each incident, with a view to improving safety and reducing the number of preventable deaths.

The Chief Psychiatrist must be notified of the deaths of all mental health inpatients where an inpatient is defined as any person regardless of legal status who:

- had been admitted to a mental health inpatient unit
- was on approved leave from an inpatient unit
- had absconded from an inpatient unit
- had been transferred to a non-psychiatric ward during a mental health admission
- had been discharged from a mental health inpatient unit within the previous 24 hours.

In the case of deaths in the community, the Chief Psychiatrist must be notified of:

- all unexpected, unnatural or violent deaths (including suspected suicides) of people who had been registered as a mental health consumer within the previous three months or who had sought care from a mental health provider within that period and had not received treatment
- all deaths of patients under community treatment orders or non-custodial supervision orders.

People are considered to be mental health consumers until their case is closed and they have been notified of this closure (or the service has made all reasonable efforts to do so).

The Chief Psychiatrist also requires notification of the deaths of people detained in an emergency department or non-psychiatric ward under the Mental Health Act and those receiving care from a mental health community support service.

The Chief Psychiatrist is accountable for the following functions with respect to consumers' deaths:

- to maintain a database of reportable deaths of clients of public mental health services in Victoria
- to request the findings of coronial investigations and contribute to coronial processes if requested by a coroner
- to review clinical reports provided by services to identify systemic issues
- to identify statewide issues and provide guidance to mental health services to help reduce and prevent deaths and provide safe and effective services.

Reportable deaths in 2018–19

In 2018–19 mental health services reported 427 deaths of which 24 were defined as inpatient deaths (see above). By comparison, the numbers of total and inpatient deaths in 2017–18 were 371 and 36 respectively. This represents a reduction in rates of inpatient deaths, and a modest increase in rates of community deaths, when adjusted for population (Table 4). The seeming increase in community mortality rates stems principally from more accurate knowledge of deaths by suicide within three months of discharge from a mental health service. This improvement in data accuracy results from a data linkage project between the department and the Coroner's Court of Victoria. Service providers are not informed of all the deaths of people discharged from their care. The Coroner, by contrast, learns of almost all such deaths.

Of the 427 notified deaths in 2018–19, 291 were categorised as unnatural or unexpected and 76 were due to natural causes. The cause of death had yet to be ascertained in 60 cases (Table 5). Most unnatural or unexpected deaths arose in the 20–59-year age group. Natural deaths were more frequent in older age groups. The numbers of deaths of uncertain cause increased in 2018–19 relative to previous years because the new form used by service providers to notify the Chief Psychiatrist of deaths allows clinicians to defer disclosing a likely cause of death until the Coroner makes a final determination.

Of the 24 deaths of inpatients, 16 were categorised as having unnatural or unexpected causes, including six suicides (compared with 12 suicides in 2017–18). The remaining eight deaths resulted from natural or unascertained causes. Three of the six suicides occurred within an inpatient unit. One occurred while on approved leave, one followed transfer to a medical ward and another occurred within 24 hours of discharge from hospital. There were no deaths after absconding from an inpatient unit or while waiting in an emergency department for a bed to become available.

Table 4: Reportable deaths per 100,000 Victorian population, 2014–15 to 2018–19

Reportable deaths	2014–15	2015–16	2016–17	2017–18	2018–19
Community deaths	4.81	5.70	5.76	5.35	6.25
Inpatient deaths	0.45	0.51	0.58	0.57	0.34
All deaths	5.26	6.21	6.34	5.92	6.62

Table 5: Reportable deaths by category, 2014–15 to 2018–19

Reportable deaths by category	2014–15	2015–16	2016–17	2017–18	2018–19
Unnatural, unexpected	75%	58%	71%	76%	68%
Natural	20%	31%	28%	19%	18%
Not yet established	5%	11%	1%	5%	14%

The OCP views every suicide in care as potentially preventable. Every number represents a person who has suffered and left behind family and loved ones. The Safewards program (described earlier in this report) promotes greater engagement with inpatients from mental health clinicians with a view to addressing the concerns that might prompt thoughts of self-harm. In addition, services now regularly audit mental health inpatient units to identify and remediate the physical elements of buildings that present risk. Within the community, initiatives such as the Hospital Outreach Post-suicidal Engagement (HOPE) project seek to reduce the numbers of suicides of people who presented to emergency departments after an episode of self-harm or with suicidal ideation.

Restrictive interventions – adult inpatient units

Restrictive interventions are defined in the Mental Health Act as the use of seclusion or bodily restraint. Seclusion is 'the sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave' (s. 3). Bodily restraint is 'a form of physical or mechanical restraint that prevents a person having free movement of his or her limbs' (s. 3).

The Act provides that a person may only be placed in seclusion or restraint to prevent imminent and serious harm to the person or another person or, in the case of restraint, to administer treatment. The principles outlined in the Act specify that people receiving mental health services should be treated in the least restrictive way possible, meaning that seclusion and restraints can be applied only after all reasonable and less restrictive options have been tried or considered and found unsuitable.

The Chief Psychiatrist and Chief Mental Health Nurse share a commitment to reducing and, where possible, eliminating restrictive interventions in mental health services, in alignment with the *Fifth national mental health plan.* A number of Victorian Government initiatives, such as Safewards, aim to encourage alternative clinical practices.

Data on the use of restrictive interventions are shown separately for inpatient and secure extended care units. As a result, the numbers of events listed below cannot be compared directly with those listed in reports prior to 2016–17. This change in practice standardises Victorian reporting modalities across a number of national data platforms.

Seclusion

Table 6 lists the numbers of episodes of seclusion in acute inpatient units per 1,000 occupied bed days. Rates have fallen in adult and specialist clinical program areas over the past five years and remain low in services for older people. Rates increased in child and youth services in 2018–19 because of the challenges presented by very small numbers of young people with complex combinations of mental illness and disability, and the small number of beds representing 1,000 bed days. Notwithstanding this, seclusion rates lay below the current statewide benchmark of 15 or fewer episodes per 1,000 occupied bed days in all program areas except for the forensic program. The OCP continues to work closely with Forensicare to develop strategies to reduce the use of restrictive interventions, with some improvement in practice since 2017–18.

Table 6: Seclusion episodes per 1,000 occupied bed days, by clinical program, 2014–15 to 2018–19

Clinical program	2014–15	2015–16	2016–17	2017–18	2018–19
Adult	10.3	11.9	11.3	10.4	9.2
Aged	0.8	1.0	1.8	1.2	0.7
Child and youth	5.5	5.5	5.4	8.8	12.1

Clinical program	2014–15	2015–16	2016–17	2017–18	2018–19
Forensic	11.7	13.1	28.7	34.3	26.8
Specialist	2.2	0.5	3.1	0.6	0.4
All programs	8.0	9.1	9.9	9.6	8.4

Table 7 shows that, when seclusion happened, it represented a single occurrence within the whole period of an admission. Multiple episodes of seclusion were relatively uncommon. This pattern has remained consistent in recent years.

Table 7: Frequency of seclusion episodes within a single admission, 2014–15 to 2018–19

Number of episodes	2014–15	2015–16	2016–17	2017–18	2018–19
1	860	903	950	894	868
2	253	260	258	242	223
3	94	118	96	119	101
4	54	61	54	54	53
5	35	52	35	30	28
6	15	20	28	23	16
7+	49	76	77	70	64

In 2018–19 seclusion episodes that lasted four or fewer hours accounted for 52 per cent of all episodes compared with 43 per cent in the previous year (Table 8).

