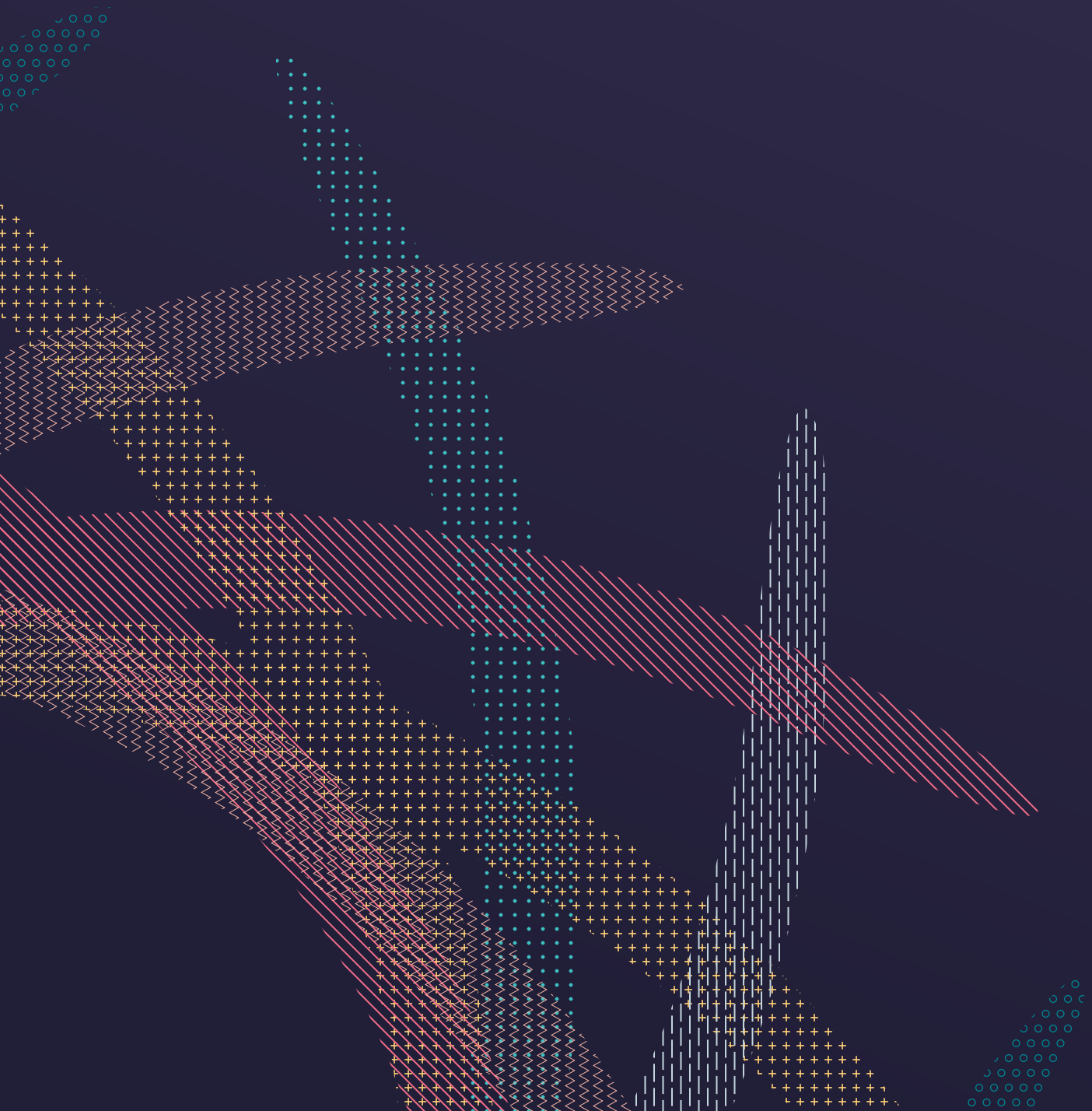
Royal Commission into
Victoria's Mental Health System

Final Report

Volume 1

A new approach to mental health and wellbeing in Victoria



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Victoria's Mental Health System

Volume 1
A new approach to mental health and wellbeing in Victoria

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Except where otherwise indicated, the images in this publication show models and illustrative settings only, and do not necessarily depict actual services, facilities or recipients of services. This publication may contain images of deceased Aboriginal and Torres Strait Islander peoples.

In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Indigenous' or 'Koori/Koorie' is retained when part of the title of a report, program or quotation.

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Letter of transmittal

Royal Commission into
Victoria's Mental Health System

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The Hon. Linda Dessau AC
Governor of the State of Victoria
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MELBOURNE VIC 3004

Your Excellency

In accordance with the Amended Letters Patent dated 26 May 2020, we have the honour of presenting to you the final report and recommendations of the Royal Commission into Victoria's Mental Health System.

It consists of five volumes and a summary:

Volume 1: A new approach to mental health and wellbeing in Victoria

Volume 2: Collaboration to support good mental health and wellbeing

Volume 3: Promoting inclusion and addressing inequities

Volume 4: The fundamentals for enduring reform

Volume 5: Transforming the system—innovation and implementation

Yours sincerely

Penny Armytage AM
Chairperson

Professor Allan Fels AO
Commissioner

Dr Alex Cockram
Commissioner

Professor Bernadette McSherry
Commissioner

3 February 2021

Acknowledgement of Aboriginal land and peoples

The heritage of Aboriginal communities throughout Victoria is vibrant, rich and diverse. We value these characteristics and consider them a source of strength and opportunity. We recognise that the leadership of Aboriginal communities and Elders in Victoria is crucial to improving outcomes for Aboriginal people. Also to be acknowledged, however, are the devastating impacts and the accumulation of trauma resulting from colonisation, genocide, the dispossession of land and children, discrimination and racism.

The Royal Commission into Victoria's Mental Health System proudly acknowledges Aboriginal people as the First Peoples and Traditional Owners and custodians of the land and water on which we rely. We acknowledge that Aboriginal communities are steeped in traditions and customs, and we respect this. We acknowledge the continuing leadership role of the Aboriginal community in striving to redress inequality and disadvantage, and the catastrophic and enduring effects of colonisation.

We recognise the diversity of Aboriginal people living throughout Victoria. Although the terms 'Koorie' and 'Koori' are commonly used to describe Aboriginal people of south-east Australia, we use the term 'Aboriginal' in this report to include all people of Aboriginal and Torres Strait Islander descent who are living in Victoria. This approach is consistent with the language conventions of key Victorian frameworks such as the *Aboriginal Affairs Framework 2018–2023*.

The Royal Commission is conscious that its work is taking place concurrently with renewed efforts to achieve constitutional recognition of Aboriginal peoples and treaty processes that are underway in Victoria. We commit to building on this momentum and to ensuring our work is shaped by the voice of Aboriginal people.

Contents

Foreword

The shared humanity of our community can be measured by the way we treat one another—including the kindness, compassion, dignity and respect we show. Empathy should enable us to reach out, understand and support people who are experiencing poor mental health or living with mental illness or psychological distress to fully and effectively participate in our society.

Yet historically, interest from successive governments and the community in mental health and wellbeing has been low. Despite the wide-ranging negative impacts, other priorities have been elevated ahead of mental health. This has resulted in a mental health system that fails to support, and in some instances even harms, those who turn to it. Demand has outstripped supply; the system reacts to mental health crises rather than preventing them; and the preferences of people living with mental illness or psychological distress are often ignored.

These are the characteristics of a 'broken' system. It has been labelled as such by the Premier, the Hon. Daniel Andrews MP,[1] and by countless people living with mental illness or psychological distress, families, carers and supporters, as well as by those working in the system. Ms Honor Eastly, a witness before the Commission, shared:

> **It wasn't until I started working in advocacy in the mid 2010s that I started to understand that a big part of what I was dealing and struggling with was a broken and traumatic system. I had, up until that point, thought that what was happening was because I was a broken and ill person.[2]**

Despite the system's failings, people have been treated with empathy and respect. As one person described: 'I was lucky to find the treating doctor that I have. She's saved my life dozens of times through compassionate, evidence-based care.'[3] These experiences, however, are few and far between.

In November 2019, the Commission delivered its interim report. It found that Victoria's mental health system had catastrophically failed to meet expectations and was woefully underprepared for current and future challenges. These include population growth, changing demographics, people's evolving expectations and unexpected disasters.

Despite the goodwill and commitment of many people who work in the system, it is hampered by historical and structural challenges that have emerged and persisted over several decades. Underinvestment, poor system planning, limited accountability and disregard for consumers' preferences have ensured good mental health and wellbeing remain a low priority across government and the community. Stigma and discrimination have entrenched this.

The implications for people living with mental illness or psychological distress, families, carers and supporters are stark. An undersupply of community-based services has contributed to an over-reliance on crisis responses and medication. Many people cannot access suitable services, and even when they can, services are difficult to navigate and often do not meet their needs. People are told they are not 'sick enough' to access specialist services. Human rights are breached unjustifiably through excessive use of coercive practices. Families, carers and supporters feel ignored by the system. Suicide continues to have a profound impact across communities.

People expect compassion and kindness from the system, but it can traumatise and retraumatise those it seeks to support.

The system's failures are relevant to everyone. Most Victorians, directly or indirectly, will experience poor mental health. It is incumbent on us, as a community, to ensure that mental health and wellbeing is not consigned to the shadows. Our families, friends, loved ones, neighbours and colleagues must be able to depend on a responsive and high-quality mental health and wellbeing system.

Despite the numerous reviews that have preceded this inquiry, royal commissions represent a unique opportunity to review systems because of their independence, neutrality and transparency.[4] Royal commissions can provide a lasting legacy and realise the hopes and ambitions held by many:

> It is appropriate that those who lead [royal commissions] and those who observe [royal commissions] appreciate the strategies they can use to raise the odds that they will leave enduring legacies of public value.[5]

This royal commission has examined the mental health system in its entirety, with a commitment to learn from those who have been affected—both positively and negatively—by the system. It has engaged extensively with people with lived experience of mental illness or psychological distress, families, carers and supporters, including people from diverse communities, Aboriginal Victorians, members of the workforce, academics, advocates and government officials.

Showing exceptional determination, people with lived experience have shared deeply personal stories in the hope of shaping a better future for themselves and others. Their experiences and perspectives have informed the Commission's reforms.

Building on the interim report's recommendations, this final report outlines a set of reforms to create a mental health and wellbeing system that is contemporary and adaptable. The future system is centred on a community-based model of care, where people can access treatment, care and support close to their homes and in their communities.

The new mental health and wellbeing system will be built on compassion. Many people with lived experience of mental illness or psychological distress, families, carers and supporters have shared with the Commission the difference compassionate responses can make:

> Compassion goes a long way. It helps you get a foot in the door—more than a foot. You're invited into that person's life and you can start a dialogue.[6]

The Commission's reforms also look beyond the system, recognising that other social services, such as housing, education and justice, and the places people live, work and connect, shape people's mental health and wellbeing. In this sense, good mental health and wellbeing is a responsibility shared by government and all members of the community. Victoria needs to be a place where people look out for one another, build social connections and treat others with empathy.

The future system will not be a collection of discrete reforms tacked on to an antiquated system, but a fundamental redesign.

While the case for change had already been established throughout 2019, great pressures were placed on the mental health system during the final term of the Commission's inquiry. This included the severe 2019–20 bushfire season and the COVID-19 pandemic. These events shone further light on the pressures on the mental health system, but also on how services were willing to adapt and respond.

The Commission's work has also coincided with an increased focus on mental health and wellbeing at both the state and Commonwealth levels. Political and cross-party interest at the highest levels of government is important if longstanding pleas to reform the mental health system are to be acted on. After decades of a failing system, there is great urgency that reform commences now. This requires strong political leadership to ensure change endures and for Victoria to be looked to as a leader.

The Commission has also observed an increase in open and respectful public discourse about the need for good mental health and wellbeing. This was apparent in the Commission's 2019 public hearings and has also been evident during the COVID-19 pandemic.

This goodwill matters.

People have engaged with the Commission openly, willingly and collaboratively. The Commission has consulted extensively to develop its recommendations and set out the steps for redesigning and implementing a responsive and high-quality mental health and wellbeing system.

A clear path for reform has been set and the momentum for change cannot be lost.

There must be leadership and collaboration between individuals, all levels of government, service providers, the workforce, related systems and the community for reform to last. Critically, people with lived experience must work together with mental health professionals and others to lead, shape and drive change.

Everyone must come together in a balanced, respectful and thoughtful way. Collaboration and mutual respect will be vital to realising the Commission's vision of a transformed mental health and wellbeing system.

Time is of the essence. Victorians should not have to wait any longer for services and supports that are accessible, humane and compassionate. Implementation should commence immediately.

The Commission extends its gratitude to everyone who has contributed and shaped its thinking.

The Commission commends this final report to the people of Victoria and the Governor of Victoria.

1 The Age, Commissioners Named in Bid to Fix State's "Broken" Mental Health System, 24 February 2019, p. 2.

2 *Witness Statement of Honor Eastly*, 14 September 2020, para. 67.

3 Anonymous 236, *Submission to the RCVMHS: SUB.0002.0021.0007*, 2019, p. 1.

4 Michael Mintrom, Deirdre O'Neill and Ruby O'Connor, 'Royal Commissions and Policy Influence', *Australian Journal of Public Administration*, (2020), 1–17 (p. 2).

5 Mintrom, O'Neill and O'Connor, p. 15.

6 *Witness Statement of 'Michael Silva' (pseudonym)*, 22 June 2020, para. 42.

A note on content

The Royal Commission recognises the strength of people living with mental illness or psychological distress, families, carers and supporters, and members of the workforce who have contributed their personal stories and perspectives to this inquiry.

Some of these stories and the Commission's analysis contain information that could be distressing. You might want to consider how and when you read this report.

Aboriginal readers are advised that this report may contain photos, quotations and/or names of people who are deceased.

If you are upset by any content in this report or if you or a loved one need support, the following services are available to support you:

- If you are not in immediate danger but you need help, call **NURSE-ON-CALL** on **1300 60 60 24**.
- For crisis support, contact **Lifeline** on **13 11 14**.
- For support, contact **Beyond Blue** on **1300 224 636**.
- If you are looking for a mental health service, visit **betterhealth.vic.gov.au**.
- **If you are in a situation that is harmful or life-threatening, contact emergency services immediately on Triple Zero (000)**.

Terminology and language

Language is powerful and words have various meanings for different people.

There is no single set of definitions used to describe how people experience their mental health. This diversity is reflected in the many terms used to capture people's experiences throughout the evidence put before the Commission.

As stated in the Commission's interim report, words and language can have a lasting impact on a person's life. They can empower and embolden. They can be used to convey hope and empathy. But they can also be divisive when used to dispossess and divide, and to stigmatise and label.

The Commission has considered the many perspectives on terminology, and acknowledges that language can be deeply contested and nuanced. Although it has at all times tried to use inclusive and respectful language, the Commission is aware that not everyone will agree with the terminology used.

Another consideration for the Commission has been this report's broad audience, including people with lived experience, their carers, families and supporters, workers in the mental health system, government and the wider Victorian community. This diverse audience needs to be able to read the report and understand its intent at this point in time in the development of the mental health system.

Below is a list of important terms in the report and how the Commission understands them. This list largely reflects the requirement to align with definitions outlined in the Commission's letters patent. It is also consistent with the Commission's interim report for the purposes of clarity.

Carer	Means a person, including a person under the age of 18 years, who provides care to another person with whom they are in a relationship of care.
Consumer	People who identify as having a living or lived experience of mental illness or psychological distress, irrespective of whether they have a formal diagnosis, who have used mental health services and/or received treatment.
Family	May refer to family of origin and/or family of choice.
Good mental health	A state of wellbeing in which a person realises their own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to their community.

Lived experience	People with lived experience identify either as someone who is living with (or has lived with) mental illness or psychological distress, or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness or psychological distress. People with lived experience are sometimes referred to as 'consumers' or 'carers'. The Commission acknowledges that the experiences of consumers and carers are different.
Mental health and wellbeing system	The Commission outlines in this report its vision for a future mental health and wellbeing system for Victoria. Mental health and wellbeing does not refer simply to the absence of mental illness but to creating the conditions in which people are supported to achieve their potential. As part of this approach, the Commission has also purposefully chosen to focus on the strengths and needs that contribute to people's wellbeing. To better reflect international evidence about the need to strike a balance between hospital-based services and care in the community, the types of treatment, care and support the future system offers will need to evolve and be organised differently to provide each person with dependable access to mental health services and links to other supports they may seek. The addition of the concept of 'wellbeing' represents a fundamental shift in the role and structure of the system.
Mental illness	A medical condition that is characterised by a significant disturbance of thought, mood, perception or memory. The Commission uses the above definition of mental illness in line with the *Mental Health Act 2014* (Vic). However, the Commission recognises the Victorian Mental Illness Awareness Council Declaration released on 1 November 2019. The declaration notes that people with lived experience can have varying ways of understanding the experiences that are often called 'mental illness'. It acknowledges that mental illness can be described using terms such as 'neurodiversity', 'emotional distress', 'trauma' and 'mental health challenges'.
Psychological distress	One measure of poor mental health, which can be described as feelings of tiredness, anxiety, nervousness, hopelessness, depression and sadness. This is consistent with the definition accepted by the National Mental Health Commission.
Social and emotional wellbeing	Being resilient, being and feeling culturally safe and connected, having and realising aspirations, and being satisfied with life. This is consistent with *Balit Murrup*, Victoria's Aboriginal social and emotional wellbeing framework.

Treatment, care and support	The Commission uses this phrase consistently with its letters patent. This phrase has also been a deliberate choice throughout this report to present treatment, care and support as fully integrated, equal parts of the way people will be supported in the future mental health and wellbeing system. In particular, wellbeing supports (previously known as 'psychosocial supports') that focus on rehabilitation, wellbeing and community participation will sit within the core functions of the future system.

The Commission only departs from these terms when referring to specific data sources, describing research works, or quoting an individual or organisation. The original language is retained wherever possible to accurately reflect the views and evidence presented to the Commission. For example, the Commission quotes individuals and organisations that sometimes refer to 'mental disorder', rather than the Commission's preferred terms of 'mental illness or psychological distress'. Terms such as 'disorder' can be pathologising and stigmatising, so the Commission only retains them if others use them to convey a specific meaning.

Personal stories and case studies

Throughout all phases of its work, the Commission has heard from people with lived experience of mental illness or psychological distress, families, carers and supporters, members of the workforce, organisations, experts and members of the broader Victorian community through consultations, submissions, correspondence, public hearings and witness statements.

Based on these sources, the Commission has included a selection of personal stories that appear throughout this report. These stories provide the individual's personal recollections of their interactions and experiences with Victoria's mental health system.

The Commission has also included a selection of case studies that are primarily about services or approaches that illustrate reform opportunities or innovation.

The Commission wanted to consider a broad range of ideas for improving the mental health system. Therefore, some of these personal stories and case studies include perspectives from outside of Victoria.

With the permission of the individuals involved, these have been modified for privacy and confidentiality where appropriate. In some instances, the Commission has also made non-publication orders to protect privacy and confidentiality.

Commissioners' reflections

Compassion.

That one word—and all it encompasses—has resonated with us throughout our time as Commissioners.

Many people with lived experience of mental illness or psychological distress, and their families, carers and supporters, spoke to us about the difference that compassionate care made to their lives.

At the same time, we heard of the many challenges to providing safe and compassionate mental health care, treatment and support. These challenges include resource pressures that limit time for the development of therapeutic relationships, risk-averse and coercive cultures within services and social inequities.

The recommendations we make in this report seek to create a mental health and wellbeing system built on compassion.

While numerous national and state inquiries into mental health services over the decades have made countless recommendations, this Royal Commission has the advantage of examining the Victorian mental health system in its entirety.

Unlike other royal commissions, our terms of reference do not refer to making redress for past systemic failures. Rather, they direct us to report on how a reformed system can ensure 'that all those in the Victorian community experience their best mental health'.

This allows us to consider not only issues relating to the development and delivery of mental health services, but also ways to prevent poor mental health, such as through public health strategies and the promotion of human rights.

We first met as a group at the Premier's public announcement of the Royal Commission on Sunday, 24 February 2019. We have different disciplinary backgrounds and professional experiences, but from the start we all recognised the privileged position bestowed upon us.

We expected to be subject to a high level of public scrutiny and that expectation was realised. Although none of us was appointed as a full-time Commissioner and some had to balance other duties, we chose to work as equals with regular meetings and open communication.

Enormous public trust has been placed in this Royal Commission to reform Victoria's mental health system to one built around compassion and hope. We have been guided throughout by the thousands of Victorians who have made their perspectives clear about needing and wanting a well-functioning mental health system.

Many people with lived experience of mental illness or psychological distress presented a hopeful vision of a mental health system. They would like to see a system that works well and makes sure their voices are heard at all levels of service delivery, policy, research, evaluation, leadership and governance.

Many of those who support people living with mental illness expressed their hope that the Royal Commission can bring about much needed and lasting change. These support people included family members and carers, advocates and volunteers, members of non-governmental organisations and the mental health workforce.

We agreed at our first meeting on 7 March 2019 that we needed to engage with as many people as possible from communities around Victoria, as well as those who had direct experience of the mental health system.

Our letters patent directed us to establish an Expert Advisory Committee to be chaired by Professor Patrick McGorry AO and which must include people with lived experience. The committee was duly established and we have been grateful for the considered and detailed advice the eight members of that committee provided us throughout our processes.

Our work was shaped by our legal duties under Part 2 of the *Inquiries Act 2014* (Vic). We held formal hearings at the Melbourne Town Hall in 2019 to ensure evidence could be tested by lawyers in public. We chose the Melbourne Town Hall because of its accessibility by public transport to enable as many people as possible to attend in person. The hearings were live-streamed via the internet.

We also heard from thousands of Victorians through surveys, roundtables, formal hearings and submissions. Participants included people living with mental illness, family members and carers, mental health practitioners, researchers and advocates, among others.

Unexpected interruptions to our work led us to adapt to new ways of meeting and communicating. During our time as Commissioners, the Premier declared a State of Disaster for Victoria on two occasions.

The first related to the bushfires that occurred during the 2019–20 summer. The second, in August 2020, was in response to the spread of COVID-19.

These declarations were made because of extraordinary emergencies constituting 'a significant and widespread danger to life or property in Victoria'.[1]

The emergencies have greatly affected the mental health and wellbeing of the Victorian community and our responses to them will shape how we react to future challenges. The level of cooperation across and between governments, organisations and communities in response to COVID-19, for example, provides a hopeful glimpse of new ways of working together.

In this final report, we provide a blueprint for a reformed mental health and wellbeing system that will stay relevant in ever-changing and challenging times. As we stated in our *Interim report*, good mental health has remained low on the agenda for public investment. Complacency and meagre expectations have stifled reform. This is shameful and must stop. The mental health and wellbeing system must never again be as neglected as it has been.

The responsibility for a well-functioning mental health and wellbeing system should not belong to government alone. We have a collective opportunity to ensure all Victorians experience their best mental health.

Many Aboriginal and Torres Strait Islander people refer to social and emotional wellbeing as a concept arising in connection to land, culture, spirituality, family and community. For many African Australians, the philosophy of *ubuntu* describes how we all come into the world with obligations to others and they in turn have obligations to us.

Whatever terms we use, good mental health and wellbeing is closely tied to our connection to others. This informs our emphasis on mental health treatment, care and support in the community, as well as the notion that we are all accountable for a system that must move beyond crisis-driven care.

Our first principle underlying a reformed mental health and wellbeing system is that it respects the inherent dignity of people living with mental illness and provides holistic support to ensure their full and effective participation in society.

We have heard confronting stories of how some people's experiences of the current mental health system have exacerbated their pain and distress. This is unacceptable.

Establishing a royal commission can shine a light on what has remained hidden for too long. During our time as Commissioners, we have been buoyed by the openness with which people have talked about stigma and discrimination directed towards those living with mental illness.

Many Victorians have spoken about their experiences of poor mental health and mental illness, some for the first time. There have also been new and encouraging discussions across the country about the importance of nurturing good mental health and wellbeing.

We are grateful for the general willingness, goodwill and commitment of members of governments, universities and non-governmental organisations who have supported the Commission's inquiry, including the generous assistance provided by local, national and international experts.

We are also greatly indebted to all who worked within and beyond the Royal Commission to ensure its processes were carried out smoothly and efficiently. Time constraints have led to many staff members working above and beyond the call of duty.

We have received invaluable assistance from the Commission's CEO, Jodie Geissler, and all staff members, specialist advisers to the Commission and the members of the Expert Advisory Committee. We also acknowledge Senior Counsel Assisting Lisa Nichols QC (during 2019) and Stephen O'Meara QC (during 2020) and Junior Counsel Georgina Coghlan (now Senior Counsel) and Junior Counsel Fiona Batten. We thank all who have contributed to the development and writing of this report.

The experience of serving the people of Victoria on this Royal Commission has been humbling, challenging and rewarding. Our obligation to act in the public interest guided our approach, both to our analysis of the material presented to us and to developing recommendations for a reformed mental health and wellbeing system built on compassion.

We dedicate our endeavours to all those living with mental illness and their families, carers and supporters.

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1 *Emergency Management Act 1986* (Vic), sec. 23(1).

Introduction

Introduction to the report

This is the final report of the Royal Commission into Victoria's Mental Health System. It builds on the Commission's interim report and articulates a vision for a reimagined system that will support the mental health and wellbeing of Victorians for generations to come.

The recommended reforms aim to rebalance the current system so that most services are delivered in the community close to where people live, work and study. A focus on preventing mental illness and promoting good mental health and wellbeing will be central to the redesign of the system, reducing reliance on services alone. When people do need the support of services, most will receive the treatment, care and support they need through community-based services. Hospitals will respond to the needs of people who require highly specialised or acute care, and residential services will support people who need longer periods of rehabilitation following a period of mental illness or psychological distress.

Building on the recommendations made in the Commission's interim report, the reforms outlined in this report will ensure the mental health and wellbeing system responds to the needs of Aboriginal people. It will support the principles of self-determination, with Aboriginal social and emotional wellbeing services designed and led by Aboriginal communities.

In the new system, services will be comprehensive and holistic and will integrate mental health and wellbeing services with other supports for living well. Two aligned systems, one for infants, children and young people and one for adults and older adults, will be streamed to respond to different developmental needs and stages of life.

Reflecting the strong and vibrant diversity of Victoria's population, the system will respond to the needs of individuals, families, carers and supporters from Victoria's diverse social cohorts and communities.

New leadership will ensure people with lived experience of mental illness or psychological distress, families, carers and supporters have an authentic and valued role in the ongoing development of the system and the delivery of services. New governance arrangements will ensure greater accountability back to people and communities.

The historically overlooked and de-prioritised mental health system will be a relic of the past.

The Commission's processes to design the future mental health and wellbeing system have been rigorous and considered. The future system presented in this report has been shaped by the contributions of thousands of Victorians, including those with lived experience of mental illness or psychological distress, families, carers and supporters, people from diverse communities, mental health workers, researchers, service providers and others. Their contributions were broad and covered a wide range of experiences of all parts of the mental health system and those systems that intersect with it such as the education, criminal justice system and the homelessness and housing systems.

The deep knowledge of people who have experience of Victoria's mental health system has been complemented by the advice and expertise of people in other Australian jurisdictions, and from around the world. A wide array of research and data has further enriched the Commission's understanding and has ensured the system of the future has been designed on the best available evidence. Chapter 39: *The work of the Commission* outlines how the Commission undertook its task.

The knowledge and evidence from these diverse sources underpin every topic in this final report.

The report is a companion piece to the interim report. It comprises five volumes. This introduction provides an overview of the full report and is followed by an introduction to the first volume, *A new approach to mental health and wellbeing in Victoria*.

The Commission's purpose and establishment

A royal commission is the highest form of inquiry on matters of public importance in Victoria.

On 22 February 2019, Her Excellency the Hon. Linda Dessau AC, the Governor of the State of Victoria, established the Royal Commission into Victoria's Mental Health System. The Governor appointed Ms Penny Armytage AM as the Chair of the Commission and Dr Alex Cockram, Professor Allan Fels AO and Professor Bernadette McSherry as Commissioners.

On the day the Commission was established, the Premier, the Hon. Daniel Andrews MP, said the mental health system was 'broken'. He added:

> until we acknowledge that and set a course to find those answers and a practical plan for the future, people will continue to die, people will continue to be forever diminished.[1]

The Victorian Government has made a public commitment to implement all the Commission's recommendations.[2]

The letters patent that officially established the Commission require it to report on:

> how Victoria's mental health system [could] most effectively prevent mental illness, and deliver treatment, care and support so that all those in the Victorian community [could] experience their best mental health, now and into the future.[3]

The Commission was asked to deliver an interim report by 30 November 2019 and a final report by 31 October 2020. Due to the widespread impacts of the COVID-19 pandemic, the deadline for the final report was amended to 5 February 2021.[4]

The interim report

The interim report details the outcomes of the Commission's first 10 months of work and should be read in conjunction with this final report. It gives an overview of the current state of the mental health system in Victoria. Community consultations, online and written submissions, roundtable discussions, consultations with an Expert Advisory Committee, public hearings, data and research all contributed to the interim report.

This initial report made clear the extent of the reform required to give Victorians the mental health and wellbeing system they need and deserve. It was clear that the system, as it currently stood, was not well prepared for the extent of reform needed. On this basis, the report made nine recommendations to lay the foundation for future reform and provide an initial response to the urgent need for additional services.[5] These initial recommendations are currently being implemented.

The case for reform

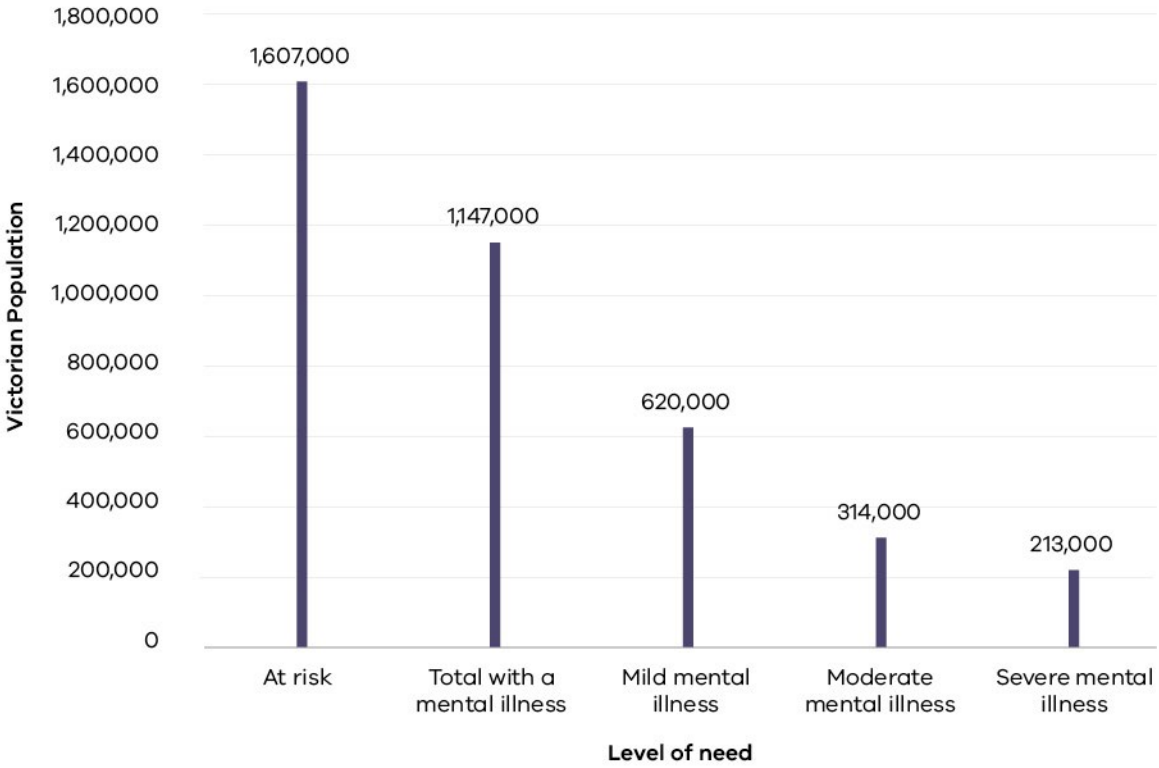
The interim report presents a detailed picture of the context for reform across all aspects of service delivery and operations in the current mental health system. This picture is based on detailed analysis of the extent of and trends in mental illness and psychological distress among Victorians, and by the contributions of people who use—and try to use—the system, and those who work in it.

Inconsistent data collection and different definitions of mental illness make it difficult to present an accurate picture of the number of people in a population who experience mental illness at any given time. Data analysed for the interim report estimates that around 20 per cent of the population experience some degree of mental illness or psychological distress in any given 12-month period.[6]

Figure 1 sets out the projections for the number of Victorians who will experience mental illness during the 12-month period of 2021.

The Commission notes that the diagnostic and medical framing of the language used to describe prevalence in the data is at odds with the wider approach taken by the Commission elsewhere in this report to understand experiences of mental illness or psychological distress. The descriptions of levels of 'illness' in the figure do not convey the broader and dynamic nature of mental health and wellbeing, and some of the terms used can be stigmatising and disempowering.[7] The terms used in the data are, however, commonly used in existing mental health frameworks and literature.[8] The Commission is reporting this data in order to present an accurate and consistent picture of the estimated number of people who are likely to experience mental illness or psychological distress in 2021.

Figure 1: Estimated prevalence of mental illness, Victoria, 2020–21



Level of need and services required according to the Fifth National Mental Health Plan

At risk groups
(early symptoms, previous illness) Mainly self-help resources, low intensity interventions including digital mental health.

Mild mental illness
Mix of self-help resources including digital mental health and low intensity face-to-face services. Psychological services for those who require them.

Moderate mental illness
Mainly face-to-face clinical services through primary care, backed by psychiatrists where required. Self-help resources, clinician-assisted digital mental health services and other low intensity services for a minority.

Severe mental illness
Clinical care using a combination of GP care, psychiatrists, mental health nurses, allied health professionals. Inpatient services/pharmacotherapy/psychosocial support services/coordinated multiagency services for those with severe and complex illness.

Sources: Commission analysis of the Department of Health (Commonwealth), *National Mental Health Service Planning Framework*; Department of Health (Commonwealth), the Fifth National Mental Health and Suicide Prevention Plan 2017; Department of Environment, Land, Water and Planning, Victoria in the Future 2019.

As the figure indicates, it is no small number. An estimated 1,147,000 people in Victoria are likely to experience some level of mental illness or psychological distress at some point in 2020–21. Another way to think about this is to imagine that this is someone in every family or in every close friendship group who will need treatment, care or support in 2020–21.

A further 1,607,000 Victorians will be at risk of developing mental illness, either showing signs or having previously experienced an episode of illness.

This is a major health and wellbeing problem for Victoria and must be comprehensively addressed. As Victoria continues to respond and recover from COVID-19, now more than ever, working to support the mental health and wellbeing of the community must be a priority—a reality recently acknowledged by the Victorian Premier, who said, '[a]s we recover from this pandemic, we can't lose sight of what matters most—the health and wellbeing of our families, friends and communities.'[9]

As well as affecting many Victorians, the interim report noted that mental illness accounts for a substantial proportion of what is termed the 'burden of disease' in Australia, or the cumulative impacts of the number of people affected, deaths and associated costs. When substance use and addiction are included, mental illness is second only to cancer.[10] The estimated 'burden of disease' from mental illness is higher in Victoria than most other states and territories and has worsened marginally between 2011 and 2015 (the most recent period for which data are available).[11]

Despite the high prevalence and substantial impact of mental illness and psychological distress on Victorians, there is an insufficient and piecemeal approach to preventing poor mental health and to promoting good mental health. The insufficient focus on, and resourcing of, prevention contributes to the constant and growing pressure on the state's already under-resourced mental health system.

The Commission's interim report discussed the nature and extent of under-resourcing in the mental health system as a longstanding problem that was identified more than a decade ago.[12] The situation has worsened over time. The lack of investment in the mental health system, coupled with increasing demand pressures, has meant that services have become crisis-driven, and many who require specialist mental health services do not receive it.[13]

The meagre resources in the public mental health system are currently directed to people with the most severe and urgent or acute experiences of mental illnesses, and yet frequently fail to provide treatment, care and support of the necessary intensity and duration even for this group.

However, under-resourcing is only part of the picture. The multiple sources of evidence that the Commission considered in preparing the interim report highlighted problems with many aspects of the system's operation including service planning, design and mix, leadership and governance, and workforce capacity and capability.

In its interim report, the Commission noted that the existing Victorian mental health system has 'catastrophically failed to live up to expectations'.[14] It described how, despite the ambitious reform agenda articulated in the 1990s, the inadequate funding and planning that followed, together with increased demand, have led to a mental health system that is unable to support the mental health and wellbeing needs of the Victorian community.

The Commission found that the existing service system is fragmented, with large gaps between the different types of services available. It found 'a serious and often detrimental mismatch between what individuals seek and what the system offers'.[15] Weak governance arrangements and a lack of coordination between the Commonwealth and the Victorian governments have caused access and navigation challenges for people living with mental illness or psychological distress, families, carers and supporters.

This situation has been long in the making, as successive governments have neglected the development of the mental health system.

Interim report recommendations

In its interim report, the Commission was clear that large-scale, transformational change was required but that groundwork needed to be laid before it could pursue the kind of ambitious reform agenda that was required.

To begin to address this lack of preparedness, the interim report's nine recommendations focused on areas to be addressed as a priority. These recommendations would enable the Victorian Government to lay a strong foundation for reform while the Commission continued to build its understanding of the possibilities to fundamentally transform the system. It undertook this work with consumers, families, carers and supporters, people who work in the mental health system, academics, researchers and other experts.

The Commission recommended in its interim report that the Victorian Government:

1. establish a new entity, the Victorian Collaborative Centre for Mental Health and Wellbeing, to bring people with lived experience together with researchers and experts in multidisciplinary clinical and non-clinical care to develop and provide adult mental health services, conduct research and disseminate knowledge with the aim of delivering the best possible outcomes for people living with mental illness or psychological distress
2. provide funding for 170 additional youth and adult acute mental health beds to help address critical demand pressures
3. expand follow-up care and support for people after a suicide attempt by recurrently funding all area mental health services to offer the Hospital Outreach Post-suicidal Engagement (HOPE) program
4. expand Aboriginal social and emotional wellbeing teams throughout Victoria, supported by a new Aboriginal Social and Emotional Wellbeing Centre
5. establish Victoria's first residential mental health service designed and delivered by people with lived experience of mental illness or psychological distress and offered as an alternative to acute hospital-based care
6. expand lived experience workforces (including the consumer workforce and the family, carers and supporters workforce) and extend workplace supports for their practice
7. develop education and training pathways and recruitment strategies to prepare for workforce reform and address current workforce shortages

8. design and implement a new approach to mental health investment comprising a new revenue mechanism (a levy or tax) for the provision of operational funding for mental health services and a dedicated capital investment fund for the mental health system
9. establish the Mental Health Implementation Office as a new, temporary administrative office in relation to the Department of Health and Human Services under the *Public Administration Act 2004* (Vic) to implement the Commission's recommendations.

The Victorian Government has begun implementing these recommendations, funded through an initial commitment of almost $870 million in the 2020–21 State Budget.[16]

Guiding principles

As well as making recommendations to be addressed as a priority, the interim report set out guiding principles for the remainder of the Commission's inquiry and the development of its final recommendations. They reflect the Commission's aspirations for a future system that better supports the mental health and wellbeing of all Victorians.

The guiding principles have informed the policy directions that the Commission has developed, tested and refined during the second part of its work. They have helped provide consistency within and across the topics covered in the final report and have acted as a standard to guide development of the recommendations. The Commission has made minor updates to the wording of the principles to align with language used in its final reform directions (refer to Chapter 2: *The Commission's approach to reform*).

The conduct of the Royal Commission

The Commission's task was to conduct a policy-based inquiry—in other words, to examine policy and research, to undertake analysis and to make recommendations to inform the design of the future mental health and wellbeing system. The Commission went about its task in an open, transparent and inclusive way, including following 'best practice approaches to engagement with people with lived experience' as required by its letters patent.[17]

Throughout its deliberations, the Commission was supported by an Expert Advisory Committee made up of members with lived experience and professional and sector experience with Victoria's mental health system. It was chaired by Professor Patrick McGorry AO, Professor of Youth Mental Health at the University of Melbourne and Executive Director of Orygen. The committee provided formal advice across the life of the inquiry on a range of topics including how to involve stakeholders in the Commission's processes, how to raise awareness of mental health and wellbeing, and the likely impact of the Commission's findings and recommendations.

The Commission began by conducting open community consultations around the state and made a public call for submissions. Commissioners undertook site visits and a range of individual meetings to help understand the issues and to further define the scope of the Commission's work. This was followed by public hearings and roundtables—all of which substantially informed development of the interim report.

In the second phase of its work, the Commission undertook targeted consultation that would further the design of the new mental health and wellbeing system. Ideas and options for reform were developed through focus groups, with input from people with lived experience of mental illness or psychological distress, families, carers and supporters across Victoria.