Table 8: Duration (hours) of acute inpatient seclusion episodes, 2014–15 to 2018–19

Duration	2014–15	2015–16	2016–17	2017–18	2018–19
Fewer than 4 hours	1,509	1,735	1,624	1,504	1,652
4–12 hours	646	730	862	908	709
More than 12 hours	533	660	995	1,066	817

Restraint

Bodily restraint refers to physical restraint (placing hands on a person to restrict movement) and mechanical restraint (the use of devices, such as belts, for the same purpose). Applying mechanical restraint typically involves using physical restraint for very brief periods. The Act requires that mental health services inform the Chief Psychiatrist of both types of practice.

Table 9 shows bodily (physical and mechanical) restraint episodes per 1,000 occupied bed days in acute inpatient units over a four-year period. Rates rose in adult, child and youth and forensic programs. This most probably reflects a clearer understanding of, and compliance with, reporting requirements achieved through close engagement with the OCP. As mentioned already, the growing clinical complexity encountered on child and adolescent wards also makes a contribution.

Table 9: Bodily restraint episodes per 1,000 occupied bed days, 2015–16 to 2018–19

Program	2015–16	2016–17	2017–18	2018–19
Adult	9.8	8.4	8.9	10.4
Aged	5.0	7.3	6.4	5.9
Child and youth	13.9	17.8	33.4	45.3
Forensic	172.4	115.8	146.6	162.1
Specialist	1.8	1.1	1.1	0.5
All programs	25.6	19.0	22.6	25.7

Table 10 shows that physical restraint accounted for the vast majority of instances. The increase in numbers in 2018–19 most probably reflects improved reporting of those very brief periods of hands-on restraint associated with the move to seclusion rooms or administering injected medications.

Table 10: Type of restraint episodes, 2015–16 to 2018–19

Restraint type	2015–16	2016–17	2017–18	2018–19
Physical	7,380	6,433	8,321	9,991
Mechanical	1.049	496	350	384
Physical and mechanical	1.062	301	169	118

When restraint was applied, it typically represented a single occurrence within the whole period of an admission (Table 11). Multiple episodes of restraint were relatively uncommon. This pattern has remained consistent in recent years.

Table 11: Frequency of restraint episodes within the same hospital admission, 2015–16 to 2018–19

Number of episodes	2015–16	2016–17	2017–18	2018–19
1	809	843	863	960
2	274	210	279	277
3	98	98	112	134
4	59	69	64	69
5	39	28	34	53
6	17	26	26	32
7+	116	124	133	165

With respect to duration, the number of episodes of any type of restraint in excess of 12 hours has fallen by 71 per cent relative to 2015–16 (Table 12). As with Table 11, the increase in numbers in 2018–19 for restraint episodes fewer than three minutes most probably reflects improved reporting of very brief periods of hands-on restraint associated with the move to seclusion rooms or the administration of injected medications. This approach, consistent with the Mental Health Act, facilitates the opportunity for alternative strategies, such as sensory modulation, change of environment and activity, to be used.

Table 12: Duration of physical, mechanical and combined restraint episodes, 2015–16 to 2018–19

Duration	2015–16	2016–17	2017–18	2018–19
Fewer than 3 minutes	4,978	3,479	4,807	6,082
3–14 minutes	3,825	3,010	3,416	3,785
15–59 minutes	339	325	339	335
1 to fewer than 4 hours	186	282	166	219
4 to fewer than 12 hours	73	89	66	46
12 or more hours	90	45	42	26

Appendix: Restrictive interventions in secure extended care units

Data on the use of restrictive interventions in secure extended care units (SECUs) is provided separately.

Seclusion

Table A1 shows that seclusion episodes per 1,000 occupied bed days in SECUs fell relative to 2017–18 and remains below the levels reported in 2015–16.

Table A1: SECU seclusion episodes per 1,000 occupied bed days, 2014–15 to 2018–19

Seclusion episodes	2014–15	2015–16	2016–17	2017–18	2018–19
Number of episodes	2.8	2.0	2.5	2.8	1.7

Most seclusion episodes represented a single occasion of seclusion within an episode of admission to a SECU (Table A2).

Table A2: Frequency of SECU seclusion episodes within the same admission, 2014–15 to 2018–19

Number of episodes	2014–15	2015–16	2016–17	2017–18	2018–19
1	21	24	19	21	23
2	7	6	9	11	5
3	4	2	4	4	2
4	2	2	2	3	1
5	1	–	–	1	–
6	3	1	1	2	1
7+	4	3	3	3	3

More than half of all episodes (68 per cent) of seclusion lasted fewer than four hours (Table A3).

Table A3: Duration (hours) of SECU seclusion episodes, 2014–15 to 2018–19

Duration	2014–15	2015–16	2016–17	2017–18	2018–19
Fewer than 4 hours	71	47	41	68	47
4–12 hours	32	19	37	28	21
More than 12 hours	9	19	25	26	12

Restraint

In 2018–19 the use of restraint in SECUs fell slightly after an increase in the previous year (Table A4).

Table A4: SECU bodily restraint episodes per 1,000 occupied bed days, 2015–16 to 2018–19

Bodily restraint episodes	2015–16	2016–17	2017–18	2018–19
Number of episodes	3.0	2.2	2.9	2.7

Most people who were restrained were restrained on a single occasion (Table A5).

Table A5: Frequency of SECU restraint episodes within the same admission, 2015–16 to 2018–19

Number of restraint episodes within the same admission	2015–16	2016–17	2017–18	2018–19
1	14	27	17	28
2	6	2	4	6
3	4	1	8	5
4	2	3	2	1
5	1	–	1	–
6	–	–	1	–
7+	5	4	5	6

Most episodes of restraint involved physical rather than mechanical restraint (Table A6).

Table A6: Type of SECU restraint episodes, 2015–16 to 2018–19

Restraint type	2015–16	2016–17	2017–18	2018–19
Physical	103	85	121	105
Mechanical	19	5	7	16
Physical and mechanical	5	2	–	1

More than half of the episodes of restraint (58 per cent) lasted fewer than three minutes (Table A7).

Table A7: Duration of SECU physical, mechanical and combined restraint episodes, 2015–16 to 2018–19

Duration	2015–16	2016–17	2017–18	2018–19
Fewer than 3 minutes	55	40	58	70
3–15 minutes	50	44	58	37
16–59 minutes	20	4	8	6
1 to fewer than 4 hours	1	3	3	9
4–11 hours	1	1	1	–
12 or more hours	–	–	–	–

Royal Commission into
Victoria's Mental Health System

ATTACHMENT NC-8

This is the attachment marked 'NC-8' referred to in the witness statement of Dr Neil Coventry dated 29 July 2020.

Victorian Agency for Health Information

Impact of COVID-19 on mental health services in Victoria

Preliminary measures of access, activity and outcomes

Report for week commencing 1 June 2020

VICTORIA State Government

About the report

This report has been prepared by the Victorian Agency for Health Information (VAHI) to provide the Department of Health and Human Services with regular information on select measures of access, activity and outcomes arising from publicly-funded mental health (MH) and alcohol and other drug (AoD) treatment services in Victoria. Its development was prompted by the COVID-19 pandemic, and the need for regular information to support greater understanding of its impact.