Complementing the contributions to the inquiry from people with lived experience, the Commission sought input from people whose expertise comes from professional involvement in the mental health system in Victoria and elsewhere, including researchers, mental health practitioners and clinicians, managers and administrators. Roundtables, panels and additional witness statements were used to gather information on topics that were considered to be high priority, and to test ideas as they were developed.

Through this process of continuous involvement, the Commission was able to develop and clarify its thinking and refine its ideas until it was satisfied that the future system design would achieve 'practical, prioritised, efficient and sustainable outcomes'.[18]

Overall, the Commission received more than 12,500 contributions to its work, including through consultations, focus groups, roundtables, public hearings, witness statements, surveys, workshops and more than 3,200 submissions from individuals and organisations.[19] This substantial participation conducted over nearly two years informed the Commission's recommendations and will continue to inform implementation.

Navigating the report

This final report spans five volumes containing 40 chapters and 65 recommendations. While topics have been dealt with separately to make it easier to explain the main aspects of the future system, no single volume, chapter or recommendation operates in isolation. Together, they articulate the Commission's vision for the future mental health and wellbeing system.

- **Volume 1** details the contextual factors shaping the mental health system and the landscape within which it will be reformed. It explains the Commission's approach to redesigning Victoria's mental health system and the need for improved accountability for the outcomes that matter to people living with mental illness or psychological distress, families, carers and supporters. It outlines how the future system will be grounded in an approach to mental health and wellbeing that considers the broad range of causes and consequences of mental illness or psychological distress and seeks to improve the mental health of all Victorians. This volume then sets out the fundamental architecture of the new service system—a system that will be based in the community and will deliver services that are accessible and simpler to navigate, with clear pathways to timely and appropriate supports.
- **Volume 2** describes the collaboration and partnerships needed in the environments in which people live, learn and work to promote good mental health and wellbeing. It also outlines an improved mental health and wellbeing system response for people of all ages. It explains how the system will work for infants, children and young people, and for older adults. It details major reforms that will provide an improved response for people who have experienced or are experiencing trauma, and for people who need supported housing. Finally, the volume describes the coordination required in the new system to implement wider strategies and actions on suicide prevention and response.

- **Volume 3** outlines how the system will promote inclusion and address inequities in the mental health and wellbeing system. It describes the central role of people with lived experience of mental illness or psychological distress, families, carers and supporters in the future system. It explains how the new system will support Aboriginal social and emotional wellbeing, and how it will respond to the needs of diverse communities. It details integrated approaches to treatment, care and support for people with co-occurring mental illness and substance use or addiction. It also details the future system design for people living with mental illness who are in contact with the criminal justice system, including the youth justice system. It addresses how the new mental health and wellbeing system will provide an improved response to people who live in rural and regional Victoria. Finally, it describes what will be done to address stigma and discrimination.
- **Volume 4** describes how the new system will be led, governed, supported and overseen. It details the commissioning and partnership arrangements required to support and drive the delivery of services that meet people's needs. It explains the features that will ensure the system provides high-quality and safe services. Finally, it outlines what is required to support a sustainable workforce for the future.
- **Volume 5** starts by looking forward, outlining how the system will continue to be transformed. It sets out the technology, information and expertise required for a contemporary system, and how it will drive continuous improvement. It also details considerations for implementing the Commission's recommendations and proposes a 10-year implementation agenda that comprises three waves of reform. The volume concludes by looking back at the work and processes of the Commission itself.

Volume 1: A new approach to mental health and wellbeing in Victoria

Introduction

This volume details the contextual factors shaping the mental health system and the landscape within which it will be reformed. It explains the Commission's approach to redesigning Victoria's mental health system and the need for improved accountability for the outcomes that matter to people living with mental illness or psychological distress, families, carers and supporters. It outlines how the future system will be grounded in an approach to mental health and wellbeing that considers the broad range of causes and consequences of mental illness or psychological distress and seeks to improve the mental health of all Victorians. This volume then sets out the fundamental architecture of the new service system—a system that will be based in the community and will deliver services that are accessible and simpler to navigate, with clear pathways to timely and appropriate supports.

The Commission's approach to reform

The mental health and wellbeing system of the future will need to support the diverse needs of people living with mental illness or psychological distress, families, carers and supporters. As the events of 2020 have clearly demonstrated, it will also need to be a system designed to adapt and respond to unforeseen pressures.

The Commission has identified the major trends and themes affecting the system, including large-scale events—bushfires and COVID-19, issues of population change and increased use of technology—and the critical features that a future system must have to deliver better and more equitable outcomes for Victorians. These features include a responsive and integrated system with community at its heart, having contemporary and adaptable services, re-establishing confidence through effective prioritisation and collaboration, and establishing a system attuned to promoting inclusion and addressing inequities.

To achieve this, the Commission adopted a 'systems approach' to transform the mental health system. This broadened the Commission's focus beyond the obvious components of the current mental health system and helped it to consider a wider range of seen and unseen 'system conditions' that influence the system—both positively and negatively.

The Commission also recognises that achieving good outcomes for individuals, including people with lived experience of mental illness or psychological distress, families, carers and supporters, and for the workforce and community, is fundamentally important and foundational to the Commission's reform agenda. The Commission recommends a new *Mental Health and Wellbeing Outcomes Framework* that adopts a broad view of mental health and wellbeing outcomes—for individuals and the population—over short-, medium- and long-term timeframes.

Refer to Chapter 1: *The reform landscape*, Chapter 2: *The Commission's approach to reform* and Chapter 3: *A system focused on outcomes*.

Taking a public health approach to mental health and wellbeing

The future system will be grounded in an approach to mental health and wellbeing that considers the broad range of causes and consequences of mental illness or psychological distress and seeks to improve the mental health of all Victorians. The public health approach that the Commission has laid out promotes the human rights of people who experience mental illness or psychological distress by recognising their dignity and freedom as well as their right to the highest attainable standard of physical and mental health. This approach has been developed following deep consideration of the factors that shape good mental health and wellbeing, with a focus on the whole of the Victorian population. It will implement measures to promote good mental health and prevent mental illness, including dedicated resources to address the causes of mental illness.

The public health approach is described in detail in Chapter 4: *Working together to support good mental health and wellbeing*.

The new service system architecture

The new service system architecture will bring together responses that promote good mental health and wellbeing, a broad range of government and community services, and primary and secondary mental health–related services with a diverse mix of mental health and wellbeing services at the local, area and statewide levels.

Two aligned service systems will be established—one for infants, children and young people up to their 26th birthday (discussed in Volume 2 of this report) and the other for adults and older adults.

The future system is based on a community-based model of care where people receive the most appropriate treatment, care and support for their needs at any given point, close to where they live, to the extent that this is possible. Mental health and wellbeing treatment, care and support will be integrated with the support that people receive for their physical health care. For those who need it, mental health and wellbeing treatment, care and support will be integrated with support for substance use or addiction.

Community mental health and wellbeing services will not only expand in volume and reach. To support a consistent and responsive service offering, as well as dealing with current inequities and variability in the services that are available, all community mental health and wellbeing services will offer three core functions:

- an expanded range of treatments and therapies and wellbeing supports (currently known as 'psychosocial supports'), improved care planning and coordination, day-to-day practical assistance and connections to other community services including housing
- services to help people find and access treatment, care and support and a new comprehensive response to emergencies and crises that is available 24 hours a day, seven days a week
- supports for primary and secondary care providers (such as GPs and community health services) from mental health specialists, or shared care arrangements between specialists and GPs and community health services to better support consumers.

The future system will comprise a new architecture.

Mental health and wellbeing services will consist of six levels spanning from informal supports through to the most intensive statewide services. Fundamental reform will occur via 50–60 new Adult and Older Adult Local Mental Health and Wellbeing Services. Dedicated local services for infants, children and young people will also be a feature of the new mental health and wellbeing system.

Treatment, care and support of people with high-intensity needs will be provided through 22 Adult and Older Adult Area Mental Health and Wellbeing Services and 13 Infant, Child and Youth Area Mental Health and Wellbeing Services.

Mental health and wellbeing services will be organised around eight regions overseen by Regional Mental Health and Wellbeing Boards. Existing boundaries will be realigned, with catchments dismantled. People will not be turned away from services because of where they live.

Better linked statewide services, including with the Commission's proposed Collaborative Centre for Mental Health and Wellbeing, will reduce the distance people need to travel to access highly specialised treatment, care and support. The new system architecture is described in full in Chapter 5: *A responsive and integrated system* and Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*. New structures to support the management and oversight of the system are described in *Volume 4: The fundamentals for enduring reform*.

Improving access to community mental health and wellbeing services, crisis responses and bed-based services

The Commission's reforms will deliver a service system that is accessible and simpler to navigate, with clear pathways to timely and appropriate supports. Integration between services mean people will be supported to get the right treatment, care and support at the local, area or statewide level, or via other services such as GPs. People will also be able to find clear and up-to-date information on services from a website designed to help them better understand their mental health and wellbeing needs, to find services and supports and to connect with online self-help resources. A new statewide phone line will be established.

There will also be an expanded crisis response. Each Adult and Older Adult Area Mental Health and Wellbeing Service will provide a coordinated 24/7 telephone or telehealth service for people in mental health crisis. The service will be accessible to people in the community who are in extreme distress, and to providers.

The expanded crisis response will provide crisis assessment and immediate support and will be able to mobilise a crisis outreach or emergency service response. The service will also provide referral and follow-up as required. Staff will include clinicians and peer workers.

Supplementing these approaches, a range of alternative responses for people in crisis will be developed including safe spaces and drop-in centres, crisis respite facilities and a crisis stabilisation facility for adults and young people.

Finally, there will be better support for police and ambulance call-outs where they are attending to a mental health–related emergency. A 24/7 telehealth model will be implemented, combined with in-person co-responses where a mental health professional will accompany first responders. A secondary triage and referral service will be used to divert those people who do not need a police or ambulance response. These reforms are described in Chapter 8: *Finding and accessing treatment, care and support* and Chapter 9: *Crisis and emergency responses*.

Bed-based services will also be reformed. The Commission has once again recommended additional beds be delivered; and in the new system, treatment, care and support will be respectful, compassionate and delivered with a focus on safety. New models of care will be developed for delivery by multidisciplinary teams and in various settings, including people's homes.

There will be new rehabilitation services within system-wide rehabilitation pathways aimed at providing extended and intensive support to people who need ongoing mental health care with extra supports. New models will be co-designed and trialled in community care and secure extended care settings. Chapter 10: *Adult bed-based services and alternatives* provides further detail.

The Commission acknowledges the sexual and gender-based violence that occurs in some inpatient and residential settings. This must be a relic of the past. Measures to address violence and ensure the safety of all will be introduced into hospital and other residential settings.

Together, the reforms outlined in this volume set out a new approach to mental health and wellbeing in Victoria built around a community-based model of care where it is easier for people to get the treatment, care and support they need, when they need it, and as close to home as possible.

1 The Age, 'Commissioners Named in Bid to Fix State's "Broken" Mental Health System', 24 February 2019.

2 Victorian Government, 'Announcement: Royal Commission into Mental Health Speech', 2018, p. 4.

3 Victorian Government, 'Royal Commission into Victoria's Mental Health System—Letters Patent', 2019, para. I.

4 Victorian Government, 'Royal Commission into Victoria's Mental Health System—Amended Letters Patent', 2020.

5 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, Part 5.

6 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 26.

7 Victorian Mental Illness Awareness Council, *Correspondence to the RCVMHS: CSP.0001.0125.0001, Response to Questions on Issues Affecting Consumers Labelled with 'Serious and Persistent Mental Illness'*, 2020, p. 3; Carol Harvey and others, *Models of Care for Victorians Living with Severe and Persistent Mental Illness and Complex Multiagency Needs: Literature Review and Key Reform Considerations. Report Prepared for the Royal Commission into Victoria's Mental Health System*, 2020, pp. 7 and 10.

8 The Australian College of Mental Health Nurses, *Submission to the RCVMHS: SUB.0002.0013.0020*, 2019 Appendix 1, p. 24; National Mental Health Service Planning Framework, *Introduction to the NMHSPF*, 2019, p. 20; *Witness Statement of Amelia Callaghan*, 5 May 2020, para. 18; Commonwealth Department of Health, *The Fifth National Mental Health and Suicide Prevention Plan*, 2017, p. 20; Productivity Commission, *Mental Health Inquiry Report, Volume 1*, 2020, p. 26; National Mental Health Commission, *Contributing Lives, Thriving Communities: Report of the National Review of Mental Health Programmes and Services: Summary*, 2014, p. 5; *Witness Statement of Bill Buckingham*, 7 July 2020, paras. 104–106; Elizabeth Leitch and others, *Implementing a Stepped Care Approach to Mental Health Services with Australian Primary Health Networks*, 2016, p. 7.

9 The Hon. Daniel Andrews MP, Premier of Victoria, 'Media Release: Putting the Mental Health of Victorians First', 12 November 2020, p. 1, <www.premier.vic.gov.au/putting-mental-health-victorians-first>, [accessed 12 November 2020].

10 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 29.

11 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 30.

12 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 116.

13 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, pp. 112–113.

14 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 1.

15 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 159.

16 The Hon. Daniel Andrews MP, Premier of Victoria.

17 Victorian Government, 'Royal Commission into Victoria's Mental Health System—Letters Patent', para. IV (f).

18 Victorian Government, 'Royal Commission into Victoria's Mental Health System—Letters Patent', para. III.

19 For more detail on the Commission's approach and engagement, refer to Volume 5.

Chapter 1

The reform landscape

1.1 The importance of context

The Royal Commission's interim report explored the many factors that shape mental health and wellbeing, including psychological, biological and social factors that can change over a lifetime.[1] Good mental health is not just the absence of mental illness; it is the ability to lead a life of value. This means a health response, while critical, alone is not enough.

Mental health means different things to different people, but the World Health Organization defines it as:

> **a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.**[2]

Mental health therefore stretches beyond a single system, and promoting good mental health is a major responsibility shared by the community. It requires broad, forward-looking social and health policy and structures, public information and engagement, and education.

Understanding this broad context, the Commission formed a view that transforming Victoria's mental health system would involve the 'full continuum' of effort from prevention, and promotion of mental health, through to improved treatment, care and support for people living with mental illness or psychological distress.

It also determined that to design a new system, it needed to engage widely with people to hear about their experiences of Victoria's mental health system. It had to understand the expectations and needs of Victorians now and into the future, how those considerations might change, and what would need to be put in place to enable the system to adapt.

This chapter draws on the Commission's interim report findings on the experiences of mental health and wellbeing. It outlines some of the main contextual factors the Commission considered in undertaking its consultations, deliberations and system design, including the context within which the system currently operates, and the trends that will shape it moving forward. It then explains what these factors mean for the reform agenda.

Chapter 2: *The Commission's approach to reform* builds on the discussion in this chapter and explores the processes and approach the Commission used to develop its blueprint for transformation.

1.1.1 An evolving landscape

Victoria's mental health system sits within the health system. This system is complex, and compared with other service systems, it has some unique features including: involvement from all three levels of government—Commonwealth, state and local; universalism through access to Medicare; private health funding and insurance; and a mix of service offerings and evolving financial arrangements.

Reforming these structural complexities, as important as they are to the provision of health services—and to people's experiences of these services—is outside the scope of this Commission. However, the Commission was interested in exploring which of these broad features of the health system present an opportunity for mental health reform; for example, it considered whether the Victorian mental health system could use universal platforms such as maternal and child health services, or whether the shared interests of governments could be harnessed to respond to the poor health outcomes of the 'missing middle'.

Further, the Commission explored the reform approaches governments, here in Australia and internationally, have used to overcome structural complexities in healthcare systems. These include shifting the focus from providers to consumers; seeking value for expenditure in terms of consumer outcomes; using information to create better systems; and dealing with quality of care and population health concerns. All of these approaches can apply to the context of mental health, and are examined in this report.

The Commission also explored the well-recognised relationship between mental health and the broader social determinants of health. While social service systems were beyond the scope of the Commission's letters patent, critical connections between these systems and mental health and wellbeing were examined. The Commission chose to focus on several of these intersections within the remit of the state government in depth, particularly housing, justice and alcohol and other drug services, and did so through its community consultations, public hearings and analysis of the data. Further, the Commission considered large-scale social service inquiry and reform efforts occurring concurrently in other jurisdictions—for example, the Royal Commission into Aged Care Quality and Safety and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

During the Commission's final months, the Commonwealth Government publicly released the Productivity Commission's *Mental Health Inquiry Report*. The Commission was cognisant of the unique opportunity presented through the timing of that report and the synergies between and across the proposed agendas. The Productivity Commission's program of work, along with that of other inquiries, is cited throughout this report.

Importantly, however, the Commission committed not only to transforming a system within its current context but to an enduring reform program. The Commission sought advice from a variety of experts in systems design and other fields to identify the most important trends and ongoing issues that would shape Victoria and therefore the system for many years to come.[3] These trends are presented below.

Large-scale disruptions

There were large-scale disruptions during the Commission's term, including a severe 2019–20 bushfire season and the COVID-19 pandemic. These events affected the Commission's direction and approach and changed many Victorians' ways of living. Mr Terry Symonds, the then Deputy Secretary, Health and Wellbeing, of the former Department of Health and Human Services, summarised the impact of these events on Victorians, including on their mental health:

> I think it is appropriate to acknowledge … how difficult 2020 has been for the Victorian community. The pandemic, which overlapped with the devastating bushfires over the 2019–2020 summer, has had longer-lasting impacts on us than on other parts of the country. The toll this is taking on our collective mental health cannot be underestimated.[4]

These bushfires were devastating. Due to the scale of the fires and the impact on people's properties, it is considered to be Australia's most destructive fire season on record.[5] Thousands of Victorians experienced great distress and uncertainty as towns and families were evacuated and people faced the prospect of losing their homes and loved ones.

It was also a long fire season, with record-breaking temperatures and extremely low rainfall leading to 3,500 different fires in Victoria during this period.[6] This meant that people—particularly those living in rural and regional Victoria—experienced extended periods of fear and loss. Many Victorians are likely continuing to experience these feelings because of the bushfires.[7] As the Royal Commission into National Natural Disaster Arrangements described:

> Thousands of Australians – locals and holidaymakers – became trapped. Communities were isolated, experiencing extended periods without power, communications, and ready access to essential goods and services, or access to cash or EFTPOS to pay for their most basic needs.[8]

For Victoria, this fire season marked a decade since the 2009 Black Saturday bushfires. That disaster, which resulted in 173 fatalities, had a significant impact on the wellbeing of many Victorian families and communities.[9] One study found that three to four years after the bushfires, rates of people reporting symptoms that indicated 'mental health problems that were beyond levels likely to be manageable' and that 'may require professional support' were approximately double the levels expected in a population not affected by disaster.[10]

Unfortunately, the incidence of severe weather-related events is only likely to increase. It is likely that climate change may be associated with more frequent large-scale bushfires in the future and that fire seasons like those of 2019–20 will not be considered unusual.[11] Other climate-related events such as drought are also likely to recur and will have a lasting impact on businesses and on people's livelihoods and wellbeing, particularly in rural and regional communities.

The 2019–20 bushfires overlapped with the introduction of COVID-19 to Australia and its spread in the community. The COVID-19 pandemic has had broad and significant economic and social impacts for Victorians. People have lost their lives, loved ones and endured long periods of separation from their friends and families.

The world is still coming to understand how severely the COVID-19 pandemic has affected people's mental health. However, studies indicate there may be increased rates of depression and anxiety, as well as substance use and suicidal thoughts.[12] In particular, lockdowns and working from home are likely to have increased people's feelings of loneliness and social isolation while reducing behaviours that support good mental health.[13]

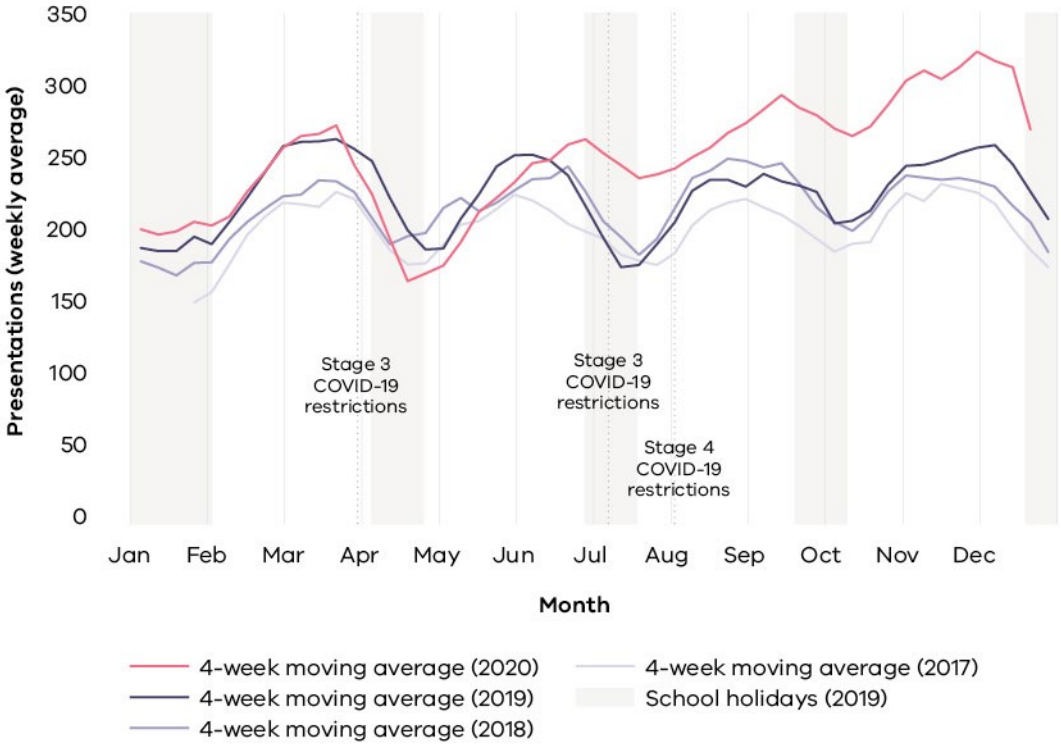
The increase in job losses and economic uncertainty is also having an impact on mental health and wellbeing. A Black Dog Institute survey of 5,070 people during the first COVID-19 lockdown found that half of respondents reported 'moderate to extreme' worry about their financial situation[14] and more than three-quarters reported their mental health was worse since the outbreak began.[15] Indeed, the statistics on the pandemic's financial impact on Australia are sobering. On 2 September 2020 Australia officially fell into a recession for the first time since 1991, with Australian gross domestic product down 7 per cent in the June quarter, the largest quarterly fall on record.[16] A report released by the City of Melbourne in August 2020 estimated that for both the City of Melbourne and Victoria, monthly job losses were 'threefold higher than those of the 90s recession'.[17]

There are also a number of population groups that may be more strongly affected by the COVID-19 crisis than the general population, such as older adults, healthcare workers, COVID-19 patients and their families, children and women.[18] As illustrated in Figure 1.1, and described in more detail in Chapter 13: *Supporting the mental health and wellbeing of young people*, the negative mental health impacts of COVID-19 have been particularly striking for Victoria's young people. Ms Kym Peake, the then Secretary of the former Department of Health and Human Services, goes further, describing how the unprecedented impacts of the COVID-19 pandemic are likely to 'compound disadvantage for vulnerable Victorians and increase demands on Victoria's mental health system in the short and longer term.'[19]

The Victorian Government's service delivery data illustrates some of the early effects the pandemic and associated lockdown measures have had on Victorians' mental health needs. As shown in Figure 1.2, the number of mental health-related ambulance cases—where Ambulance Victoria has attended to a patient at a scene and filled out a patient care record—has increased this year. This report explores many other trends related to the COVID-19 pandemic and its effects.

The Commission also heard of some positive outcomes associated with the large-scale disruptions of 2020. The Commission observed that many mental health services and organisations adapted quickly, offering new services, including through digital mediums. This new approach has worked well for some, as people can receive services within their own homes, and creates efficiencies for providers.[20] Digital service delivery can also reduce barriers for people living in rural and regional areas or who may otherwise struggle to attend services (such as those with limited physical mobility) and has the potential to do so long after the pandemic has been brought under control. These themes are explored in Chapter 24: *Supporting the mental health and wellbeing of people in rural and regional Victoria* and Chapter 34: *Integrating digital technology*.

Figure 1.1: Number of mental health–related presentations to emergency departments, among people aged 0–17 years, Victoria, 2017 to 2020



Source: Department of Health and Human Services, Victorian Emergency Minimum Dataset 2017–18 to 2020–21.

Notes: Excludes type of visit code '19' (COVID-19 assessment clinic) and triage category code '6' (Dead on arrival). Interim data only. Data extracted 21 December 2020.

Stage 3 COVID-19 restrictions: Was implemented on 30 March 2020 and again on 8 July 2020 for metropolitan Melbourne and allowed people to leave their home for only four reasons: work, caregiving or receiving, exercise and shopping for essential goods and services.

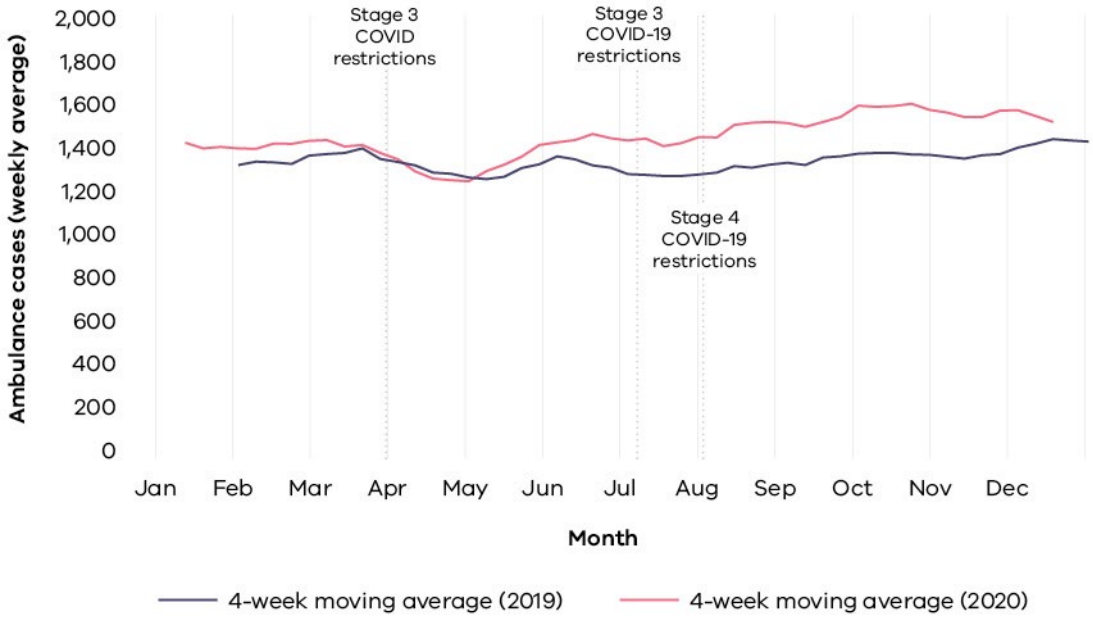
Stage 4 COVID-19 restrictions: Was implemented on 4 August 2020, and in addition to the restrictions under Stage 3, additional restrictions limited travel to up to 5 kilometres from a person's home for necessary goods and services. Only one person per household could leave home to shop once per day. Curfews were in place from 8:00 pm to 5:00 am every night to reduce the number of people leaving their homes and moving around.

Second step: Was implemented on 13 September 2020 for regional Victoria and on 28 September 2020 for metropolitan Melbourne, and eased restrictions with a strong focus on moving activity into outdoor well-ventilated, outdoor areas wherever possible. The second-step restrictions balanced population mobility and wellbeing while ensuring the infection rates were driven down.

Third step: Was implemented on 16 September 2020 for regional Victoria and on 27 October 2020 for metropolitan Melbourne, and eased restrictions with a focus on reopening core components of the economy in a safe and steady way. A key milestone during this step was the alignment of metropolitan Melbourne and regional Victoria restrictions on 8 November 2020.

Last step: Was implemented on 22 November 2020, and eased restrictions with a focus on enhancing social interactions such as increasing private gathering limits and permitting non-contact and contact sports, as well as further changes to support Victoria's economic revival.

Figure 1.2: Number of mental health–related ambulance cases, Victoria, 2019 to 2020



Source: Ambulance Victoria.

Notes: Reports the number of ambulance cases where the clinical information captured within the patient care record indicated the case was mental health–related. Includes emergency and non-emergency cases where Ambulance Victoria has attended to a patient at a scene and filled out a patient care record. Interim data only. Data extracted 22 December 2020.

Stage 3 COVID-19 restrictions: Was implemented on 30 March 2020 and again on 8 July 2020 for metropolitan Melbourne and allowed people to leave their home for only four reasons: work, caregiving or receiving, exercise and shopping for essential goods and services.

Stage 4 COVID-19 restrictions: Was implemented on 4 August 2020, and in addition to the restrictions under Stage 3, additional restrictions limited travel to up to 5 kilometres from a person's home for necessary goods and services. Only one person per household could leave home to shop once per day. Curfews were in place from 8:00 pm to 5:00 am every night to reduce the number of people leaving their homes and moving around.

Refer to Figure 1.1 for more information about COVID-19 restrictions in Victoria.

The Commission also witnessed how the pandemic has helped increase the community's focus on mental health. Governments in Australia and around the world have introduced new initiatives and strategies to support people's mental health.[21] It is also possible that the shared experience of living through the pandemic may unite people and increase their kindness and empathy towards each other, as United for Global Mental Health noted:

> The mantra 'We are all in this together' signals the universality of this shared experience and many are offering psychosocial social support to one another.[22]

At the individual level, the pandemic also provided positive opportunities for people with lived experience of mental illness and psychological distress to share what they had learnt from dealing with panic with the broader public.[23]

The pandemic has also prompted a positive shift in the use of data between health services, academia and research institutes, and government. It has encouraged the integration of information—such as advice from health experts and rapid literature reviews—in public policy and government decision making.

The Victorian Government has shown it can act swiftly to create the senior policy bandwidth needed to work collaboratively to solve complex problems and meet shared goals.[24] All of these advances will be critical in rolling out the Commission's reform agenda.

In summary, the major disruption of the COVID-19 pandemic has challenged and changed what many, including the Commission, had identified as the forces and trends shaping the mental health system. The pandemic has made some services, like telehealth, come to the fore. It has also changed other patterns in Victoria, such as population growth. Crucially for this Commission, it has increased pressure on the social determinants of mental health like unemployment. Ultimately, though, the COVID-19 pandemic, like the bushfires, has made Victorians more aware of the importance of mental health and wellbeing and of the critical importance of adaptive service systems. As described in Chapter 36: *Research, innovation and system learning*, the Commission has designed a system that includes the necessary capabilities to foster ongoing improvement, learning and adaption.

Population growth and demographic changes

Population and demographic trends are critical in system design because they can help governments decide how services should be resourced and distributed, and therefore how quickly and equitably they can respond to consumers' needs.

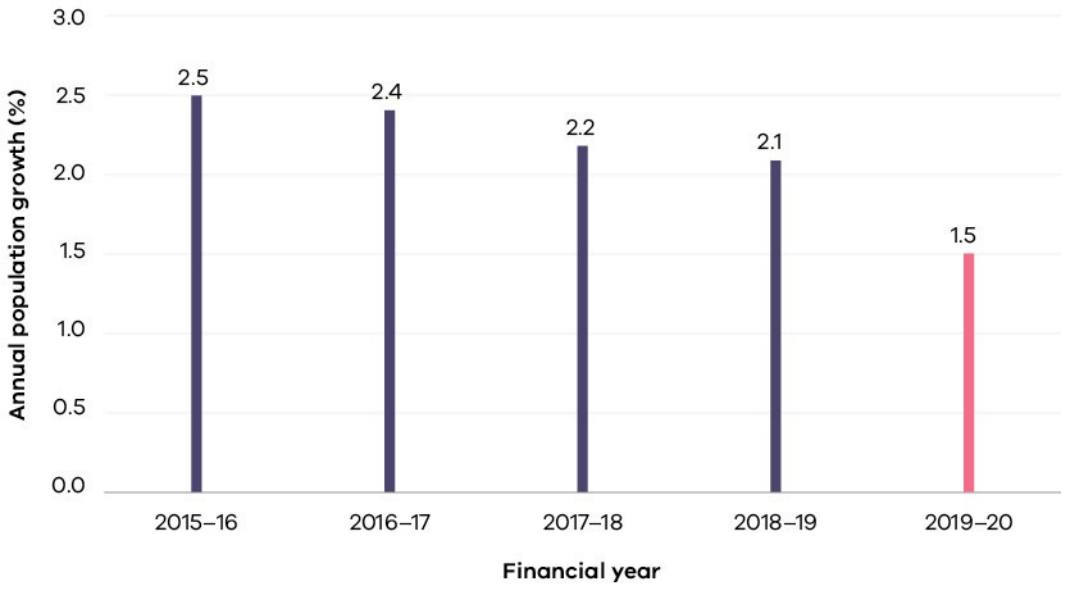
Victoria has been Australia's fastest-growing state, changing the way social and health services must be planned. Victoria's population grew by 98,000 people in the 2019–20 financial year. Melbourne was also Australia's fastest-growing capital city. In 2017 it was predicted that Melbourne's population would surpass Sydney's between 2031 and 2057.[25] As shown in Figure 1.3 and Figure 1.4, at the time of writing, largely due to COVID-19 and the associated decline of overseas migration, population growth has slowed, making it difficult to predict future trends with certainty.

At the 2016 Census, 49.1 per cent of Victoria's residents were either born overseas or have one parent who was born overseas.[26] This is an increase from 46.6 per cent in 2011 and 43.6 per cent in 2006.[27] The proportion of Victorians speaking a language other than English at home was 26.0 per cent in 2016 compared with 23.1 per cent in 2011.[28] The needs of Victoria's culturally diverse communities are important to service planning, particularly for those in the community who have survived trauma and dislocation, such as refugees or asylum seekers.

The population of Aboriginal people in Victoria is also growing, increasing by almost 10,000 between 2011 and 2016, growing from 37,992 to 47,788.[29] As discussed further in Chapter 20: *Supporting Aboriginal social and emotional wellbeing*, the principle of Aboriginal self-determination must be central to the design and delivery of social and emotional wellbeing support services for Aboriginal people.

The movement of the population within Victoria and settlement patterns also greatly affect the design and planning of mental health services. People living in rural and regional communities already require more, and more accessible, mental health services than those living in central Melbourne.[30]

Figure 1.3: Annual population growth, Victoria, 2015–16 to 2019–20



Source: Commission calculation using Australian Bureau of Statistics, Australian Demographic Statistics, 2015–16 to 2019–20, cat. no. 3101.0, Canberra <www.abs.gov.au/statistics/people/population/national-state-and-territory-population/jun-2020>, [accessed 17 December 2020].

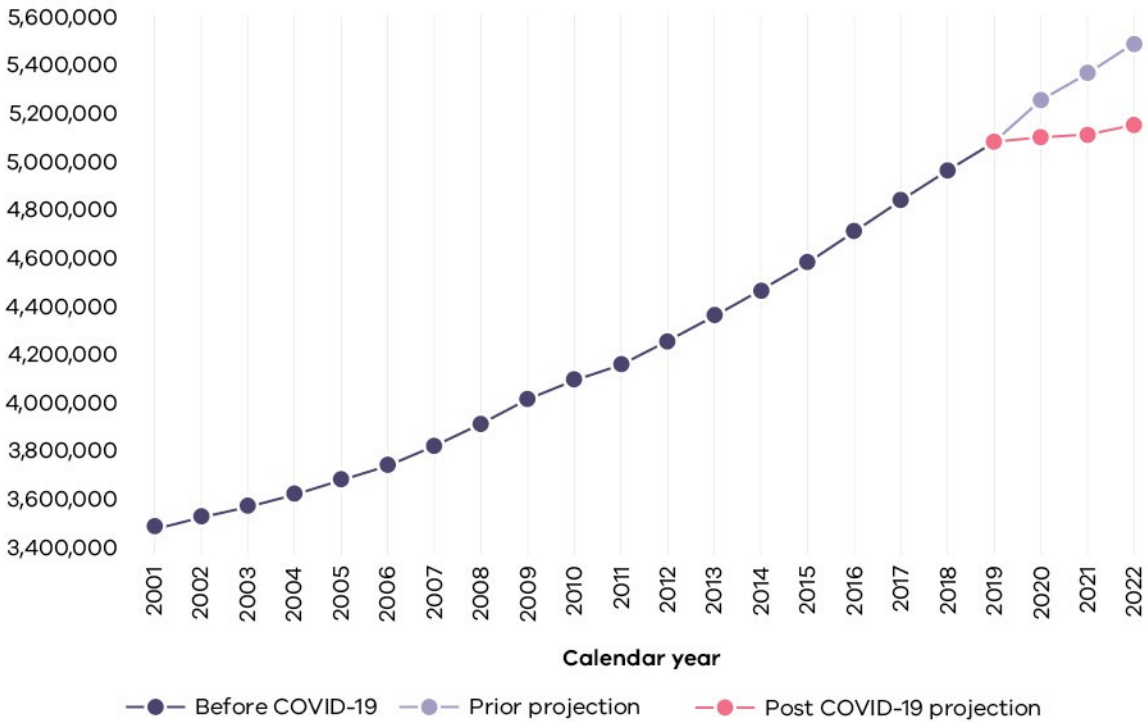
Note: Changes are partially impacted by the COVID-19 pandemic and the resulting Australian Government closure of the international border from 20 March 2020.

Census data indicate that over the past decade there has been a trend towards people moving from capital cities to regional areas.[31] While data on the effects of the COVID-19 pandemic on population movement is still emerging, anecdotal evidence suggests that more Melbournians are interested in moving to rural and regional areas for a better quality of life.[32] With working from home being a 'new normal', long commutes to work in the city are less likely to feature in some workers' lives. This means the detrimental effects of commutes, such as the disparity between the quality of life in the inner city versus that in middle- and outer-suburban communities, are likely to decrease.[33] Further, remote working arrangements may give people in rural and regional communities access to a greater variety of jobs, with better pay than jobs in rural and regional communities typically offer.[34]

Critically, in addition to population shifts, Victoria's population is also ageing. As with much of the global population, declining fertility rates and increased life expectancy are causing a rise in the proportion of older Victorians across the state. As of 2019 it was estimated that during the next three decades the number of people aged 65 years or older will double, rising from 16 to 21 per cent of the Victorian population.[35]

The ageing population means that the nature of services required from government is shifting. The Victorian Government will need to strengthen its focus on supporting older adults to remain independent and actively participate in society. Prevention of mental illness among older Victorians, and support for older people living with mental illness, is explored in Chapter 14: *Supporting the mental health and wellbeing of older people*.

Figure 1.4: Population growth, Victoria, 2001 to 2022



Sources: Australian Bureau of Statistics, National, state and territory population, June 2020, <www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release#states-and-territories>, [accessed 30 December 2020]; Commonwealth Government, *Budget 2019–20: Federal Financial Relations, Budget Paper No. 3*, 2019.

Rising inequality and insecurity

Inequality was a theme regularly raised to the Commission; in particular, how social and health inequalities affect or determine mental health and wellbeing, and how a transformed system might respond to varying needs across communities.

As the Productivity Commission noted in its 2018 report, *Rising Inequality: A Stocktake of the Evidence*, wealth inequality in Australia has steadily grown since the early 2000s.[36] Moreover, the inequality is stark: the average wealth of a household in the highest 20 per cent of Australian income earners is 100 times that of the lowest 20 per cent.[37]

Mental health is shaped by the social, economic and physical environments in which people live.[38] Research indicates that those who experience poverty and/or disadvantage face an increased risk of developing a mental illness and experience disproportionately poor health outcomes.[39] For example, unemployment and job insecurity is linked with poor mental health,[40] as are other factors such as housing and access to resources such as water and food.[41]

As the World Health Organization's Commission on Social Determinants of Health expressed, to improve population health outcomes action must be taken to improve people's daily living conditions—including tackling the inequitable distribution of power and resources:[42]

> The development of a society, rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health.[43]

Social disadvantage such as poverty is not the only social determinant of mental illness—gender discrimination, poor social status, family violence and physical ill-health are also factors.[44] Some of the most powerful causes of inequality in access to mental health services 'are the social conditions in which people are born, grow, work, live and age, as well as the systems that shape daily life.'[45]

Victoria's existing mental health system is characterised by inequality, as access to services is often determined by a person's age, residence, cultural background and identity. For example, inconsistencies in the availability of mental health services exist in different parts of Victoria. While the divide is most acute between rural and metropolitan areas of the state, within Melbourne there are great discrepancies. As Associate Professor Dean Stevenson, Clinical Services Director at Mercy Mental Health, told the Commission:

> I strongly believe that, if you live in Wyndham, or you live in Footscray or you live in Toorak, you should be able to access the same level and the same quality of services, and that's not the case across Metropolitan Melbourne.[46]

In Victoria's existing mental health system, inequality can be perpetuated if a person is unable to pay for services. Out-of-pocket expenses can sometimes result in consumers on lower incomes being unable to afford the treatment, care and support they need,[47] especially where they need to bear part of the cost to see a private psychiatrist. Even people who can afford to pay part of the fee may have to wait to see someone, particularly in rural and regional areas.[48] To increase equality for all Victorians—irrespective of where they live or their socioeconomic status—governments will need to consider how to increase the equity of supports.