New to this edition are measures concerning aspects of AoD treatment services, including new clients, commenced service events and client-reported outcomes at assessment. For future issues, we will continue to explore ways to measure different aspects of the COVID-19 impact on Victorians, which may include:

- ambulance attendances for MH and AoD-related issues
- contacts to mental health support lines and other support services
- clinician and consumer-reported outcome measures for consumers accessing clinical mental health services (i.e. HoNOS, BASIS-32).

Clinical mental health data in the report should be considered alongside more detailed information available within quarterly mental health performance reports. These quarterly reports present information specific to adult, older persons, child, youth and adolescent, extended treatment and forensic mental health settings, and can be accessed at: https://www2.health.vic.gov.au/mental-health/research-and-reporting/mental-health-performance-reports.

In addition to Victorian data in this report, the Commonwealth is developing regular reports on funded primary care activity (MBS, telehealth and crisis lines/online services). The Commonwealth has indicated they hope to share reporting with jurisdictions.

Feedback on this report is welcome, and can be provided to:

Director Health System Reporting, VAHI
vahi@vahi.vic.gov.au

About the data

Data used to calculate the measures in this report were sourced from the following data collections. Under the Department's *Policy and Funding* Guidelines, timelines for data submission by service providers differ by collection. This report includes the latest available data from these collections based on their respective data submission timelines, along with a same period last year (SPLY) comparison were available.

	Submission timelines
Mental Health Community Support Services Minimum Dataset (MHCSS)	30 days post quarter
Mental Health Triage Minimum Dataset	15th of every month
Victorian Alcohol and Drug Collection (VADC)	15th of every month
Victorian Emergency Minimum Dataset (VEMD)	5pm each weekday[i]
Client Management Interface / Operational Data Store (CMI/ODS)	Twice daily (Admissions, transfers, seps.) 10th of every month (contacts, outcomes, seclusion)

Contents

Emergency department presentations

Number of mental health-related presentations to ED

Mental health-related emergency department presentations include those with one or more of the following recorded: diagnosis of ICD-10AM F01-F99 code; psychiatric examination; suicide attempt, ideation or risk recorded; discharged to a mental health bed, unit or residential facility; referred by a mental health clinician or advisory line; and those apprehended under section 351 of the *Mental Health Act 2014*. Reported by departure date.

Excludes Type of Visit Code '19' (COVID-19 Assessment Clinic), and Triage Category '6' (Dead on Arrival).

Source: VEMD.
Date extracted: 29 May 2020.

Latest 30 day avg.: (28 May 2020)	SPLY:	Variance: (%)
244	262	-6.9%

Number of mental health-related presentations to ED, patients aged under 18 years

Reports mental health-related emergency department presentations, excluding patients aged 18 years and over, and those with an unknown or unidentified age. Reported by departure date.

Excludes Type of Visit Code '19' (COVID-19 Assessment Clinic), and Triage Category '6' (Dead on Arrival).

Source: VEMD.
Date extracted: 29 May 2020.

Latest 30 day avg.: (28 May 2020)	SPLY:	Variance: (%)
30	35	-14.3%

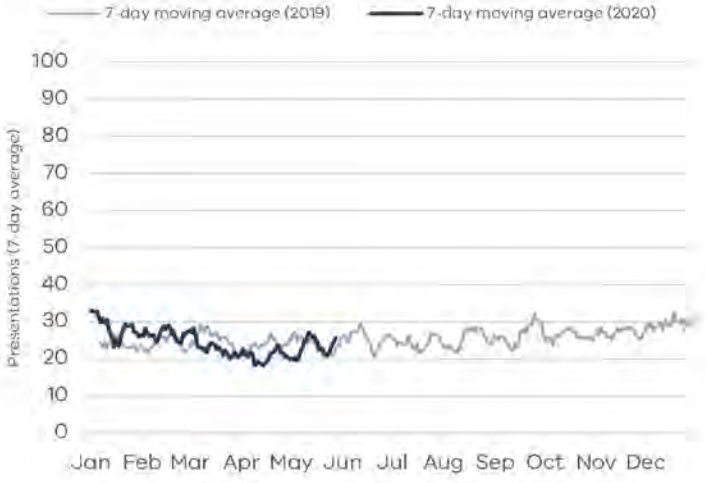
Number of mental health-related presentations to ED, patients aged 65 years and over

Reports mental health-related emergency department presentations, excluding patients aged 18 years and over, and those with an unknown or unidentified age.

Reported by departure date.

Excludes Type of Visit Code '19' (COVID-19 Assessment Clinic), and Triage Category '6' (Dead on Arrival).

Source: VEMD.
Date extracted: 29 May 2020.



Latest 30 day avg.: (28 May 2020)	SPLY:	Variance: (%)
24	24	0.0%

Emergency department presentations

Number of intentional self-harm presentations to ED

Intentional self-harm emergency department presentations include those with a recorded human intent code of '2', '18', '19', '20' (intentional self-harm), and/or those with a primary, secondary or tertiary diagnosis of 'R4581' (suicide attempt / ideation). Reported by departure date.

Excludes Type of Visit Code '19' (COVID-19 Assessment Clinic), and Triage Category '6' (Dead on Arrival).

Source: VEMD.
Date extracted: 29 May 2020.

Latest 30 day avg.: 60 (28 May 2020) **SPLY:** 67 **Variance:** -10.4% (%)

Number of alcohol and other drug-related presentations to ED

Alcohol and other drug-related emergency department presentations include those with a range of primary or additional diagnoses, and/or departure code of '10'. Refer to appendix 1 for details. Reported by departure date.

Excludes Type of Visit Code '19' (COVID-19 Assessment Clinic), and Triage Category '6' (Dead on Arrival).

Source: VEMD.
Date extracted: 29 May 2020.

Latest 30 day avg.: 66 (28 May 2020) **SPLY:** 71 **Variance:** -7.0% (%)

Suicide surveillance

The most recent suicide data surveillance is for the week May 22 to May 28 2020. The number of deaths is in what would be considered the normal range.

For Victoria as a whole, and for regional Victoria the number of deaths for the month 29 April to 28 May is the lowest figure for any of the previous 12 months. The number of deaths for the month for the regional areas is also the lowest figure for any of the previous 12 months.

There is no substantial variation from expected patterns when breakdown of the information by age range or sex is considered in review of the data over the past week or month.

Mental health triage services

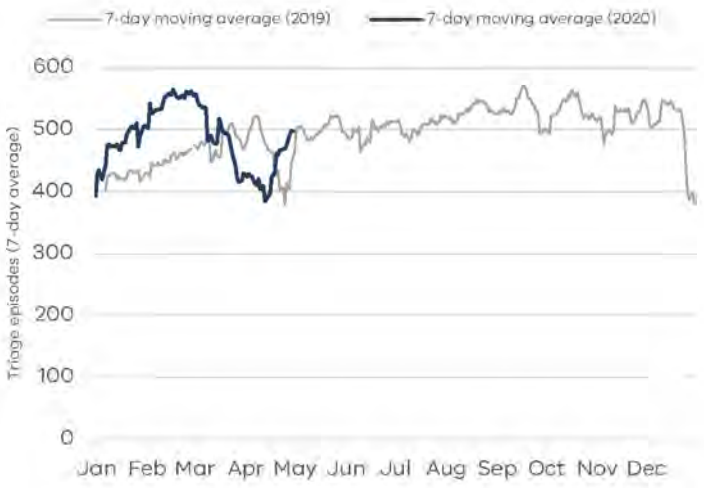
Refer to appendix 2 for a description of mental health triage services and triage scales.