Not only are inequality and social disadvantage bad for population health outcomes, but excessive inequality can also erode the stability of society and undermine public trust in governments and their services. Research undertaken by the Organisation for Economic Co-operation and Development indicates that income inequality prevents proportions of the population from fully participating and investing in society, and can impede economic growth.[49] This persistent disadvantage can also erode social cohesion and public trust:

> Excessive inequality in any society is harmful. When people with low incomes and wealth are left behind, they struggle to reach a socially acceptable living standard and to participate in society … When a minority of people accumulate income and wealth well above the rest of the population, this can lead to excessive concentration of power that becomes self-perpetuating, fraying the bonds of social cohesion and trust.[50]

These are critical but complex considerations in system design. The Commission was bound by its letters patent to reform the mental health system and therefore committed to embedding design elements to reduce inequality. The Commission's recommendations seek to make future mental health and wellbeing services more equally available to people of different age groups, those living in different areas across Victoria (including rural and regional communities) and diverse groups.

It acknowledges, however, that to improve mental health outcomes and re-establish trust in the system, a whole-of-government and community response is required to address social inequalities. Related findings are articulated in detail in Chapter 3: *A system focused on outcomes* and Chapter 4: *Working together to support good mental health and wellbeing*.

Technology and ways of working

Technology has been increasingly used and relied upon over the last decade, and this trend has rapidly accelerated in the context of COVID-19.[51]

New technology is one of the biggest forces transforming our interactions, and it is reshaping service systems globally and locally.[52] In countries like Australia, digital technology has become central to the way many people live. It permeates people's work and social lives, influencing how they communicate, find, receive and share information, and how they engage with services.[53]

Technological innovations continue to radically transform many sectors and how people engage with them, streamlining and improving the consumer experience to make accessing and receiving products or services customer friendly, individualised and quick. Over the past 10 years, sectors such as banking, commerce, travel, insurance and retail have all adopted digital and technological solutions to redesign how they connect with people. These sectors have overhauled their front-end entry and navigation approach, with most shifting to digital platforms.[54]

These changes have led some people to expect fast, personalised and easy experiences when they engage with services across all sectors.[55] This includes government services, which are increasingly moving to digital formats in response to these changed expectations.[56]

Recent developments in information and technology present opportunities for the Victorian Government in its delivery of the future mental health and wellbeing system. It now has the ability to collate and use data to inform the development and delivery of more personalised and readily accessible services. As Professor Mario Alvarez-Jimenez, Director of Orygen Digital, told the Commission: '[e]merging technologies will increase the reach, intensity, personalisation and immediacy of mental health care.'[57]

It is important to note, however, that in some ways the rise of technology and shift to digital services may be increasing inequality and limiting the ability of some to participate in society. As one participant at the Commission's roundtable on innovation said:

> what we're seeing a lot through COVID, is people adopting technology. And it's been great, except for the people who can't access technology, who don't know how, who can't afford technology [or] who don't have the literacy to use it.[58]

Not only is technology changing the way people engage with and deliver services but it is also changing the way they work. Technology is increasingly used to give people greater flexibility in the hours and location of their work, and they are working from home more often.[59] While this gives people more freedom in how they use their time, and supports workforce diversification, the impact of flexible working arrangements on people's health and wellbeing is still largely unknown.[60] The role of digital technology in the future mental health and wellbeing system is outlined in Chapter 34: *Integrating digital technology*.

This trend is also changing the nature of the workforce. While it gives some people more options, it heightens uncertainty for others. There are increasing numbers of platforms, for example, that specialise in matching workers with potential clients who want tasks done purely online. Such work, often characterised as part of the 'gig economy', enables people to work as much or as little as they choose.[61] However, though people gain the ability to work on their own terms (that is, where they want, when they want), many workers both within and outside the gig economy feel uncertain about and insecure in their employment. One recent study indicated that 83 per cent of employees report fear about losing their job due to the gig economy, a looming recession, a lack of skills, cheaper foreign competitors and automation.[62]

The Commission is aware there are different views about the rise of technology and the impact it has on mental health. For example, while evidence suggests that social media can pose a risk to people's mental health and wellbeing, some studies indicate that online social networks can provide feelings of increased emotional support and belonging and therefore support mental health.[63] Professor Rob Moodie, Deputy Head of School and Professor of Public Health at the University of Melbourne, reflected on this conflicting evidence in his witness statement:

> **Social media can be damaging for mental health. It has definite upsides to help people connect, to form groups to stay in contact. But it also has in my view, a paradoxical ability to divide and isolate people in an unprecedented way. It is said that 'comparison is the thief of joy'. Social media invites people to constantly compare themselves with others. The premise of social media was that it should connect us, but I worry that we are replacing real hugs with 'e-hugs' and this sense of separation and constant comparison is detrimental to our individual and collective health. The ability to remain anonymous, to troll, to cyberbully is not only devastating in terms of damaging mental health but can lead to forms of tribalism and fragmentation which in turn makes it hard for effective policy making and effective governance.**[64]

Exploring this complex societal issue was not directly within the Commission's remit. However, the Commission recognises the importance of promoting and protecting the mental health and wellbeing of young people, who may not yet grasp the challenges of social media and the inherent impact it can have on wellbeing in a rapidly changing world. These themes are explored in Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect*.

The fragmenting nature of social connection

The level of social connection and support that exists between individuals and groups within a population—also referred to as 'social capital'—is critical for maintaining mental health and wellbeing, both for people individually and for society as a whole.

Increased social capital is associated with improved mental health. It is particularly important for preventing mental illness and addressing risk factors such as social isolation and loneliness.[65] A study that systematically reviewed household income and labour dynamics in Australia found that Australians who felt they had a greater sense of belonging, higher levels of practical support and greater trust in others reported better mental and general health.[66] Research also suggests that social capital helps people recover from mental illness.[67]

Over the past decade, Australia's social capital has been changing and may be declining in some areas. The Australian Bureau of Statistics found that rates of volunteering, engaging in social groups (such as sport or arts) and participating in civic groups and organisations (such as unions and political parties) are all in decline. It also found that digital forms of communication and social networking had provided new and different opportunities for people to connect with others.[68]

The ways in which people connect and engage is changing, shifting from traditional community-based institutions such as churches to online platforms and social media, particularly in the context of the COVID-19 pandemic. This is leading to both poorer mental health and more complexity in delivering mental health services because, as Professor Moodie observed, '[t]hose who are alone and have poor mental health … are less likely to know where to find mental health services and whom to contact'.[69]

In particular, research indicates that Australians are experiencing higher rates of social isolation and loneliness. This is especially true for older Victorians, aged 65 years or older[70] and for young people aged 15–25.[71] As explored in Chapter 11: *Supporting mental health and wellbeing in the places we work, learn, live and connect* social isolation and loneliness are risk factors for various physical and mental conditions, such as 'cognitive decline, depression, and heart disease.'[72] Chapter 14: *Supporting the mental health and wellbeing of older people* illustrates the impacts that social isolation and loneliness can have on the mental health and wellbeing of older Victorians.

Evidence before the Commission highlighted how the declining role of community-based organisations and associations can increase feelings of social isolation:

> **One of the key ways for people to support their mental health is their capacity to be a part of a group or collective, which promotes a sense of identity, inclusion and belonging. Historically, there were relatively stronger community-based organisations and large associations—such as the Returned and Services League, Scouts and Guides, and Country Women's Association—that promoted and supported social connectedness … As the strength and membership of these social institutions and associations have started to decline, so too have people's feelings of belonging and community. With the increasing atomisation of our society over the coming decades, people may find it increasingly difficult to achieve a feeling of belonging.[73]**

Community expectations and trust

The Commission has conducted its work in a context within which expectations for service delivery are high.

The community expects governments to be effective and to deliver beneficial outcomes while being efficient and economical in their spending.[74] As noted earlier in this chapter in relation to digitalisation and service reform, many people have come to expect personalised, customised, real-time and interactive services and products.[75] Mental health services are one form of care where there will be heightened expectations of service providers.

There is a strong correlation between providing a good experience for consumers and building and maintaining public trust in governments:

> **Customers often use the quality of customer experience as a proxy for measuring government performance and its ability to provide essential services, often at critical life stages. Given that customers are setting a high bar for government services, and that bar is rising, governments have an imperative to act fast on customer experience to influence trust.[76]**

Trust in government is at an all-time low. In December 2019 the Australian Election Study revealed that only 25 per cent of Australians considered that governments could be trusted to do the right thing. This was the lowest score recorded since this data started being collected in 1969 and is almost a 20 percentage point decline since 2007.[77] Trust in leadership appears to be highest when it is localised—for example, with local community leaders.[78] Indeed, the Commission observed during the COVID-19 pandemic that governments had to work more closely with local leaders to build communication and connection.

Levels of trust and satisfaction with how democracy works in Australia is also linked to income. The lower a person's income, the less satisfied they are with democracy.[79] An inability to influence decision making, and rising inequality, may be contributing to the lack of trust the community has in government. A lack of public trust also appears to be driven by 'a growing sense of inequality and unfairness in the system.'[80]

These considerations illustrate the need for issues of equality and community engagement to be part of service and systems design, with citizens more actively engaged in decision making and reform. They also point to the need for institutions that generate trust through accountability and transparency. These critical themes are explored in Chapter 27: *Effective leadership and accountability for the mental health and wellbeing system—new system-level governance*.

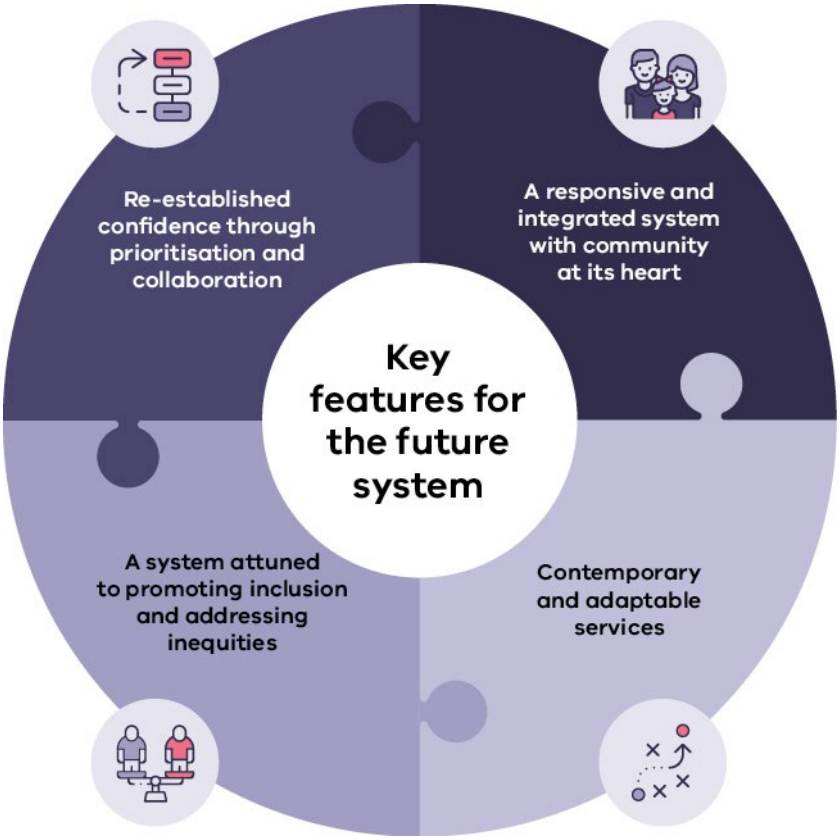
1.2 Implications for reform—critical features in a new system

In today's environment of change, disruption, rising inequality, uncertainty and social fragmentation, supporting the mental health and wellbeing of Victorians is more important than ever. As the Commission concluded in its interim report, however, for too long Victoria's mental health system has been a low priority and under-resourced. It cannot meet current expectations and is ill-prepared to respond to future trends.

But there are signs of positive change. Before the COVID-19 pandemic, the Commonwealth and state governments started to show greater recognition of the importance of mental health and wellbeing, and now in response to the pandemic, they are placing even greater importance on this aspect of people's lives. Now, the Victorian Government needs to take advantage of this momentum and rebuild the state's mental health system.

The Commission, considering the trends outlined in this chapter, has identified several features critical to reforming the mental health system. These features—as outlined in Figure 1.5 below—will collectively strengthen the system to improve the mental health and wellbeing of Victorians. A future system that comprises features of prioritisation, collaboration, adaptability, simplicity and equity will be better positioned to meet the mental health and wellbeing needs of Victorians in a world where these needs are continually shifting and evolving.

Figure 1.5: Features of the reformed mental health and wellbeing system



Re-established confidence through prioritisation and collaboration

Because there are indications that public trust in government is low, the Commission has concluded that the Victorian Government will need to engage citizens and empower local communities differently if it is to deliver on the Commission's reform agenda. This is especially true for a system such as the mental health system, where the relationship between the government, service providers and people with lived experience is impeded by many factors: a history of service failures, a lack of accountability and widespread stigma and discrimination against people living with mental illness or psychological distress.

People should expect and trust that when they need treatment, care and support, they can receive it in the public health system. In relation to mental health, however, this is not currently the case. As the Commission described in its interim report, there are many Victorians who need specialist public mental health services but are not receiving support.[81] It also identified that those who are receiving support are not always receiving high-quality care.[82]

But there is hope that this Commission and the Victorian Government's commitment to undertake the recommended reform will bring change. People are hopeful that they, and their families and loved ones, will be able to receive quality services that ultimately help them to live more fulfilling and healthy lives. As one person said, 'As consumers all we have is hope. We need real change.'[83]

The Victorian Government will need to build on the momentum gained in recent months and years, delivering on its public commitment to fully implement all of the Commission's recommendations and prioritise the mental health and wellbeing of the Victorian community for many years to come.

In addition to prioritising the mental health and wellbeing system, the Victorian Government will need to change the way it engages with the community. The Victorian Government should consider Victorians as active partners in designing and delivering services, rather than passive recipients of services designed by someone else, and it should involve Victorians from all kinds of backgrounds, locations and age groups in this process.

Another way to rebuild the public's trust is to expand the system's boundaries. Because trust in government is strongest at the local level, the government needs to look beyond traditional services and peak organisations to consider and take advantage of the strengths of trusted local institutions. In fact, it is impossible for one single entity or system alone to tackle the complex challenges the Commission has identified, such as rising inequality, social fragmentation and large-scale disruptions. As explored in this report, the Victorian Government will need to work collaboratively with different levels and portfolios of government, service providers and communities to promote mental health and wellbeing and to deliver a variety of supports from different providers in a coordinated way. Public and private sectors must also find new ways to work together.

Ms Sue Williams, CEO of Cabrini Health Australia and Board Member, Victorian Institute of Forensic Mental Health, who gave evidence in a personal capacity, said there is much potential in this regard:

> I think that if there was greater understanding of the respective sectors and their core capabilities, both sectors would be more willing to collaborate. This can be done in a variety of ways including, for example, through … partnerships, joint training initiatives … all of which can help to cross-fertilise ideas, break down barriers …[84]

The new system stewards must redefine and broaden what constitutes expertise; they must elevate lived experience by treating consumers, families, carers and supporters as partners and experts in their own right; and they must embrace and invite new actors—people and organisations—into the system. This requires new ways of working to harness commitment and diverse ideas:

> For consumers to be heard, especially at the higher levels, or at any level of an organisation, organisations need to go out of their way to listen to them. Rather than encouraging consumers to speak in ways that are easier to listen to, sometimes organisations need to improve their ability to hear.[85]
>
> [Better solutions would be possible if] the decision makers heard from and actually understood the people experiencing the problem.[86]

Collective effort and shared purpose can also help people trust the system again. Through its work, the Commission has been concerned that many organisations and individuals working in the system have not been consistently unified in their calls for change. If the mental health system of the future is to be successful greater unity will be required, and the current and emerging actors within the mental health system will need to collaborate to keep mental health a priority:

> In order for government not to exploit potential divisions in mental health advocacy arising from potentially conflicting priorities, and thereby turn its back on continuing systematic reform (or merely grease the squeakiest wheel), it is critical that a broad-based coalition of stakeholders take a single, unified message to government and deliver it effectively and repeatedly … and that individual stakeholder groups stand solidly in support of this coalition.[87]

One step in this direction was the Commission's recommendation to establish the Collaborative Centre for Mental Health and Wellbeing, which will embody a new approach to mental health characterised by collaboration, responsiveness and continuous improvement (the role and functions of the collaborative centre are outlined in Chapter 36: *Research, innovation and system learning*).

A responsive and integrated system with community at its heart

In this uncertain and complex environment, and where responsibility for the Victorian mental health system is shared between the Victorian and Commonwealth governments, it is critical that people are supported to access and navigate the system. People should be placed at the centre of the service system, and agencies should work together to create a system that respects the experience and needs of individuals. The system should also have localised community care at its heart.

Together, these elements will make up the new responsive and integrated system the Commission envisages, as outlined in Chapter 5: *A responsive and integrated system*. To deliver it, the Victorian Government will need to work with the service system, and in partnership with local and Commonwealth governments.

By working with local and Commonwealth governments to clarify governance arrangements and deliver more integrated services, the Victorian mental health system will become easier for consumers, families, carers and supporters to navigate. It will be critical that the Victorian Government implements the Commission's reform agenda in a way that, at all times, keeps the focus on the experience of its consumers. This will ensure consumers, families, carers and supporters are more easily able to find and receive services.

Community is, of course, important for more than just service provision. The Commission considers social connection as fundamental to mental health and wellbeing. Building and maintaining social connection requires active contributions from all parts of a community. Professor Sir Michael Marmot, Director of the Institute of Health Equity at University College London, giving evidence in a personal capacity, summarised this point:

> All of us in the community have a role to play in supporting good mental health and wellbeing. As we say … 'health is a human right'—'do something; do more; do better'.[88]

This goes beyond the activity of collaboration to the complexities inherent in human nature and to concerns of connection and belonging. As Mr David Pearl, innovator, author and public speaker of The Studios, London, giving evidence in a personal capacity, shared with the Commission:

> My observation is that people feel more well when they belong somewhere to something. It is obvious and a cliché, but a lot of people don't feel they belong … There is a difference between physical proximity and the feeling of being connected, and we shouldn't confuse them.[89]

A system has to be 'alive' to these considerations—the important 'civic building blocks that can enhance an individual's sense that they are valued'.[90]

Contemporary and adaptable services

In today's environment, where consumers expect more personalised, real-time and interactive services, the Victorian Government will need to use technology to deliver services in a way that is convenient and adaptable to people's needs. This will also require using data and information to help services to deliver better outcomes.

Uncertainty is more prevalent than ever. The government will need to equip the future mental health and wellbeing system to adapt and respond to change. Large disruptions and shocks are likely to continue, be they natural disasters, pandemics or economic downturns. Many strategies assume that the state can predict, plan, command and control. In the case of major and unforeseen disruptions, however, another set of skills is needed—skills in 'adaptive, collaborative, local responses to complex policy issues.'[91] Associate Professor Simon Stafrace, Chief Adviser for Mental Health Reform Victoria, who gave evidence in a personal capacity, told the Commission:

> The difference between technical and adaptive challenges [is] starkly evident in the response of nations to the 2020 coronavirus pandemic … The technical challenge of preventing and treating the infection is similar in each country, but the adaptive challenge draws on an infinite number of individual, interpersonal, social, cultural, political and economic factors unique to each community.[92]

The Commission explored how it could create an adaptive system that uses research and evaluation to drive data- and evidence-informed policy and innovation to grow and improve. Importantly, the Commission has recommended a system that is designed to listen to, learn from and be led by the people it serves. As Ms Mary-Ann O'Loughlin AM, former Deputy Secretary of Skills and Higher Education, in the New South Wales Department of Education giving evidence in a personal capacity states:

> Adaptive responses are participatory and collaborative, including with deep community engagement and multiple stakeholders: they need to be informed by 360-degree intelligence and have broad-scale ownership. They must draw upon local knowledge and frontline workers. They must be strongly informed and shaped by the local context and social networks.[93]

A system attuned to promoting inclusion and addressing inequities

Recognising the effects of rising inequalities, the Commission concluded that it would be necessary to embed the goal of equity in its design of the future mental health and wellbeing system. As Professor Sir Marmot told the Commission:

> Unfair distribution of [power, money and resources] creates avoidable health inequalities, known as health inequities. Conversely, health equity 'means fair opportunity to live a long, healthy life. Inequities in health are not inevitable or necessary they are unjust and are the product of unfair social, economic and political arrangements'.[94]

To achieve health equity, the system manager, the Victorian Department of Health, must be able to respond to people and populations in Victoria with the greatest need by redistributing resources and by carefully considering how to arrange services to provide adequate, localised care. This will be particularly important for already underserviced parts of the state, or certain disadvantaged populations, and will require better funding, planning and commissioning arrangements.

The Department of Health must also respond and adapt as the factors driving inequity evolve. It should work to take action, along with other departments and governments, to improve the determinants of mental health. As Ms Georgie Harman, CEO of Beyond Blue, stated:

> **Mental illness prevention approaches must consider the uneven distribution of risk and protective factors, including socioeconomic disadvantage. The social determinants of health are particularly influential (e.g. unemployment, poor education, inadequate housing) and should be prioritised.**[95]

While many of these considerations are outside the Commission's scope, it has recommended in Chapter 3: *A system focused on outcomes* establishing an outcomes framework to better inform decision making and drive accountability for mental health and wellbeing.

To address inequities, the new system must have inclusion at its heart. Many different perspectives will be needed to shape the system of the future, and a key part of this process is to ensure socially excluded populations are, to quote Professor Sir Marmot, brought 'in from the cold … to provide them with the opportunity to be part of a diverse and flourishing society.'[96]

1.2.1 Using the critical features to create change

The features identified above—prioritisation, collaboration, adaptability, responsiveness and equity—have guided the Commission in its work, which, as determined by its terms of reference, was to 'report on how Victoria's mental health system can … [support Victorians] to experience their best mental health now and into the future'.[97]

The terms of reference focus on the mental health and wellbeing of Victorians and reinforce the future-focused intent of this inquiry. The Commission's role was not to concentrate on mental health services or providers, governance and funding issues alone, or indeed on any specific component of the mental health system. Instead, it was asked to take a system-wide view with the aim of improving outcomes for the Victorian community. The Commission took this to mean that it needed to extensively examine demographic and societal trends, the broader context or 'conditions' of the system that influence its operation, and the parts—or levers—of the system where a small change would produce a large, positive impact.

Designing a new system that acknowledges the current shortfalls within the system but also looks forward to the future was a challenge for the Commission. How it undertook that work—that is, its approach to systems design—is the subject of the next chapter.

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Chapter 2

The Commission's approach to reform

2.1 The need for a systems approach to redesign Victoria's mental health system

The Commission determined early on that major changes would be needed to create a mental health and wellbeing system that delivers better mental health and wellbeing outcomes for Victorians. There are entrenched problems with the current system, some of which reflect the unintended consequences of deliberate decisions by successive governments.

As the Commission noted in its interim report, Associate Professor Simon Stafrace, Program Director of Alfred Mental and Addiction Health, Alfred Health at the time, and now Chief Adviser of Mental Health Reform Victoria, described the effect of these decisions:

> the system is achieving exactly the results it was set up to achieve, every time a decision was made to take funding out, without keeping track of its impact on patients and their families. It is achieving the results it was set up for, every time decisions were made to fragment the system further by introducing elements that linked poorly with one another and that were not integrated with the broader health system of preventative primary health … every time we … turned a blind eye to deteriorating hospitals, the sub-standard accommodation, the homelessness, the poverty and the violence that is all too common an experience for people with severe mental illness. … We all have a hand in where we are today.[1]

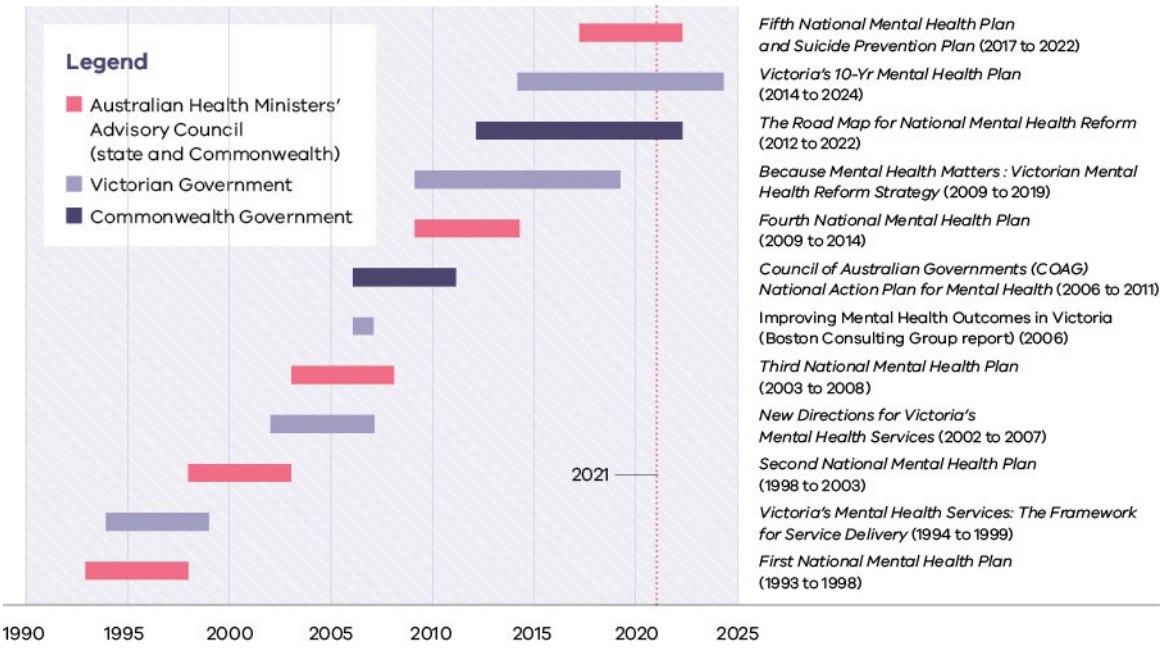
Governments have made many attempts to improve mental health outcomes in Victoria. Since the early 1990s, there have been at least 12 Commonwealth or Victorian Government 'strategic plans' for mental health (refer to Figure 2.1).[2]

The Victorian Government's 1994 *Victoria's Mental Health Services: The Framework for Service Delivery* was one of these plans. The framework laid a strong foundation for reform and aimed to achieve 'the same high standards in our mental health system as are expected in our general health system.'[3] Despite these ambitions and the strength of the government's proposed approach, investment in the mental health system continued to be insufficient to meet the needs of people living with mental illness. This remains the case today.[4]

The Victorian Government has known for at least a decade of these challenges. As described in a mental health strategy for 2009 to 2019:

> Action is needed not only to address the current needs of the Victorian population but to plan for the projected numbers of people likely to be seeking help for mental health problems in ten years' time.[5]

Figure 2.1: Plans and reports relating to Victoria's mental health system, 1990 to date



Source: Adapted from *Witness Statement of Associate Professor Ruth Vine*, 27 June 2019, para. 96.

The Commission found that this continued lack of investment in, and failure to give priority to, mental health relative to other areas of health expenditure are the result of deep-seated stigma and discrimination, among other factors. The Commission's evidence suggests that community attitudes can prevent people with mental health issues from seeking support and reduce policymakers' willingness to invest in mental health.[6] As one doctor submitted:

> services and research funding are not fairly distributed based on need—I see 'physical' health conditions such as cancer receiving disproportionately larger funding and world-class health services, when the need is much greater for mental health. The stigma is top-down and until the Government leads by showing parity and fairness, the people with mental illness will feel stigmatized. Until the message that mental health IS health, then we are never going to reduce stigma.[7]

2.1.1 A system in need of transformation

Due to a continued lack of funding and neglect, the Victorian mental health system is ill-equipped to meet Victorians' mental health needs.

To compound the situation, population growth and other societal changes have contributed to a significant increase in the estimated number of Victorians requiring mental health services.[8] In an already under-resourced system, these demand pressures mean that many people living with mental illness or experiencing psychological distress—including people who require intensive supports—can not access mental health and wellbeing services. In short, the system rations the vital mental health services that Victorians need.

System pressures, such as under-resourcing and outdated infrastructure, make it challenging for the mental health workforce to provide effective, contemporary care. There are also workforce shortages and an unevenly distributed workforce often more pronounced in rural and regional areas.[9] As outlined in the Commission's interim report, staff feel they are being deskilled and constrained by working environments that do not support their practice or development.[10]

In addition to these pressures, there is no clear oversight of mental health service delivery. A major contributor to the system's complexity, in fact, is that no single entity has complete oversight or control of the mental health system, and responsibility for funding and oversight is primarily shared between the Commonwealth and Victorian governments.[11] This has led to inadequate system planning characterised by limited demand forecasting, fragmented approaches across catchment areas, poor infrastructure planning and piecemeal implementation of previous reforms.[12] It also means that any major system reforms must overcome traditional sector, government or departmental boundaries of responsibility, which can act to limit collaboration, accountability and oversight. The Commission has also observed that the lack of oversight, in particular, has also contributed to inadequate monitoring and measurement of consumer outcomes and the inefficient and ineffective allocation of funding.[13]

When the Commission considered these factors together, it was clear that simply identifying improvements to the existing system would not deal with the root causes of current failures, and the ineffectiveness of past reforms reinforced that point. Instead, the Commission decided to undertake a transformational redesign of how mental health treatment, care and support are delivered in Victoria. This led the Commission to publicly commit to delivering an 'ambitious blueprint' to transform the mental health system into a mental health and wellbeing system, despite the complexities involved in doing so.

2.1.2 The nature of complex systems

It is difficult to achieve positive and enduring change in any complex system, including Victoria's mental health system.[14] This is because the features of complex systems can lead to unpredictability and unintended outcomes.

Complex systems are a group of visible and invisible interconnected parts that function together to achieve a goal. They are often characterised by:

- interdependent relationships with other systems
- deep, interdependent relationships between system parts, including parts that operate as a 'system within a system'
- dynamic behaviour, including an ability to self-organise, adapt, learn and develop new features over time in response to change, the outcomes of which are often unpredictable.[15]

These features, together with the challenges they pose to system-wide transformation, are briefly described in the following sections.

Interdependence

Complex systems are by their nature 'open' systems with fluid boundaries. They do not exist in isolation and often share deeply interdependent relationships with parts of other systems.[16] It is often unclear where one system stops and another starts because of these relationships and the various influences one system may have on another. Relationships across system or sector boundaries relating to policy, governance, funding or regulation mean achieving change or working towards a specific outcome will involve people with different interests in multiple systems.

The relationship between the mental health system and the housing sector illustrates this interdependence: just as mental health can affect a person's housing stability, a person's housing stability can also affect their mental health.[17] This means that decisions that substantially impact housing affordability or access to public and social housing can in turn influence a person's mental wellbeing, the subsequent demand on services and the mental health and wellbeing outcomes of consumers—issues that are managed primarily by the mental health system.[18]

Interdependent relationships between systems can also produce positive outcomes. This occurs when policy, funding and governance decisions are made in one system having first considered and understood the interdependent relationships with other systems. For example, evidence highlights how investing in integrated housing and support for young people living with mental illness not only improves mental health outcomes but also goes on to have a positive impact on consumer and system outcomes in other sectors including general health care, criminal justice and social services.[19]

While the Commission was limited in its scope to the mental health system, it has identified opportunities for integration with relevant sectors throughout this report.

Dynamic behaviour

Complex systems, such as Victoria's mental health system, are also characterised by their dynamic nature—how they change, grow or decline in response to broader changes within or around the system. For example, emergent digital technologies continue to shape the way the mental health system delivers treatment, care and support. There is growing use of and support for digital self-help tools,[20] and helplines such as Beyond Blue, Lifeline and Suicide Call Back now offer, or are moving to offer, multichannel and flexible access to support through text and web-based chat services.

Although constant change and adaptation occurs in complex systems, the exact nature and outcomes of this change are not entirely predictable. Changes in one part of a complex system have the potential to create large changes in other parts of the system that can be seemingly unrelated in time, proximity or proportion to the initial change.[21] This means that attempts to change a complex system can often produce unintended outcomes or consequences in other parts of the system.[22]

Figure 2.2 outlines how broader changes in and around the mental health system cause the system to adapt, creating a range of unintended consequences for services, those seeking mental health and wellbeing support, and the broader public.

Figure 2.2: Example of unintended outcomes caused by system adaptation

Complex systems not only constantly change but also have the capacity to self-organise, learn and evolve over time. Without a deliberate intervention or change, a complex system is capable of developing new (emergent) features, functions or purposes. Emergent features can improve the system's ability to meet a desired purpose, or erode it. In Victoria's mental health system, the inability of the system to meet the needs of the 'missing middle' is an example of an undesirable system feature that has evolved over time. A large service gap exists for people who cannot access mental health services because their needs are too complex for primary care services but who also do not meet the high threshold for treatment in a public specialist clinical mental health service.[23]

This has emerged as a consequence of funding structures and investment decisions; demand pressures; service fragmentation; and inadequate community-based service capacity. This 'missing middle' is now a defining feature of the current system.[24]

Understanding such adaptive and emergent features can only occur with a deep analysis of system parts, their interrelationships and the overarching purpose guiding system behaviour.[25]

The challenge of achieving positive and enduring change

The Commission used a 'systems change' approach to design the future mental health and wellbeing system described in this report. Systems change refers to processes, methods or practices that change the underlying influences on system behaviour, the way system actors (including the people who regulate, fund, work in and govern the system) behave, or how the overall system functions.

Systems change cannot be achieved by directing or controlling a complex system to produce an outcome.[26] The relationships between system parts, together with the constantly changing nature of complex systems, mean complex systems must instead be influenced or encouraged to produce a desired outcome. This is achieved by shifting the underlying conditions that hold the most influence over how the system, and those people within the system, operate.[27]

In relation to the mental health system, for example, this may require changes to parts of the system that appear distant, unrelated or even counterintuitive to achieving the desired outcome. These underlying system conditions include:

- structures, policies and practices
- resources (such as people, knowledge, information, infrastructure or funding)
- the relationships between system actors or parts
- the values, beliefs and attitudes that inform how people interact with or operate in the system.[28]

A deep and accurate understanding of these underlying conditions, how they relate and how they influence the behaviour of the mental health system will commonly reveal the changes that are most likely to produce the intended outcome in the system. While smaller, isolated or temporary changes to the system could be achieved by changing the underlying conditions of the system, the success of enduring and positive system-wide transformation is likely to rely on other factors including:

- the clarity of the vision for change
- the strength and unity of leadership
- the degree to which system actors, consumers, families, carers and supporters are engaged and empowered
- whether a culture of ongoing learning and improvement is fostered as part of the change process.[29]

Traditional problem-solving approaches may not adequately consider these factors, and therefore they are not effective tools to promote systems change.[30] Instead, a broad range of systems-specific methods and tools can be used to create positive and enduring change in complex systems.[31]

David Stroh, who writes about 'systems thinking', suggests that one of the main differences between traditional problem-solving approaches and systems approaches is the priority placed on motivation, collaboration, a continuous learning mentality and identifying the underlying system conditions that will produce positive changes across the system.[32] These approaches force a deep awareness and understanding of the features of complex systems and make the transformation of such systems possible (refer to Box 2.1).

Box 2.1: How systems thinking deals with challenges of change in complex systems[33]

Systems thinking:

- motivates people to change because they discover their role in worsening the problems they want to solve
- encourages collaboration because people learn how they are creating the unsatisfying results they experience
- focuses on a few important changes over time to achieve large system-wide impacts that are also sustainable
- promotes continuous learning, which is an essential characteristic of meaningful change in complex systems.

2.1.3 The complexity of Victoria's mental health system

Victoria's mental health system is indeed a complex system. As discussed in Chapter 1: *The reform landscape*, it is heavily influenced by the wider context in which it operates, and its components are very closely connected. Its complexity arises from three main features:

- the complex nature of poor mental health and mental illness, the social factors that affect people's mental health, and the resulting relationship between the mental health system and other service systems
- the scale and diversity of different system parts and individuals, groups or organisations that operate in or influence the way a system behaves, including the complex relationships between the parts of the system
- the different perspectives of system actors, consumers, families, carers and supporters on issues relating to mental health.

The complexity of mental health and its causes

The causes of poor mental health are complex. Mental illness can be influenced by people's social, cultural, economic and physical environments. Public housing, social security, general health, education, justice and employment policy and services can all affect a person's mental health and wellbeing.[34] A person's access to mental health services can also be influenced by surrounding social conditions that have little direct connection with the mental health system.[35] These factors mean the mental health outcomes of the Victorian community do not rest within the control of any one system, sector or entity.[36] Any attempt to change Victoria's mental health system must consider this broader 'mental health ecosystem'—including the interrelations within and between other systems, sectors and the mental health system.[37]

The scale and diversity of system parts and relationships between them

The scale, diversity and relationship between the parts and actors within Victoria's mental health system also contribute to its complexity. The Commission estimates that more than 1.1 million Victorians will experience mental illness each year.[38] Many will seek or use some level of informal or formal support through Victoria's mental health system.

The system provides diverse mental health services including: primary care and general counselling; clinical treatment and wellbeing supports (currently called 'psychosocial supports'); public specialist mental health services; and emergency and crisis services. These services are delivered in different settings—including homes, community-based clinics, private practices and hospitals—and access to services is often organised by a combination of age, location and severity of illness.

The mental health workforce is similarly diverse, with medical, nursing and allied health staff, peer workers and a wide range of social and community service professionals providing services to consumers. It is in fact so diverse that historically it has been difficult to determine its exact make-up.[39]

The relationships between the different structural parts of the system—or system enablers—that support the delivery of mental health treatment, care and support also contribute to the system's complexity. Mental health service providers and services are subject to varying governance, funding and regulatory arrangements. These arrangements may be specific to particular services, workforces, locations or consumers. Specific arrangements also apply to broader functions beyond service delivery. These include data and information management, research and innovation functions.

In addition, the shared roles and responsibilities of the Commonwealth and Victorian governments provide another major source of complication. Each government applies different governance, funding and regulatory approaches to the system depending on service and provider type.

The lack of clarity about these different approaches contributes to the complexity and fragmentation of the system.[40] This view is shared by all levels of government, with the Prime Minister stating at the release of the Productivity Commission's *Mental Health Inquiry Report* that 'the system is too complex and uncoordinated …', and calling for streamlined processes to resolve those 'important areas … where mental health services have been found to be ambiguous or missing'.[41] This is a view strongly shared by those who experience and work in the system and has been acknowledged by and between services themselves.[42]

Different views about mental health

A range of perspectives about mental health also contribute to the system's complexity. Aligning the interests of those who regulate, fund, govern, use, need, work in or benefit from the system is difficult.

Even within these individual interest groups, there can be vast differences in views about how mental health treatment, care and support should be provided, why rates of mental illness remain relatively constant and why problems with the mental health system persist.[43]

These diverse perspectives and interests form part of the fabric of Victoria's mental health system. While they may not be visible, they comprise the values, attitudes and beliefs, power dynamics and relationships that create the underlying conditions for the system's operation.

2.1.4 Changing the mental health system

This complexity, and the level of change envisaged by the Commission, required an inquiry process that went beyond identifying opportunities for isolated improvements to the existing system. As one person told the Commission, '[w]e don't want to fill in the pot holes, we want a new road.'[44]

The Commission determined that Victoria's mental health system needed more than improvements to obvious system structures or to existing services or programs. It needed more than just funding for new programs. Instead, it needed a systems approach to change—an approach that sought to understand the underlying conditions that would transform the current mental health system into a mental health *and wellbeing* system that measures good mental health in terms of a person's ability to participate, enjoy and achieve their full potential in all aspects of life. To achieve this transformation, this systems change approach would also have to support a fundamental shift in the purpose and structure of the mental health system towards a focus on responsive and accessible community-based services that are integrated with other services to support consumers' wellbeing.

Adopting a systems approach to achieve this transformation has meant responding to the complexity of the system, clarifying areas of focus, determining the major system levers necessary for enduring and positive change, and fostering a culture of inclusive engagement throughout the Commission's inquiry.

2.2 How the Commission adopted a systems approach

The Commission used a range of processes to develop its understanding of the existing system and to identify the most effective reform options. These included formal inquiry processes such as gathering evidence through public hearings, community engagement and public submission processes. The Commission also regularly exercised its power to require relevant organisations to produce documents and other evidence under the *Inquiries Act 2014* (Vic) to support its inquiry.

To supplement these, and to inform its approach, the Commission also drew on academic research and literature on systems change, including the systems change framework (refer to Figure 2.3). This framework is similar to other methodologies used to support systems approaches, including the United Kingdom Design Council's 'double diamond' innovation framework and the 'transformative systems change' framework created by Professor Pennie Foster-Fishman and colleagues.[45]

The systems change framework comprises a four-stage process of inquiry:

- **define the situation**—define the purpose of the system and the planned change
- **gain clarity**—better understand the underlying problems and conditions that affect the system
- **find leverage**—find out where to intervene in the system for the greatest impact
- **act strategically**—take steps to create and sustain positive change.

Each stage provided a way to frame and understand the Commission's focus and activities. The stages encouraged the Commission to consistently 'lift' its analysis and discussions to focus on reforms that would transform Victoria's mental health system, not just improve its parts.