Number of mental health triage episodes

Reports the number of mental health triage contacts resulting in a triage scale being assigned.

Excludes mental health triage data for Goulburn Valley Health and Royal Children's Hospital.

Data source: Mental Health Triage MDS. Date extracted: 28 May 2020.



Latest 30 day avg: 446 (30 Apr 2020) **SPLY:** 469 **Variance:** -4.9% (%)

Number of mental health triage episodes with triage scale 'A' or 'B' – emergency or crisis response required

Reports the number of mental health triage contacts resulting in a triage scale 'A' or 'B' being assigned (emergency services or crisis response required).

Excludes mental health triage data for Goulburn Valley Health and Royal Children's Hospital.

Data source: Mental Health Triage MDS. Date extracted: 28 May 2020.

Latest 30 day avg: 52 (30 Apr 2020) **SPLY:** 50 **Variance:** +4.0% (%)

Mental health triage services

Number of mental health triage episodes with triage scale 'C' or 'D' – urgent or semi-urgent response required

Reports the number of mental health triage contacts resulting in a triage scale 'C' or 'D' being assigned urgent or semi-urgent response required).

Excludes mental health triage data for Goulburn Valley Health and Royal Children's Hospital.

Data source: Mental Health Triage MDS. Date extracted: 28 May 2020.

Latest 30 day avg: 91 (30 Apr 2020) **SPLY:** 99 **Variance:** -8.1% (%)

Number of mental health triage episodes with triage scale 'E' - non-urgent response required

Reports the number of mental health triage contacts resulting in a triage scale 'E' being assigned (non-urgent response required).

Excludes mental health triage data for Goulburn Valley Health and Royal Children's Hospital.

Data source: Mental Health Triage MDS. Date extracted: 28 May 2020.

Latest 30 day avg: 102 (30 Apr 2020) **SPLY:** 120 **Variance:** -15.0% (%)

Number of mental health triage episodes with triage scales 'F' or 'G' - no mental health service response required

Reports the number of mental health triage contacts resulting in a triage scales 'F' or 'G' being assigned (no mental health response required).

Includes triage episodes resulting the provision of advice or information, or a referral to an alternative provider.

Excludes mental health triage data for Goulburn Valley Health and Royal Children's Hospital.

Data source: Mental Health Triage MDS. Date extracted: 28 May 2020.

Latest 30 day avg: 201 (30 Apr 2020) **SPLY:** 200 **Variance:** +0.5% (%)

Consumers accessing clinical mental health services

Number of 'active' mental health consumers

Reports the distinct count of consumers in an open acute/subacute inpatient or residential episode, or those with a recorded ambulatory contact within the preceding 90 days.

Data source: CMI/ODS.
Date extracted: 15 May 2020.

Latest 30 day avg: (30 Apr 2020)	40,194	**SPLY:**	40,335	**Variance:** (%)	-0.3%

Number of new consumers accessing clinical mental health services

Reports the distinct count of consumers in an open acute/subacute inpatient or residential episode, or those with a recorded ambulatory contact within the preceding 90 days, who have not previously accessed clinical mental health services in the last 5 years.

Data source: CMI/ODS.
Date extracted: 15 May 2020.

Latest 30 day avg: (30 Apr 2020)	54	**SPLY:**	63	**Variance:** (%)	-14.3%

Bed-based clinical mental health services

Net operational bed capacity since 1 July 2019

Reports the net number of operational acute, subacute and residential mental health beds since the start of 2019-20.

Data source: CMI/ODS.
Date extracted: 22 May 2020.

Latest 30 day avg: -13 beds (21 May 2020)

Latest 60 day avg: -5 beds (21 May 2020)

Number of admissions to an acute mental health inpatient unit – all settings

Reports the number of admissions to all acute inpatient units, including within adult, older person, child youth and adolescent and forensic mental health settings. At an individual unit level, this measure is based on the originating inpatient unit. Consumers may be subsequently transferred to other units at the same campus during the same admitted episode. Includes same day stays.

Data source: CMI/ODS.
Date extracted: 22 May 2020.

Latest 30 day avg: 75 (21 May 2020) **SPLY:** 75 **Variance:** 0.0% (%)

Bed occupancy, excluding leave – adult acute

Reports bed occupancy within adult acute inpatient units, excluding leave.

Excludes Orygen.

Data source: CMI/ODS.
Date extracted: 22 May 2020.

Latest 30 day avg: 89% (21 May 2020) **SPLY:** 93% **Variance:** -4% (nominal)

Bed-based clinical mental health services

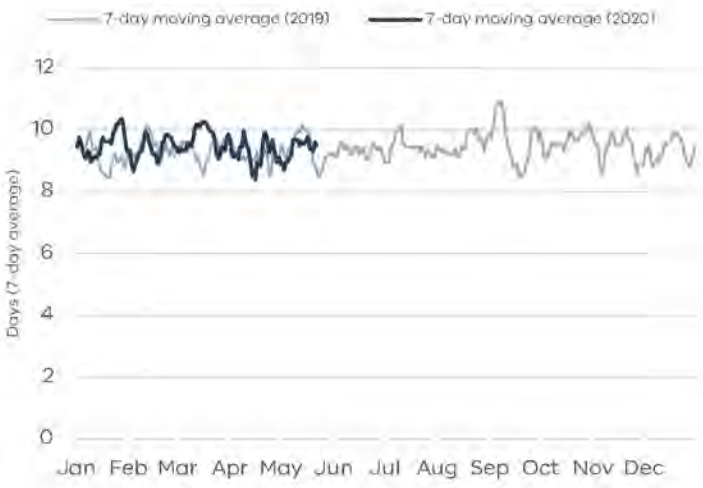
Trimmed average length of stay (days) within an inpatient unit (≤35 days) – adult acute

Reports the average length of stay (days) of separations from an inpatient unit, excluding same day stays and separations with an average length of stay greater than 35 days.

Measure calculation is based on episode start and end dates and not individual admission events within an episode.

Excludes Orygen.

Data source: CMI/ODS.
Date extracted: 22 May 2020.



Latest 30 day avg: 9.3 (22 May 2020) **SPLY:** 9.3 **Variance:** 0.0% (%)

Percentage of ended inpatient episodes with 'significant improvement' – adult acute

Reports the percentage of ended inpatient episodes with a 'significant' positive change in HoNOS calculation between admission and separation from an inpatient unit.

A 'significant' improvement is considered to have occurred when there is a positive variance of >0.5, as calculated by measuring the difference between valid HoNOS scores at inpatient admission and separation, and dividing by the standard deviation of admission HoNOS scores.

Excludes Orygen.

Data source: CMI/ODS.
Date extracted: 15 May 2020.