The systems change framework also reflects the Commission's efforts to embed a broader systems-change mindset in its work. Encouraging systems practice, purposeful engagement with interested parties, and ongoing reflection and learning helped embed this mindset. Box 2.2 explains this concept.

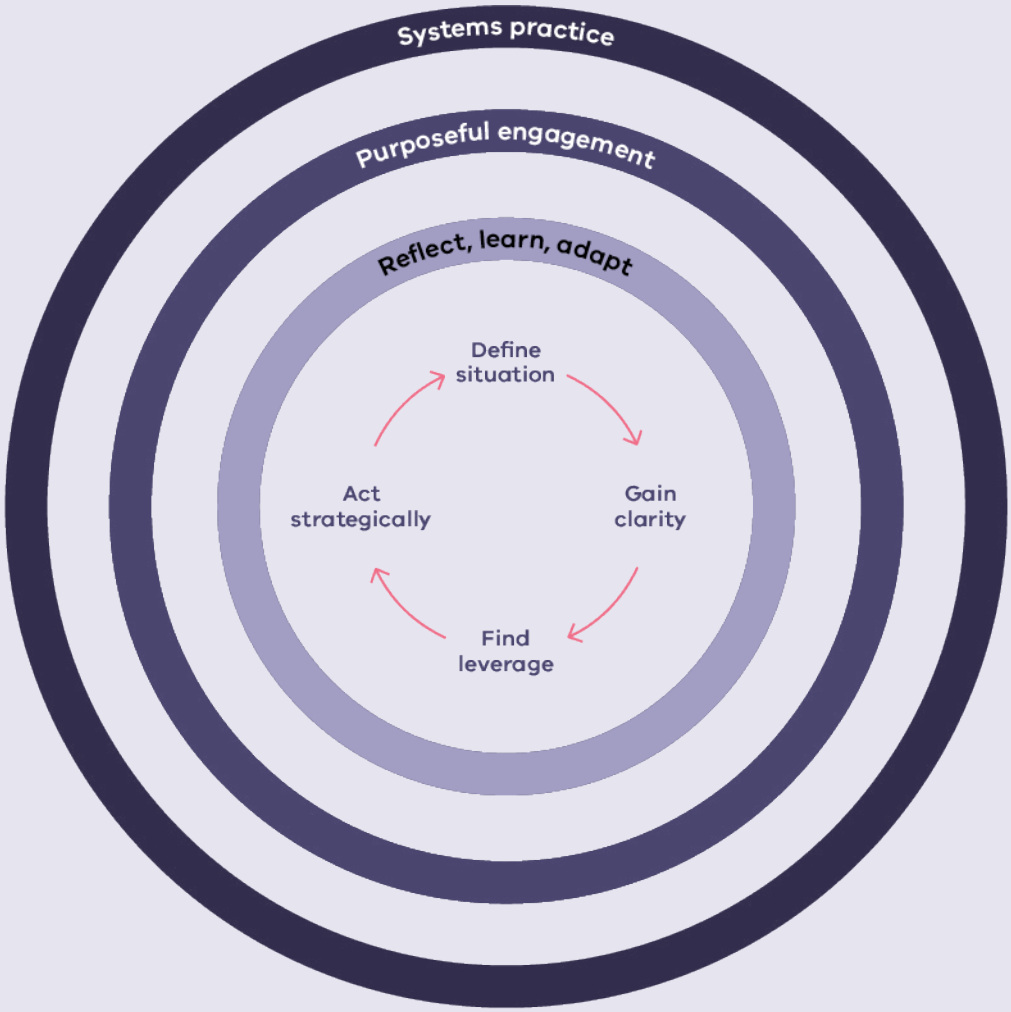
2.2.1 Purposeful engagement

The experiences, perspectives and expertise of the public, particularly people with lived experience, formed a critical part of the Commission's inquiry process.

This sentiment was reflected in the Commission's first public statement:

> We want to hear from as many different people as possible and we will provide multiple ways for people to share their experiences and make contributions throughout the life of the Commission. This will be a Royal Commission for all Victorians.[46]

Figure 2.3: Systems change framework



Source: Dr Seanna Davidson and Michelle Morgan, *Systems Change Framework*, 2018, pp. 5–6.

Box 2.2: How the Commission embedded a systems-change mindset in its work

Systems practice meant tackling ambiguity, complexity and uncertainty with confidence. It involved looking across the system to assess potential impacts of change, down into detailed system parts to identify the root cause of issues and then lifting back up to see how, as a whole, the Commission's reforms would work together to achieve a single, unified purpose.

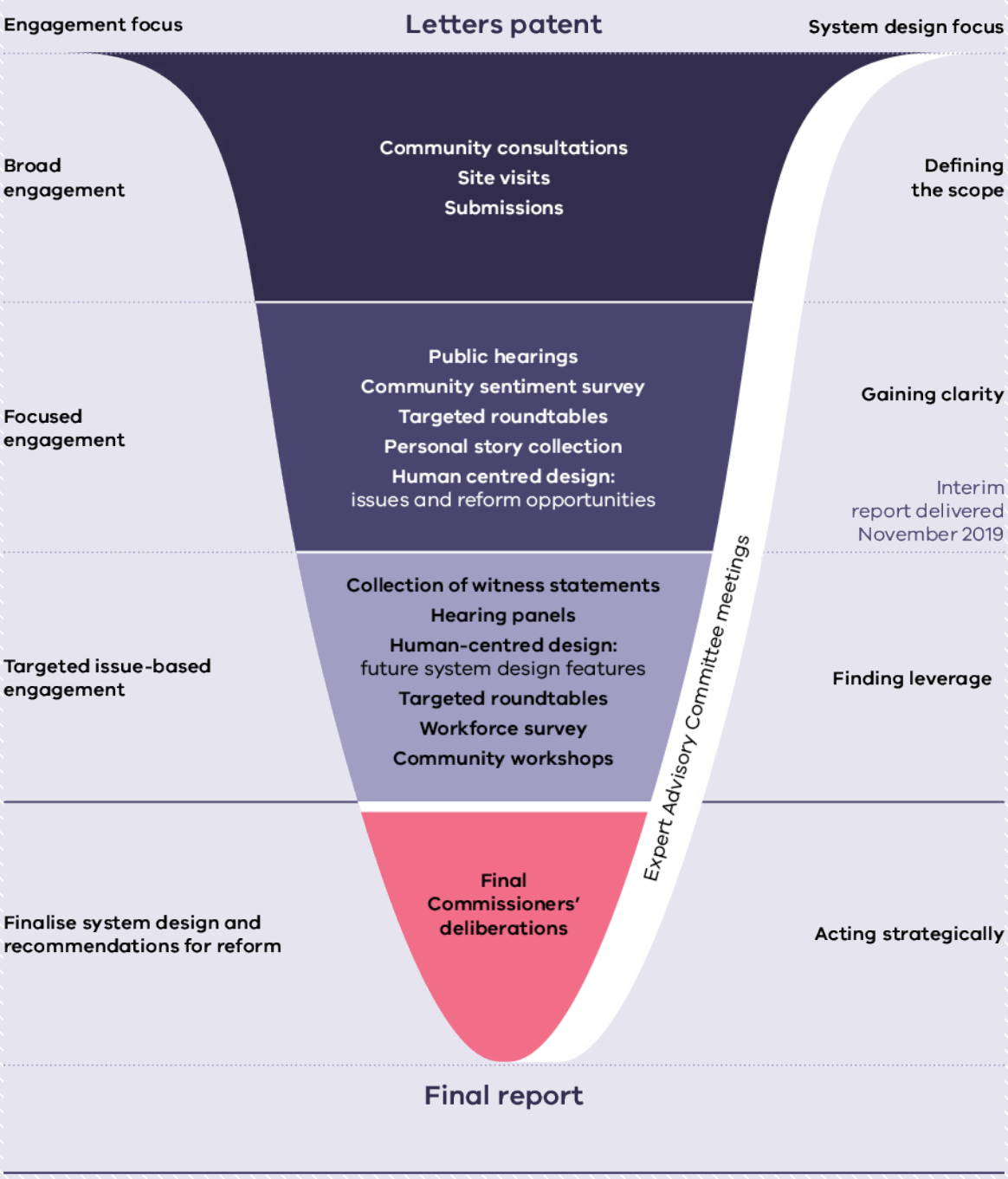
Purposeful engagement acknowledged the important role of the public in shaping the Commission's reforms. In particular, the Commission listened to the voices of people with lived experience, the mental health workforce and people with diverse expertise in areas outside of the mental health system. By supporting continued conversations between people with diverse perspectives, expertise and experiences, the Commission made it possible for new insights about the system to emerge and be incorporated into the future system's design.

The Commission's continued **reflection, learning and adaptation** promoted a flexible and responsive approach to uncertainty and complexity. It adapted to major societal events like the 2019–20 summer bushfires and the COVID-19 pandemic and their social, economic and mental health implications. It also adapted its work to reflect major policy developments that came from royal commissions and inquiries happening at the same time, the Productivity Commission's *Mental Health Inquiry Report*, and new funding and program initiatives announced by the Victorian and Commonwealth governments.

Systems change begins with diverse, deliberate engagement. Understanding diverse views—and the different histories, cultures and goals that inform them—is critical to identifying reform opportunities.[47] Deliberate and focused engagement also helps transform systems by finding the systemic and often hidden causes of issues, identifying overlooked resources and seeing familiar issues in new ways.[48]

To foster inclusive and diverse engagement in the process, the Commission tailored its approach at each stage of the inquiry (refer to Figure 2.4). Early on, the Commission undertook broad engagement to provide opportunities for the public to identify underlying issues with the current system and to share their ideas about how to reform it. This feedback helped further define the main reform challenges and opportunities for further investigation.

Figure 2.4: The Commission's engagement activities



As the inquiry progressed, the Commission's engagement approach became more focused. This helped clarify the underlying system conditions contributing to the current state of the system and to identify which system levers should be used to effect major transformation. The Commission heard from people with a detailed understanding of the mental health system, including consumers; families, carers and supporters; the workforce; mental health academics; and government officials with system responsibilities.

The Commission used public hearings, witness statements, roundtables, focus groups and targeted consultations to understand these different experiences and perspectives. This input helped the Commission test its understanding of the system and gain deeper insights into the issues identified by the public.

As the Commission's attention shifted to identifying opportunities for reform, it used witness statements, targeted panel hearings, a dedicated Expert Advisory Committee and Consumer Foundations Working Group, roundtables and focus groups to inform its deliberations. These processes brought together perspectives on one or more specific reform issues identified by the Commission.

Throughout the inquiry the Commission also considered broader expertise outside Victoria's mental health system. It engaged with mental health experts in most Australian states and territories and sought specific advice from international experts in mental health policy and service delivery, lived experience, system governance and performance monitoring, as well as healthcare system transformation and design. The Commission obtained valuable insights from New Zealand, the United Kingdom, Scotland, Canada and the United States through these engagements.

The Commission's engagement activities are described in more detail in Volume 5 of this report.

2.2.2 Promoting the voices of those with lived experience

Alongside the Commission's broader engagement approaches, it sought to harness the perspectives of people with lived experience.

The central role of lived experience in systems change is highlighted in systems literature.[49] This is most clearly described by healthcare systems expert Professor Jeffrey Braithwaite and colleagues, who argue that placing the patient (or consumer), their experience and wellbeing at the heart of system reform is the 'most crucial' lesson of successful healthcare reform in recent times.[50]

The Commission adopted specific and tailored engagement approaches to promote the voices of people with lived experience. These included holding dedicated consumer and family, carer and supporter 'human-centred design' focus groups and establishing a Consumer Foundations Working Group to provide the Commission with further consumer perspectives across its work program. Human-centred design involves putting the user at the heart of the design process to support citizen-centric decision making and create health policy solutions that better serve the community.[51]

These approaches were designed to challenge the prevailing power dynamics of the system reported by people with lived experience. For example, in the Commission's focus groups, people with lived experience of mental illness or psychological distress described feeling invisible and having little influence, neither in the community, nor within the services and structures of the mental health system:

> I want to be respected. I feel like I'm not listened to. I feel I'm unsafe, lonely, isolated and trapped in in-patient centres … There's a lack of respect, dignity and compassion.[52]
>
> it just ma[kes] you feel disheartened … like that you can't go back [to a service provider] because then they're not actually listening. They're looking for [a] box to tick on paper. And that's their purpose rather than actually understanding what you … need.[53]

Similar experiences were also identified through family, carer and supporter focus groups:

> we're often kind of delegated to being invisible, but we don't want to be invisible anymore.[54]
>
> at the end of the day, you know, I feel like I was absolutely left behind and I fell through the cracks.[55]
>
> I think in that sense, as a carer I'm not listened to … sometimes I need that support and guidance to help me and even still, there are situations where it doesn't matter how hard I fought, I'm not going to be listened to.[56]

As consumer academic Ms Cath Roper and colleagues note, without acknowledging or dealing with these power imbalances, those with the most power will continue to enjoy 'the greatest influence, regardless of the quality of their ideas or skills.'[57]

The Commission is grateful for the diverse contributions it received from people with lived experience. These contributions are highlighted throughout this report.

2.3 How the Commission identified problems and reform opportunities

In complex systems it is common for undesirable outcomes or positive changes to come from parts of a system that are hard to see. They can result from the relationship between system parts or actors, the distribution of power, organisational culture or deeply held and hidden assumptions, values or beliefs—often termed 'mental models'.[58]

For this reason, in the early stages of engagement the Commission sought to clarify the underlying conditions of the mental health system that contributed to people's negative mental health outcomes and experiences. At the same time, the Commission also worked to find out people's aspirations for treatment, care and support experiences. The aim was to look deep within the system to identify the right changes, in the right parts of the system, that would transform the system as a whole.

Both traditional inquiry processes—such as submissions, public hearings and community consultations—and more innovative engagement processes supported the Commission during this stage. For example, the Commission engaged a market research company to conduct a community sentiment survey that helped identify current attitudes and perceptions about people living with mental illness and about Victoria's mental health system. The survey results helped to shape the Commission's reforms relating to stigma, discrimination and the role of communities, places and sectors in promoting better mental health.

2.3.1 Understanding different perspectives

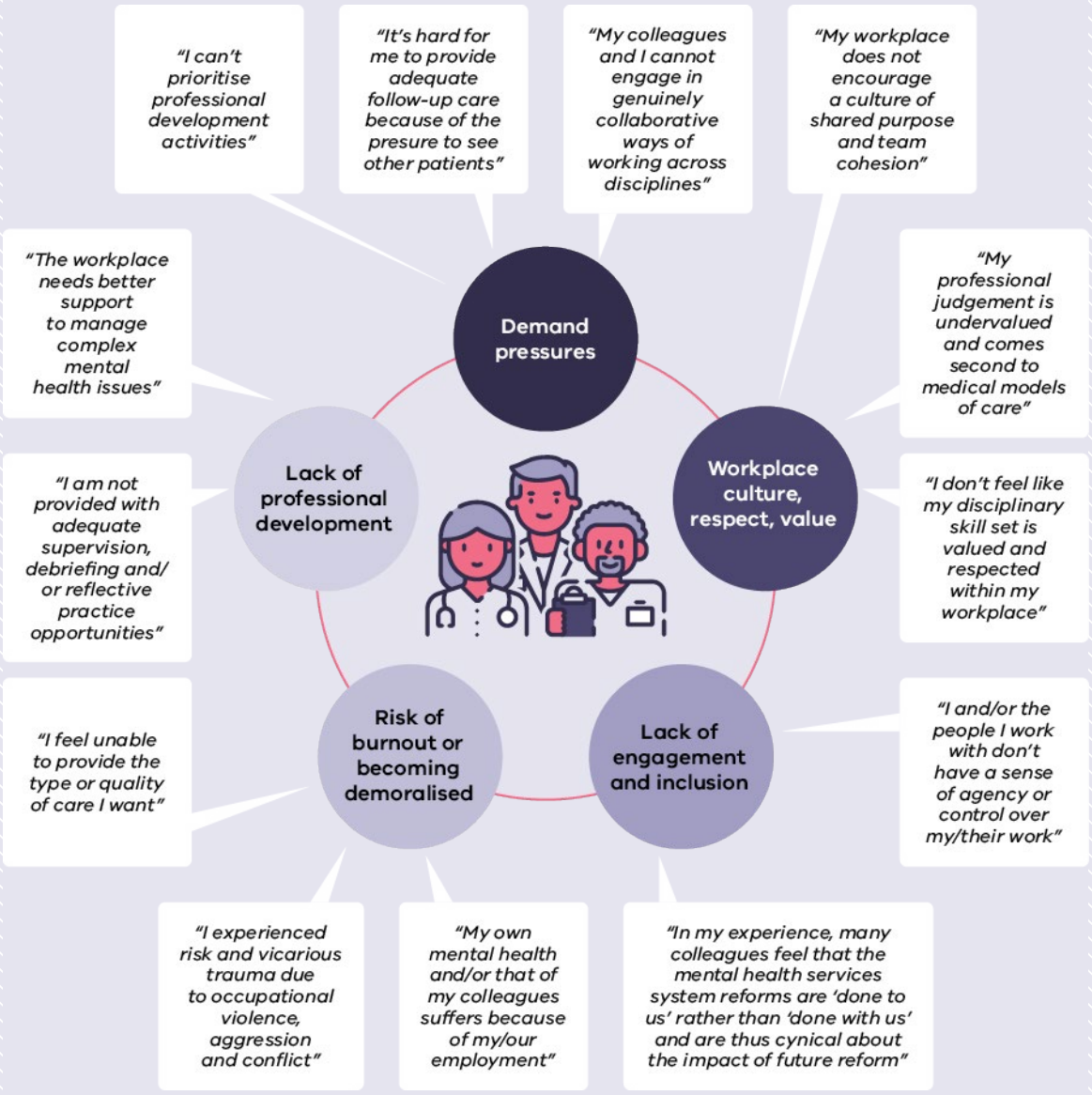
It is important to consider diverse perspectives to understand not only the system but also how to change it.[59]

The Commission used human-centred design activities, formal hearing panels and issues-based focus groups to gain new insights into the mental health system and to clarify where the underlying problems and potential opportunities for reform existed.

Drawing on human-centred design practice, the Commission hosted a range of focus groups with consumers, families, carers and supporters as well as representatives of the mental health workforce.

Through these workshops, participants helped the Commission clarify priorities and the main aspirations they held for a future mental health and wellbeing system. This allowed the Commission to compare the perspectives of people from different groups, ages and locations to identify points of commonality and difference for further investigation. Problems and opportunities were categorised by theme to guide subsequent reform deliberations. For example, Figure 2.5 shows how contributions from workforce focus groups were thematically grouped and considered by the Commission.

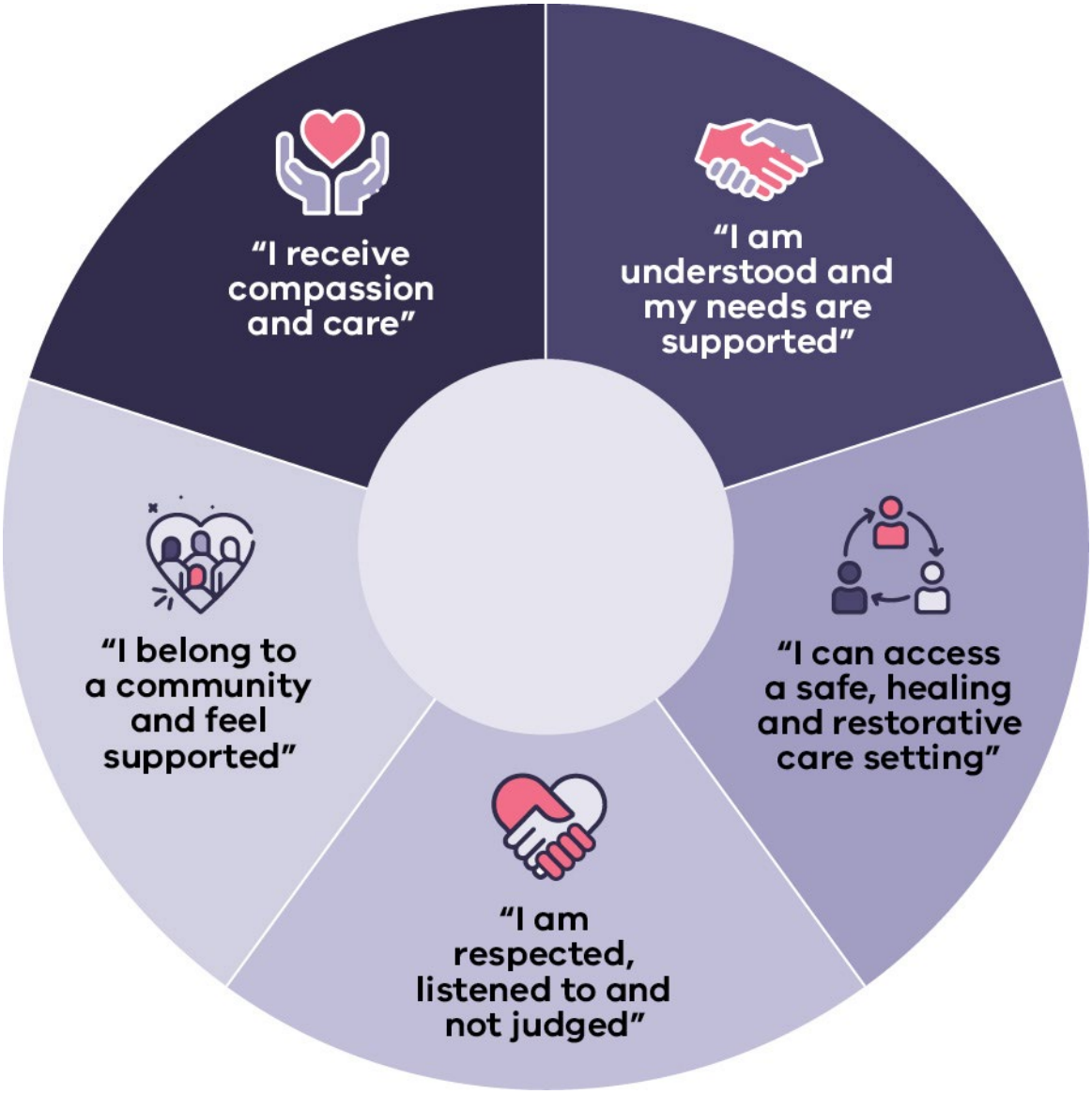
Figure 2.5: Top issues of concern identified at workforce focus groups



Source: RCVMHS, *Workforce Human-Centred Design Focus Group: Record of Proceedings*, 2020.

The Commission noted that even though different groups had different experiences and perspectives, this did not always lead them to identify different priorities for change. For example, consumers, families, carers, and supporters often had very similar hopes for the future mental health and wellbeing system. These were captured in five overarching statements about the future (refer to Figure 2.6).

Figure 2.6: Overarching statements about the future of mental health and wellbeing services identified through human-centred design



Source: ThinkPlace Australia, Correspondence to the RCVMHS: CSP.0001.0113.0001, Phase 1, Human Centred Design Insights Report: Validation of the Current System Experiences of, and Aspirations for, Victoria's Mental Health System, 2020, p. 16.

The Commission used hearing panels as another approach to participation. Organised by topic, these panels provided the Commission with the perspectives of multiple experts at the same time. Panels comprised people with lived experience expertise and people with service delivery, system management, regulation, governance, legal and academic expertise. Experts shared their perspectives on evidence before the Commission, discussed ideas for reform and responded to the ideas and perspectives of other panellists. These panel discussions were led by Counsel Assisting the Commission.

2.3.2 The role of data, research and traditional inquiry methods

The Commission also used traditional inquiry methods to clarify underlying system structures. In addition to the 3,267 submissions and detailed engagement summaries it considered, the Commission used more than 7,500 research articles and reports to understand current issues and reform opportunities. During the inquiry, more than 12,000 pages of analysis were produced and considered as part of the Commissioners' formal deliberations and discussions alone.

Data also helped deepen the Commission's understanding of the current system. The Commission used the Victorian Social Investment Integrated Data Resource to consider the mental health and wellbeing needs of certain populations at a specific time (cross-sectional data) and over time (longitudinal data). Longitudinal datasets provide valuable insights about mental health over a lifetime, which cannot be derived from standalone datasets. This data resource combined information on Victorian health care, community care, education, crime and safety.

The Commission also created a merged deidentified dataset. This included a range of Victorian and Commonwealth data. It provided new insights into how Victorians use mental health services and allowed the Commission to undertake analysis that had not previously been possible. This merged dataset helped the Commission understand how consumers use Victoria's mental health services and other intersecting service systems (such as housing and justice). This provided the Commission with insights relating to different cohorts and demographics, and helped identify priority groups and services for integration. Examples of these innovative approaches to data, including to inform workforce planning, are highlighted throughout this report.

2.3.3 Partnering with global experts

The Commission partnered with international experts and universities to support the identification of leading practice in systems design, and to place its work in a wider context. Leaders in areas as diverse as business, academia, systems engineering and design, implementation science, public policy, regulation, digital services and social innovation provided valuable expertise to the Commission.[60]

They helped the Commission to distil the complexity of Victoria's mental health system, to place it in a wider societal context, and to identify opportunities to reform it. In particular, the Commission acknowledges those who advised it through its systems advisory function, and the Monash University Sustainable Development Institute, which held several 'future focused' workshops for the Commission. Others also pushed the Commission beyond a traditional mode of inquiry; for example, the Business Council of Australia hosted a roundtable with large digital companies; and Mr David Pearl, founder of Street Wisdom, educated staff on the power of community and the value of place. Chapter 39: *The work of the Commission* outlines the breadth of this engagement.

2.3.4 Perspectives on problems and reform opportunities across the mental health system

People's individual experiences and professional perspectives, combined with detailed research and data analysis, strengthened the Commission's understanding of Victoria's mental health system. This meant the Commission saw beyond individual events, experiences and perspectives to identify important patterns or trends within, and across, the system.

Some parts of the system were more obviously identifiable—like its structures, policies and processes. Others were less visible, like the power dynamics at play and the way the system allocates its resources. As illustrated in Box 2.3, deeply held and often hidden assumptions, values or beliefs (mental models) can also have a significant effect on how a system operates.

In systems practice, this process is commonly associated with the 'iceberg model'.[61] As inputs are collected and analysed as a whole, they form the basis for deep insights beyond those easily seen on the surface of the system. Figure 2.7 shows the relationship between individual inputs, system insights and the underlying problems or opportunities for change. The Commission repeated a similar process for each systemic pattern or trend it identified.

Themes emerged from individual events and experiences shared with the Commission, as well as from analysis of systems performance information and data. The Commission used these themes when it went on to identify which changes could be used to effect enduring and positive system transformation.

Box 2.3: The influence of 'mental models' on the way systems work

Mental models are often overlooked when examining systems. They reflect society's deepest assumptions, values and beliefs, and have a critical influence on how systems work.[62] If harnessed correctly, they are capable of totally transforming the way systems work.[63]

The Commission identified underlying assumptions, attitudes, values and beliefs that contribute to a damaging mental model of mental health in Victoria. If these are not addressed, they will reduce the effectiveness of the Commission's other reforms:

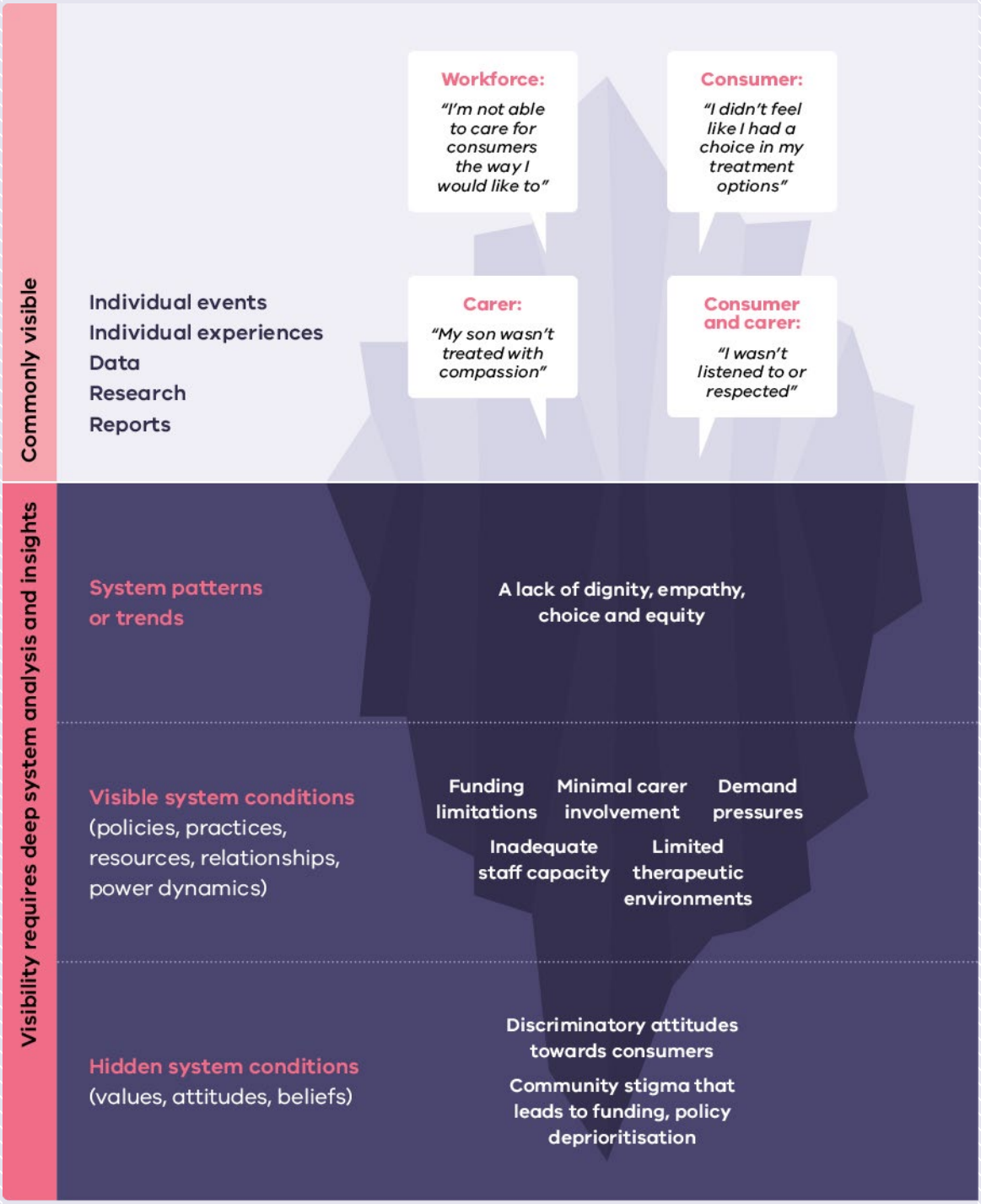
- The public still struggles to understand mental illness and lacks empathy for people living with mental illness. This in turn causes self-stigmatisation of people living with a mental illness, and it can discourage them from getting help.[64]
- Stigma, discrimination and prejudice are still common experiences for people with mental illness. Ms Kym Peake, the then Secretary of the former Department of Health and Human Services, identified these beliefs and attitudes towards people with mental illness as being 'at the heart' of the imbalance in how the general health and mental health sectors are resourced.[65]
- There is a widespread belief—based on isolated events, fear or ignorance—that people with mental illness are dangerous. This can result in risk-averse policies that reflect public fear or ignorance rather than evidence, and may have a greater than necessary impact on people with mental illness.[66]

One of the clearest examples of damaging mental models of mental health was expressed by Professor Patrick McGorry AO, Executive Director of Orygen and Professor of Youth Mental Health at the University of Melbourne who gave evidence in a personal capacity. Professor McGorry explained the prevailing 'bigotry of low expectations' that erodes the effectiveness of the mental health system:

> [the bigotry of low expectations is] about the low expectations that we've been forced to have for recovery in our [mental health] patients. … the system is forced into just accepting that the best that you can do for a patient is that they can be not acutely unwell and bothering the emergency department. … And more subtly, if they're just at home and they're reasonably happy and not suicidal or depressed, but not working and just languishing, that's also okay.[67]

Chapter 25: *Addressing stigma and discrimination* further discuses stigma and discrimination and the Commission's related reforms.

Figure 2.7: Identifying the underlying problems with Victoria's mental health system



Source: Adapted from David Peter Stroh, *Systems Thinking for Social Change: A Practical Guide to Solving Complex Problems, Avoiding Unintended Consequences, and Achieving Lasting Results* (Vermont: Chelsea Green, 2015), p. 49.

2.4 Finding ways to transform Victoria's mental health system

Having identified the underlying parts of the system—from structures to mental models—contributing to current problems, the Commission started considering potential reform opportunities. From here, it shifted its focus to transforming the system. At this stage of the inquiry, the Commission wanted to identify systems levers—that is, those parts of the system where a small change would create large, positive changes across the system.

2.4.1 A clear vision to support reform

Before examining ways to change the system, the Commission needed to identify the desired outcomes of the system's transformation.[68] The Commission's guiding principles, which were developed following its community consultations, served this purpose (refer to Figure 2.8). These principles reflect the Commission's aspirations for a new mental health and wellbeing system. The Commission's recommendations each contribute to one or more of these principles.

2.4.2 Identifying 'levers' of change

As stated at the beginning of this chapter, changing a complex system is difficult. System transformation occurs when a profoundly different structure, culture or level of performance emerges due to changes to what has previously been accepted as a possible or necessary outcome of the system.[69] It is more than adding new parts to the system or improving existing ones; it involves rethinking how the system's structures, relationships and culture work.[70] The United Kingdom's National Health Service highlights how visible and less visible parts of a system, such as relationships, values and mindsets, must be considered as part of systems change:

> to bring about fundamental change in complex systems we also need to recognise the importance of patterns of positive mindset and behaviour.
>
> Often, the failure to achieve fundamental change through re-organisations, new programmes, and service re-design efforts lies in the fact that the underlying patterns of relationships, decision-making, power, conflict and learning in the system remain unchanged and unchallenged.[71]

Recognising that systems change requires 'shifting the conditions that are holding the problem in place',[72] the Commission had to 'lift' its thinking to identify the system levers capable of transforming Victoria's mental health system.

Figure 2.8: Guiding principles for Victoria's mental health and wellbeing system

Guiding principles for Victoria's mental health and wellbeing system

The Royal Commission acknowledges that mental health and wellbeing is shaped by the social, cultural, economic and physical environments in which people live and is a shared responsibility of society.

It envisages a mental health and wellbeing system in which:

1	The inherent dignity of people living with mental illness or psychological distress is respected, and necessary holistic support is provided to ensure their full and effective participation in society.
2	Family members, carers and supporters of people living with mental illness or psychological distress have their contributions recognised and supported.
3	Comprehensive mental health treatment, care and support services are provided on an equitable basis to those who need them and as close as possible to people's own communities—including in rural areas.
4	Collaboration and communication occur between services within and beyond the mental health and wellbeing system and at all levels of government.
5	Responsive, high-quality, mental health and wellbeing services attract a skilled and diverse workforce.
6	People with lived experience of mental illness or psychological distress, family members, carers and supporters, as well as local communities, are central to the planning and delivery of mental health treatment, care and support services.
7	Mental health and wellbeing services use continuing research, evaluation and innovation to respond to community needs now and into the future.

Note: These principles are in large part based on the many contributions made to the Commission, as well as relevant international documents such as the United Nations' *Convention on the Rights of Persons with Disabilities*, the World Health Organization's publications on mental health (including its 2014 report with the Calouste Gulbenkian Foundation on the social determinants of mental health) and legislation such as the Commonwealth Government's *Carers Recognition Act 2010*.

To do this, the Commission lifted its focus away from the detailed specifics of underlying problems and opportunities to look across the system and consider how system-wide conditions were keeping the system, and its problems, in place.[73] As outlined below, these systems conditions include:

- readily visible parts, such as government policies, organisational practices or the allocation of resources
- observable parts, such as relationships and connections or power dynamics
- hidden parts, such as underlying beliefs or values.[74]

Once these conditions were understood, 'system levers'—places where a seemingly small or discreet shift in one part of the system produces big changes across the system—could be identified and actioned.[75]

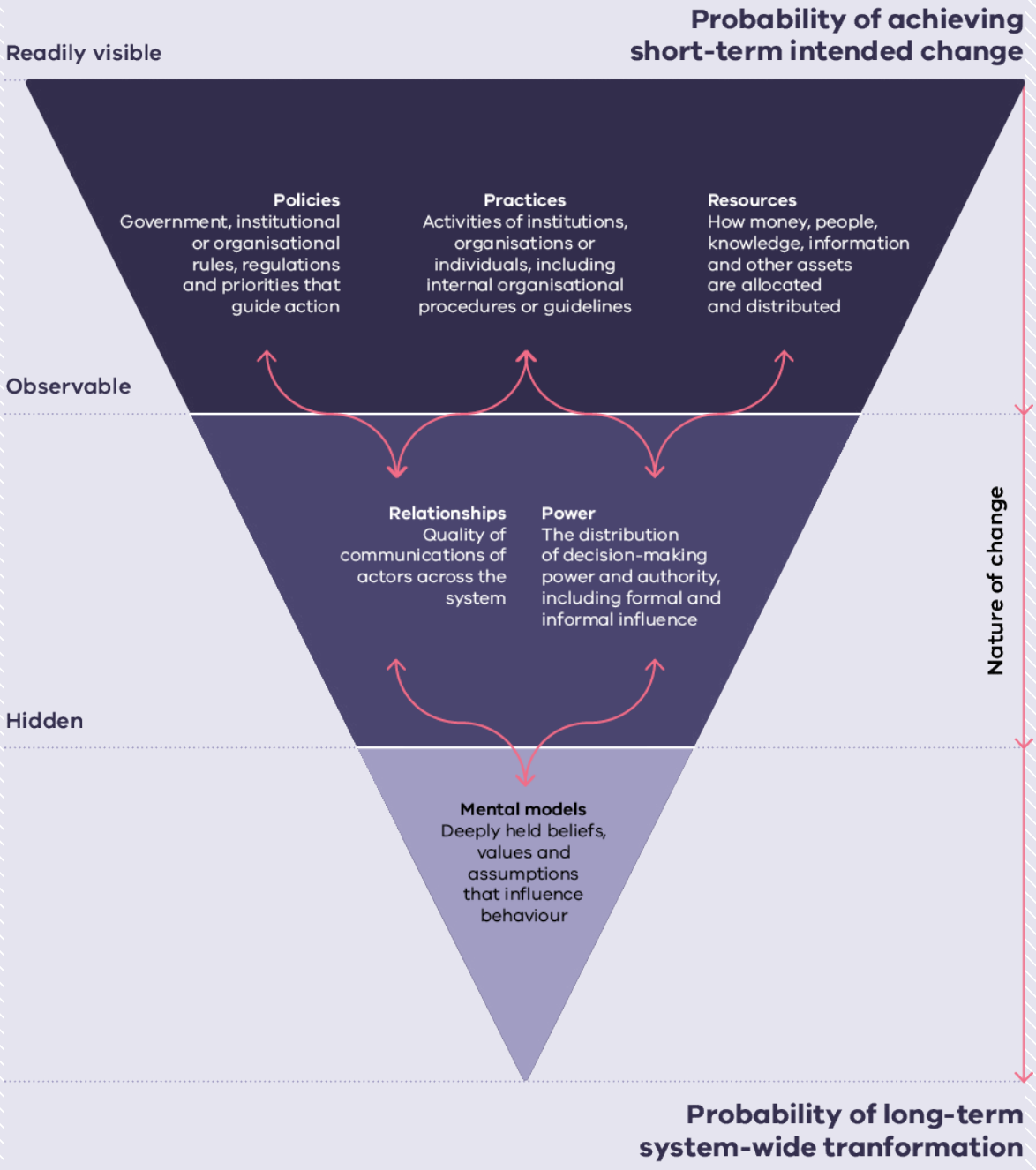
The Commission first exercised this approach in its interim report, laying the groundwork and immediate priorities for change. For example, the 'lever' of the Victorian Collaborative Centre for Mental Health and Wellbeing, while just one institution, holds a mandate to influence mental health and wellbeing treatment, care and support across Victoria, with a view to changing some of the 'deeper' characteristics of the system. While the Collaborative Centre will affect observable system conditions by increasing system resourcing and improving mental health treatment, care and support practices and system-wide policies, its core functions will also address, in some way, the relational, power and mental models that influence the current system's operation. A core function of the Collaborative Centre, as described in the interim report and evidenced by the centre's title—is collaboration: to bring together people with lived experience, including consumers, families, carers and supporters, researchers, and clinicians to 'work together to improve service delivery and research.'[76] It should also have influence beyond the service system, with its role described as 'positively influenc[ing] the way society thinks about mental health'[77] and its purpose including 'to demystify perceptions that perpetuate the stigma and discrimination that people living with mental illness continue to experience.'[78]

As Figure 2.9 shows, system-wide transformation requires changes to all conditions—those that are readily visible, those that are observable and those that are hidden. In addition to changes to direct policies, practices and resources, the Commission considered reforms that would:

- improve relationships and connections across different parts of the system
- tackle power imbalances between system actors, consumers, families, carers and supporters
- challenge deeply rooted attitudes, values and beliefs that were inconsistent with the Commission's vision for reform.

Unless these conditions are aligned with the Commission's overarching reform intent, changes to structures, policies and resources would be unlikely to achieve the profound transformation that is required.

Figure 2.9: Conditions of systems change



Source: Adapted from John Kania, Mark Kramer and Peter Senge, *The Water of Systems Change*, 2018, p. 4.

2.4.3 Identifying reform directions to transform Victoria's mental health system

The Commission sought ideas for reforms that would 'shift the conditions' of Victoria's mental health system. The initiatives it identified built on work done during the Commission's 2019 participation activities—particularly the human-centred design focus groups—and again focused on consumers, families, carers and supporters, the workforce, and people with specific expertise in different parts of the mental health system.

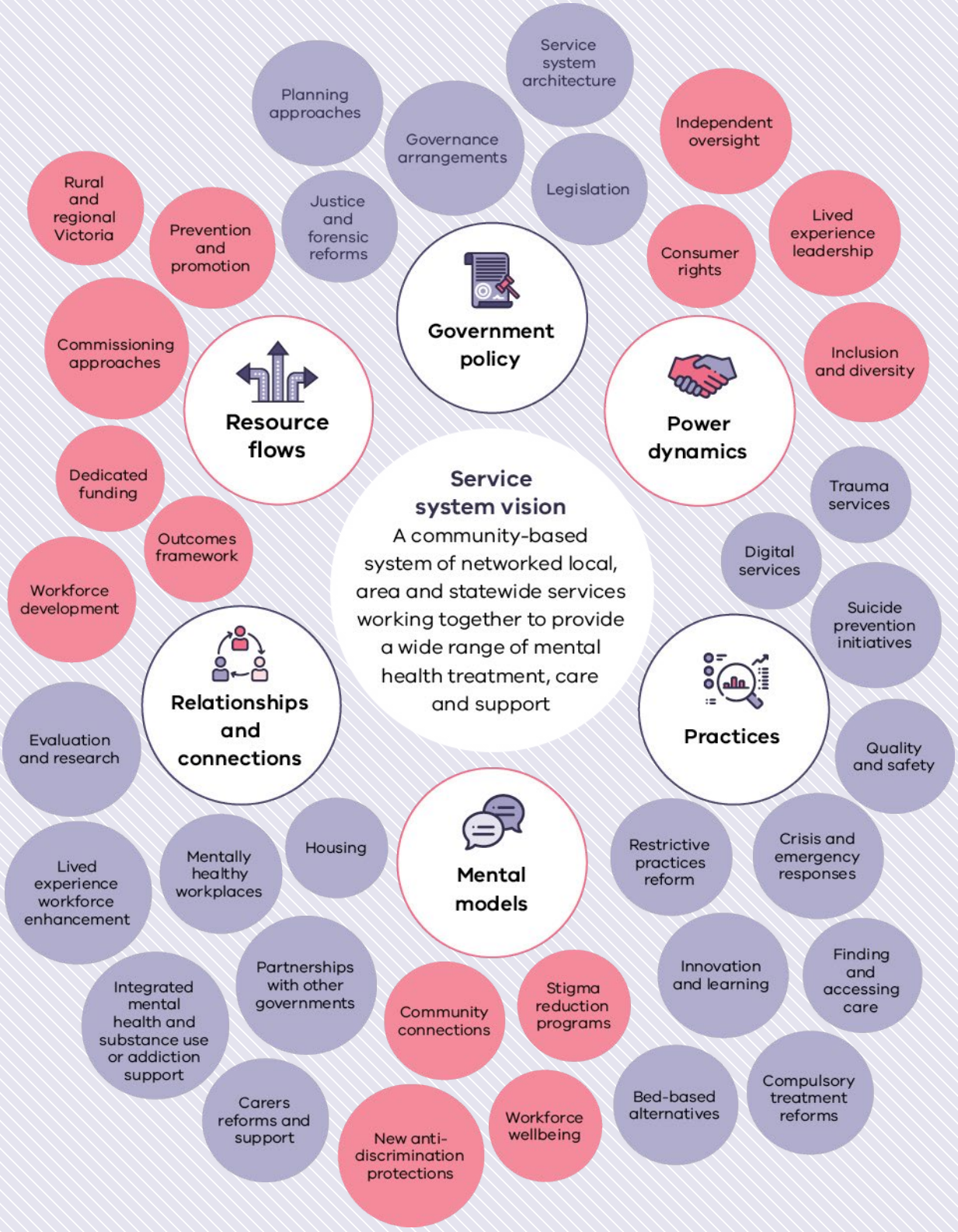
Participants identified future design features that would contribute to more compassionate, effective and contemporary mental health treatment, care and support services. These features helped shape the Commission's final recommendations.

The Commission used the results of its various participation activities to identify and refine a number of potential reforms. This work was informed by broader engagement activities with experts in related systems in Victoria, across Australia and internationally, as well as dedicated data, policy and research analysis activities.

Final recommendations were then formulated based on their capacity to transform Victoria's mental health system in line with the Commission's guiding principles. This assessment was made by determining the capacity of the recommendation to shift the necessary underlying conditions of the system. They were also tested to ensure they were enduring, and in line with letters patent, sustainable and practical.

Figure 2.10 shows the conceptual relationship between the recommendations and the underlying conditions in the Commission's vision for a transformed mental health and wellbeing system.

Figure 2.10: How the Commission's recommendations seek to influence the underlying conditions of systems change.



2.5 Acting strategically to implement systems reform

Taking action to change the conditions of the mental system as proposed in the Commission's recommendations is the final stage of the systems change framework. This is more commonly referred to as reform implementation.

While the Victorian Government will be responsible for implementing the Commission's recommendations, it will be guided in this by the Commission's implementation approach. This approach is outlined in Chapter 37: *Implementation*. The Commission encourages the following implementation considerations for achieving systems change.

2.5.1 A commitment to purpose

The complex and emergent nature of systems requires an adaptive implementation approach.[79] In fact, the ability to adapt to local conditions, share decision-making authority and promote local reform innovations are hallmarks of high-performing systems.[80]

The Commission's reform ambition is more than the sum of its parts. During implementation, the Victorian Government will need to hold the vision and aspiration of this Commission as a whole. Recommendations have been designed to work together, and implementation must consider the relationships between reforms. Strict implementation approaches that focus on acquitting specific recommendation requirements rather than working to achieve the Commission's overarching reform intent risk undermining the scale of system transformation imagined by the Commission.

For this reason, wherever possible, the Commission has adopted a 'minimum specification' approach to its recommendations. This approach emphasises both the Commission's reform intent and the necessary reform action. In doing so, the Commission aims to balance clear and precise descriptions of what is required to transform the system with clear statements about what the reforms should ultimately achieve.

Outside of stipulating minimum requirements of the recommended action, the Commission has embedded, where appropriate, a level of flexibility within its recommendations. This ensures those who will implement the recommendations can account for factors such as broader changes to the system's environment that occur after the Commission's inquiry, or the particular needs or conditions of local communities.[81] Rather than fostering a 'set and forget' implementation mentality, it is the Commission's hope that implementing its recommendations is a catalyst for new and continued learning and improvement guided by the Commission's reform intent.

2.5.2 Continued listening, engagement and learning

Meaningfully connecting with diverse system actors, especially people with lived experience, has been at the heart of the Commission's approach. This connection has deepened the Commission's understanding of the complexity of the system and guided its thinking about reform. To implement the Commission's recommendations effectively, the Victorian Government must continue to listen to and learn from the ideas, experiences and perspectives of those in the system as it moves from the high-level system design outlined by the Commission, into detailed design and delivery. This includes those using it, those working in it, those managing it and the wider public. Understanding the true effect of the proposed reforms—both on people and the broader system—can only be achieved through diverse and continued purposeful engagement with those in the system. The Commission emphasises that people with lived experience, alongside the mental health workforce, must be involved in the implementation process and be part of the new decision-making structures that will lead the future mental health and wellbeing system.

The Commission also emphasises the critical role of 'cycles of learning' in ensuring the continual evolution and growth of the mental health and wellbeing system beyond the Commission's reforms.[82] A learning culture is an essential part of reform implementation. People in the system must be encouraged to collaborate and learn, be supported to challenge and improve prevailing attitudes, behaviours or practices and be equipped with timely and accurate information to measure and improve outcomes. This learning culture must be grounded in effective research, evaluation and innovation initiatives. These themes are explored in Chapter 36: *Research, innovation and system learning*.

2.5.3 Leadership, collaboration and accountability

Achieving enduring change requires strong leadership. Strong leadership must continue to advocate a clear and inspiring vision for system reform, service improvement and better consumer outcomes. It must be capable of identifying and harnessing the strengths, energy and contributions of diverse interests in the system to achieve that vision and hold services accountable for delivering better outcomes. Without this, as the Hon. Julia Gillard AC, Chair of Beyond Blue notes, there is a risk that government inaction is justified by division or competition between key players: 'decision-makers get let off the hook if advocates compete and criticise, rather than cohere.'[83]

Similarly, collaboration between governments, across different sectors and between service providers will also be a feature of effective implementation efforts. This will require new approaches to overcome traditional barriers to collaboration including policy, sector and government boundaries. Efforts to align the interests of different governments, sectors and service providers to achieve mutually beneficial outcomes will be required; and these efforts must be underpinned by genuine engagement and, where appropriate, shared decision making.

Effective governance and accountability arrangements are required to instil public confidence in the mental health and wellbeing system. They are also a critical supporting function for system leadership and cross-sector and cross-government collaboration.[84] The system leadership and oversight functions of the Mental Health and Wellbeing Commission will hold a central function in this regard. The new commission must work to elevate the status of mental health across government and the broader community, and demonstrate an ongoing commitment to holding the government to account for realising the reform vision outlined in this report.

2.5.4 Sequencing implementation efforts for success

The scale of the system reform envisaged by the Commission and reflected in its recommendations will lead to one of the most substantial service system transformations in Victoria's recent history. It will also reflect a significant undertaking for the Victorian Government—particularly in light of the policy, budget, workforce and mental health service demand pressures associated with the COVID-19 pandemic and the 2019–20 summer bushfires.

In designing an implementation approach for its reforms, the Commission has been conscious of recommending an approach that balances the pace and scale of reform with the urgency of addressing the substantial problems outlined in its reports. The Commission has given priority to the implementation of recommendations within the first two years of government receiving its report that:

- respond to urgent service requirements
- deal with the deeper underlying system conditions that will lay the groundwork to sustain successful broader reform efforts over multiple years
- reflect the building blocks (or are a necessary precondition) for other recommendations.

The Commission has further sequenced the implementation of its remaining recommendations over two further waves of reform that extend over a 10-year period. This approach will support existing and new organisations to fulfil their immediate service delivery requirements, build new capabilities required for the reforms and support a sustained, long-term commitment to reform over successive years.

The Commission's broader implementation approach is outlined in Chapter 37: *Implementation.*

2.5.5 A long-term focus on better outcomes

As noted earlier, the implementation of reforms outlined in this report, will require a 'lift' in focus from the specific requirements of each recommendation, to a longer-term vision for the collective impact of the reforms. The implementation process must consider the system-wide implications of the Commission's recommendations, and maintain a focus on the desired outcomes, particularly the health outcomes, of the reform agenda.

As outlined in the Commission's letters patent, the Commission was asked to be strategic and to focus on outcomes as it conducted its inquiry. The Commission has worked to give priority to recommendations that will individually and collectively improve outcomes for people living with a mental illness; their families, carers and supporters; the mental health workforce and the broader public.

As the next chapter: Chapter 3: *A system focused on outcomes* shows, the reform agenda for the Victorian Government includes developing a *Mental Health and Wellbeing Outcomes Framework* that will guide the planning and investment decisions for the system in the future. An outcomes approach will support the Victorian Government, across all portfolios, to work together towards the ultimate vision for the system, and will act as a guiding light to support reform activity. The Commission expects this outcomes approach to continue to push the boundaries for system reform beyond the life of this Commission and its recommendations—which will be a collaborative effort.

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60 The Commission established an expert systems advisory function in November 2019. The advisory function had a flexible membership to reflect the specific needs of each stage of the Commission's inquiry. It included diverse expertise in systems reform from across Australia and overseas. The following people supported the Commission through this function: Professor Luis Salvador-Carulla, Head of the Centre for Mental Health Research at the Research School of Population Health, College of Health and Medicine, Australian National University, Canberra; Professor Richie Poulton, Co-Director, National Centre for Lifecourse Research, University of Otago, New Zealand; Ms Allison Costello, Director of the Policy and Innovations Branch, Ontario Ministry of Health and Long-Term Care, Canada; Dr Robyn Mildon, Founding Executive Director of the Centre for Evidence and Implementation, Melbourne; Professor Iven Mareels, Chair of Electrical and Electronic Engineering, Electrical and Electronic Engineering, The University of Melbourne; Professor Ezekiel Emanuel, Vice Provost for Global Initiatives, University of Pennsylvania, United States. They contributed to the Commission but were in no way associated with its final deliberations and findings.

    The Commission's systems approach was also informed by Professor Rod Glover and the team at the Monash Sustainable Development Institute. The Commission also acknowledges Dr Seanna Davidson, Director, The Systems School and Dr Fiona McKenzie, Director, Orange Compass for their contributions.

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Chapter 3

A system focused on outcomes

Recommendation 1:

Supporting good mental health and wellbeing

The Royal Commission recommends that the Victorian Government:

1. build on the interim report's nine recommendations and develop a *Mental Health and Wellbeing Outcomes Framework* to drive collective responsibility and accountability for mental health and wellbeing outcomes across government portfolios.
2. through a newly established Mental Health and Wellbeing Cabinet Subcommittee, chaired by the Premier (refer to recommendation 46(2)(a)), use the *Mental Health and Wellbeing Outcomes Framework* to monitor outcomes to inform planning and policy decisions.
3. use the *Mental Health and Wellbeing Outcomes Framework* as a mechanism to inform government investment processes and assess the benefits, including the economic benefits, of early intervention.
4. update the *Mental Health and Wellbeing Outcomes Framework* and publicly report on progress against outcomes at a service, system and population level, every year.

3.1 A new approach to outcomes

Achieving good outcomes for individuals, including consumers, families, carers and supporters, and for the workforce and community, is fundamentally important and foundational to the Commission's reform agenda. The terms of reference in the Commission's letters patent specifically direct the Commission to inquire into ways to deliver the best mental health system outcomes, and then to recommend the process by which to deliver those improved outcomes for Victorians.[1]

Outcomes are, of course, the consequences of actions or interventions, such as the way services are delivered. They indicate what is working and what is not. When outcomes are articulated to define an aim and that is then monitored, reported and used to make comparisons—they serve several functions. These include supporting government and service providers to deliver treatment, care and support to achieve the best health, wellbeing and safety of Victorians, and promoting accountability and confidence in the system.

It is the Commission's expectation that an outcomes approach that is transparent and captures what matters most to people; that is applied to government, service providers and the broader system, will help, through and as part of systems design, transform the mental health and wellbeing system.

The Commission recognises that it is not alone in calling for an outcomes approach. In contributing to the Commission, many people and organisations asked the Commission to consider outcomes and outcomes measurement[2] and their ideas on how to improve mental health and wellbeing outcomes are shared throughout this report. Outcomes frameworks provide the instrument to connect ambition with policy, service delivery and agenda setting, and are increasingly used by governments to do so. As Dr Michael Porter points out, they should be seen collectively as a core foundational element of an evolving health system:

> Achieving good … health outcomes is the fundamental purpose of health care. Measuring, reporting, and comparing outcomes is perhaps the most important step toward unlocking rapid outcome improvement … Outcomes are the true measures of quality in health care … Thus, outcome measurement is perhaps the single most powerful tool in revamping the health care system.[3]

However, maximising the multiple purposes of outcomes, and embedding them in processes to facilitate change, is not without its complexities. There are challenges in adopting an outcomes approach—outcomes can be difficult to define and often concentrate on immediate results rather than the longer term. As Dr Porter notes:

> There is no consensus on what constitutes an outcome, and the distinctions among care processes, biologic indicators, and outcomes remain unclear in practice. Outcome measurement tends to focus on the immediate results of particular procedures or interventions, rather than the overall success of the full care cycle for medical conditions or primary and preventive care.[4]

In its 2019 report on mental health outcomes, the King's Fund acknowledged the tension between different approaches to outcomes—in particular, balancing the population health perspective with an emphasis on the individual:

> Should we focus on improvements in the overall health and wellbeing of the population … ? Or should we focus on delivering responsive care that is tailored to individuals, attending to their personal needs and aspirations? Both are laudable objectives, and the simple answer is that we should try to do both, but they do not sit entirely comfortably together. Some service users and professionals clearly believe that the balance has shifted too far towards the pursuit of generalised outcomes for the population rather than attending to the individual. Any approach to outcomes that loses sight of the individual is surely part of the problem, rather than the solution, and unlikely to lead to humane or effective care.[5]

While the Commission agrees there are multiple points of balance to be struck, it recommends a new *Mental Health and Wellbeing Outcomes Framework* that adopts a broad view of mental health and wellbeing outcomes—for individuals and the population—over short, medium and long timeframes. This is a key feature of the systems approach the Commission has used, discussed in Chapter 2: *The Commission's approach to reform*. As leading systems thinker and author Mr David Stroh points out:

> it is easy to be seduced by short-term data and readily measured outcomes even though they might not be indicative of long-term gains. By contrast, systems thinking focuses on both qualitative and quantitative data [and] assesses progress differently over multiple time horizons …[6]

Adopting a broad perspective of outcomes is necessary to reflect 'the realisation that [the public service works] in complex, interwoven systems where boundaries are fuzzy, and governments engage with many other actors to achieve outcomes'.[7] Reflecting this complexity will require the *Mental Health and Wellbeing Outcomes Framework* to serve multiple functions. At its core, however, it should support the evolution of the mental health and wellbeing system using a 'whole-of-system' approach—enabling service providers, regions, communities and all levels of government to collaborate and drive positive change.

From a 'whole-of-government' perspective in Victoria, the framework will improve accountability and collaborative decision making across and between government portfolios. This will require deep consideration of the breadth of potential factors contributing to achieving good mental health and wellbeing outcomes, regardless of which government portfolio is responsible. When implemented effectively, the *Mental Health and Wellbeing Outcomes Framework* will help shift the emphasis from narrow, fragmented and transactional decision making to a broad, holistic and system-level perspective of mental health and wellbeing. This new perspective will be better at identifying what works and more capable of embedding positive improvement across the mental health and wellbeing system.[8]

Specifically, the benefits of an outcomes approach will include:

- **providing a true measure of healthcare quality to guide improvement efforts**—from immediate outcomes of treatment, care and support, to longer term recovery[9]
- **improving planning and investment decisions**—by supporting different participants in the service system to come together to consider trade-offs and make appropriate decisions; sometimes greater spending in the short term can open new opportunities for improved outcomes and cost savings in the medium to long term[10]
- **ensuring greater government and provider accountability**—measuring only outputs can result in too much focus on tracking individual items, such as services delivered; measuring outcomes, however, moves the focus to value delivered[11]
- **allowing the system to adapt deliberately and incrementally over time**—health systems have historically used intensive, one-off interventions to overcome problems; increasing the emphasis on outcomes, including long-term outcomes, can shift the emphasis from one-off approaches that favour 'quick wins' to approaches that are steadier, more incremental and generate long-term gains.[12]

Additional evidence before the Commission supporting each of these benefits is discussed throughout this chapter. Key terms are listed in Table 3.1.

Ultimately, the Commission considers that a clear and consistent vision, reflecting a common approach to system outcomes, will be critical in unifying the diverse interests, skills and experience of those participating in the system and its reform. It will also be critical in holding them accountable for their contributions towards those outcomes. This is particularly important in mental health systems, which have been characterised as being 'squandered by territorialism' in a climate of limited resourcing and severe demand pressures.[13] As the Hon. Julia Gillard AC, Chair of Beyond Blue, said, all parts of society must work together to ensure the success of the future mental health system:

> Whole-of-government, whole-of-sector, whole-of-community, every-one of us has a role to play.[14]

Table 3.1: Key terms

Outcomes domains	Categories or groups of outcomes relating to broad areas of mental health and wellbeing. For example, outcome domains could relate to providing safe and high-quality mental health services, or could relate to consumer satisfaction with service delivery and treatment, care and support.
Indicators	Qualitative or quantitative measures that can help determine change or progress and can be used to determine whether short-, medium- or long-term outcomes are being achieved. When indicators are used to measure the outcomes of a particular program or intervention (for example, resulting from reforms), they are measured from a baseline (before the program or intervention), at regular intervals after the intervention starts, and at the end.[15]
Outcomes	Changes to the health or wellbeing of a person, group or population that result from some kind of intervention or multiple interventions. Interventions are defined very broadly and include particular models of treatment, care or support or making health services more accessible or acceptable to consumers. Individual health outcomes are measures of individual health and wellbeing status. These can be measured in the short, medium and long term. Population-level outcomes are measures of aggregated data on the health of a population—for example, the population of Victoria or Australia. Outcomes are measured using indicators.
Whole-of-government	Although there is no universally agreed definition of whole-of-government approaches (often interchangeably referred to as 'joined-up approaches'), the Commission uses this phrase to denote different areas of government (for example, health, human services, justice and corrections) working together to achieve shared outcomes.[16]
Whole-of-system	The Commission's terms of reference define the mental health system by reference to mental health services that are funded wholly, or in part, by the Victorian Government. As the terms of reference define the remit of the Commission, it is these services that largely, although not solely, form the focus of the report. When the Commission refers to 'whole-of-system' in relation to the mental health system, the reference is to a broader system. This includes not only public sector bodies and organisations at the federal, state and local government levels. It includes all people and organisations who participate in—or are connected with—the new mental health and wellbeing system recommended by the Commission.

3.2 Fundamental challenges with previous approaches

Governments are increasingly developing outcomes frameworks to guide their efforts in particular policy areas, and Victoria is no different. Outcomes frameworks have been established in Victoria across multiple policy areas—including family violence, Aboriginal affairs, disability and community resilience—with the central goal of ensuring adaption, learning, iteration and improvement.[17]

Victoria's first early attempt at a mental health outcomes framework was *Because Mental Health Matters*: *Victorian Mental Health Reform Strategy 2009–2019*. The strategy stated that '[m]ental health reform needs to be driven by a set of agreed outcomes, regular monitoring of progress, and accountability structures that provide transparency on what is being achieved'.[18] Recognising the broad factors that influence mental health and wellbeing, the strategy committed to developing 'new monitoring and accountability arrangements based on a shared whole-of-system outcomes framework incorporating health and social indicators that reflect broader individual and community goals'.[19] While no indicators were proposed, and the outcomes set were only preliminary, the structure recognised the inherent requirement to consider mental health in a wider societal context.

This work was taken forward under *Victoria's 10-Year Mental Health Plan*, released in November 2015. The plan also recognised that a broad perspective is required to support mental health and wellbeing, one that goes beyond the mental health system:

> **Universal education and healthcare, liveable cities, good jobs, safe communities, stable and affordable housing and healthy families are among the building blocks of mental health and wellbeing.**[20]

Reflecting this broad perspective, the plan's outcomes extended to inclusion and participation, recovery and self-management (refer to Table 3.2).[21] The government continues to develop and refine these outcomes and reports against them (including new and revised outcomes) annually in *Victoria's Mental Health Services Annual Report*.[22]

In the latest annual report, released in December 2020, data was reported against 12 of the 16 outcomes, with four of the indicators still being developed.[23] Data indicates that some progress has been made in recent years—for example, in relation to the mental health and wellbeing of Victorians—with the proportion of the Victorian adult population with high or very high levels of psychological distress decreasing slightly overall across the three years prior to 2018 (from 17 per cent to 15 per cent).[24] In relation to the majority of other outcomes, however, the data showed little improvement, relatively stable results, or slight declines. In particular, the measures indicate issues with equality of outcomes, with data showing that Aboriginal Victorians continue to be over-represented in clinical mental health services[25] and suggesting the proportion of the Victorian rural population experiencing high or very high levels of psychological distress has been slowly increasing.[26] It should be noted, that accurate results may, however, only emerge after long periods of time.[27]

Table 3.2: Current Victorian mental health outcomes in *Victoria's 10-Year Mental Health Plan*

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

Source: Department of Health and Human Services, *Victoria's Mental Health Services Annual Report 2019–20*, 2020, p. 18.

Mental health outcomes are also captured and reported at the national level. This occurs annually through the Productivity Commission's *Report on Government Services*, covering Australian, state and territory governments' management of mental health and mental illnesses. While largely focused on service provision, the annual report does cover issues of prevalence of mental illness, social and economic inclusion of people living with mental illness, stigma and discrimination.[28] However, measures against the indicators are limited in number and largely based on historical considerations. For example 'timely access to mental health care' does not reflect contemporary community service provision, and in 2020 is still reported as the proportion of people who present to an emergency department, and the time it takes for them to be seen.[29]

More broadly, the National Mental Health Commission monitors major mental health system reforms and the mental health system generally. It reported on these matters in its annual national report and in the *Fifth National Mental Health and Suicide Prevention Plan, 2018 Progress Report*.[30] In 2018 the National Mental Health Commission released a new monitoring and reporting framework for mental health and suicide prevention, using the framework to identify outcomes based on the *Contributing Life Framework*.[31] The *Contributing Life Framework* considers factors that influence a person's mental health. It also recognises that while access to healthcare services is important, this alone may not enable people living with mental illness or psychological distress to live fulfilling lives. Acknowledging that there is no single definition for 'fulfilling lives', the National Mental Health Commission describes it as:

> a fulfilling life enriched with close connections to family and friends, good health and wellbeing to allow those connections to be enjoyed, having something to do each day that provides meaning and purpose, whether it be a job, supporting others or volunteering, and a home and being free from financial stress and uncertainty.[32]

The Victorian Government already supports a collective approach to outcomes, as noted in the *Outcomes Reform in Victoria* report.[33] Encouragingly, this report recognises that shared outcome frameworks provide a common language and a 'starting platform' to support collaborative action on shared outcomes.[34] This can, in turn, assist government 'to consider the broader social, economic and environmental drivers of outcomes, and … ensure frameworks cut across traditional policy divisions'.[35] The Commission agrees with the direction of this work, which states that outcomes need to be 'clear, unambiguous and high-level statements about the things that matter for people and communities'.[36]

These efforts demonstrate that governments are interested in understanding and publicly reporting on outcomes. Yet, as explored below, fundamental challenges with approaches to date have contributed to the aspirations of the state and national frameworks not yet being fully realised and translated into action. A bolder approach is required.

3.2.1 Mental health outcomes approaches have been narrowly applied

The mental health outcomes approach adopted in Victoria demonstrates a commitment to a wide definition of mental health and the importance of wellbeing. For example, *Victoria's 10-Year Mental Health Plan* contains the domain that 'Victorians with mental illness live fulfilling lives of their choosing, with or without symptoms of mental illness',[37] with associated outcomes measures including financial security, social engagement and economic participation.[38]

However, significant shortcomings include that only two of the six indicators that relate to living a 'fulfilling life', namely learning and education, and stable housing, have been established and applied since the plan was launched in 2015.[39] Even with this rectified, outcomes measures need to be taken further and connections between them developed. As Professor David Copolov AO, Professor of Psychiatry and Pro Vice Chancellor of Major Campuses and Student Engagement at Monash University noted:

> I consider that the most important outcome measures for anyone with any mental illness are that they: (a) have the best quality of life possible, which optimises their capacity to contribute to society and to enjoy close social connectedness; (b) are in an integrated system where they go from hospital into the community knowing that there is security of accommodation joined up with various services, including employment, legal, and social services and the provision of educational opportunities.[40]

For this to happen, Professor Copolov argued that outcome measurement needs to be reformed to capture a comprehensive view of people and their circumstances.[41]

Indeed, the Commission has heard that current approaches do not always measure the things that are most important to people. For example Ms Cath Roper, Consumer Academic of the Centre for Psychiatric Nursing at the University of Melbourne reflected that services do not measure a person's sense of agency over their own lives.[42]

Ms Mary O'Hagan MNZM, Manager Mental Wellbeing at Te Hiringa Hauora in New Zealand shared similar observations:

> If the people who use services designed these measures they would look completely different. They would not obsess over symptoms and risks and deficits but would be focused on holistic wellbeing and on the things that are important to us all: How do I feel about myself? Am I connected to a social network and a cohesive culture and family? Do I have secure housing? Do I have a valued contributing role? ... [43]

The Productivity Commission also recognised the importance of the social determinants of mental health and the need for a focus on wellbeing in outcomes approaches. The Productivity Commission was, however, critical of the current approach to monitoring and reporting outcomes:

> Given the importance of social determinants and the effects of mental ill-health on a person's functioning, a lack of monitoring and reporting on personal factors, such as employment, physical health and income, is a significant shortcoming.[44]

As recognised in the Commission's interim report, and discussed in Chapter 4: *Working together to support mental health and wellbeing,* the causes of poor mental health are multifaceted.[45] Across people's life spans, mental health and wellbeing outcomes are shaped by factors including: genetic and neurobiological factors; life experiences; and social, cultural, economic and environmental conditions.[46] Broadly, social determinants can act as 'risk factors', increasing the likelihood of developing poor mental health or impeding recovery; or they can be 'protective factors', which may prevent or reduce the negative impacts of some forms of mental illness, or facilitate recovery.[47]

Social determinants influencing mental health and wellbeing outcomes extend beyond the reach of mental health and health policy portfolios. Because mental illness is associated with several social factors, access to mental health services alone does not go far enough in responding to poor mental health and wellbeing outcomes.[48] For example, Ms Robyn Kruk AO, Interim Chair of Mental Health Australia, giving evidence to the Commission in a personal capacity, stated that many of the 'levers' that can improve mental health outcomes do not directly relate to health or mental health. Effective action, therefore, requires a variety of outcomes to be described, measured, monitored and reported.[49]

Using narrowly focused mental health outcomes measures also risks 'skewing' the attention within both services and the system more broadly. James Mansell, an independent consultant with experience using data to support investment approaches to state sector reforms in New Zealand, advised that a broad range of indicators are needed for a 'balanced system':

> Indicators overly focused on … high-risk adverse events tend to skew the system towards being too coercive and too focused on tertiary responses and risk management, rather than on lifting general well-being.[50]

Adopting a narrow range of outcomes measures can have unintended consequences. For example, if services adopt a narrow focus to manage occupational safety, they may become over-reliant on risk management and assessment,[51] which in turn may lead to increased use of restrictive practices (further discussed in Chapter 31: *Reducing seclusion and restraint*). Mental health services need other options to improve the safety of consumers and staff, and to reduce the use of seclusion and restraint. This includes alternatives that respond to increasing distress or agitation, help prevent conflict and enable earlier interventions (de-escalation).[52] Adopting a comprehensive outcomes framework can support this by broadening the approach of service delivery beyond the sole focus of managing risk, to instead simultaneously provide safe environments for consumers and staff and promote delivery of recovery-oriented treatment, care and support, and uphold the rights of consumers.

Finally, it is important that outcomes measures, once properly and comprehensively established, are applied across multiple settings and cohorts. As the Victorian Auditor-General acknowledged in a 2019 review of Victoria's mental health system, indicators of the outcomes within *Victoria's 10-Year Mental Health Plan* are currently only collected for people living with mental illness or psychological distress who are already in contact with the mental health system:

> There are few measures in the outcomes framework for the 10-year plan that directly capture performance against providing access to services or increasing service reach—this is despite the acknowledged performance problems in this area—which shows a lack of focus on the most pressing issue the system faces.[53]
>
> There are no measures of wait times for services, the numbers of consumers declined or delayed service due to capacity constraints, or consumer-reported experience of service accessibility.[54]

The importance of capturing outcomes across the population, including regionally, is discussed in section 3.3.

3.2.2 Government silos work against efforts to improve outcomes

The influence of siloed approaches to interrelated social and policy challenges is well documented in Australia and internationally. These challenges are also apparent in Victoria's mental health system. Mental health services are not well connected with each other, with other health and treatment services, or with other support systems and services.[55] In the absence of a whole-of-government approach spanning areas of government:

> A single agency will often not recognise or respond effectively to the inter-connections between the outcomes it is seeking and those sought by other agencies. This fragmentation means there is no-one with visibility of the system as a whole and of its performance.[56]

In her evidence, Ms Carolyn Gullery, Executive Director of Planning, Funding and Decision Support for the Canterbury District Health Board in New Zealand, gave an example of the duplication and potential fragmentation that can result from health system silos:

> In my experience, health systems end up looking like how the funders organise themselves. If funders of the health system organise themselves in silos, then the health system will also work in competitive silos duplicating service responses.[57]

Mental health and wellbeing outcome frameworks that adopt a whole-of-government approach have the potential to create a more complete picture, support connections and align efforts towards common goals.[58] Because the system is so complex, and the needs of individuals are varied and often interrelated, the overall effectiveness of the system hinges on the actions of multiple participants, their relationships with one another and the structures that guide them.[59] Building a shared understanding about interrelated outcomes and ways of working across program and organisational boundaries is therefore critical.[60] But the way in which governments are structured and currently organised reinforces siloed approaches to decision making. These structures sometimes present barriers to effectively responding to the multifaceted needs of individuals.[61]

The National Mental Health Commission reflected:

> there is currently a fragmented approach to dealing with social determinants and their influence on mental health, with responsibility for mental health-related policies and programs dispersed across Australian Government portfolios … Mental health and social determinants policies should not be created in silos.[62]

Silos can also result in a failure of departments or policy areas outside of mental health—for example, employment or justice—to view mental health as an area of shared responsibility:

> where mental health-related data is collected, and could contribute to person-centred, outcomes-focused monitoring and reporting, it is unclear to what extent it is used. … This could be in part because mental health is not seen as a key area of responsibility of non-health portfolios.[63]

It is the Commission's view that—given different departments and portfolios influence mental health and wellbeing outcomes both positively and negatively—they should be collectively accountable for ensuring outcomes improve over time. The existing mental health outcome frameworks do not recognise the interdependencies between different portfolios, nor do they facilitate collective accountability, both in Victoria and nationally. Existing frameworks and measures mostly do not support government agencies to work as one, do not support shared understanding and shared direction, and do not support difficult decisions about prioritising investments and understanding trade-offs.

3.2.3 Siloed funding and budget processes impede collaborative investment

Silos between government departments can be exacerbated by siloed funding and budget process arrangements. Placing a greater emphasis on outcomes in commissioning—the planning, purchasing and monitoring of services—can help overcome existing silos and bring disparate parts of the system together around a shared focus. Mr Terry Symonds, the then Deputy Secretary of Health and Wellbeing in the former Department of Health and Human Services, suggested that:

> At all levels, the outcomes focus of commissioning will be an engine for collaboration. The outcomes that consumers and communities nominate as the most important cannot be achieved by any one service, or any one level of government. When there is a genuine shift towards outcomes, it heightens the incentive to collaborate.[64]

Despite the best efforts of individual departments to work together to manage systems and commission appropriately, structural challenges in overarching budget processes exist. In particular, a singular focus on the funding and accountability of individual portfolios, departments and service providers make it difficult to collaborate. Mr David Martine PSM, Secretary of the Department of Treasury and Finance, told the Commission:

> The output funding model is premised on holding individual departments and portfolio Ministers to account for delivery of an output … This can present challenges where effective delivery of an output relies on the effective delivery of related outputs, which is common in social services. For example, there is a presumed interdependent relationship between homelessness and mental health service systems.[65]

Another shortcoming of the budget model is its spotlight on individual activities and services over a single year or four-year budget cycle. This does not encourage joined-up or long-term investment approaches. This often leads, for example, to failing to prioritise resources for prevention activities. Mr Martine acknowledged this context:

> the output model is focussed on the activities and services delivered, with reporting on agreed performance measures generally framed around a financial year. Outcomes are often measurable only over a longer timeframe, particularly to test the impact and sustainability of gains over time.[66]

This view was supported by Mr Andrew Greaves, Victoria's Auditor-General, who was critical of the public sector's approach to outcome measurement and the output funding model:

> Systemically, I note the lack of a mature outcome measurement and reporting framework has been, and remains, a feature of the Victorian public sector. While reporting on outputs is important, the output-based budgetary framework has not fostered, and is in many respects antipathetic to, measuring and reporting on outcomes.[67]

But the current model does not mean collaboration is impossible. Mr Martine gave evidence that:

> While the output model ostensibly does not support funding a single output across multiple portfolios or departments … additional arrangements are put in place such as providing funding to multiple departments for the individual aspects of a joint or common activity for which each is responsible. This is sometimes referred to as a whole of government approach …[68]

While the Commission recognises efforts towards greater cross-portfolio collaboration in relation to mental health and wellbeing funding and budget processes, the current system needs to change to enable a longer term, true whole-of-government investment approach.

3.2.4 Limited use of information and data in performance management and system oversight

Outcomes frameworks, when implemented effectively, should operate at two levels: supporting collective stewardship of an entire system, as well as individual organisational accountability—for example, through performance monitoring (discussed in Chapter 28: *Commissioning for responsive services*). To enable this, the right information needs to be collected (specific but also broad in nature, as discussed in section 3.2.1), and then used and reused in clear accountability structures, at the service provider level, regionally and statewide.

Governments at all levels already collect information on mental health and wellbeing, but, as multiple participants of the Productivity Commission mental health inquiry noted, it is not effectively rationalised.[69] The Productivity Commission also noted that even where data is collected and has the potential to translate into meaningful person-centred reporting, how it is used often remains unclear.[70]

There is no indication that the mental health outcomes reported annually in *Victoria's Mental Health Services Annual Report*, nor by the National Mental Health Commission, are used to drive accountability, or inform decision making. Indeed, the Victorian Auditor-General's report on child and youth mental health noted that in Victoria, the former Department of Health and Human Services lacked a 'clear method' for monitoring and overseeing the mental health system.[71] This not only makes it hard to advise government on system challenges or resource needs, but it also makes it difficult for the department to fulfil its role to protect 'the most vulnerable' Victorians.[72]

The Victorian Government has recognised that strong oversight and management is required to achieve good outcomes:

> We would welcome the Royal Commission's advice on how we could progress with developments to ensure we have the system capabilities to support strong management and oversight, focused on achieving outcomes for individuals and the community.[73]

The need for strong accountability and oversight is also a challenge facing the Commonwealth Government. A recent review of the Australian public service by the Australia and New Zealand School of Government examined how accountability could be improved to drive better government decision making. The review highlighted the need for change in the way the public service evaluates outcomes and learns from this evidence to continually improve.[74]

This challenge and desire for change is also global. A report on member countries of the Organisation for Economic Co-operation and Development stated:

> The quantity of performance information available to decision makers has substantially increased; however, countries continue to struggle with issues of quality and with ensuring information is used in decision making. It takes time to develop … indicators, and even longer to change the behaviour of key actors in the system (politicians and bureaucrats) so that they use this information …[75]

Impediments to the change sought—that is, better information collection to drive better accountability—are many but include limited or inconsistent data collection and reporting[76] coupled with limitations relating to leadership and coordination.[77] The Commission's view is that the new *Mental Health and Wellbeing Outcomes Framework* will address these challenges, as explored below.

3.3 A new mental health and wellbeing outcomes framework for Victoria

As outlined in Chapter 2: *The Commission's approach to reform*, there are entrenched problems with the current mental health system, which in most part reflect the unintended consequences of decisions by successive governments. That chapter, and the Commission's interim report, note that 'the [current] system is achieving exactly the results it was set up to achieve'.[78]

Yet many people have shared with the Commission their ideas and vision for the outcomes they seek from a reformed system, as expressed throughout this report. Distilled from the Commission's human-centred design work and described in Chapter 2, common, high-level outcomes identified by people with lived experience include: access to safe, healing and restorative care settings; receiving compassion and care; and belonging to a supportive community.[79]

The new *Mental Health and Wellbeing Outcomes Framework* for Victoria must build on the Commission's work and provide a clear picture of what a high-quality, contemporary mental health and wellbeing system looks like. The framework will represent a public commitment to the vision for a transformed system.

As outlined throughout this report, improving the mental health and wellbeing of Victorians will require action through a whole-of-system and whole-of-government approach. This will enable all levels of government, service providers, businesses and communities to collaborate to drive change. As Dr Margaret Grigg, CEO of Forensicare, told the Commission, '[t]he complexity of the mental health system is that there is no single agent that can be responsible for all the mental health outcomes of a community'.[80] Indeed, as stated in a personal capacity by Professor Sir Michael Marmot, Director of the Institute of Health Equity at University College London, taking action to reduce particular inequalities 'does not require a separate health agenda, but action across the whole of society'.[81]

3.3.1 Design features of a new mental health and wellbeing outcomes framework

The Commission has developed a set of design features to be used by the Victorian Government to guide establishment of the new *Mental Health and Wellbeing Outcomes Framework*. These features have been informed by witness statements, public submissions, expert advice, the wider academic literature and reference to other mental health and wellbeing outcomes frameworks. The design features are set out in Box 3.1.