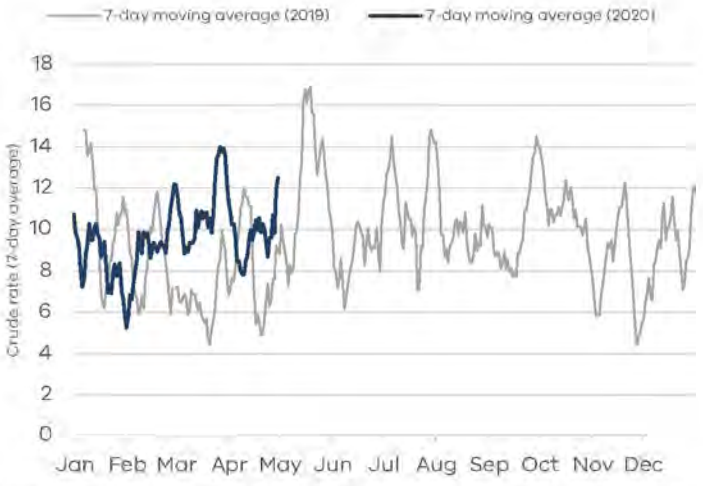
Latest 30 day avg: 78% (30 Apr 2020) **SPLY:** 77% **Variance:** +1% (nominal)

Rate of seclusion episodes per 1,000 occupied bed days within an inpatient unit – adult acute

Reports the crude rate of ended seclusion episodes per 1,000 occupied bed days within inpatient units, excluding leave, same day stays and units that do not have a seclusion room.

Excludes Orygen.

Data source: CMI/ODS.
Date extracted: 15 May 2020.



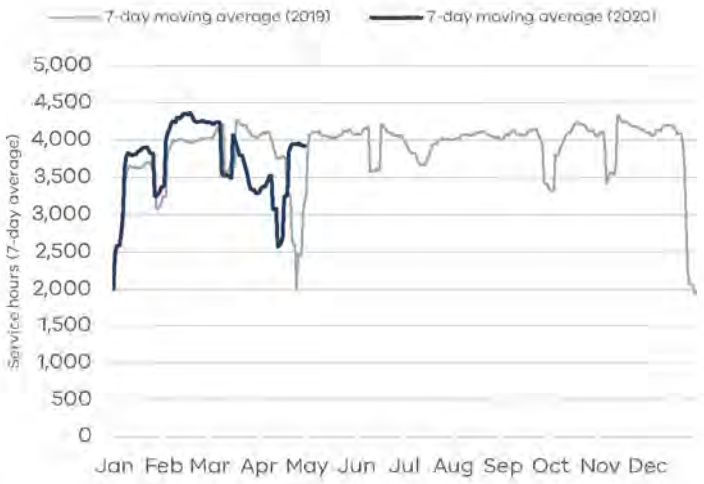
Latest 30 day avg: 9.9 (30 Apr 2020) **SPLY:** 8.6 **Variance:** +15.1% (%)

Community-based clinical mental health services

Number of ambulatory service hours

Reports type 'A' & 'E' registered, type 'B' unregistered and type 'C' community contacts." Service Hours" is defined as contact hours adjusted for group session contacts. (For group contacts – multiply contact duration by number of Healthcare Professionals present, and divide by the number of patients involved). Note that 1) Veterans, CEED & The Bouverie Centre contacts and 2) contacts recorded against inpatient or residential program types, are excluded.

Data source: CMI/ODS.
Date extracted: 15 May 2020.



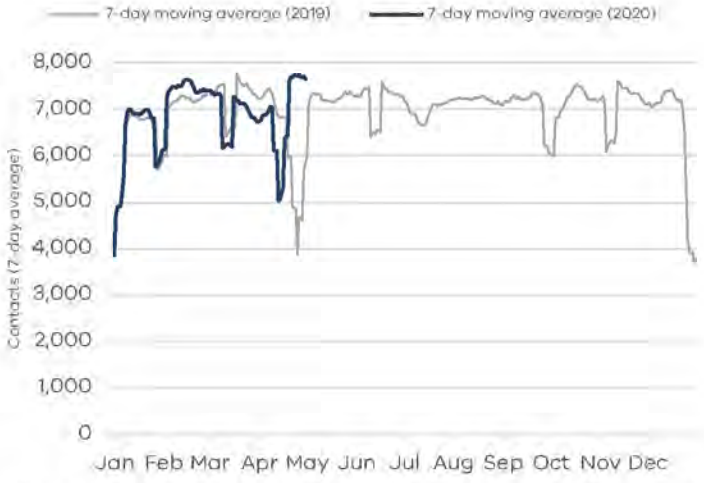
Latest 30 day avg: 3,599 (30 Apr 2020) **SPLY:** 3,533 **Variance:** +1.9% (%)

Number of ambulatory service contacts

Reports the number of service contacts, by sector, including type 'A' and 'E' registered, type 'B' unregistered and type 'C' community contacts, and excluding (a) Veterans, CEED and the Bouverie Centre contacts and (b) contacts recorded against inpatient or residential program types.

Service contacts are defined as contacts adjusted for group session contacts. For group session contacts, contact duration is multiplied by the number of healthcare professionals present, and divided by the number of consumers involved.

Data source: CMI/ODS.
Date extracted: 15 May 2020.



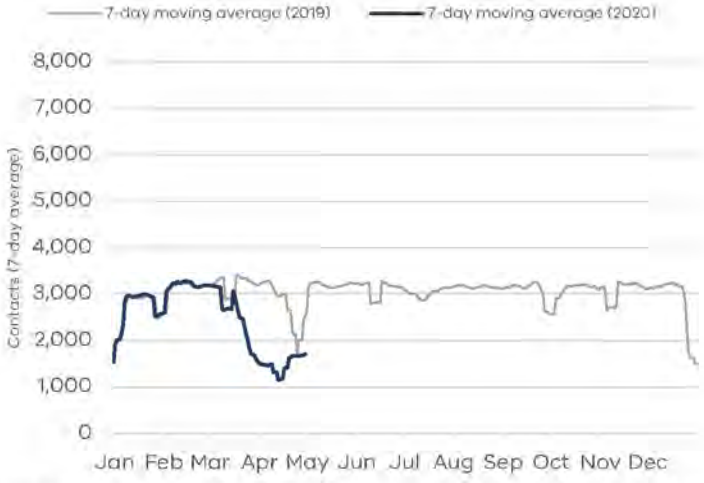
Latest 30 day avg: 7,081 (30 Apr 2020) **SPLY:** 6,447 **Variance:** +9.8% (%)

Number of direct (face-to-face) ambulatory service contacts

Reports the number of face-to-face service contacts where the provider was in the same room as the consumer, including type 'A' and 'E' registered, type 'B' unregistered and type 'C' community contacts, and excluding (a) Veterans, CEED and the Bouverie Centre contacts and (b) contacts recorded against inpatient or residential program types.

Service contacts are defined as contacts adjusted for group session contacts. For group session contacts, contact duration is multiplied by the number of healthcare professionals present, and divided by the number of consumers involved.

Data source: CMI/ODS.
Date extracted: 15 May 2020.



Latest 30 day avg: 1,551 (30 Apr 2020) **SPLY:** 2,816 **Variance:** -44.9% (%)

Community-based clinical mental health services

Number of ambulatory service contacts by telephone

Reports the number of service contacts where the provider contacted the consumer by telephone, including type 'A' and 'E' registered, type 'B' unregistered and type 'C' community contacts, and excluding (a) Veterans, CEED and the Bouverie Centre contacts and (b) contacts recorded against inpatient or residential program types.

Service contacts are defined as contacts adjusted for group session contacts. For group session contacts, contact duration is multiplied by the number of healthcare professionals present, and divided by the number of consumers involved.

Data source: CMI/ODS.
Date extracted: 15 May 2020.