The features identified by the Commission have also, in part, been guided by advice from James Mansell, who delivered an 'information blueprint' to the Commission that outlined the essential information and structures required to support decisions based on outcomes.[82]

Box 3.1: Design features of contemporary mental health and wellbeing outcomes frameworks

Mental health and wellbeing frameworks must be developed with people, not for people

Extensive engagement, with broad representation from those who use, work in, regulate, fund and oversee mental health systems, and also those who work in adjacent social services, should inform the development of mental health and wellbeing outcomes frameworks. It is crucial that the framework be created in partnership with consumers, families, carers and supporters, and as captured in recommendation 49—outcomes must reflect what matters most to the people who are the beneficiaries of the service or system.[83] As the Commonwealth Treasury has previously suggested, 'it is individuals who count and what they value in life that matters'.[84]

Mental health and wellbeing frameworks must take a broad view of mental health and wellbeing

Mental health and wellbeing should be defined broadly in mental health and wellbeing outcomes frameworks, and should consider the social determinants of mental health and a community's own perspectives on what contributes to good mental health and wellbeing. Access to housing, education, meaningful employment and living free from discrimination should be considered.[85] Some frameworks go further, considering a person's relationship to their surroundings, feelings of safety and their capacity to enjoy the natural and built environment, including their ability to be mobile.[86] Other frameworks consider the idea of individual 'opportunity'. This approach highlights how wellbeing is affected by a person's real, substantive, legal and social opportunities to live a life they value.[87] Considering 'opportunity' helps to highlight the importance of achieving equitable wellbeing outcomes, the relationship to social justice and to rights across a community.

Mental health and wellbeing outcomes frameworks must draw on diverse inputs

Traditional population health and service performance measures must be combined with other information to provide a rich and accurate picture of the impact of investment decisions and service interventions. Population, consumer satisfaction and workforce surveys and linking administrative data across government portfolios are examples of additional information inputs that should be considered.[88] Economic analyses of wellbeing can also take into account factors such as the distribution and sustainability of opportunities and other factors that contribute to wellbeing, such as individual and community risk and complexity of life choices.

Mental health and wellbeing outcomes frameworks should include regular reporting requirements, including public reporting against strategic objectives that drive accountability

Regular public reporting, including against identified targets and timeframes, is commonly used to keep governments, system managers and service providers accountable for improving outcomes. For example, the Australian Capital Territory's wellbeing framework publicly reports against all indicator data every two years,[89] while the World Health Organization's *Mental Health Action Plan 2013–2020* centres on global and national mental health targets including, for example, reducing the rate of suicide in member states.[90]

Mental health and wellbeing outcomes frameworks should adopt a whole-of-system lens that informs the decisions and activities of service providers, governments and the wider community

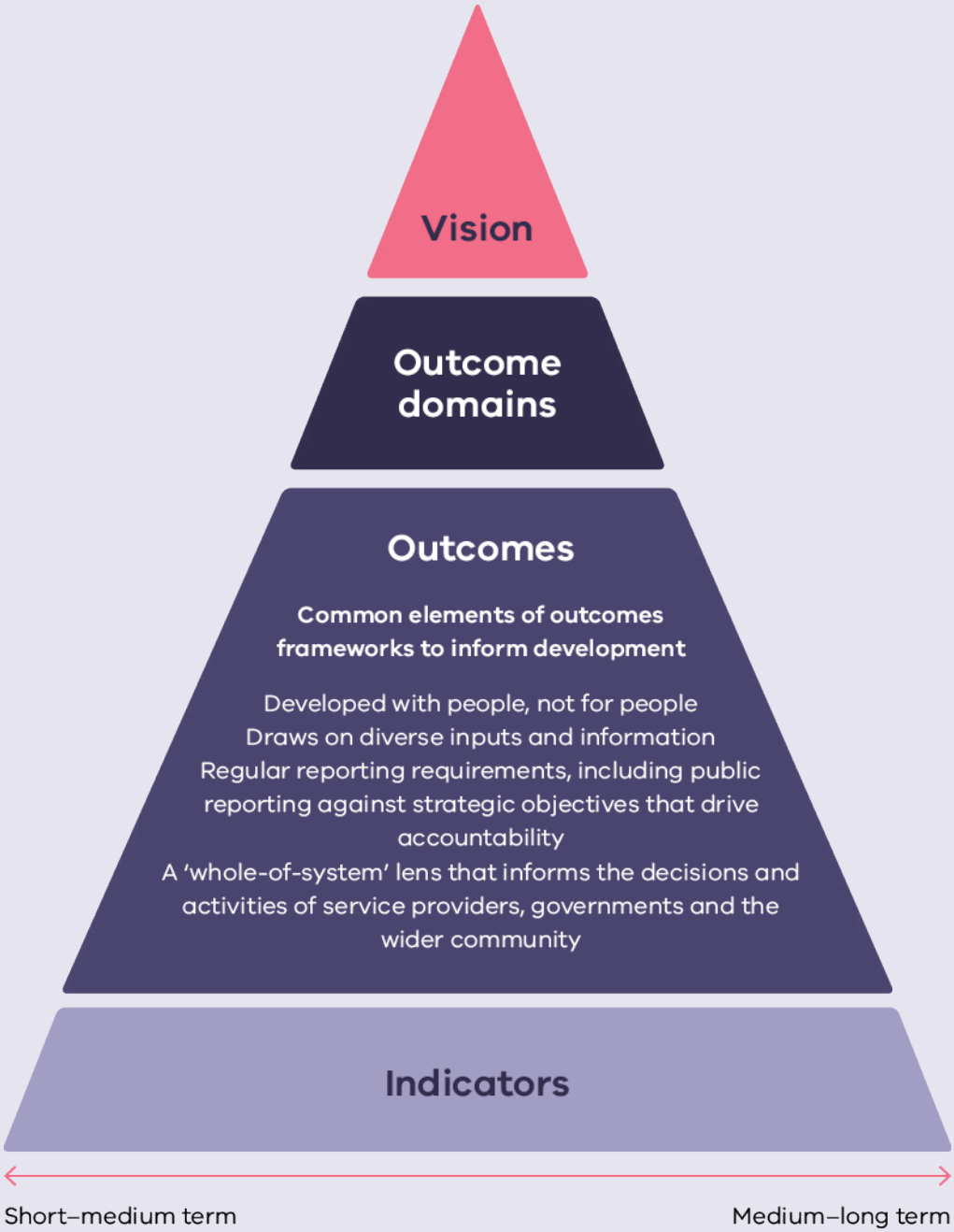
Mental health and wellbeing outcomes frameworks serve multiple, interrelated functions. They should guide decisions, including investment decisions, by providing services and governments with an evidence base for 'what works'. They should provide a clear picture of the quality and effectiveness of treatment, care and support provided by services, as well as the impact of those services on the mental health and wellbeing of the population.[91] Effective frameworks will also influence the wider community. They harness and unify the efforts of non-government organisations, entrepreneurs, businesses, local community groups, schools and individuals to contribute to outcomes.[92]

3.3.2 Key components of a new mental health and wellbeing outcomes framework

Using the design features, the Commission recommends that the government develops a *Mental Health and Wellbeing Outcomes Framework* including outcomes domains, outcomes and indicators. The framework will measure individual and population-level outcomes, and include targets as strategic objectives. Figure 3.1 depicts the key components of the framework.

The Commission has set its **vision** for the new mental health and wellbeing system through its guiding principles. The Commission's vision should be used as the foundation for developing the framework's vision.

Figure 3.1: An overview of the key components of the future *Mental Health and Wellbeing Outcomes Framework*



Outcomes domains are an important organising feature of a comprehensive and meaningful outcomes framework. They are a mechanism by which desired outcomes can be strategically and clearly mapped to the overarching vision.[93] As noted by the former Department of Health and Human Services in the *Victorian Public Health and Wellbeing Outcomes Framework*:

> Domains are organising principles or 'dimensions' … The domains provide 'line of sight' from the overall vision to the outcomes, and describe key components of achieving the vision. These are our 'descriptions of success'.[94]

In relation to outcomes domains, the Productivity Commission indicated that the National Mental Health Commission should monitor progress against outcomes in the five broad outcome domains from the National Mental Health Commission's *Contributing Life Framework*:

- thriving, not just surviving
- ensuring effective care, support and treatment
- engaged in meaningful activity
- maintaining connections with family, friends, community and culture
- feeling safe, stable and secure.[95]

Given the breadth of reform recommended by the Commission, and its vision for a new mental health and wellbeing system, the Commission recommends that the Victorian Government considers adopting these broad outcomes domains as a 'starting point' or basis for the new outcomes framework. Nesting within the outcomes framework will be more specific outcomes domains for service delivery, as part of the new performance monitoring and accountability framework recommended in Chapter 28: *Commissioning for responsive services*. The performance monitoring and accountability framework will comprise a uniform set of performance domains, adopted from the *National Mental Health Performance Framework 2020*,[96] that will provide a clear and consistent set of expectations for service delivery—that it is appropriate, effective, connected, safe, accessible and that it delivers value. The first four of these domains also relate to quality and safety, and are discussed further in Chapter 30: *Overseeing the safety and quality of services*.

3.3.3 Outcomes and indicators in the framework

Outcomes and **indicators** sitting within the **outcomes domains** should be framed by a person-centred approach to outcomes measurement, as noted by the Productivity Commission.[97] As Dr Alice Andrews, Director of Education in the Value Institute for Health and Care and Assistant Professor in the Department of Medical Education at the University of Texas' Dell Medical School, said:

> We must measure what we achieve for and with patients rather than what we do to them, in order to identify where improvements are needed.[98]

At the individual level, measurement should occur over the short–medium term and the medium–long term. The rationale for the measurement approach at the individual level is that it balances immediate results of particular interventions—for example, wait times in emergency departments—with the longer term health and social outcomes that matter to the person:[99]

> Outcomes should be measured for each medical condition covering the full cycle of care. … It is the overall results that matter, not the outcome of an individual intervention or specialty (too narrow), or a single visit or care episode (too short). … For chronic conditions and primary and preventive care, outcomes should be measured for periods long enough to reveal the sustainability of health and the incidence of complications and need for additional care.[100]

> We need to create incentives or other measures to make the system accountable for long term outcomes, which are much more meaningful indicators of 'success' for the people who are using the services.[101]

Medium to longer time horizons also enable a deeper exploration of the value of alternative approaches to delivering mental health and wellbeing treatment, care and support. As outlined in Chapter 13: *Supporting the mental health and wellbeing of young people*, for example, it is widely accepted that early intervention improves outcomes in the early years of an illness. A reformed system and the collection of information across a longer timeframe will increase the evidence base in relation to the longer term benefits of early intervention approaches. The new outcomes framework must capture and measure these benefits.

To aid implementation of an outcomes framework in Victoria, in Table 3.3 the Commission presents an example of an approach to outcomes and indicators that importantly incorporates both individual (short–medium term and medium–long term) and population levels. At the population level, a range of measures can be brought together to help understand whether the whole population is healthy and flourishing. But individual outcomes are important too. For example, comparing population-level outcomes with outcomes of specific consumer groups and individuals can highlight where there are significant differences. These differences can provide valuable insights, informing where further attention and new and different approaches may be required. There is further discussion of individual and population approaches to outcomes in the following sections.

The Commission presents two examples of an applied approach to outcomes and indicators, including targets as strategic objectives, from an individual outcomes perspective and from a population outcomes perspective, in Figure 3.2.

3.3.4 Individual mental health and wellbeing outcomes

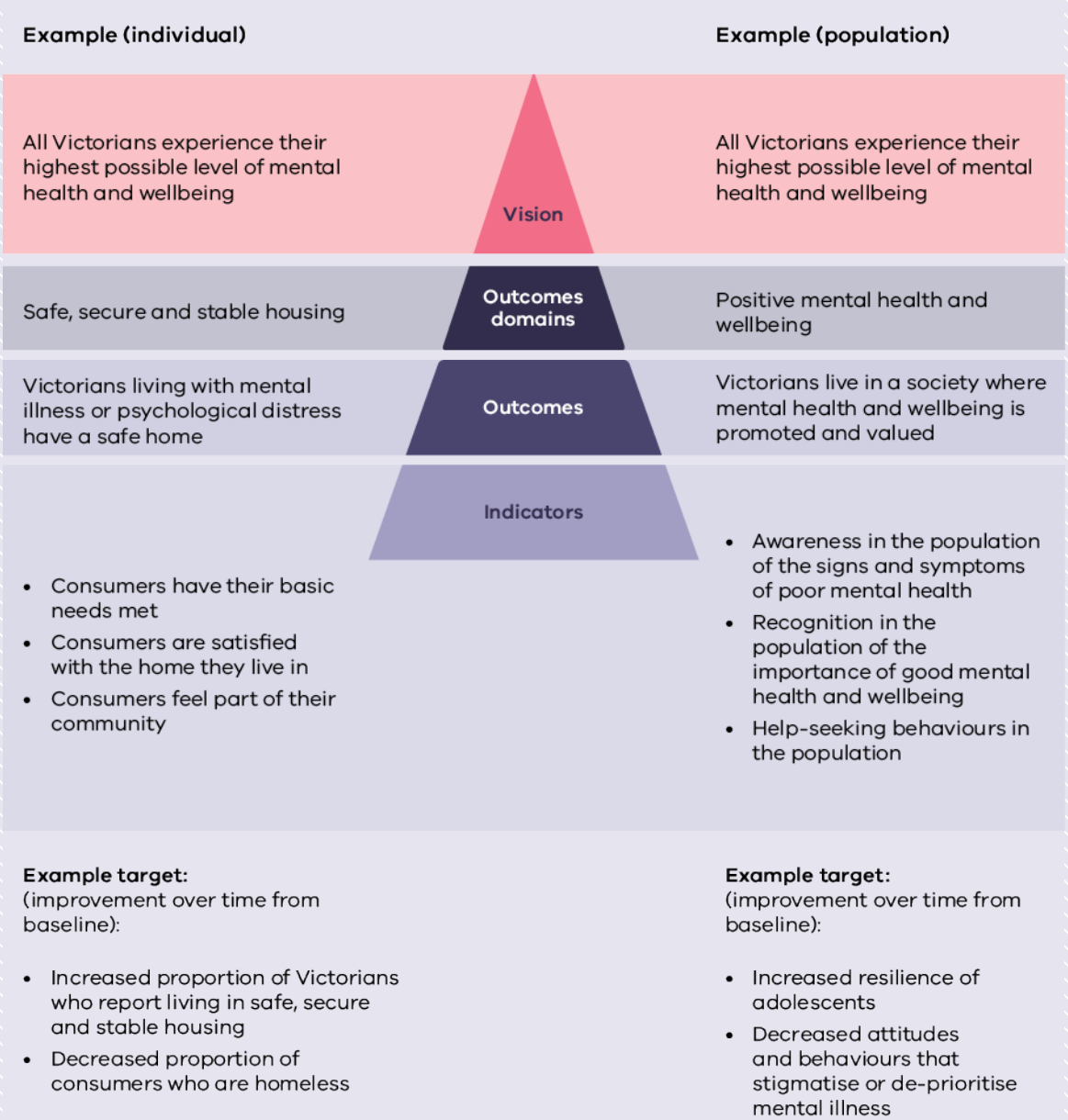
As outlined in Table 3.3 a critical component of a new outcomes framework will be individual mental health and wellbeing outcomes—measured in the short, and medium–long term. In her evidence, Mrs Lucinda Brogden AM, Chair of the National Mental Health Commission, commented on the importance of individual, consumer-level monitoring and reporting:

> Monitoring how well consumer and carer needs are being met is a key component of monitoring the performance of the mental health system. Ongoing monitoring and reporting [at the consumer level] also contributes to service improvements and improved future outcomes for consumers and carers.[102]

Table 3.3: Example approach to outcomes and indicators across the individual and population levels

	Mental health and wellbeing outcomes *What outcomes are meaningful to consumers, families, carers and supporters, service providers, the workforce and the Victorian community? How should the mental health and wellbeing system collectively maximise individual outcomes?*	**Indicators** *What information can be used to measure mental health and wellbeing outcomes*[103]
Individual short–medium-term outcomes	Short-term outcomes relate to individual experiences of services (reported by consumers, families, carers and supporters or the workforce), as well as changes in mental health and wellbeing for consumers, such as physical health changes, resulting from interventions (within or across models of care).	Examples include rates of emergency department access, clinical outcomes before and after treatment, care and support, family, carer and supporter satisfaction with services, including measuring people's sense of agency and engagement.
Individual medium–long-term outcomes	Measuring mental health and wellbeing outcomes in the medium–long term is important and should include clinical and consumer-reported outcomes. Further, medium–long-term outcomes will include factors that affect a person's longer term mental health and wellbeing outcomes and include housing, employment, education, social connectedness and substance use or addiction.	Examples include service delivery and associated wellbeing outcomes, including related government areas (employment, financial and legal assistance, alcohol and other drug services). These indicators must include consideration of whether gains in wellbeing are sustainable and whether they endure after the service has ceased.
Population outcomes	Population outcomes are designed to measure the mental health and wellbeing of all Victorians. This includes people who are not currently accessing, and those trying to access, mental health or wellbeing services. Population outcomes can measure things such as community resilience including after large-scale adverse events such as bushfires. Measuring population wellbeing outcomes should include a broad range of factors that support wellbeing such as housing, employment, financial inclusion, income, educational attainment, social and community connectedness and personal safety. Some population outcomes will be measured at the national level—for example, through the National Mental Health and Wellbeing Survey.	Examples of population indicators can include: quality of life; psychological distress in the community; statewide suicide rates; community resilience and recovery rates after community trauma (such as bushfires); rates of homelessness; rates of employment; education attainment rates; crime rates; community perceptions of safety surveys; family violence rates; rates of family breakdown including child protection; financial exclusion and income disparity.

Figure 3.2: Applied approach to outcome domains, outcomes and indicators



Source: Example (individual) adapted from: Stephen Bennett and Lena Etuk, *Developing a Shared Outcome Framework for the Housing and Homelessness Sectors, Project 2: Homelessness Sector Outcomes,* 2017, p. 14.

Measuring and monitoring outcomes at the individual level also contributes to a more equitable system, ensuring the outcomes achieved in relation to different cohorts—for example, age, gender or location cohorts—are visible and comparable.

Dr Andrews suggested that, over time, a greater focus on equitable service delivery, is likely to reduce health disparities:

> **If we do not measure health outcomes for every single patient, we do not know the extent of these disparities. Once we know, we need to redesign health systems and services so better health is available to all.**[104]

Current approaches to measuring individual outcomes for consumers includes the use of Health of the Nation Outcome Scales—a 12-point scale used by health professionals in public mental health services to measure clinical complexity and outcomes of treatment. The Commission notes the many uses of the Health of the Nation Outcome Scales, but also the differing views about its utility as a measure of understanding effective treatment, care and support.[105] Recognising these challenges, while at the same time acknowledging the importance of monitoring outcomes of short-term experiences of services, in Chapter 28: *Commissioning for responsive services*, the Commission proposes a more holistic and comprehensive approach to individual outcome measures that will build on and complement current approaches.

It is also important to measure individual outcomes in the medium–long term. This includes measuring longer-term mental health and wellbeing outcomes where treatment, care and support is enduring. Further, it is important to measure accurately how poor mental health outcomes affect outcomes in the justice, child protection, family violence and employment systems; and how poor outcomes in these sectors affect mental health and wellbeing. Measuring these outcomes will provide a 'compelling case and narrative evidence for earlier investment or [illustrate] the failures of earlier stages of the system to turn lives around.'[106]

For example, and as discussed in Chapter 16: *Supported housing for adults and young people*, a medium–long-term outcome measure may relate to the availability of safe, secure and stable housing. While mental illness does not guarantee a person's trajectory to homelessness, it does increase a person's likelihood of experiencing housing instability or homelessness, and vice versa.[107] Without access to stable housing, it can be difficult for a person to concentrate on anything other than finding a safe place to live, including their own mental health and wellbeing.[108]

When a person does access a mental health service but lacks safe or stable housing, the mental health treatment, care and support received can also be compromised if they are discharged into homelessness or other forms of inadequate housing.[109] This is of particular interest, as well as concern for the Commission, given that in 2019–20 there were 13,647 public specialist mental health consumers of all ages experiencing housing problems in Victoria.[110]

The relationship between mental health, housing and homelessness demonstrates the importance of collecting meaningful and dynamic information about the housing-related outcomes of consumers involved with Victoria's mental health system. Figure 3.2 contains an example of an individual outcome, indicators and targets relating to housing availability for Victorians living with mental illness or psychological distress.

3.3.5 Population mental health and wellbeing outcomes

Outcome measures must also consider regional and whole-of-population outcomes. This is necessary to support a balanced approach to planning and decision making and to align government and community focus on mental health and wellbeing and changes in population mental wellbeing over time.[111] Population outcomes can measure whether people are resilient and well supported in their community. They can also indicate whether the mental health and wellbeing system supports people to get the right service at the right time.

Recognising the broad range of factors contributing to mental health and wellbeing, population outcomes include: community resilience and recovery rates after community trauma (such as bushfires or other natural disasters); rates of employment; education attainment rates; crime rates; community perceptions of safety; family violence rates; rates of family breakdown including involvement of child protection services; financial exclusion and income disparities; and legal need and access to justice. Outcomes might also be developed with reference to research about specific indicators of disadvantage. The *Mental Health and Wellbeing Outcomes Framework* will seek to bring into prominence the relationship between these factors and mental health and wellbeing.

In addition to whole-of-population measures, the *Mental Health and Wellbeing Outcomes Framework* should measure outcomes for people who may be at risk of experiencing mental illness or psychological distress. Mental Health Victoria and the Victorian Healthcare Association argue that effectively responding to the different needs of different population groups should feature in the Commission's recommendations and reforms:

> **specific consideration [should be] given to the specific needs of all key population groups to ensure equity across all demographics including age, gender, location, race/ethnicity, sexuality, gender, identity, health status and life experiences … Otherwise, there is a risk that broad system reform will further entrench the invisibility of population groups whose individuated needs differ to the needs of the 'mainstream' population.**[112]

One of the most effective ways to combat the risk of specific population groups becoming 'invisible' is to develop outcomes and indicators that take account of specific groups to determine if their outcomes are comparable with the broader population. Anglicare Victoria submitted to the Commission that this approach will play an important role in making the new mental health and wellbeing system more equitable by providing 'a better basis for ensuring that high-risk groups are being effectively supported and that available resources are being most appropriately targeted'.[113]

However, to measure outcomes in this way, care and attention must be paid to what data is used to measure outcomes and how information is collected. There are particular populations whose experiences and outcomes may not be captured using traditional data collection methods: for example, people who live in supported accommodation may not be reached by household or phone survey methods (a common way to measure population mental health). Alternative arrangements will need to be established as part of the information architecture discussed in section 3.4.2.

3.3.6 Carefully designed targets

Well-designed targets—stipulating specific, defined outcomes—send a clear signal that motivates people and encourages them to prioritise activities to achieve the target over other activities.[114] Ms Kym Peake, then Secretary of the former Department of Health and Human Services, considered targets to be one way to ensure 'mental health remains front-and-centre of government's agenda'.[115]

Targets can also drive a more balanced approach to service delivery across both community-based services and acute care in hospital settings—a foundational consideration throughout this report. Mr Angus Clelland, CEO of Mental Health Victoria, considers there is a place for targets to encourage balanced investment that does not prioritise one part of the system over another:

> **Community-based services can be delivered at considerably lower cost than hospital-based mental healthcare services, although neither is a replacement for the other. We need to ensure that investment is appropriately balanced between services to ensure the optimal benefit for individuals, families and carers, and the State. We need to set access, quality and outcome targets to be worked towards which can be monitored by a statewide oversight body …**[116]

But targets can also have unintended consequences. They may encourage effort and resources to be moved away from where they are needed. Targets may also lead to 'gaming', where efforts lead to improved performance against a target, with no net social benefit.[117] James Mansell's 'information blueprint' supports a balanced approach to avoid directing efforts to selected areas of the system to the detriment of others.[118] Setting targets should be an active process, with recalibration and balancing over time. Rather than providing an indication of a pass or fail, they should be considered strategic objectives.

Targets may play an important role in developing system priorities. For example, the Transport Accident Commission has shifted to a safe-system approach in relation to road safety. In doing so, it has adopted the 'Towards Zero' target in relation to the Victorian road toll. Multiple specific initiatives are then implemented under the umbrella of the 'Towards Zero' system target—for example, the Safety Barriers Save Lives initiative.[119]

The Department of Health already identifies service-specific targets for mental health. For example, the *Victorian Health Services Performance Monitoring Framework 2019–20* describes using targets and other intelligence to identify areas of risk and poor performance. In particular the framework highlights the importance of trends against targets and also contextual factors that influence them.[120] The targets within the framework, however, are not used for broad strategic application, nor shared in the context of developing system priorities, nor for continuous improvement with year-on-year monitoring towards a desirable goal. The Commission considers that the Department of Health should adopt an alternative approach using carefully designed targets for these purposes as part of the new *Mental Health and Wellbeing Outcomes Framework*.

3.4 Accountability for the framework

The Commission has outlined the design features, laid a foundation for a vision, suggested outcome domains and has given guidance and direction regarding outcomes and indicators in this and other chapters. The full *Mental Health and Wellbeing Outcomes Framework*, however, must be developed methodically as the Victorian Government works through its implementation agenda. Importantly, the framework cannot be static. It must be 'up to the moment', and so it should be developed contemporaneously at the same time as the first wave of the Commission's reforms, and regularly refreshed. Current whole-of-system and whole-of-government input is required, as is leadership from people with lived experience of mental illness or psychological distress, and the expertise of families, carers and supporters, mental health and wellbeing services, other social and related services, researchers and the workforce. It will be updated and expanded as information architecture is reformed and grows, yielding richer and more interlinked sources of data over time.

The framework will be agreed through a consultation process with community, and accountabilities against the outcomes will be clearly defined. While departments and organisations may individually be responsible for specific outcomes, collective accountability will be established through whole-of-government arrangements.

Importantly, the *Mental Health and Wellbeing Outcomes Framework* should, over time, align with any national guidance and standards for reporting requirements.

3.4.1 Responsibility for the development and oversight of the framework

A range of information and inputs are required for the *Mental Health and Wellbeing Outcomes Framework* to function effectively (refer to section 3.4.2), from multiple government departments and agencies, the Department of Health, the Department of Premier and Cabinet, the Department of Treasury and Finance, and the new Mental Health and Wellbeing Commission. Collectively these departments and the new Commission should work together to establish the *Mental Health and Wellbeing Outcomes Framework* and ensure the framework is aligned to the whole-of-government outcomes approach so there is consistent language across portfolios.

Mr Symonds agreed with the importance of a range of institutions supporting the framework, suggesting that a mental health commission has an important role:

> I think we can do more to aggregate consumer outcomes and feedback and use them, along with other data and inputs, to drive improved performance at both the system and service level. A Commission, as in the case of New Zealand, may champion and support that.[121]

As a new impartial body, the Mental Health and Wellbeing Commission, outlined in Chapter 27: *Effective leadership and accountability for the mental health and wellbeing system—new system-level governance*, should monitor the new *Mental Health and Wellbeing Outcomes Framework*. Responsible for holding the government to account for the overall performance and quality and safety of the mental health and wellbeing system, and elevating and sustaining mental health and wellbeing as a priority in government decision making, it will be well placed to report, annually on progress.

In his advice to the Commission, James Mansell suggested that an independent approach is critical to maintaining the integrity of the information and in preserving trust in government:

> Because the government is not just a rule maker, but also a participant with [its] own interest in reusing information, and the most coercive of the parties, consideration must be given to limiting [its] power such that trust is maintained.[122]

This approach is also supported by the National Mental Health Commission, which considered that coordination of a whole-of-government approach must be separate from the body that monitors and reports on system outcomes:

> It is important that the responsibility for policy delivery and coordination be separated from the responsibility to monitor, evaluate and report on policy outcomes, so that independence and integrity can be achieved for both functions.[123]

The framework should align with the current Victorian outcomes guidance and standards discussed earlier in this chapter.[124] At a minimum, reports issued by the Mental Health and Wellbeing Commission must contain: service, system and population-level data; tracking against set targets over time; and short–medium and medium–long-term data. Each of these data items must be broken down so they can be used at the regional and area levels, as well as at the statewide level. The new commission will also generate reports for community and government institutions to ensure transparency and inform decision making.

3.4.2 Information architecture for the framework

The new *Mental Health and Wellbeing Outcomes Framework* cannot succeed without information and associated architecture. In this context, 'information architecture' refers to the 'designed foundation for how information can be acquired, integrated, organised and used in shared use environments'.[125] Creating a culture of good-practice information collection, use and sharing is essential to enable a more coherent, efficient and impactful system.[126] Using shared and diverse data, information, knowledge and expertise is crucial to transforming systems[127] and crucial to an outcomes approach. It allows for good measurement and visibility of outcomes, including the suitability, efficiency and effectiveness of programs and policies.[128]

The National Mental Health Commission and the Productivity Commission both highlighted the need for future mental health services and systems to be underpinned by high-quality information and data to improve consumer outcomes and system accountabilities.[129]

The datasets used to measure outcomes are diverse.[130] They include:

- administrative data—for example, de-identified consumer records
- linked data—for example, Commonwealth-funded services
- consumer, family, carer, supporter and workforce experience data
- pathways data and population outcomes data.

The new framework must provide for collection of required datasets.

If the *Mental Health and Wellbeing Outcomes Framework* is to truly be person-centred, its supporting information architecture must also be person-centred. This requires information to be captured, analysed and reported in a way that creates a meaningful picture of outcomes. Achieving this requires an information architecture that meets three core objectives:

- It must draw on information that reflects the diversity of services that support consumers.
- It must support a multivariant (multi-outcome) analysis of consumers' mental health and wellbeing outcomes by considering them alongside broader consumer outcomes that affect mental health and wellbeing—such as housing, employment and physical health considerations.
- It must enable a longitudinal (long-term) view of outcomes capable of distinguishing between limited short-term gains and sustainable long-term improvements, including the ability to quantify and report on the benefits of prevention and early intervention initiatives.[131]

Additionally, information architecture must support the collection of workforce experience data, recognising that more active efforts are needed to improve the wellbeing of the workforce, and its crucial role in a contemporary mental health and wellbeing system. Monitoring the wellbeing of the workforce, and associated initiatives, is discussed in Chapter 33: *A sustainable workforce for the future*.

Achieving these core objectives will require the department to use a range of individual and population-level datasets, including those that may need to be extracted from broader service and government portfolio repositories such as justice and housing. The framework must allow the datasets to be linked and brought together, with appropriate safeguards. Chapter 35: *New approaches to information management* outlines the Commission's vision for contemporary information management approaches for the future mental health and wellbeing system. An aggregated (de-identified) data repository will be fundamental to a new information management system. This repository will need to capture and link service information, intervention information and outcome information to help identify where service and system improvement is needed. A future mental health and wellbeing system will see consumers, families, carers and supporters, service providers and frontline workers involved in the design and implementation of future information management arrangements.

3.4.3 Alignment with the Commonwealth's mental health and wellbeing framework

As described throughout this report, there is considerable complexity and duplication between the Victorian-funded and Commonwealth-funded aspects of Victoria's mental health system.

Each level of government takes a different approach to measuring and reporting outcomes. The Productivity Commission acknowledged that this imposes an 'excessive administrative burden'.[132] Different reporting approaches are especially challenging for non-government organisations that must balance multiple unique reporting requirements for different commissioning bodies.[133] This restricts performance comparisons across providers, reduces accountability and limits the ability of providers to learn from one another.[134]

A common set of outcomes at the state and national levels can support 'one system' and coordinated action across levels of government, encouraging both horizontal and vertical integration.

In its *Mental Health Inquiry Report*, the Productivity Commission called for greater national leadership to streamline reporting, reduce burden and improve standardisation:

> Australian, State and Territory Governments should provide national guidance to standardise reporting requirements across regions. This would reduce administrative burdens for service providers and facilitate comparisons on a consistent basis for planning and research purposes.[135]

This problem is also recognised by the National Mental Health Commission. In its submission to the Productivity Commission mental health inquiry, it stated that it:

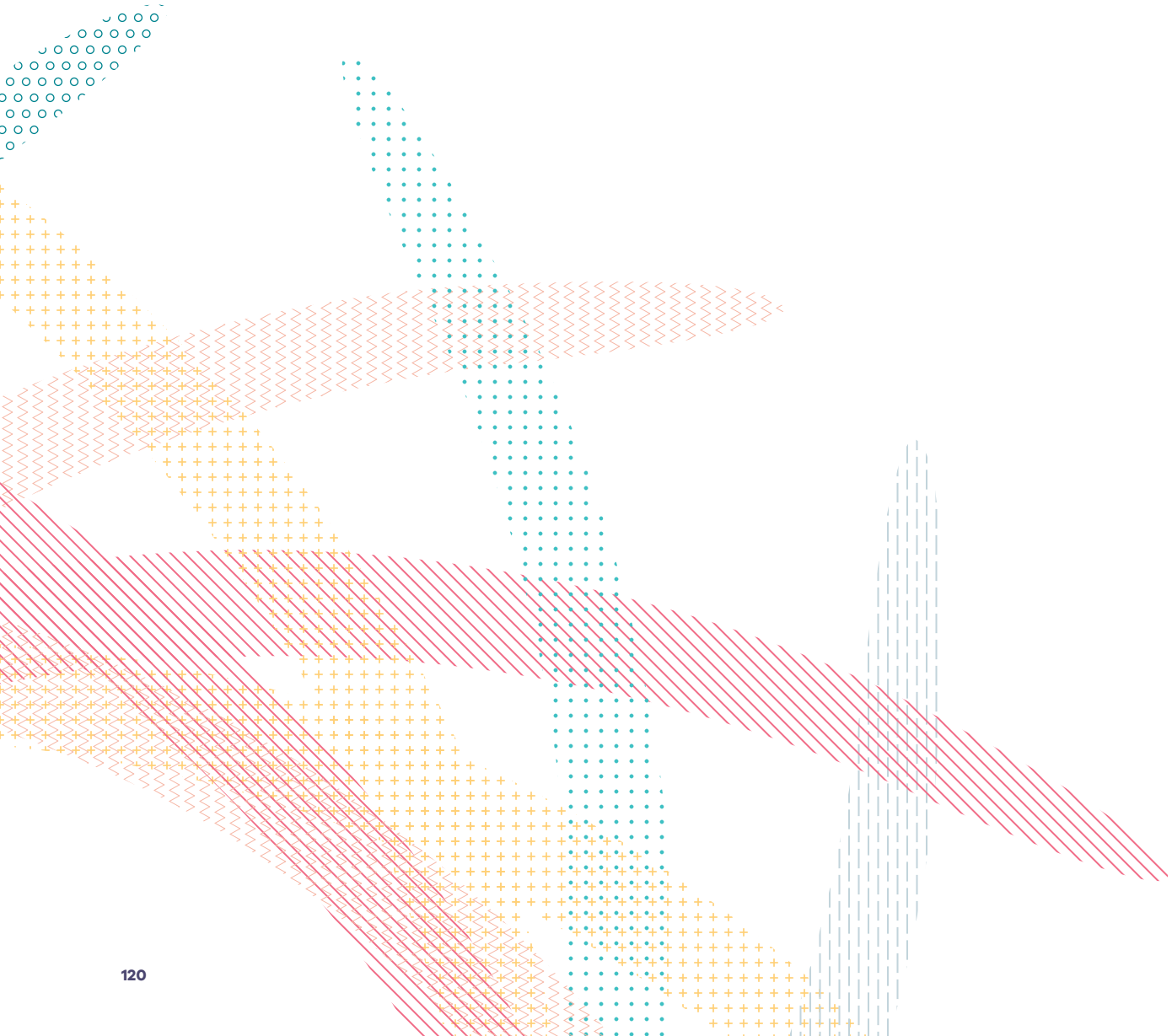
> recognises there is still much to do to move the routine monitoring and reporting focus towards consumer and carer outcomes and include social determinants through a cross-portfolio remit.[136]
>
> supports the intent of the draft recommendation for the Australian Government to establish a National Mental Health Strategy to cement cross-portfolio whole-of-government efforts and coordinate the supporting strategies into a shared outcome model. In effect, this is what is being achieved through the Vision 2030 and its roadmap.[137]

This Commission acknowledges the commitments made by the Victorian Government in recent policy statements and submissions to the Commission to measure and understand outcomes, and to use this knowledge to drive a culture of collaboration, adaption and continuous learning.

Mr Symonds reflected on this commitment:

> It is my experience that, as research and data evolve over time and increase our understanding, outcomes frameworks must also be iteratively updated and improved to reflect consumer experiences, contemporary priorities and evidence. As we learn more about how to measure experiences and outcomes, we will keep improving the mental health outcomes framework, and the indicators that sit under it.[138]

The goal of the Department of Health should be to work with the Commonwealth, as part of a shared agenda and future agreements on mental health, to expand uniform state and national outcome measurements, including through formal mechanisms such as the Productivity Commission's annual *Report on Government Services*.



3.5 Using the *Mental Health and Wellbeing Outcomes Framework* for system transformation

To be effective in supporting the transformation of the mental health system, the new *Mental Health and Wellbeing Outcomes Framework* must be applied using a whole-of-system and whole-of-government approach.

The Commission's terms of reference define the mental health system as comprising mental health services that are funded wholly, or in part, by the Victorian Government. However, the Commission refers to a broader system when it uses the term 'whole-of-system'. This includes not only public sector bodies and organisations at the federal, state and local government levels; but all people and organisations who participate in—or are connected with—the new mental health and wellbeing system. The Commission's interim report outlines the scope of the current system.[139] In particular, Figure 3.1 in the interim report shows the breadth of those participating in—and connected with—the existing system.[140] They include, for example, individuals, the not-for-profit sector, other community organisations, private sector service providers, employers, private schools, private tertiary providers and religious organisations. Chapter 5: *A responsive and integrated system* describes the future design of the Victorian community-based mental health and wellbeing system.

Below are the key ways the new framework should be applied by 'system participants', including government, to support development of the new community-based mental health and wellbeing system, and broader system transformation.

3.5.1 Outcomes to inform decision making

Outcomes can be used to define and measure value, and as such they should be used to help decision-makers—including service providers and government—to understand if their actions are delivering the best outcomes for individuals and the population.

New processes to embed the new *Mental Health and Wellbeing Outcomes Framework* in decision making will be required. The new bodies, structures and entities across the system as outlined in Chapter 5: *A responsive and integrated system* and Chapter 27: *Effective leadership and accountability of the mental health and wellbeing system—new system-level governance*, must actively use the *Mental Health and Wellbeing Outcomes Framework* within their operational and executive governance arrangements to plan and make decisions.

Government-wide and community-wide approaches to mental health and wellbeing outcomes must be enabled through the recommended Mental Health and Wellbeing Cabinet Subcommittee to be chaired by the Premier. The Cabinet Subcommittee should review the outcomes reported using the new framework and use the information to inform policy and investment decisions (refer to section 3.5.2). Members of the subcommittee must be jointly accountable for these outcomes, sharing responsibility and driving collective approaches to improvement.

Only through the collective effort of ministers can government strengthen the ability across multiple portfolios to influence the social determinants of mental health and the risk and protective factors lying outside the mental health service system.

Under the new structures, accountability for outcomes will also need to flow across portfolios and through departments to portfolio agencies and other layers of government. For example, reporting on the *Mental Health and Wellbeing Outcomes Framework* at the regional level will inform the strategy, planning and decision-making functions for the recommended Regional Mental Health and Wellbeing Boards. Boards of community services, primary health services and public hospitals will use the *Mental Health and Wellbeing Outcomes Framework* in a similar way. A common framework—and reporting against that common framework—will help ensure shared responsibility for limited resources and the direction of those resources to areas where they will have the greatest impact. An example of the power of such an approach is that of the Canterbury District Health Board (refer to the case study).

New processes alone, however, will not be enough to ensure outcomes are actively used in decision making. As outlined in Chapter 2: *The Commission's approach to reform*, the characteristics of complex systems like Victoria's mental health system mean that system conditions, such as culture, values, power dynamics and relationships between people or organisations, can affect processes. Strong leadership, as occurred within the Canterbury District Health Board, will be required to encourage a new approach to decision making, and this must be demonstrated within government:

> the integration of performance measures into budgeting and management systems is not just about changing processes but is also about transforming the behaviour of both public servants and politicians throughout the political system.[141]

3.5.2 Outcomes to support data-driven investment decisions

The *Mental Health and Wellbeing Outcomes Framework* will form a link between the Commission's interim report recommendation for a new approach for mental health investment (recommendation 8) and government decision making about how best to use that investment. The new *Mental Health and Wellbeing Outcomes Framework* must be used to ensure funding, including that raised by a levy or other mechanism, is directed for maximum impact. It will deliver on what Dr Peggy Brown AO, a psychiatrist who has held a number of leadership roles in the mental health sector, considered should be a priority:

> We should have a much stronger focus on the outcomes that are being achieved for the dollars that are being spent, not just on the activity, and in particular the outcomes that matter to the people who seek our assistance …[142]

As extensively outlined in the Commission's interim report, mental health has not secured adequate funding during the past decade.[143] Higher funding for mental health in more recent years appears to be an exception to the trend over the last decade, as Ms Peake observed:

> **Taking the example of community mental health services, while considerable growth funding was allocated to community mental health services in 2016–17 (2.3 per cent) and 2017–18 (7.0 per cent), this followed a period of zero growth funding over the three years prior.**
>
> **New funding has often been allocated to smaller initiatives to 'patch-up' service gaps, rather than to core service capacity.[144]**

At the same time, other government services have on average experienced sustained operational funding growth.[145] The share of all Victorian Government health services expenditure allocated to mental health declined from 18.3 per cent in 1996–97 to 12.8 per cent in 2016–17,[146] with mental health historically being the 'poor cousin' of the health system.[147] This lower priority has also been reflected in sometimes lower levels of political support for mental health when compared with other services.[148]

The Commission recognises that government investment decisions in a fiscally constrained budget inevitably face trade-offs. Yet decisions not to invest now can have much higher costs later—as Figure 3.3 illustrates.

The Commission estimated in its interim report that the economic cost of poor mental health in Victoria is $14.2 billion a year.[149] These costs include forgone wages, out-of-pocket costs and unpaid care. They are borne by every Victorian, but people living with mental illness or psychological distress are affected the most, and families, carers, supporters, governments and employers also incur costs.[150]

On the current trajectory, a range of costs related to poor mental health is likely to increase. This is in part due to cost pressures that reflect broader community trends, including an increasing demand for mental health services. It is also due in part to higher relative costs of providing human services compared with other types of services or products.[151]

Investment to improve mental health and wellbeing brings long-term benefits. Improving mental health and wellbeing is intrinsically valuable because it has direct and indirect social and financial benefits, increasing community participation, improving productivity and reducing costs. Much of this relates to the fact that many people living with mental illness or psychological distress are in the workforce or are of working age.[152] For example, in its interim report, the Commission was able to estimate the economic benefits of improved mental health and wellbeing by providing improved treatment, care and support to reduce the intensity of symptoms and improve engagement in day-to-day activities. The Commission found that a 15 per cent reduction in the 'level of need' experienced by people diagnosed with a mental illness would deliver $1.1 billion in additional economy activity in the Victorian economy annually, reflecting the benefits of increased productivity and higher workforce participation.[153]

This chapter has already outlined how government's traditional budget processes focus too heavily on ensuring the efficiency of services and outputs. These processes have not delivered outcomes that matter to people. They have also not acknowledged the various service costs associated with these outcomes.

Case study:

Collective impact model—the Canterbury District Health Board

New Zealand's Canterbury District Health Board achieved positive population health outcomes by uniting the health sector to better use limited resources.

In 2006, under a newly established CEO, the Canterbury District Health Board made a critical discovery. Through conducting an analysis, the board found that the current way of operating was unsustainable—the board was running a deficit and population growth and ageing was creating rising admission rates and wait times. It found that, if nothing changed, Canterbury would need another hospital by 2020 (with more than 500 beds), as well as 20 per cent more GPs and practice nurses as well as an additional 2,000 residential care beds for the older adult population. Not only was there insufficient funding to establish these additional services but there was also a lack of qualified staff.

Over the course of two to three years, the board undertook a collaborative process (which included a six-week event with more than 2,000 participants from across the health system) to identify a set of strategic goals and principles. The process was underpinned by a focus on placing the patient at the centre of the service system.

In 2008 the board signed off on the set of principles that would shape the approach to redesigning services. One of these principles was that those in the health system—from primary care, to community-based services, to hospitals, public and private—would work together to recognise that there was 'one system, one budget'. Another principle was that 'Canterbury had to get the best possible outcomes within the resources available, rather than individual organisations and practitioners simply arguing for more money'. Developing and agreeing this shared vision for change was a key enabler for reform.

As Mr David Meates, the CEO, said: '[w]e need the whole system to be working for the whole system to work'.

Another key enabler for change was establishing a pooled budget. The board shifted from contracting a whole range of external services (mental health, district nursing, allied health and so on) based on input-defined, competitive and often fee-for-item-of-service contracts, to 'alliance' contracting. Alliance contracting, based on a model used in the construction industry, assumes that multiple organisations can achieve better outcomes by working together on agreed contracts.

> It is a collective contract with pre-agreed gains and losses dependent on the overall performance of all the parties, rather than with penalties solely for whoever fails within it.

While an element of competition remains because patients are still able to choose their provider and GPs choose providers to which they refer, the culture of the health system improved because different health services now have an incentive to work together to achieve better outcomes for consumers, rather than competing for funds.

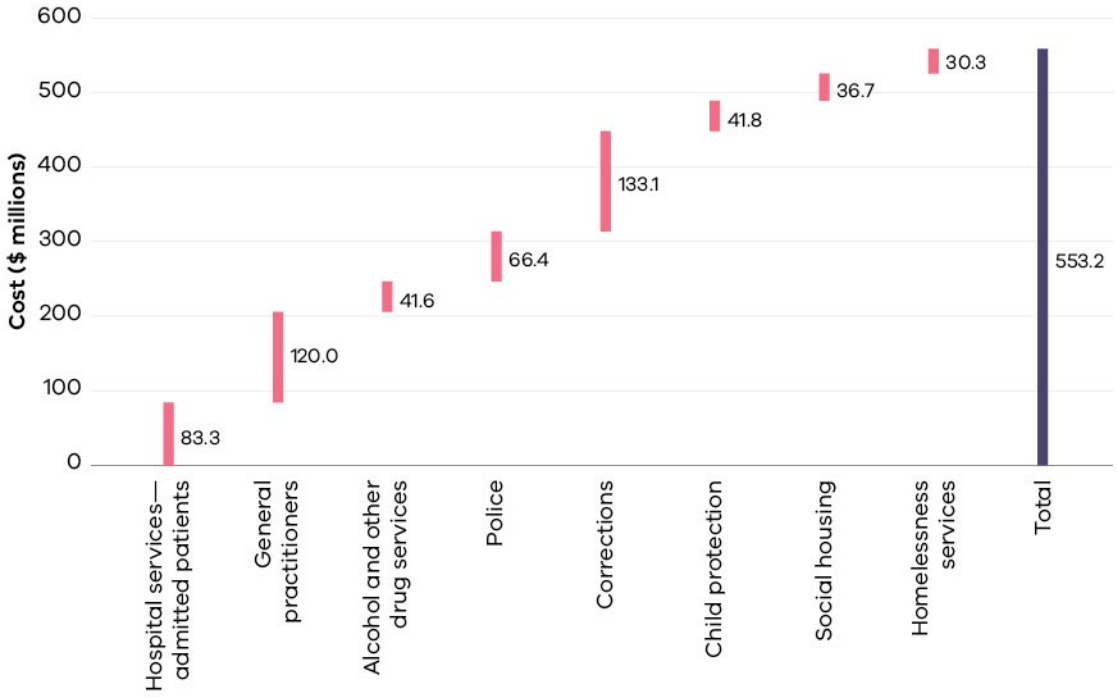
> Canterbury has, in effect, used its purchasing power and its moral influence to harness others into a joint endeavour aimed at effecting change beyond the board's purely technical reach.

These steps, along with a number of other key initiatives and reforms, led to great progress towards improving the outcomes of the Canterbury community. Over the past decade, as Canterbury has undertaken this reform, acute admission rates have continued to decline, and when comparing acute medical length of stay and readmission rates across New Zealand, Canterbury comes third among the 20 health boards across the country.

The Canterbury example illustrates how shared responsibility and a better use of limited resources can have a great impact on the health outcomes of a population.

Source: Nicholas Timmins and Chris Ham, *The Quest for Integrated Health and Social Care: A Case Study in Canterbury,* New Zealand, 2013, pp. 8–9, 15, 19 and 50.

Figure 3.3: Estimated flow-on costs of related government services as a result of poor mental health, Victoria, 2018–19



Source: Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 370 and Appendix C: Background to economic analysis.

Note: This is a conservative estimate because it only considers multiple service use among people accessing public specialist clinical mental health services in 2017–18. It does not account for people who (a) may have been accessing private services or (b) may have been living with mental illness but were not accessing public specialist clinical mental health services in 2017–18.

The Productivity Commission suggested that more focus should be placed on measuring, and reporting on, mental health expenditure:

> Monitoring expenditure on interventions is necessary for assessing their efficiency relative to alternative allocations. This information is critical for decision makers seeking to improve mental health outcomes by reallocating resources.[154]

It is important that the Victorian Government is supported to make decisions about trade-offs with the right information about the long-term consequences of these decisions on outcomes. A shared outcomes approach involves making decisions about the best use of resources and redirecting investments when they are not delivering the desired outcomes.

The Department of Premier and Cabinet's *Outcomes Reform in Victoria* report states that:

> When we know where money is spent and what it was meant to achieve, we can more confidently determine what is working, what isn't working and what needs to change. This can provide us with greater confidence to redirect resources from areas that aren't achieving our intended results, allowing us to deliver greater value to people and communities.[155]

The Commission recommends that the Victorian Government use the *Mental Health and Wellbeing Outcomes Framework* as a mechanism to inform government investment processes and assess the benefits, including the economic benefits, of early intervention.

To fully embed this new approach in budget cycles, and to facilitate transparency, an alternative approach to the traditional output performance measures in the Victorian Budget papers will be required. Single service 'output' measures should be replaced with outcomes measures that cover multiple portfolios and align with the *Mental Health and Wellbeing Outcomes Framework*.

The Commission has examined various whole-of-government approaches to social policy and investment. Box 3.2 gives an example of an outcomes approach in New Zealand that is driving a whole-of-government wellbeing investment strategy.

The Victorian Mental Health and Wellbeing Commission will report on measures under the new *Mental Health and Wellbeing Outcomes Framework*. To enable more robust investment decisions, reports must also be generated for government to coincide with key milestones in the annual budget cycle. In particular, reports will be generated to inform deliberations of the Expenditure Review Committee. This is tied to the Commission's recommended approach in Chapter 36: *Research, innovation and system learning* that adequate evaluation is a condition of funding for all new mental health programs, initiatives and innovations.

3.5.3 Outcomes to inform commissioning

While the Victorian Government will use the *Mental Health and Wellbeing Outcomes Framework* to inform its investment decisions, taking into account whole-of-system considerations and the benefits of early investment, deliberate resourcing approaches must occur throughout the system.

At the departmental and regional levels, an effective outcomes framework will help embed value-based mental health care in Victoria's new mental health and wellbeing system. 'Value-based health care' encourages service providers to achieve the best possible outcomes for consumers or patients in the most cost-efficient way.[156] In evidence to the Commission, Dr Andrews explained how achieving patient (or consumer) outcomes is the core purpose of value-based health care:

> The goal of value-based care is to create more value for patients by focusing on the outcomes that matter to them, rather than solely reducing the cost of delivering care.[157]

Box 3.2: New Zealand's National Wellbeing Budget and Strategy

In 2019 New Zealand announced the world's first 'wellbeing budget'.[158] The wellbeing budget shifted the focus from increasing gross domestic product to improving the welfare of people.

From this point, all new government spending was expected to work towards six priorities: taking mental health seriously, improving child wellbeing, supporting Māori and Pacific Island people, building a productive nation, transforming the economy and investing in New Zealand. Wellbeing is the focus of each priority.

The first wellbeing budget had a strong focus on mental health and the broader determinants of mental health. Speaking publicly about this budget, the New Zealand Prime Minister, the Rt Hon. Jacinda Ardern, declared:

> Of course in order to tackle mental health issues, we must look at the complex and interwoven issues that contribute to them. There is no point in targeting mental health if we don't also invest in homelessness, family violence, poverty and other issues that contribute to stress in life. And that's what this Wellbeing Budget has done.[159]

The success of the budget is measured by the Treasury's *Living Standards Framework*.[160] The *Living Standards Framework* contains 12 measures of wellbeing, including measures of health, housing, knowledge and skills, social connections and jobs and earnings.[161] The measures are publicly available on an interactive 'dashboard' on the New Zealand Treasury's website.[162]

The *Living Standards Framework* is a way to support government agencies to be more cohesive so public policy on wellbeing, spending and other government interventions is aligned to improving intergenerational wellbeing.[163]

The New Zealand Treasury recognised that its economic analysis 'focuses on increased incomes, and is separated from departmental expectations and expenditures that have wider wellbeing objectives'.[164] The framework and dashboard are designed to improve the consistency of the Treasury's economic and fiscal advice across the whole range of economic, social and environmental policy.[165]

The New Zealand Treasury considers providing better intelligence means that governments will make more informed decisions. While government decisions are often political and ethical in nature, Treasury expects that choices will be made with greater awareness of the trade-offs.

> Ultimately, decisions about acceptable levels of factors within the Framework, distributional choices, and trade-offs between competing goods are ethical and political in nature and are therefore not amenable to definitive policy solutions. However, highlighting these choices and trade-offs will help ensure Treasury's advice is robust and that governments' decisions are well-informed.[166]

The Treasury is planning to refresh the framework in 2021, its website stating:

> We continue to develop the framework to reflect the feedback we have heard and as we learn more about what is needed to make it more useful in our advice to officials and ministers.[167]

The Commission's recommended approach to value-based funding, to be pursued in parallel with implementing an activity-based funding model for mental health services, is described in detail in Chapter 28: *Commissioning for responsive services*. To be successful, the Commission believes these reforms require a clear and transparent outcomes framework that takes a whole-of-system view of performance. By defining the 'outcomes that matter' to consumers, the 'value' of mental health treatment, care and support can be measured and monitored by Regional Mental Health and Wellbeing Boards, the Department of Health and the Mental Health and Wellbeing Commission and used by service providers and consumers.

Measuring individual consumer outcomes will be instrumental in supporting new ways of funding and commissioning across the entire mental health and wellbeing system. These new approaches will focus on value and outcomes rather than just activity and outputs. It will complement the Commission's recommendations around developing consumer-completed measures and family, carer and supporter completed measures, outlined in Chapter 28.

The *Mental Health and Wellbeing Outcomes Framework* is a core input into value-based health care. By helping to identify what matters most to consumers, an outcomes framework will support value-based funding approaches to align with, rather than inhibit, the existing, intrinsic motivations of professionals to deliver the best possible care.[168] This will be achieved by 'align[ing] the work and incentives of health care delivery with the reason most health professionals entered the field in the first place—to help people achieve better health'.[169]

Most importantly, however, because value-based health care will be framed by the outcomes that matter most to consumers, it will offer providers greater flexibility to listen, and respond, to the diverse needs of consumers. As one consumer noted, 'helping' consumers must start with a focus on what a consumer needs, not a funded or required activity of a provider:

> You have to make a system where people don't do things to follow the *rules*; they do things to follow their *heart*. … I need help. But I want it done with a better understanding [of] … what I need, not what they need to give me.[170]

3.5.4 Outcomes to drive improvement and enhance confidence in the system

Outcomes can encourage collaboration by creating a 'collective sense of purpose, importance and direction'.[171] The transparent use of outcomes can help direct reform endeavours and 'provide a shared view as to whether reforms are being achieved'.[172] Ms Peake suggested that broad and inclusive outcomes that respect the contributions of different professions, sectors and organisations can help to 'coalesce efforts across functional and professional boundaries'.[173] Coalescence of efforts through collaboration across functional and professional boundaries—inside and outside government—is a key contributor to a system that improves and evolves through learning and adaption. This is because participants adapt and change the system—and change their own behaviour—in response to measured outcomes.

As noted in Chapter 36: *Research, innovation and system learning*, an adaptive system is one that can identify and test new ideas, gather evidence about what works, and translate this into effective treatment, care and support. In an adaptive 'learning' system, evidence about what works is used to continually improve professional practice, service design and system policy and to drive collaboration. 'Feedback loops' are required between different types of research, services, government and consumers to successfully translate evidence into practice. Those feedback loops are strengthened by a framework against which outcomes can be measured.

To facilitate this learning and evolution, clear and transparent reporting of the *Mental Health and Wellbeing Outcomes Framework* will be required. The measures of the framework should be reported annually and be provided regularly to the Mental Health and Wellbeing Cabinet Subcommittee for review. This body holds ultimate accountability for the outcomes reported.

The Mental Health and Wellbeing Commission must also generate regular reports for community, service providers and government institutions to inform decision making and their approach to the reform agenda.

There are numerous examples of the role a transparent approach to outcomes can play in driving service improvement. Sweden has long been a global leader in value-based health care, which it envisioned as a structure for rebuilding healthcare systems. Dr Porter describes Sweden as having 'the overarching goal of value for patients', shifting health care from siloed considerations such as access, cost containment or convenience.[174] Access to high-quality data has been critical to Sweden's dedicated approach to value-based care, pioneered through quality-based health registries and digital health records that 'provide quality indicators designed both to enable further improvement and to allow for the evaluation of healthcare delivery'.[175] Critically, the registries publicly post data on health quality indicators. The Swedish National Board of Health and Welfare and the Swedish Association of Local Authorities and Regions jointly publish regional and service-level comparisons of healthcare quality and efficiency, including outcomes related to different health conditions, the impact and effectiveness of drug therapies, and patient access, experiences and confidence in service providers.[176]

Karin Göransson, a policy analyst at the Swedish Association of Local Authorities and Regions, explained how publishing data on quality and value of health care is improving outcomes for people in Sweden:

> **In Sweden, the national quality registries give a unique possibility to achieve the goal of equal care and treatment. … They provide knowledge of how healthcare works and can be improved. These registries, together with the traditional health data registries, have helped save many lives and improve healthcare in Sweden.**[177]

This kind of transparency ensures consumers and communities have confidence in the services they are using—a system without data is a system in which the confidence of consumers and the public is more likely to erode over time.

A further example of the use of transparency to support an adaptive learning system is Ontario, Canada's Rapid Improvement Support and Exchange, profiled in Chapter 36: *Research, innovation and system learning*. Box 3.3 outlines how transparent sharing of provider experiences supports an adaptive learning system.

Box 3.3: Ontario's Rapid Improvement Support and Exchange (RISE)

RISE is a collaborative platform designed to help new Ontario Health Teams to learn and improve quickly by trialling and evaluating local approaches and sharing findings about the outcomes with other teams. It is a model that continually 'ups its game in achieving the quadruple aim of improving care experiences and health outcomes at manageable per capita costs and with positive provider experiences'.[178]

According to RISE, rapid learning and improvement involves six steps:[179]

- identifying a problem or goal
- designing a solution based on data and evidence
- implementing the plan (possibly in pilot and control settings)
- evaluating to identify what does and does not work
- adjusting, with continuous improvement based on what was learned from the evaluation and from other health teams
- disseminating the results to improve the coverage of effective solutions across the health system.

RISE supports rapid learning and improvement among teams through coaching, collaboratives and communities of practice. The research expertise and resources provided by RISE enable teams to assess and share experiences of success and failure. As outlined in Chapter 36: *Research, innovation and system learning,* over time, this transparent sharing and dissemination of findings builds capacity for Ontario to become a sustainable, self-improving system.

As these examples indicate, decision making and informed approaches to investment require outcomes and indicators to be measured and reported. But outcomes frameworks should not just be used as 'internal tools'. Outcomes and measures must be shared and communicated broadly to provide information, influence behaviour and enable deliberation, collaboration and learning. This transparent approach will promote engagement and strengthen confidence in the system, which is particularly important for people working in the system and those who use it:

> Transparency around outcomes is also very important for consumers. It is important that a consumer feels confident choosing a particular health service because they know they will get better care.[180]

Combined with the Commission's recommended approach to service delivery, which includes greater choice for consumers, and the recommended structural enablers for a new 'learning' system outlined in Volume 5, the *Mental Health and Wellbeing Outcomes Framework* will chart the course for better treatment, care and support, and improved mental health outcomes.

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Chapter 4

Working together to support good mental health and wellbeing

Recommendation 2:

Governance arrangements for promoting good mental health and preventing mental illness

The Royal Commission recommends that the Victorian Government:

1. establish within the Mental Health and Wellbeing Division, a Mental Health and Wellbeing Promotion Office, led by a Mental Health and Wellbeing Promotion Adviser, who reports to the Chief Officer for Mental Health and Wellbeing (refer to recommendation 45(1)).
2. enable the Mental Health and Wellbeing Promotion Office to develop and coordinate a statewide approach to the promotion of good mental health and wellbeing and the prevention of mental illness which:

    a. delivers the economic and social benefits of good mental health and wellbeing across the population;

    b. is informed by public health principles;

    c. promotes and is informed by human rights; and

    d. focuses on reducing inequities in mental health and wellbeing outcomes.

4.1 Promoting good mental health and wellbeing

4.1.1 Shifting the focus to 'mental wellbeing'

At the heart of the Commission's reforms is a vision for a mental health and wellbeing system that fundamentally shifts its focus towards promoting and delivering good mental health and wellbeing. As Ms Georgie Harman, CEO of Beyond Blue, observed:

> We largely have a system built for adults in crisis, rather than a system that invests proactively in mental health promotion and prevention aimed at families, communities and universal settings like schools.[1]

In delivering on the recommended reforms, the Victorian Government must aspire to what the World Health Organization describes as a 'state of well-being' in which 'an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community'.[2]

Good mental health is about more than an absence of mental illness.[3] As part of its inquiries, the Commission held several community workshops that included small group discussions on personal interpretations of mental health. One participant explained how their group viewed mental health:

> We talked about attitudes of confidence and self-esteem, balancing core values and actions, sense of community. We talked about connection to community, being able to have a sense of control, and less uncertainty about the future. We talked about the ability for us to understand when things are not going right, when we're not happy.[4]

VicHealth—the Victorian Health Promotion Foundation—also describes 'mental wellbeing' as having many components:

> Mental wellbeing is a dynamic state of complete physical, mental, social, and spiritual wellbeing in which a person can develop to their potential, cope with the normal stresses of life, work productively and creatively, build strong and positive relationships with others and contribute to the community.[5]

VicHealth's definition of mental wellbeing is adopted in this chapter.

Promoting mental wellbeing and preventing mental illness will be essential strategies for Victoria's future mental health and wellbeing system. Achieving a better state of mental health and wellbeing requires new approaches to strengthen prevention and promotion, to ensure all parts of government and the Victorian community play their role, and to focus on the whole population—including but not limited to people with lived experience of mental illness. This will require the Victorian Government to be bold and to invest in prevention now, in order to achieve a reduction in mental illness in the future.

4.1.2 A future with less mental illness

The primary reason to increase investment in preventing mental illness is the potential to reduce human suffering and to improve people's quality of life. Evidence indicates that prevention strategies can reduce the prevalence and therefore the personal impacts of mental illness, as described in section 4.2; at the same time, there is evidence to indicate that prevention can also reduce the financial losses and economic costs to society that are associated with mental illness.

The Commission's interim report highlighted that approximately 20 per cent of Victorians will experience a mental illness in any given year.[6] Mental illness, and injury from suicide or self-harm, is one of the top five 'burden of disease' groups in Australia.[7] Victoria has a higher estimated burden of disease from mental illnesses than most other states and territories.[8] In 2015, the burden of disease from mental illnesses in Victoria was estimated to be 26.5 disability-adjusted age-standardised life years lost per 1,000 people in the population.[9] In its interim report, the Commission estimated that the economic cost of poor mental health to Victoria is $14.2 billion per year.[10]

The Productivity Commission's *Mental Health Inquiry Report* noted that 'anxiety and depressive disorders are the most common form of mental illness, accounting for approximately half of the health loss due to mental illness'.[11] The Productivity Commission estimated that in 2018–19 the cost of mental ill-health and suicide to the Australian economy was up to $70 billion per year.[12] This included direct expenditure to care and services, the cost of lower economic participation and lost productivity, and the cost of replacing support provided by carers. The Productivity Commission estimated there was an additional annual cost of $151 billion attributed to disability and premature death due to mental illness.[13]

Many of these costs are likely to be avoidable. The Productivity Commission has recommended reforms across prevention, early intervention and improved mental health service delivery.[14] It has estimated that the benefits resulting from its recommended reforms 'could reach up to the equivalent of nearly $18 billion per year (an improvement of up to 84,000 quality-adjusted life years)'.[15] These benefits would arise from improved quality of life, increased incomes and reduced government expenditure.[16]

Researchers at the London School of Economics and Political Science and associated organisations have examined the estimated return on investment from prevention strategies and the lifelong costs that can be avoided.[17] They found, for example, that:

> **in the United States, targeted programs were shown to generate a positive return on investment, taking into account benefits to the health, education, and criminal justice sectors, as well as the labor market upon reaching adulthood. These ranged between $1.80 and $3.30 for every $1 spent on programs targeted at children with behavioral problems.[18]**

The research also found that prevention programs targeting parents could generate a return of up to $9.29 for every $1 spent.[19] In Australia, the Productivity Commission found significant returns for employers who invest in workplace mental health initiatives and referred to estimates that for every $1 invested in workplace initiatives, the return ranges from $1 to $4.[20]

Evidence indicates a stronger economic case for some types of prevention activity than others.[21] Those with a stronger case were reported as including measures to tackle bullying and insecure housing and initiatives to support employment and access to nature and green spaces.[22]

4.1.3 Defining 'prevention' and 'mental health promotion'

In relation to mental illness, the term 'primary prevention' describes policies, initiatives or activities that seek to 'prevent the initial occurrence of a disorder'.[23] An important feature of primary prevention is its focus on the whole population. This is what ultimately distinguishes it from early or 'secondary' intervention, or treatment, care and support services, which are sometimes categorised as 'tertiary' interventions.[24] Primary prevention is achieved by reducing the risk factors associated with mental illness and strengthening protective factors.[25] It aims to prevent the illness or condition occurring in the first place.[26] The World Health Organization's *Mental Health Action Plan 2013–2020* identified prevention as a priority strategy for improving population health and wellbeing.[27] Throughout the remainder of this chapter, 'prevention' is used to denote primary prevention.

The promotion of good mental health—commonly referred to as 'mental health promotion'—describes 'actions and advocacy to address the full range of potentially modifiable determinants of health, including actions that allow people to adopt and maintain healthy lives and those that create living conditions and environments that support health'.[28] Mental health promotion is a strategy to improve the mental health of everybody in the community, whether they experience mental illness or not.[29] The Commission emphasises that it is possible for people to flourish and experience mental wellbeing throughout their lives, even at the same time they may be experiencing mental illness.[30] In a wider sense, mental health promotion efforts can 'raise the position of mental health' and promote awareness of mental health at every level, from individuals and families through to government and business.[31] Throughout the remainder of this chapter, 'promotion' is used to denote mental health promotion.

Prevention and promotion are related and overlapping strategies.[32] Throughout this chapter and report, references to 'prevention and promotion' refer to the prevention of mental illness and the promotion of mental health and wellbeing, unless specified otherwise. These strategies seek to ensure that people who are well are supported to remain well, and they help promote good mental health for people living with mental illness. In its submission, VicHealth highlighted that prevention and promotion have the potential to change the lives of many Victorians, now and in the future.[33] The Victorian Council of Social Service also emphasised that increased use of prevention strategies can contribute to a reduction in the prevalence, incidence and impact of mental illness.[34] The evidence for this is discussed in the next section.

Professor Rob Moodie, Deputy Head of School and Professor of Public Health at the University of Melbourne, highlighted that a strengthened approach to prevention will support greater integration of prevention and promotion strategies with treatment, care and support services. He described the importance of having a strong and effective treatment, care and support system while also ensuring those working in the system are aware of, engaged in and supportive of actions to prevent people from becoming ill in the first place.[35]

Ms Nicole Bartholomeusz, Chief Executive of cohealth, described how reducing the prevalence of mental illness will deliver benefits to the mental health service system by reducing costs and service demands on the tertiary mental health system.[36]

Prevention United also described prevention and promotion strategies as being complementary to mental health treatment, care and support:

> **Prevention and treatment are complementary rather than competing endeavours and it is essential to focus on both if we are serious about reducing the impact of mental health conditions on individuals, their loved ones and on the whole community.**[37]

The Commission also recognises that increased mental health promotion activity and the delivery of efforts to prevent mental illness are likely to improve health equity more broadly. This is explored further in Volume 3: *Promoting inclusion and addressing inequities*. As the World Health Organization observes, government investment in public health contributes to reducing health inequalities in the long term.[38] Ms Robyn Kruk AO, Interim Chair, Mental Health Australia, giving evidence in a personal capacity, described how a focus on determinants will assist governments in tackling health inequities:

> **The mental health of people is affected by the social, economic, and physical environments in which they live. Many risk factors for mental illness are associated with social inequalities. Implementing strategies to address the social determinants of mental health will improve the living conditions of people across the life stages, and reduce risks of the mental health issues associated with social inequalities.**[39]

The Commission heard that mental health promotion and efforts to prevent mental illness have an important place alongside treatment, care and support in addressing health inequities. For example, Mind Australia called for 'policy and program solutions that remedy inequalities in social and economic determinants in equal measure to those that deal with the clinical treatment and management of the symptoms of mental illness'.[40]

4.2 The case for prevention

There have been significant global developments in the field of primary prevention over the past 20 years following advice from the World Health Organization to give priority to population-wide interventions and primary prevention strategies.[41] There is a growing body of evidence that indicates prevention can be effective in reducing the prevalence and cost of mental illness as described in section 4.1.2.[42]

There is limited evidence that some forms of mental illness, such as schizophrenia and bipolar mood disorder, can be prevented.[43] However, there is evidence to indicate that some preventative approaches can delay the onset or reduce the severity of psychosis.[44]

A recent review of prevention evidence found that, in some circumstances, it is possible to prevent the onset of anxiety conditions, certain forms of depression, certain behavioural disorders and substance use or addiction.[45] The review identified the types of strategies that can be effective in reducing risk factors and strengthening protective factors across a range of settings and age groups. These strategies include:

- parenting programs
- social and emotional development programs
- creating supportive environments for mental health
- strengthening community action for mental health
- developing mentally healthy public policy.[46]

In its submission, Prevention United made the link between public policy broadly and the factors that shape mental health:

> While public policy approaches for the prevention of mental health conditions have received less explicit attention, there are nevertheless various existing policies that make an important contribution. For example, child maltreatment, family violence, racism, homophobia and transphobia are all major risk factors for mental health conditions and existing laws, regulations and policies to tackle these problems are therefore a crucial element of a comprehensive approach to prevention.[47]

Prevention United expressly highlighted the need to eliminate child abuse to reduce mental illness:

> Studies suggest that by eliminating child abuse we could potentially reduce the prevalence of anxiety and depression in our community by around 20–25%.[48]

Many government departments and portfolios have the capacity to influence these and other determinants of mental health and wellbeing, as discussed later in this chapter.

An evidence review commissioned by the National Mental Health Commission also indicated that a wide range of primary prevention programs are effective in reducing mental distress and illness.[49] The National Mental Health Commission conducted modelling to assess the potential economic benefit of investing in prevention and concluded:

> Overall the modelling shows that there is good evidence for investing in a range of preventative interventions, both on the grounds of cost effectiveness and cost savings. These include less demand on the health budget through use of mental health services (such as less hospitalisation and use of community based services), as well as increased productivity (via less absenteeism and presenteeism in the workplace).[50]

Although the evidence base is growing, Ms Harman explained the reasons behind the relative evidence gap:

> Research commissioned by Beyond Blue in 2018 revealed a lack of services or programs with prevention of anxiety and/or depression as their focus. The prevention gap is significant for mental health, though it is common to physical health as well. Given the longer timeframes and the number of people required to demonstrate preventive efficacy, it is often much easier to get funding for a treatment program, so the evidence base reflects this bias.[51]

The Commission recognises there are significant economic and other negative impacts arising from mental illness and that prevention strategies based on evidence can reduce these impacts. However, the Commission reiterates that the most important reason to strengthen prevention is to reduce suffering and promote wellness for the general community. Bethany Henry's story (overleaf) illustrates how prevention initiatives can strengthen factors that protect against mental illness and can support mental wellbeing.

The Commission envisages a future where more people like Bethany can be supported by prevention and promotion initiatives that promote human rights and ultimately improve quality of life across the population.[52] It is the Commission's position that creating a stronger focus on prevention now is essential to reducing mental illness in the future, and in supporting more Victorians to live healthier lives.

Personal story:

Bethany Henry

Bethany is 19 years old and lives in Melbourne. Bethany recently finished high school and is now employed in the university sector.

Back in 2018, Bethany was not feeling so good about herself or her place in the world.

> It probably wasn't the best time of my life mentally and physically. I had health complications, but I also had mental health complications. School wasn't very good for me, social life wasn't very good for me at the time.

Bethany heard about a young women's leadership program at the local council. All young women were welcome to sign up, so she did.

The sessions were delivered by council staff and guest speakers who covered a range of topics, including leadership, relationships and life skills. Above all, the program provided a safe environment to connect, share and learn.

Bethany said she quickly gained more confidence in herself as a result of the program and now plays a more active role in her community.

> I wasn't the type to stand up for myself or, you know, voice my own opinion … And everything in my life kind of then felt out of control because of that.
>
> I became a person who was able to stand up for myself and speak up.

Bethany explained that the session on financial literacy helped her to understand her rights at work and built her confidence to negotiate, while the session on respectful relationships helped her to see her situation with new eyes and to realise she was not being treated well. The presenters and the other young women helped her feel connected and supported. Bethany said the leadership focus was about building participants' sense of self-worth, and this helped her to see herself differently.

> I feel the leadership aspect actually comes from finding the leader in yourself.

Bethany has stayed connected to the program and her local community. She is now a mentor and guest speaker in the program and feels good about giving something back.

> It was really nice to be able to come back to the group and kind of give what I had already taken and give back to the cycle of everything that happens with these beautiful individuals.

The program has shown Bethany that her voice matters. She now believes that change is possible because she can see there are people who are willing to listen. She also said the program has given her more strength to face the challenges that life will bring, and to ask for help.

> The program has also definitely taught me that I'm allowed to not be okay. And that not being okay is a natural thing that happens in our lives. It is also okay to recover, to heal, to get support, to get help from people.

Source: RCVMHS, *Interview with Bethany Henry*, November 2020.

4.3 Designing a public health approach to strengthen prevention and promotion

In seeking to reorient the system to focus on and better promote good mental health and wellbeing, the Commission has drawn on several frameworks and approaches. This includes adopting a public health approach—underpinned by a human rights framework—to address the factors that ultimately shape mental health.

4.3.1 Focusing on the whole Victorian population

Recalibrating the mental health system from a focus on illness to a focus on wellbeing will make it a system for all Victorians. Prevention and promotion strategies will be an important vehicle for widening the focus to the entire population.[53] Indeed, a key feature of universal prevention and promotion strategies—as distinct from 'selected' or 'indicated' interventions—is their focus on the whole population.[54]

Prevention and promotion strategies should also reflect 'proportionate universalism' in the sense of policies and programs being 'universal yet proportionate to need'.[55] The principle of proportionate universalism supports investment in universal actions and interventions that are adjusted and diversified according to the level of need, rather than investment solely in programs for the most disadvantaged groups, or without consideration of differential need. The principle recognises that inequalities in physical and mental health exist everywhere. As Professor Sir Michael Marmot, Director of the Institute of Health Equity at University College London explained:

> **Mental illness, in general, follows the social gradient. There is good evidence that the more common mental illnesses (depression and anxiety) 'are distributed according to a gradient of economic disadvantage across society and that the poor and disadvantaged suffer disproportionately from common mental disorders and their adverse consequences'.[56]**

The principle of proportionate universalism is highly relevant to Victoria because some social groups and communities within Victoria experience disproportionate exposure to risk factors and determinants, and have a higher rate of mental illness.[57] VicHealth submitted that where government investment is directed to the whole population (with adjustments), rather than focusing solely on particular cohorts or communities, the benefits of investment will be distributed more evenly across the population while also supporting intensity of action where it is most required.[58]

Additionally, an intersectional approach is an important perspective through which to consider and address the convergence of multiple determinants and/or identities in shaping an individual's mental health outcomes.[59] Chapter 21: *Responding to the mental health and wellbeing needs of a diverse population* describes intersectionality in more detail.

The Commission recognises that people identify with many attributes, and concludes that an intersectionality framework has value in ensuring all Victorians have the opportunity to experience good mental health and wellbeing.[60]

Another mechanism to support population mental health and wellbeing is the adoption of a 'whole-of-life' approach to ensure actions are taken across infancy, childhood, adolescence, adulthood and older age, and at important transition stages throughout the life course.[61] Prevention strategies should be designed to address the specific risk or protective factors that are influential for the age cohort they seek to target.[62] For example, Professor Louise Newman AM, Professor of Psychiatry at the University of Melbourne and Practising Perinatal and Infant Clinician, highlighted that investment in healthy child development in the first three years of life provides a good basis for emotional health, mental health and resilience and will be likely to reduce the burden of mental illness in the future.[63]

In delivering on the reforms recommended in this chapter, the Victorian Government must ensure prevention and promotion strategies have a universal orientation. They must reach and deliver benefits for the entire Victorian population, with consideration given to different need. The strategies should reflect the differential exposure that people have to risk factors for mental illness and the different opportunities for prevention across the life course.

4.3.2 Adopting a public health approach

> Public health is defined as 'the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society'.[64]

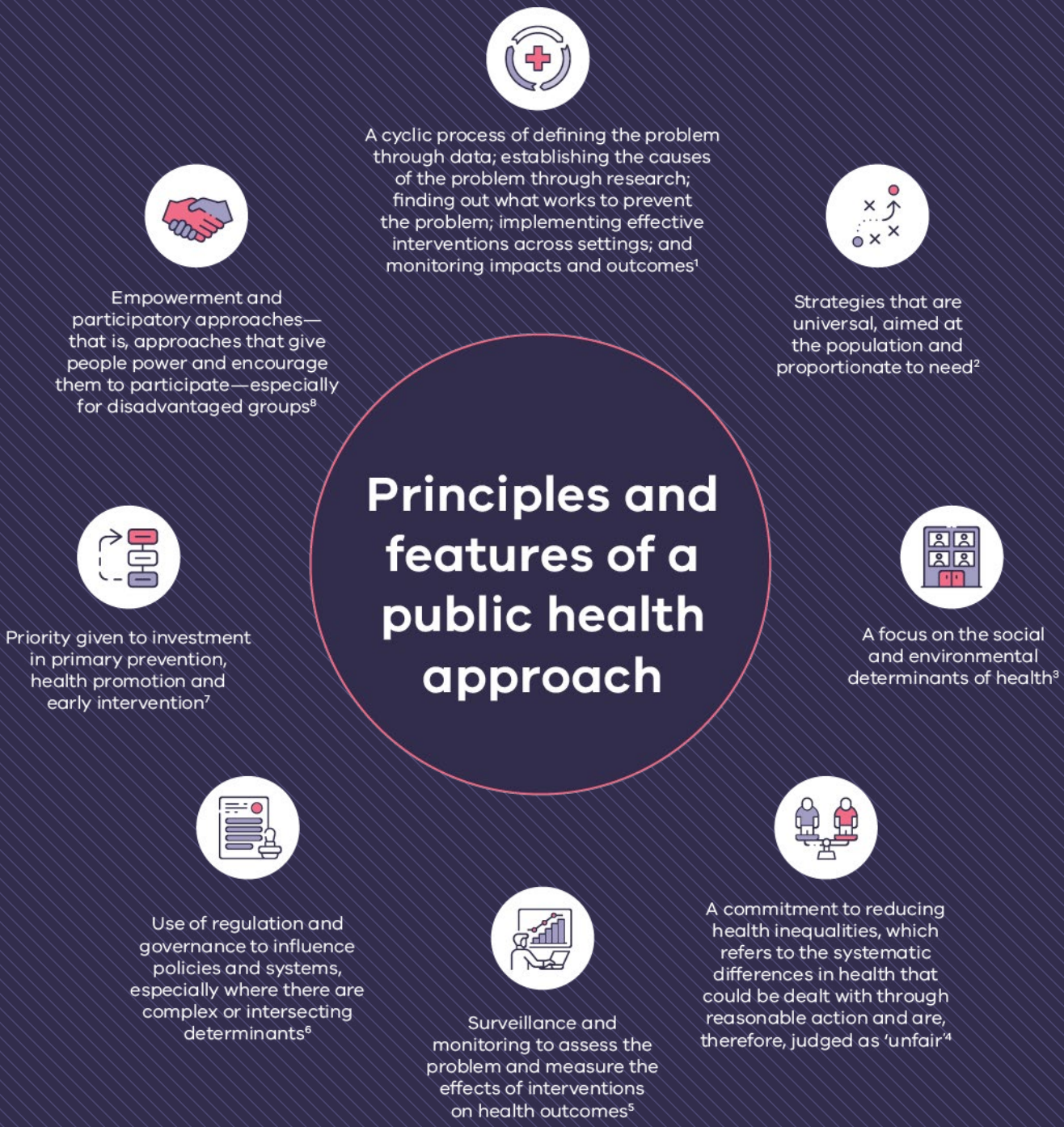
Evidence before the Commission asserts that a public health approach would considerably strengthen efforts to reduce mental illness and to increase mental wellbeing in Victoria. Professor Helen Herrman AO, former President of the World Psychiatric Association and current Head, Vulnerable and Disengaged Youth Research at Orygen stated that promotion of mental health is integral to public health and that a public health approach can encompass prevention and promotion alongside treatment, care and support.[65] Professor Sir Michael Marmot explained that public health responses are required alongside, and in addition to, individual and treatment-oriented responses because public health responses are more effective for achieving prevention outcomes.[66]

The public health approach provides a good framework to guide action and a common ground to bring diverse disciplines and sectors together. As Professor Herrman explained:

> In my experience, the term 'public health' typically refers to what a community can do in an organised and collective way to improve health in communities and reduce inequalities in health status.[67]

The principles, concepts and practices of public health are well established in relation to chronic physical illness and other forms of disease. The Commission notes that there is not only one single public health framework—rather that there are several principles and features that differentiate public health from other approaches, as summarised in Figure 4.1.