Latest 30 day avg: 4,263 (30 Apr 2020) **SPLY:** 3,031 **Variance:** +40.6% (%)

Number of ambulatory service contacts by videoconference / teleconference

Reports the number of service contacts where the provider contacted the consumer via teleconference / videoconference, including type 'A' and 'E' registered, type 'B' unregistered and type 'C' community contacts, and excluding (a) Veterans, CEED and the Bouverie Centre contacts and (b) contacts recorded against inpatient or residential program types.

Service contacts are defined as contacts adjusted for group session contacts. For group session contacts, contact duration is multiplied by the number of healthcare professionals present, and divided by the number of consumers involved.

Data source: CMI/ODS.
Date extracted: 15 May 2020.

Latest 30 day avg: 352 (30 Apr 2020) **SPLY:** 11 **Variance:** +3,100% (%)

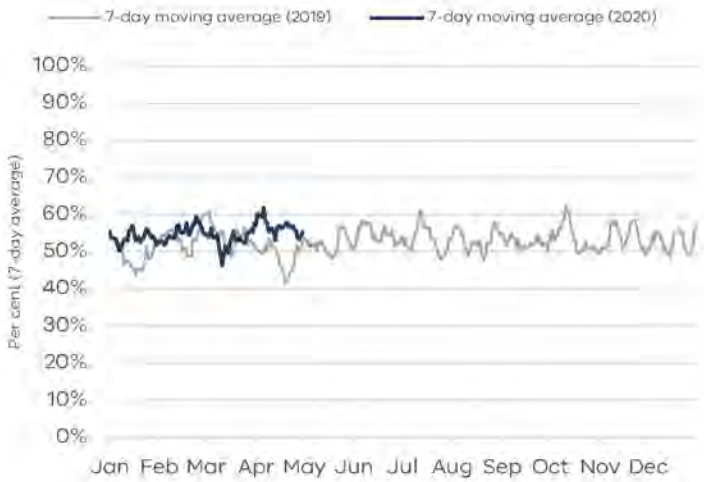
Percentage of ended community cases with 'significant improvement' - adult

Reports the percentage of completed community cases with a 'significant' positive change in HoNOS calculation between intake and case end.

A 'significant' improvement is considered to have occurred when there is a positive variance of >0.5, as calculated by measuring the difference between valid HoNOS scores at intake and case closure, and dividing by the standard deviation of intake HoNOS scores.

Excludes Orygen.

Data source: CMI/ODS.
Date extracted: 15 May 2020.



Latest 30 day avg: 57% (30 Apr 2020) **SPLY:** 49% **Variance:** +8% (nominal)

Community-based clinical mental health services

Number of direct (face-to-face) contacts within 7-days of separation from an inpatient unit – adult acute

Reports the number of discharged inpatients to private residence / accommodation from an adult acute inpatient unit who received a direct (face-to-face) contact within 7 days post-separation. Excludes same day stays.

Excludes Orygen.

Data source: CMI/ODS.
Date extracted: 15 May 2020.

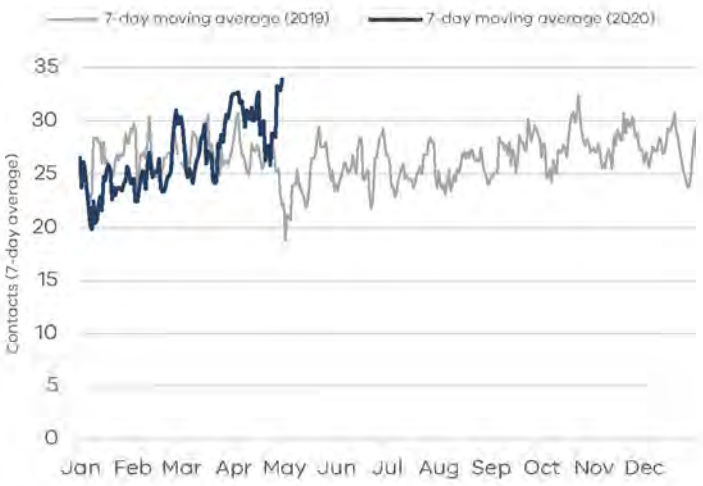
Latest 30 day avg: 8 (30 Apr 2020) **SPLY:** 15 **Variance:** -46.7% (%)

Number of contacts via telephone within 7-days of separation from an inpatient unit – adult acute

Reports the number of discharged inpatients to private residence / accommodation from an adult acute inpatient unit who received a contact via telephone within 7 days post-separation. Excludes same day stays.

Excludes Orygen.

Data source: CMI/ODS.
Date extracted: 15 May 2020.



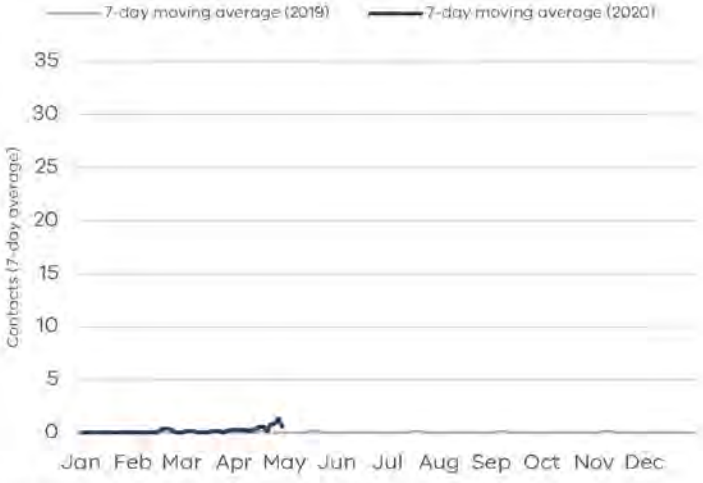
Latest 30 day avg: 31 (30 Apr 2020) **SPLY:** 26 **Variance:** +19.2% (%)

Number of contacts via video or teleconference within 7-days of separation from an inpatient unit – adult acute

Reports the number of discharged inpatients to private residence / accommodation from an adult acute inpatient unit who received a contact via video or teleconference within 7 days post-separation. Excludes same day stays.

Excludes Orygen.

Data source: CMI/ODS.
Date extracted: 15 May 2020.



Latest 30 day avg: 1 (30 Apr 2020) **SPLY:** 0 **Variance:** n/a (%)

Mental health community support services

Mental health community support services (MHCSS) are distinct from clinical mental health services, and play a vital role in supporting people with a severe mental illness and psychiatric disability throughout the recovery process.

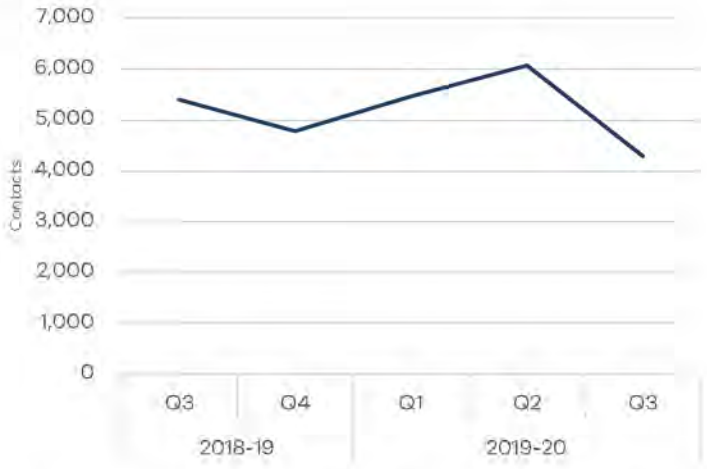
MHCSS support people with psychiatric disability to manage their self-care, improve social and relationship skills and achieve broader quality of life via physical health, social connectedness, housing, education and employment.[ii]

Number of MHCSS contacts

Reports the number of contacts recorded by MHCSS service providers. Data are available as quarterly aggregates only.

Data impacted by the transfer of mental health community support services to the NDIS. Interpret with caution.

Data source: MHCSS MDS.
Date extracted: 4 May 2020.



Latest: 4,295 (2019-20 Q3) **SPLY:** 5,401 **Variance:** -20.5% (%)

Alcohol and other drug treatment services

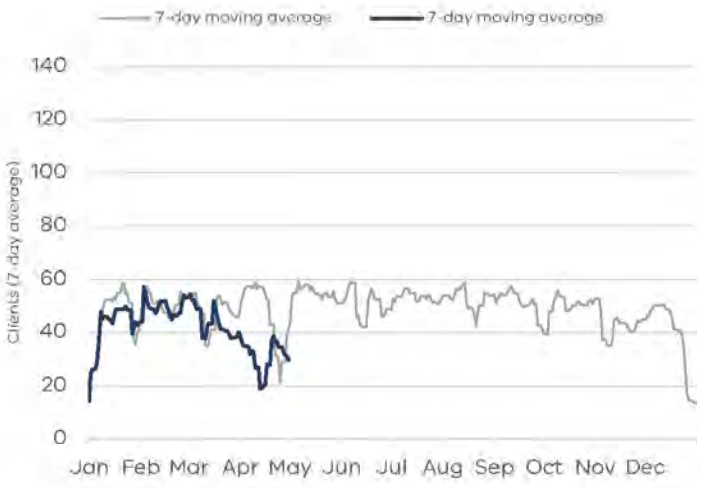
Number of new clients accessing alcohol and other drug treatment services

Reports the number of active clients accessing AoD treatment services who had not accessed AoD treatment services within the last five years.

The downward trend from March 2020 may be due to clients assuming services had closed and not seeking treatment, residential providers reducing service capacity to comply with social distancing requirements and community providers initially slowing service delivery as they pivoted to telehealth delivery modes.

This measure is sourced from the Victorian Alcohol and Drug Collection (VADC) which was established during 2018-19. Data quality and completeness issues have been observed during its establishment. Interpret with caution.

Data source: VADC.
Date extracted: 15 May 2020.



Latest 30 day avg: 31 (30 Apr 2020) **SPLY:** 49 **Variance:** -36.7% (%)

Number of commenced intake or comprehensive assessment events

Intake and assessment events are used to determine whether a client seeking help for drug use requires treatment and which treatment type they should receive.

The downward trend from March 2020 may be due to clients assuming services had closed and not seeking treatment, residential providers reducing service capacity to comply with social distancing requirements and community providers initially slowing service delivery as they pivoted to telehealth delivery modes.

This measure is sourced from the Victorian Alcohol and Drug Collection (VADC) which was established during 2018-19. Data quality and completeness issues have been observed during its establishment. Interpret with caution.

Data source: VADC.
Date extracted: 15 May 2020.

Latest 30 day avg: 69 (30 Apr 2020) **SPLY:** 102 **Variance:** -32.4% (%)

Alcohol and other drug treatment services

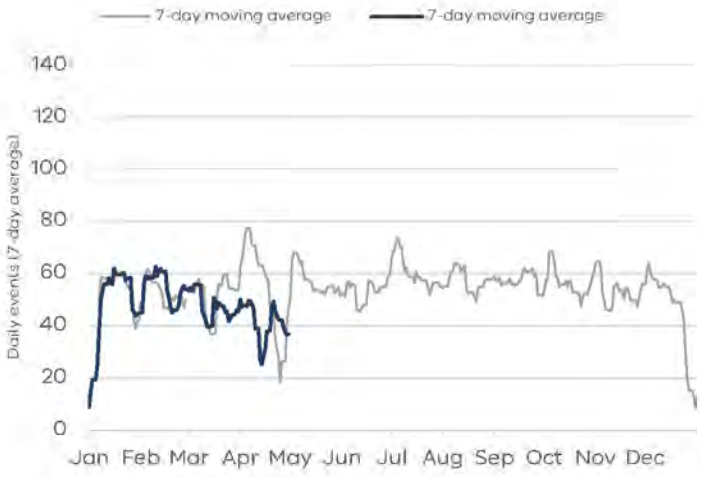
Number of commenced AoD community counselling events

Counselling is the primary community-based AoD treatment option.

The downward trend from March 2020 may be due to clients assuming services had closed and not seeking treatment, as well as community providers initially slowing service delivery as they pivoted to telehealth delivery modes.

This measure is sourced from the Victorian Alcohol and Drug Collection (VADC) which was established during 2018-19. Data quality and completeness issues have been observed during its establishment. Interpret with caution.

Data source: VADC.
Date extracted: 15 May 2020.



Latest 30 day avg: 42 (30 Apr 2020) **SPLY:** 56 **Variance:** -25.0% (%)

Number of commenced residential withdrawal treatment events

Residential withdrawal treatment supports complex clients to safely withdraw from substance dependence in a medically supervised setting.

The downward trend from March 2020 may be due to clients assuming services had closed and not seeking treatment, as well as reduced capacity at residential treatment services. Bed numbers at these services were reduced by around 30% by end of March in order to comply with COVID-19 social distancing requirements.

This measure is sourced from the Victorian Alcohol and Drug Collection (VADC) which was established during 2018-19. Data quality and completeness issues have been observed during its establishment. This likely explains the anomaly in results for April 2019. Interpret with caution.

Data source: VADC.
Date extracted: 15 May 2020.

Latest 30 day avg: 4 (30 Apr 2020) **SPLY:** 16 **Variance:** -75.0% (%)

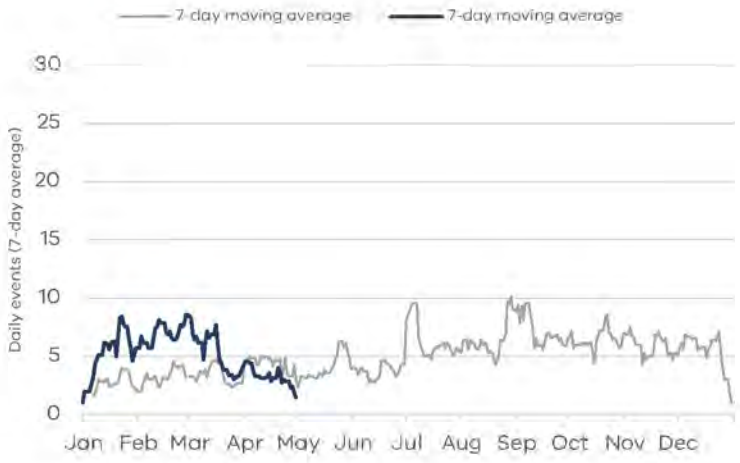
Alcohol and other drug treatment services

Number of commenced residential rehabilitation treatment events

The downward trend from March 2020 may be due to clients assuming services had closed and not seeking treatment, as well as reduced capacity at residential treatment services. Bed numbers at these services were reduced by around 30% by end of March in order to comply with COVID-19 social distancing requirements.

This measure is sourced from the Victorian Alcohol and Drug Collection (VADC) which was established during 2018-19. Data quality and completeness issues have been observed during its establishment. This likely explains the lower results for the first half of 2019. Interpret with caution.

Data source: VADC.
Date extracted: 15 May 2020.



Latest 30 day avg: 3 (30 Apr 2020) **SPLY:** 4 **Variance:** -25.0% (%)

Average Kessler Psychological Distress Scale (K10) scores at assessment

The Kessler Psychological Distress Scale is a client-reported outcome measurement scale which measures psychological distress based on 10 questions about anxiety and depressive symptoms experienced in the last four weeks. Higher scores are indicative of greater psychological distress at the time of seeking treatment for AoD use.

This measure is sourced from the Victorian Alcohol and Drug Collection (VADC) which was established during 2018-19. Data quality and completeness issues have been observed during its establishment. Interpret with caution.

Data source: VADC.
Date extracted: 15 May 2020.

Latest 30 day avg: 23 (30 Apr 2020) **SPLY:** 21 **Variance:** +9.5% (%)

Appendix 1: ICD-10AM codes for AoD-related ED presentations

Alcohol and other drug-related presentations to Victorian hospital emergency departments include presentations with a departure code of '10' (referred to an AoD service (including Counselling, Residential Withdrawal, Rehabilitation and Supported Accommodation)), and/or with one or more of the following primary or other diagnoses recorded.

F100 Simple intoxication of alcohol (excludes poisoning: T519)

F102 Alcohol dependence

F103 Mental & behavioural disorder due to alcohol use with withdrawal state

F104 Mental & behavioural disorder due to alcohol use with withdrawal state & delirium

F109 Mental & behavioural disorder due to alcohol

F110 Simple intoxication due to opioids (excludes poisoning: T402)

F112 Opioid dependence

F119 Mental & behavioural disorder due to opioids

F120 Simple intoxication of cannabinoids (excludes poisoning: T407

F129 Mental & behavioural disorder due to cannabis

F1300 Intoxication with unspecified sedative or hypnotic

F1301 Intoxication with GHB

F1309 Intoxication with other sedative or hypnotic

F1320 Unspecified sedatives or hypnotics dependence

F1390 Mental disorder due to unspecified sedative or hypnotic

F1391 Mental disorder due to GHB

F1399 Mental disorder due to other sedative or hypnotic

F140 Simple intoxication of cocaine (excludes poisoning: T405)

F149 Mental & behavioural disorder due to cocaine

F1500 Simple intoxication of stimulants (excludes poisoning: T409)

F1502 Intoxication with stimulants including caffeine

F1510 Mental & behavioural disorder due to harmful use of stimulants

F1590 Stimulants use disorder

F1600 Intoxication with unspecified hallucinogen

F1601 Intoxication with ketamine

F1609 Intoxication with other hallucinogen

F1690 Mental disorder due to unspecified hallucinogen

F1691 Mental disorder due to ketamine

F1699 Mental disorder due to other specified hallucinogen

F179 Mental & behavioural disorder due to tobacco

F180 Simple intoxication of volatile solvents (excludes poisoning: T529)

F189 Mental & behavioural disorder due to volatile solvents

F190 Simple intoxication of other or multiple drugs (excludes poisoning)

F192 Mental & behavioural disorder due to dependence on multiple drugs and psychoactive substances

F193 Mental & behavioural disorder due to multiple drug use & use of other psychoactive substance with withdrawal

F199 Mental & behavioural disorder due to other or multiple drugs
T400 Poisoning/overdose, Opium
T401 Poisoning/overdose, Heroin
T402 Poisoning/overdose, other opioids
T403 Poisoning/overdose, Methadone
T404 Poisoning/overdose, other synthetic narcotics (Pethidine)
T405 Poisoning/overdose, Cocaine
T406 Poisoning/overdose, other and unspecified narcotics
T407 Poisoning/overdose, Cannabis
T408 Poisoning/overdose, Lysergide (LSD)
T409 Poisoning/overdose, Psychodysleptic / hallucinogen
T4120 Poisoning due to general anaesthetic
T4121 Poisoning due to Gamma hydroxybutyrate (GHB)
T4122 Poisoning due to Ketamine
T4129 Poisoning due to other specified general anaesthetic
T414 Anaesthetic, unspecified
T424 Poisoning/overdose, Benzodiazepines / Alprazolam (Xanax)
T427 Poisoning/overdose, Sedative
T430 Poisoning/overdose, Tetracyclic antidepressant / Tricyclic antidepressant
T4361 Poisoning/overdose, Methamphetamine (ICE)
T4362 Ecstasy poisoning (MDMA)
T4369 Poisoning/overdose, Amphetamine / Methylenedioxymethamphetamine (Ecstasy)
T439 Poisoning/overdose, Psychotropic drug
T519 Toxic effect of alcohol
T520 Toxic effect of petroleum products
T529 Toxic effect of organic solvent (includes benzene, glycols, ketones)

Appendix 2: Description of mental health triage scales

Mental health triage is provided for all potential consumers (or people seeking assistance on behalf of a person thought to have a mental illness) at the first point of contact with mental health services. Triage may also be used for assessment of current and former consumers who make unplanned contact with the mental health service.

Triage is a clinical function. The role of the triage clinician is to conduct a preliminary assessment of whether a person is likely to have a mental illness or disorder, and the nature and urgency of the response required. Where it is considered that area mental health services are not the most appropriate option for the person, he/she should be referred to another organisation or given other advice.

Each consumer triaged by a triage unit of a mental health service is assigned one of the following triage scales.[iii]

A **Emergency services response: Current actions endangering self or others**

Action: Immediate referral. Triage clinician to notify ambulance, police and/or fire brigade.

B **Crisis mental health response: Very high risk of imminent harm to self or others**

Action: Within 2 hours. Crisis Assessment and Treatment Team (CATT) or equivalent face-to-face assessment and/or triage clinician advice to attend a hospital emergency department (where CATT cannot attend in timeframe of where the person required ED assessment/treatment).

C **Urgent mental health response: High risk of harm to self or others and/or high distress, especially in absence of capable supports**

Action: 2–12 hours. CATT, continuing care or equivalent face-to-face assessment within 12 hours and CATT, continuing care or equivalent telephone follow-up within one hour of triage contact.

D **Semi-urgent mental health response: Moderate risk of harm and/or significant distress**

Action: 12–48 hours. CATT, continuing care or equivalent face-to-face assessment.

E **Non-urgent mental health response: Low risk of harm in short term or moderate risk with high support/stabilising factors**

Action: Within 14 days. CATT, continuing care or equivalent face-to-face assessment.

F **Referral or advice to contact alternative service provider: Referral: not requiring face-to-face response from AMHS in this instance.**

Action: Triage clinician to provide formal or informal referral to an alternative service provider or advice to attend a particular type of service provider.

G **Advice or information only or more information needed: Advice or information only/service provider consultation/AMHS requires more information**

Action: Triage clinician to provide consultation, advice and/or brief counselling of require and/or mental health service to collect further information over telephone.

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[i] Department of Health and Human Services. HDSS Bulletin [Issue 227: 01 April 2020].

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