Figure 4.1: Principles and features of a public health approach



Source: 1. World Health Organization, The Public Health Approach, <www.who.int/violenceprevention/approach/public_health/en/>, [accessed 28 October 2020]; 2. World Health Organization, *Social Determinants of Mental Health,* p. 8; 3. Faculty of Public Health and Mental Health Foundation, London, *Better Mental Health For All: A Public Health Approach to Mental Health Improvement,* 2016, p. 11; 4. World Health Organization, *Equity, Social Determinants and Public Health Programmes,* 2010, p. 5; 5. World Health Organization, The Public Health Approach; 6. Sharon Friel, 'Chapter 33: Governance, Regulation and Health Equity', in *Regulatory Theory* (Canberra: ANU Press, 2017), pp. 573–590 (p. 579); 7. World Health Organization, *World Health Report 2002,* p. 147; 8. Herrman and others, 2017, p. 98.

Many of these principles and features are evident in approaches to other health and social issues in Australia such as tobacco control, road safety and trauma, HIV/AIDS reduction, obesity and overweight prevention and the prevention of violence against women.[68] Examination of the successes across these various health and social issues has highlighted the enablers and barriers for a public health approach to support measurable public health outcomes.

In her witness statement to the Commission, Ms Kruk outlined a comparison of various health movements in Australia and highlighted the success of tobacco control efforts over many decades. Ms Kruk observed that 'success was driven by the fact that there was agreement at the Commonwealth and state level about the desirability of reducing smoking rates. And a long-term commitment to jointly progress'.[69]

Ms Kruk also shared observations from the field of obesity prevention:

> **Childhood obesity can be likened to mental health in relation to the fact that it is a difficult measure to change with successful outcomes beyond the reach of any one funding body. It touches on so many aspects and areas of government. It requires involvement at the community level, in education systems and in local government.**[70]

A Victorian Government review highlighted that there has been limited success in public health approaches to obesity and attributed this to the strategies in this field being 'dispersed' and that there is 'no systematic, coordinated approach to the targeting and prioritisation of preventive strategies'.[71] To confront the many limitations on effective action in the area of obesity—such as lack of targets and agreed strategies, limited funding, underdeveloped evidence base and lack of formal mechanism to provide 'visibility and coherence'—researchers and advocates have suggested that government leadership is needed to set an agenda and create a way forward.[72]

In contrast, the same review highlighted success factors in Australia's response to the HIV/AIDS epidemic. These included the rapid establishment of coordinated strategies and the empowerment of civil society and activist groups, backed by a bipartisan, long-term and multifaceted approach.[73] The approach is discussed in the HIV/AIDS public health reform case study later in this chapter.

A public health approach is also likely to support more integrated approaches to physical health and mental health. These are strongly linked, as Dr Tim Moore, Senior Research Fellow, explained in his personal capacity:

> Mental health is intimately linked with physical health, social health, and biological health, and is shaped by our nutritional, social and physical environments and the lifestyles these allow.[74]

In its submission, VicHealth described a 'two-way' relationship between mental health and other conditions, such as cancer, chronic obstructive pulmonary disease and diabetes, and suggested that prevention and promotion for mental health would also deliver benefits in these other health areas.[75]

Despite this, the strong links between mental and physical health are not yet broadly reflected in public health approaches. Professor Ian Hickie AM, Co-Director of Health Policy at the Brain and Mind Centre, University of Sydney, explained that mental health is not yet embedded in public health priorities or approaches.[76] Professor Hickie suggested that:

> mental health needs to have a much bigger footprint within the existing public health system, which has information systems that provide real time feedback about the effectiveness of public health services and changes in the health status of populations.[77]

The Commission asserts the need for the Victorian Government to adopt a public health and human rights approach to underpin prevention and promotion efforts in the future mental health and wellbeing system, with mechanisms in place to support coordination and sustained effort. This approach will help ensure strategies target the whole population, address the many factors that shape mental health, involve many sectors taking action and are monitored more consistently. This approach also supports a focus on reducing inequalities in mental health and in society more broadly. Furthermore, this approach is also likely to strengthen embedding of mental health into Victorian public health policy and investment in relation to health and wellbeing more broadly. Finally, a public health approach will support the Victorian Government to take a more preventative approach to mental health and wellbeing.

4.3.3 A focus on human rights

The Victorian Mental Illness Awareness Council told the Commission that 'human rights are the most critical underpinning factor to achieve the aims of the Royal Commission into Mental Health'.[78] Australia is a signatory to the *International Covenant on Economic, Social and Cultural Rights*.[79] Articles 12.1 and 12.2 of the Covenant obligate States parties to 'recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' and to take steps 'to achieve the full realization of this right'.[80]

The Honourable Professor Kevin Bell AM QC, Director of the Castan Centre for Human Rights Law at Monash University, giving evidence in a personal capacity, described the role:

> Indeed, only a public health approach, with other population-wide measures, can effectively address the social determinants of mental health. However, the system must be underpinned by the normative foundation of human rights to ensure equality, non-discrimination and respect for dignity. A public health strategy is an organised program of action which should be underpinned by but cannot substitute for human rights as that normative foundation. Moreover, human rights themselves are a determinant of mental health.[81]

At the global level, there is emerging evidence that the principles of public health strongly overlap with human rights frameworks. New perspectives and insights are emerging from recent approaches to health challenges, such as poverty and indigenous health, to support the improved integration of human rights and public health.[82] The HIV/AIDS public health reform case study illustrates the impact of the public health approach in reducing HIV/AIDS. The approach had a strong focus on human rights, which was primarily achieved through collaboration and partnership approaches.

The World Health Organization's *Mental Health Action Plan 2013–2020* sets out 'cross-cutting principles and approaches' that integrate human rights and public health and applies them to mental health care *and* promotion. This includes the principle of empowering people with lived experience of mental illness in all aspects of the system and adopting a multisectoral approach.[83]

One of the four objectives of the action plan recognises that 'responsibility for promoting mental health and preventing mental disorders extends across all sectors and government departments'.[84] The action plan suggests that future international approaches to mental health and wellbeing should draw heavily on public health and human rights. The Commission has concluded that approaches to prevention and promotion in the future Victorian mental health and wellbeing system should align with these action plan principles and has embedded these considerations into its recommended reforms.

4.3.4 Influencing the factors that shape mental health

The factors that shape mental health are often referred to as the social determinants of mental health.[85] The social determinants of mental health are broad and diverse, but they are a critical consideration for reforming the mental health and wellbeing system and for creating a stronger focus on good mental health and wellbeing. Social determinants include individual characteristics, such as a person's cultural background or socioeconomic situation, as well as societal, community and environmental conditions, such as social disadvantage, discrimination or ecological events.[86]

Mrs Lucinda Brogden AM, Chair of the National Mental Health Commission, explained:

> **Some of the most powerful root causes of health inequalities are the social conditions in which people are born, grow, work, live and age, as well as the systems that shape the conditions of daily life. These conditions are collectively referred to as the social determinants of health. Social determinants can strengthen or undermine the health of individuals and communities.[87]**

The Victorian Mental Illness Awareness Council submission emphasised that a response to the social determinants of health is a vital element of the state's broader response to mental health. The submission stated that 'an effective, state-wide response to mental health must respond to social determinants, and this requires a response that stretches far beyond the health system'.[88]

Case study:

HIV/AIDS public health reform

Since the first case of AIDS in Australia almost 40 years ago, Australia's public health response to HIV/AIDS has been underpinned by a partnership approach between the Commonwealth Government, state and territory governments, people with and affected by HIV, community organisations, researchers and clinicians.

Australia's HIV/AIDS public health approach has consisted of a broad range of prevention and promotion strategies delivered in many settings over several decades. Current efforts are guided by the *Eighth National HIV Strategy 2018–2022*.

Ms Alischa Ross, former CEO of YEAH, a national health promotion organisation focused on youth-led sexual health and HIV awareness initiatives, said Australia is globally recognised for its approach to addressing HIV.

> Starting from the first National HIV strategy in 1989, Australia's response is built on a partnership approach at all levels of government, and most importantly, engaging the communities that are directly affected and the priority populations most at risk. Our early response was one of the first times that governments sat down with affected communities as equal players at the decision-making table and that's really what a partnership approach focused on action and outcomes is about.

Ms Ross said the partnership approach had been effective because of the implementation of targeted and nationalised initiatives with shared goals and indicators to measure impact.

> It's important to consider the interplay between areas of government where there are shared responsibilities to coordinate effective public health responses. Implementation plans over the years have drawn on different expertise, whether that's community groups in terms of advocacy, health promotion and prevention, or clinicians in terms of workforce development, treatment and research.

Ms Ross said the public health responses since the early 1990s, as well as the evolution of HIV treatments, have helped guide responses to other infectious diseases and public health challenges and have therefore made a major contribution.

> HIV has taught us many of the best practices that guide our current approaches to coordinated public health responses. In the case of HIV, addressing issues around stigma and discrimination have enabled wide spread prevention education and encouraged people to get tested and access treatment and support early.

Mr Simon Ruth, CEO of Thorne Harbour Health (formerly the Victorian AIDS Council), said the involvement of community organisations has been a driving force in achieving tangible outcomes.

> The community response in HIV has always been incredibly strong. It was through the campaigning from those groups, where we really pushed the notion 'talk to us not about us', that we started to get capital investment in research from government to work with them to address HIV.

Sources: Australian Government, *Eighth National HIV Strategy 2108–2020*, <www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-1/$File/HIV-Eight-Nat-Strategy-2018-22.pdf>, [accessed 9 November 2020]; RCVMHS, *Interview with Alischa Ross*, November 2020; RCVMHS, *Interview with Simon Ruth*, November 2020.

The social determinants of mental health and wellbeing can be characterised into five domains:

- Demographic factors: the specific demographic characteristics of populations that convey risk for, or protection from, mental illness (such as gender and age)
- Economic factors: the production, consumption and transfer of wealth that convey risk for, or protection from, mental illness (such as financial stability)
- Local community conditions: characteristics of an area or community that convey risk for, or protection from, mental illness over and above what is attributable to the individual characteristics of community members (such as location, access to nature and relative neighbourhood deprivation)
- Environmental events and life experiences: serious disruptions to the functioning of either a community or individual that exceed its ability to cope through use of its own resources and convey risk for mental illness (such as natural disaster and trauma)
- Social and cultural context: the ways in which the organisation of society, social interactions and relationships affect risk of, and protection from, mental illness (such as social connectedness and social participation).[89]

A range of factors can heighten or lessen the risk of poor mental health. For example, social determinants can affect the mental health of children and young people in particular, such as children who experience adversity or trauma in childhood including through child abuse or neglect, family violence, the mental illness of their parents or other caregivers, or bullying.[90] Children of parents with 'significant' mental illness are twice as likely to develop their own mental health challenges.[91] Compared with children living in the least disadvantaged areas, children living in the most socioeconomically disadvantaged locations are approximately twice as likely to be 'developmentally vulnerable' which can impact on their future mental health.[92]

There are specific risk and protective factors that affect people at different life stages, as shown in Figure 4.2. The Commission notes that supportive and positive relationships through family and social networks are an important protective factor across all life stages. The important role of social relationships and social connection is discussed further in Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect*.

Social determinants that act as risk and protective factors exist within the conditions of everyday life. This means they can be modified in everyday places or settings—for example, within families, schools, workplaces and the community more broadly. In early childhood and adolescence, for instance, some of the strongest protective factors for mental health include positive family functioning, community support and physical activity.[93] These factors are not driven by the formal mental health system.

It follows that the social determinants of mental health can be actively addressed outside of health settings and services, and by people who live and work outside the mental health and wellbeing system. Professor Sir Michael Marmot told the Commission that the 'causes of those causes' are complex and also lie outside the healthcare system.[94] This means there are opportunities to influence the drivers of mental health in settings and sectors outside of the formal mental health and wellbeing system, as well as across multiple departments and portfolios within government.

Figure 4.2: Key risk and protective factors for mental health and wellbeing by lifestage

Lifestage	Key protective factors	Key risk factors
Children 	• Positive family functioning and support • Supportive communities • Physical activity and access to green space • Foster care and kindship care • Individual resilience factors	• Factors related to refugee status • Homelessness and out-of-home care • Screen time and sedentary behaviour • Chronic illness and obesity • Maternal prenatal influenza • Food insecurity
Teenagers 	• Positive parenting style and family functioning • Positive teacher and peer relationships • Social support (including online) • Community support and sense of belonging • Physical activity and access to green space • Individual resilience factors	• High screen time, social media time and/or cyber-bullying • Poor family functioning • Chronic illness and obesity • Out-of-home care • Factors related to refugee status • High-demand academic environments • Adverse events • Substance abuse or addiction
Young adults 	• Physical activity • Social support and networks • High-quality social relationships • Supportive integrated online networks	• Social isolation and loneliness • Homelessness • Being a sexual minority • Migration • Cyber-bullying
Perinatal period 	• Social support • Physical activity	• Childhood and lifetime abuse • Chronic medical conditions • Stress and unsupportive relationships • Disturbed sleep • Multiple births • Antenatal anxiety • Substance abuse
Adults and the general population 	• Employment • Physical activity and access to green and blue space • Social support and networks • Diet and nutrition • Alcohol reduction • Own ethnic density	• Social isolation and loneliness • Insecure employment, unemployment or unsupportive work conditions • Economic inequality • Factors associated with migration and refugee status • Homelessness and poor housing conditions • Caregiving • Physical health conditions • Stressful events (including childhood events, intimate partner violence, recession and drought) • Being in a sexual minority • Food insecurity • Smoking
Older adults 	• Social support and networks • Physical activity • Internet use	• Death of a partner • Social isolation and loneliness • Being a caregiver for someone with dementia

Source: DJ Rickwood and others, 'Mental wellbeing risk & protective factors: An evidence check rapid review brokered by the Sax Institute for VicHealth', Sydney: Sax Institute, 2019.

The Healthy Parks Healthy People case study in this chapter illustrates how non-health departments can contribute to mental health objectives. As Mrs Brogden told the Commission:

> many other government portfolio areas and community services play a critical role in addressing the social determinants of health, in areas such as employment, education, housing, justice and social security.[95]

4.3.5 Many places and environments can influence mental health

The Commission recognises that prevention and promotion need to be delivered both within and outside of the mental health service system in order to address the social determinants of mental health. The places or environments for delivery are often referred to as 'settings', as described by VicHealth:

> Settings are the places and social contexts in which people engage in daily activities, where environmental, organisational and personal factors interact to affect health and wellbeing. They might be geographic areas, organisations or virtual spaces, and they are the environments in which primary prevention and health promotion action takes place.[96]

Scientia Professor Helen Christensen AO, Director and Chief Scientist at the Black Dog Institute, highlighted that targeting activity to settings will ensure that activity is spread across the community, is universal and engages the whole community.[97] The services that provide treatment, care and support play a role in prevention and promotion *alongside* the people and services in these additional settings.

Figure 4.3 summarises the many places, settings and environments in Victoria outside of the mental health system. Several mainstream settings have been identified as priority settings for mental health and wellbeing due to their high level of existing mental health promotion activity, as well as their potential to achieve considerable reach across the population. The Commission heard that these settings—specifically, communities and place-based initiatives, workplaces and employment, and education, including schools, early childhood and tertiary settings—are already active in promoting mental wellbeing and may therefore be better prepared than other sectors to implement new initiatives. These settings can also strengthen the reach of prevention and promotion because most people will participate in them at some time in their lives. The recommended approach in these priority settings is described in Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect*.

Beyond universal settings like workplaces and schools, there is emerging evidence indicating the role that other settings can have in influencing good mental health and wellbeing—including arts and creative industries; sports and recreation; digital settings; and social and community services.

Recent evidence suggests that 98 per cent of Australians engage with the arts including cultural activities, music and books, live events and online interactions.[98] Arts and cultural activities have indicated benefits for mental wellbeing, with a recent evidence review in Victoria noting that, 'overall "strong evidence" of the impact of arts interventions, programs and activities on mental wellbeing and social health was found'.[99]

Figure 4.3: The places, settings and environments that influence mental health and wellbeing

As an example, the Big Anxiety festival case study in this chapter illustrates the role that arts settings and cultural events can play in opening conversations about mental health, for people who have experienced mental illness and also for the broader community.

There is also emerging evidence about the role of sports and recreation clubs in promoting mental wellbeing. For example, a recent survey indicated that one-third of respondents in regional and state sporting associations rated mental health and wellbeing as a high priority.[100] The survey report suggested that:

> Community sport offers an ideal space to better support [mental health and wellbeing] within the community as part of a primary prevention approach. It provides a trusted network where people feel socially connected. It also offers a site where potential risk factors can be targeted and replaced with more supportive factors linked to notions of wider inclusion and connectedness.[101]

Participants in the Commission's East Gippsland Roundtable agreed there is a significant role for sport and recreation in mental health and wellbeing. One participant said, 'If we can provide a really supportive community sport framework where those incidental conversations can happen in a supportive way for young people and for adults, men and women, I think that would be really good'; however, he highlighted that more resources were needed for community sport to have an impact on mental health promotion.[102]

The role of green spaces and the natural environment in mental health promotion is also emerging. An evidence review of prevention indicated that some of the most effective interventions involved, or were delivered in, natural environments.[103] Likewise, evidence-based modelling shows that increases in neighbourhood vegetation cover may reduce symptoms of depression, stress and anxiety.[104] The Healthy Parks Healthy People Framework described in this chapter aims to increase the role of green spaces and the natural environment in promoting good mental health.

Digital environments and digital strategies are becoming essential to mental health promotion. Interventions may be placed in the digital environment itself, or they may complement interventions in offline or 'real-world' settings. However, digital strategies should not be considered standalone strategies. As Ms Harman explained:

> We should take full advantage of the wide reach of digital technologies to help people better understand and invest in their mental health.[105]
>
> In saying this, we need to remain conscious of digital inequities and accept that telehealth and digital mental health services are not the silver bullet, but must be part of the solution to system reform and to improve population mental health.[106]

Mr Matiu Bush, Founder of One Good Street and Deputy Director of the Health Transformation Lab at RMIT, expressed a similar view. Mr Bush said, 'the best interventions to tackle loneliness include a combination of tactile and digital approaches, often in combination.'[107] Mr Bush highlighted the role of digital technology in enabling social networking, in coordinating activities and volunteers and in helping families and carers. He forecasted a significant role for digital technology in prevention and promotion as Victoria's population grows older, larger and more complex, and as more Victorian startups choose to focus on mental health.[108] Mr Bush also suggested there are potential cost savings from developing technology that helps to predict and prevent mental and physical health issues.[109]

Finally, social and community services and allied health settings are also potential sites for prevention and promotion. Sectors such as housing, justice, aged care, family violence and youth services could all play a more effective role in mental health promotion. As the Victorian Council of Social Service highlighted:

> **Community services are well-connected with some of the most vulnerable members of our community. They maintain strong relationships with people who access them, and are well-placed to identify and act on the early warning signs for mental illness before a person reaches crisis point. They can also act as soft entry points to mental health services. With the right supports at the right time and in the right place, services can often intervene early and help people from becoming unwell.**[110]

Therefore, many places and environments can support mental health promotion. In addition, the Commission recognises that many professionals in varied sectors and settings can contribute to mental health and wellbeing through their everyday work practice and interactions. Ms Lin Hatfield Dodds, Associate Dean for the Australian and New Zealand School of Government of the Crawford School at the Australian National University, described in her personal capacity how prevention and promotion strategies will require input and effort from people and professionals across many sectors and many parts of the community. As Ms Hatfield Dodds said, good mental health is 'everybody's business' and 'every civil society organisation is able to support good mental health'.[111]

People and professionals in all the places and environments referred to above should be viewed as potential contributors to the 'workforce' for prevention and mental health promotion. The Prevention United submission suggested there is an opportunity in Victoria to leverage the capacity of professionals across many places and environments to support prevention and promotion while also recognising there is value in supporting mental health promotion specialists to provide leadership and guidance for others.[112]

The role of contributors and mental health promotion specialists within prevention and promotion is illustrated in Figure 4.4 and complements the role of providers of treatment, care and support. 'Contributors' may include youth workers, sports coaches, human resource managers and others who can adopt mental health promotion practices into their daily work, and have the potential to promote mental health and wellbeing in their interactions with individuals and communities. 'Specialists', on the other hand, may include health promotion officers, mental wellbeing program coordinators and prevention experts whose core business is to promote mental health and who can support prevention and promotion activity within organisations and systems. They can also provide advice and expertise to support contributors and others. There is potential to strengthen the role of both contributors and specialists within many sectors including community and social services,[113] local governments, community health, primary care, existing health agencies and mental health providers, as well as sports, education, human resources, arts and housing.[114]

Case study:

Healthy Parks Healthy People

Healthy Parks Healthy People was established by Parks Victoria in 2000 and has now become a global movement highlighting how human health and the health of nature are linked. More specifically, it promotes the many health and wellbeing benefits of connecting with nature, with a strong focus on mental health.

Parks Victoria leads implementation of the *Healthy Parks Healthy People Framework*, building cross-sector partnerships to connect people to parks for health and wellbeing benefits. Partners include environment, community and health sector organisations, corporate and philanthropic organisations, different levels of government, research partners, volunteers and a wide range of service providers.

Tony Varcoe, Director, Community Programs at Parks Victoria described the sorts of activities Parks Victoria and its partners use to promote parks as positive settings for mental health.

> Focus areas include nature-based activities (e.g. Junior Ranger, outdoor education, mindfulness in nature) to build positive child and youth mental health and resilience, encouraging park activities for healthy and active ageing (e.g. volunteering and walking), providing nature trails for people with dementia or sensory issues, nature-based programs for new migrants and refugees, improving experiences in nature for people with a disability (e.g. all abilities camping and all-terrain 'Trail Rider' wheelchairs) and partnering with Traditional Owners to facilitate access to Country for improved wellbeing.

The *Heathy Parks Healthy People Framework* contributes to outcomes for Victoria's *Public Health and Wellbeing Plan 2019–2023*, including 'improving mental wellbeing'. It includes short- and medium-term measures to assess the physical and mental health outcomes of target populations that are attributable to parks and nature.

The *Healthy Parks Healthy People Framework* is underpinned by the *Victorian Memorandum for Health and Nature*, a statement co-signed in 2017 by the Minister for Health and the Minister for Energy, Environment and Climate Change to provide stronger connections between environment and health policy.

Mr Varcoe said an interdepartmental working group was set up to develop improved collaboration within government and to deliver the intent of the Memorandum.

Photo credit: Parks Victoria

> The Working Group, including representatives from Parks Victoria, Sport and Recreation Victoria, the Department of Environment, Land Water and Planning and the Department of Health and Human Services, has initially been a small and focussed group looking to identify short to medium-term collaboration opportunities. The structure is flexible and seeks to engage both government officers and decision-makers to support integrated policy and programs.

Mr Varcoe said these connections had also informed policy changes to support mutual outcomes. This includes stronger recognition of the role of parks and open spaces in the *Public Health and Wellbeing Plan 2019–2023* and also recognition of the health and wellbeing benefits of valuing nature in *Protecting Victoria's Environment - Biodiversity 2037*, Victoria's plan to stop the decline of native plants and animals and improve our natural environment.

Source: RCVMHS, *Interview with Tony Varcoe*, November 2020; Parks Victoria, Healthy Parks Healthy People, <www.parks.vic.gov.au/healthy-parks-healthy-people>, [accessed 20 November 2020]; *Healthy Parks Healthy People Framework*, Parks Victoria, 2020.

Case study:

The Big Anxiety

The Big Anxiety is an arts festival exploring mental health founded by the University of New South Wales, in association with the Black Dog Institute, and now RMIT. Professor Jill Bennett, its Founding Director, believes that the arts are 'the best means we have for developing rich and empowering ways to communicate and share complex experience'. Accordingly, every exhibit at the festival, whether it be a hi-tech interactive environment or a one-on-one dialogue, is intended to encourage conversation about the trauma, anxieties and stresses of everyday life, and to involve people from all parts of the community to support collective mental health.

Professor Bennett explained the festival combines three elements: *people, arts* and *science*.

> *People* and communities are the key to understanding experience; the *arts* provide the means to connect; and the *science* ensures an evidence-based approach to the work of the festival.

Lived experience is critical to the festival. As Professor Bennett puts it, 'the art is generated from lived experience.' Exhibits are developed from community projects that offer high-level creative and technical support for people with lived experience to address issues central to them. The festival also nominates ambassadors, who Professor Bennett says are 'just ordinary people with some kind of lived experience'.

Professor Bennett notes The Big Anxiety is not just about what is being exhibited; it is about the nature of the engagement.

> We knew from the start that the purpose had to be to create enriching experiences for people with their own lived experience. We want the work to have direct mental health benefit. That might be in terms of promoting understanding, agency and self-reflection, and in some cases, participating is directly linked to recovery.

Using the arts as a mechanism to emphasise mental wellbeing for everyone led to the theme of the 2019 festival: cultivating empathy. Professor Bennett says that empathy is critical to enabling people to 'care and support for others and to defeat stigma'. Exhibits were designed to encourage people to reflect and to build their skills in listening to different voices. In the festival's 'Empathy Clinic', exhibits presented first-person perspectives on lived experience, to challenge assumptions and to test how sharing perspectives can change people's views.

One of the exhibits, 'Awkward Conversations', was based on the simple idea of one-to-one conversation in a supportive environment. Participants booked a conversation with a person who has some kind of lived experience with mental health challenges or disability. Professor Bennett notes the resulting dialogues were often

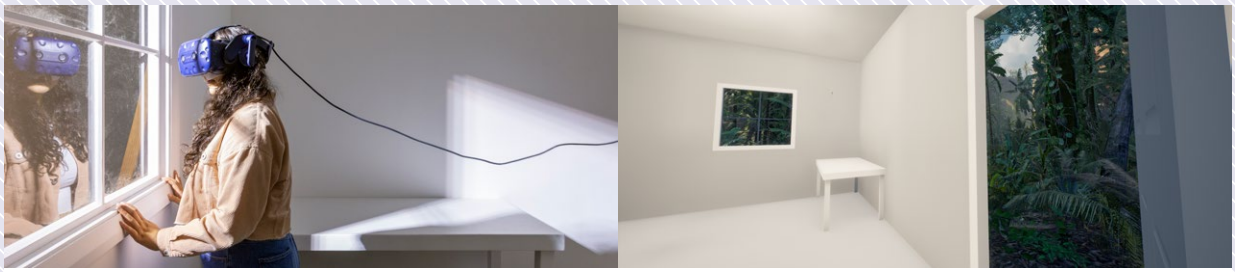


Photo credit: Jessica Maurer

'quite subtle but high impact discussions'. Another exhibit, 'Listen up', was a meditative 'soundscape' where visitors could listen to stories from Aboriginal people of trauma, violence and abuse in a supportive setting.

Professor Bennett says the real measure of the festival's success is not just the people who attend, but the quality of engagement people feel that they have experienced. Honor Eastly, one of the Festival Ambassadors explained how the festival contributes to broader wellbeing.

> The Big Anxiety is a unique opportunity to think about mental health not as a health issue, but a philosophical and cultural question. It asks of us: how do we live good lives in the modern world?

The Big Anxiety includes projects that bring people together using arts to process difficult life experiences. Jenny McNally, a survivor of institutional abuse, collaborated on an immersive film shown at the festival and spoke about how her involvement in the festival contributed to her recovery.

> I've always had trouble dealing with my journey, my journey's been very hard.
>
> I think that's the most amazing thing, was that I was believed. I've never been believed in my life. And to then go to the university and bring my children in, and to have my first born son ... to sit there and say 'Mum, this is stunning and now I understand your story, I understand who you are.' It gave me back my own reality. You know, I didn't have to pretend anymore.

Andrijana Miller, a festival volunteer with lived experience of trauma, said the festival does bring in people who would not necessarily seek help, because art is seen as 'safe'.

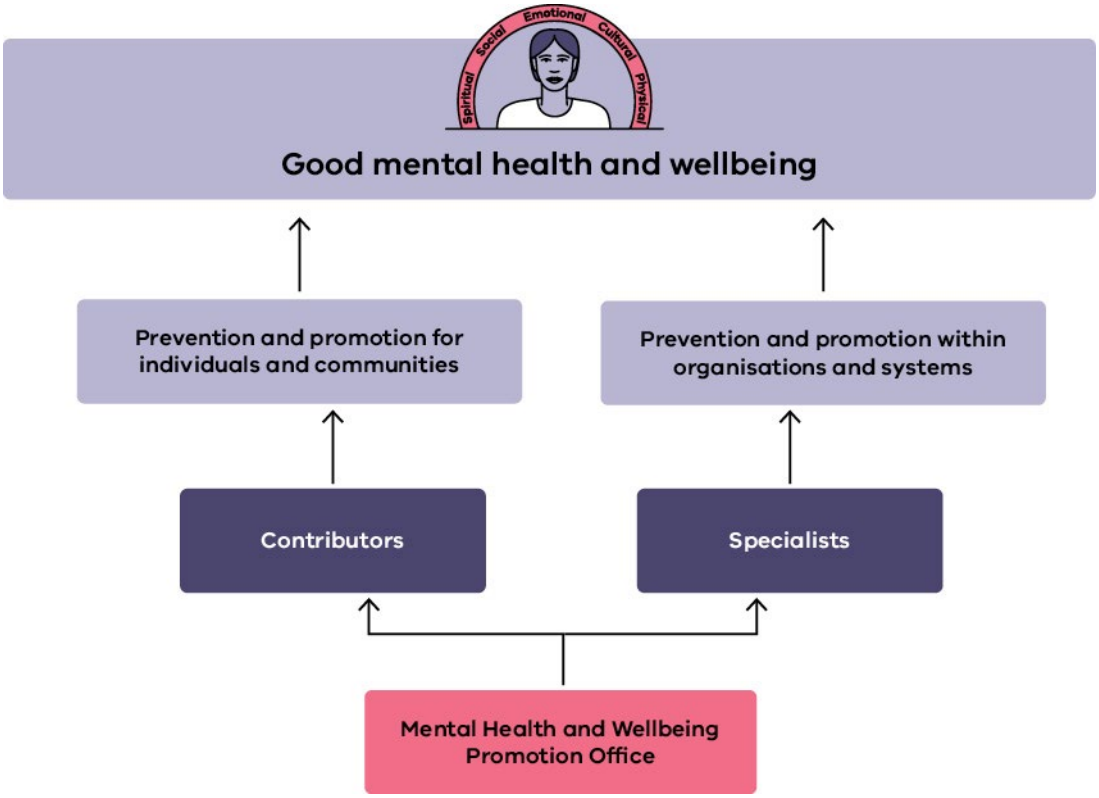
> This festival for me creates a very safe space for something that is very unsafe or creates a very unsafe experience, like a trauma or Post Traumatic Stress Disorder or anxiety.

The Big Anxiety will take place again in Melbourne in 2022, where it will explore the theme 'reimagining mental health'.

Source: RCVMHS, *Interview with Jill Bennett*, July 2020; The Big Anxiety <www.thebiganxiety.org> [accessed 22 July 2020]; The Big Anxiety 2019 Podcast Series; The Big Anxiety 2017 Festival Summary; The Big Anxiety 2019 Report; YouTube, Jenny McNally Interview, Parramatta 2017, *The Big Anxiety,* <www.youtube.com/watch?v=4hFS8-Fq-c8>, [accessed 5 November 2020]; YouTube, The Big Anxiety 2019 - Festival Highlights, *The Big Anxiety,* <www.youtube.com/watch?v=kiQMVd2XVO0&feature=emb_logo>, [accessed 5 November 2020].

However, a planned approach is required to provide the right resources, such as training and networking opportunities, to these sectors and to ensure the approach complements planned activities for the mental health workforce described in Chapter 33: *A sustainable workforce for the future*. The Victorian Government's *Building from Strength* plan, in the family violence area, provides an example of a planned approach to supporting multiple workforces both inside and outside of the formal service system, with the objective of changing outcomes for individuals and communities.[115]

Figure 4.4: The role of contributors and specialists in prevention and promotion



Another important aspect of working across places, settings and environments is the role of partnerships. Stakeholder agencies such as VicHealth emphasised that partnerships across sectors are important to support public health action and 'can increase the efficiency of systems that have an impact on health by making the best use of different but complementary resources'.[116] VicHealth also suggested that, looking to the future, 'establishing partnerships or alliances with experts from within the sector and from non-health sectors' is an important function of coordination.[117] Similarly, Professor Herrman highlighted the role of partnerships in increasing the impact of health promotion efforts and avoiding real or perceived competition for resources.[118] The critical role of partnerships has been highlighted earlier in this chapter in relation to the achievements made in tobacco control and also HIV/AIDS prevention including intergovernmental and cross-sector partnerships. The coordination of partnerships will be important in the future public health approach to mental health and wellbeing in Victoria, including collaboration across health and non-health sectors and across government and non-government agencies.

4.3.6 Supporting all Victorians to make a difference

The Commission recognises that members of the Victorian public can play a more significant role in prevention and promotion through day-to-day action in their neighbourhoods, networks and communities. Communication and social marketing are important strategies in mental health promotion to engage the general public in this way. They are part of a public health approach and should be delivered alongside other health promotion strategies such as organisational development and policy reform.[119]

In the context of mental health promotion and prevention, public communication strategies can help to increase public knowledge about what constitutes good mental health and wellbeing. This type of activity would be complementary to, but distinct from, efforts to reduce stigma and discrimination around mental illness, as described in Chapter 25: *Addressing stigma and discrimination*. Public communication can increase knowledge about the role every person can play in promoting mental wellbeing among family, friends and social networks—for example, by promoting open conversations, offering help in the community and supporting social participation. Community members told the Commission that this can be helpful long before a person experiences mental illness:

> We need more education about what mental health is. I think there could never be enough education when it comes to mental health.[120]

> If a community were better able to spot and gently interact with members of that community who are presenting, even just the beginnings—we are all under stress, these are very stressful times. A more grassroots, non-intrusive conversation would be really helpful. It's a sign of a healthy community.[121]

> We want to apply that help-offering behaviour to mental health. We want to equip men with the skills to approach a colleague and say, 'Mate, you're not looking too good. Can we have a chat about where you're at?' An offer like that can open up an honest conversation. Some people, and particularly men, may be a bit guarded, but you'd be surprised how people will open up when they're approached in a genuine way.[122]

Public communications activity also has the potential to generate support within the Victorian public for prevention and promotion:

> An effective campaign can increase the likelihood that the community will support legislative and policy changes that will have a significant positive impact on promoting mental health. These campaigns help governments garner the political will to make changes that might otherwise face insuperable opposition.[123]

In the future, public communications activity should align with prevention and promotion initiatives. However, it should specifically aim to help Victorians build the knowledge, skills and confidence needed to play a more active role in the mental health and wellbeing of their friends, families and networks. Ideally the communication activity will provide a broad and engaging call to action across the population, with a focus on wellness rather than illness.

4.4 Limitations of current approaches to promote mental health and wellbeing and prevent mental illness

4.4.1 Prevention and promotion efforts are piecemeal and uncoordinated

Many agencies in Victoria are currently delivering initiatives to promote mental health and prevent mental illness. At the state level, *Victoria's 10-Year Mental Health Plan* describes the government's intention to focus 'greater efforts in mental health promotion and illness prevention'. Responsibility for the plan ultimately sits with the Minister for Mental Health, and the Mental Health and Drugs Branch of the Department of Health is responsible for implementing it.[124] The plan describes the need to 'take action in health promotion, prevention and early intervention that is not restricted to government services' and to 'drive change through the community sector and private sector'.[125] However, the extent to which this has occurred is unclear. It is also unclear how much this plan has enhanced the government's investment in prevention, as opposed to reclassifying existing efforts, because there is limited attention to prevention and health promotion in the plan's priority actions.[126] Furthermore, the Commission heard of missed opportunities to develop 'synergies' between *Victoria's 10-Year Mental Health Plan* and other government strategies that have the potential to influence mental health and wellbeing.[127]

In addition, 'improving mental wellbeing' is a priority of the Victorian Government's *Public Health and Wellbeing Plan*.[128] This plan is an initiative of former Minister for Health Ms Jenny Mikakos and is currently coordinated by the Public Health and Prevention Unit of the Department of Health. The plan is the Victorian Government's overarching priority-setting strategy in relation to public health and wellbeing and is required by the *Public Health and Wellbeing Act 2008* (Vic).[129] The current plan (2019–2023) sets out an approach to achieving improved public health and wellbeing outcomes for 'all Victorians' and seeks to:

- encourage action around the factors that contribute most strongly to the burden of disease and health inequalities
- ensure all parts of the sector work together towards clear outcomes
- take into consideration the wider determinants of health, both social and economic, in the design and delivery of public health and wellbeing interventions.[130]

In the area of 'Improving mental wellbeing', the plan aims to achieve a reduction in the prevalence of mental illness and acknowledges links to other state-level strategies such as *Victoria's 10-Year Mental Health Plan*; however, the plan does not include any specific actions or objectives towards this goal.[131] Moreover, mental wellbeing is not included as a focus area in the plan, which means there are no specific 'strategic actions' outlined for addressing this area of health.[132]

The *Public Health and Wellbeing Plan* is also intended to provide a foundation for municipal health and wellbeing plans at the local government level. This is discussed further in Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect*. The municipal health and wellbeing plans are required by the Public Health and Wellbeing Act. When being prepared, the municipal plans must have regard to the state plan.[133] Local councils play an important role in mental health as community leaders, planners, employers, managers of public spaces and providers of services and infrastructure.[134] Chapter 11 also describes the many examples of mental health promotion efforts that have been carried out by community leaders and community-led organisations, often with very limited resources.

However, in its submission, the Victorian Council of Social Service noted significant gaps in the outcomes reporting across the two state government plans, which are discussed in the next section of this chapter:

> **While the Department of Health and Human Services (DHHS) tables a Mental Health Services annual report in Parliament each year, this report focuses heavily on the work of DHHS and the clinical mental health sector. No data is available or reported against many of the outcomes related to broader wellbeing measures, including participation in education, work or community life. The Public Health and Wellbeing Plan also provides an important platform for measuring population level health outcomes. However, its scope is limited to the health and human services areas of government.**[135]

In addition to the statewide plans described above, the Victorian Government also provides health promotion funding and prevention guidance to support delivery of prevention and promotion at the community level—for example, through primary care partnerships, women's health agencies and community health agencies.[136]

VicHealth also plays an important role in supporting action through cross-sector partnerships and community mobilisation, and contributes substantially to the research and evidence base for mental wellbeing.[137] Indeed, VicHealth led the first attempt to coordinate and provide a framework for prevention and promotion efforts in Victoria in 2005.[138] VicHealth's current strategy to improve mental wellbeing focuses on increasing social connection for young people and improving gender equality.[139]

While there is a moderate level of activity and many stakeholders in prevention and promotion, the main weakness in the current system is the gap in coordination of public health efforts. The Victorian Council of Social Service suggested that, to take a strategic approach to mental health promotion and prevention in Victoria, a new approach is required that provides 'system oversight and guidance' and offers capacity to 'coordinate investment, research and monitoring'.[140] Witnesses such as Professor Herrman identified the need for 'coordinated efforts' to support many actors and agencies to deliver an integrated approach to health promotion.[141] The former Department of Health and Human Services was responsible for leading public health approaches across many health areas, including mental health; however, following COVID-19 there has been recognition that changes are required in departmental structures to allow for a more dedicated focus on specific portfolio areas.[142]

The Commission agrees with Prevention United's assessment that:

> 'Everyone' does a 'bit' of prevention, but no-one seems to 'own' prevention and accountability is not transparent. As a result, while there is activity on multiple fronts, it's unclear how much is being invested, in what way, and whether it's having an impact. We're pedalling but we're not necessarily moving forward.[143]

Prevention United advocated for establishing a new entity with leadership responsibility:

> In our view, the best way to overcome this fragmented approach to the prevention of mental health conditions is to devolve responsibility for planning, commissioning, coordinating and monitoring initiatives (directly or indirectly) focused on the prevention of mental health conditions, to a new entity tasked with fostering a multi-sectoral approach.[144]

4.4.2 There are gaps in measuring and monitoring outcomes

Measuring the impact of prevention is difficult because it involves measuring the absence of a problem, rather than the absence of a service or the outcome of services.[145] This means a different measurement approach is required.

The Victorian *Public Health and Wellbeing Progress Report*,[146] published in 2019, reflects the public health and wellbeing priorities identified in the *Victorian Public Health and Wellbeing Plan 2015–2019*. The progress report provides a snapshot with respect to the key indicators of health and wellbeing.[147] However, the report draws on limited data and surveillance to measure improvements in mental health and wellbeing, a deficiency that also characterises the scorecard of *Victoria's 10-Year Mental Health Plan*. Annual reporting on that plan includes some selected measures of mental wellbeing but does not provide any surveillance or monitoring in relation to the social determinants of mental health across the population.[148]

In the *Primed for Prevention Consensus Statement*, several mental health organisations called for improved tracking of investment and outcomes in prevention. They suggested that a priority action is to:

> Develop a prevention monitoring framework, in consultation with key stakeholders, and embed prevention indicators into regular national population level surveys and reporting frameworks.[149]

Prevention United submitted that a coordinated approach to prevention monitoring would support quality assurance and the development of implementation standards for prevention programs; it would also support public reporting of outcomes arising from government investment in prevention.[150]

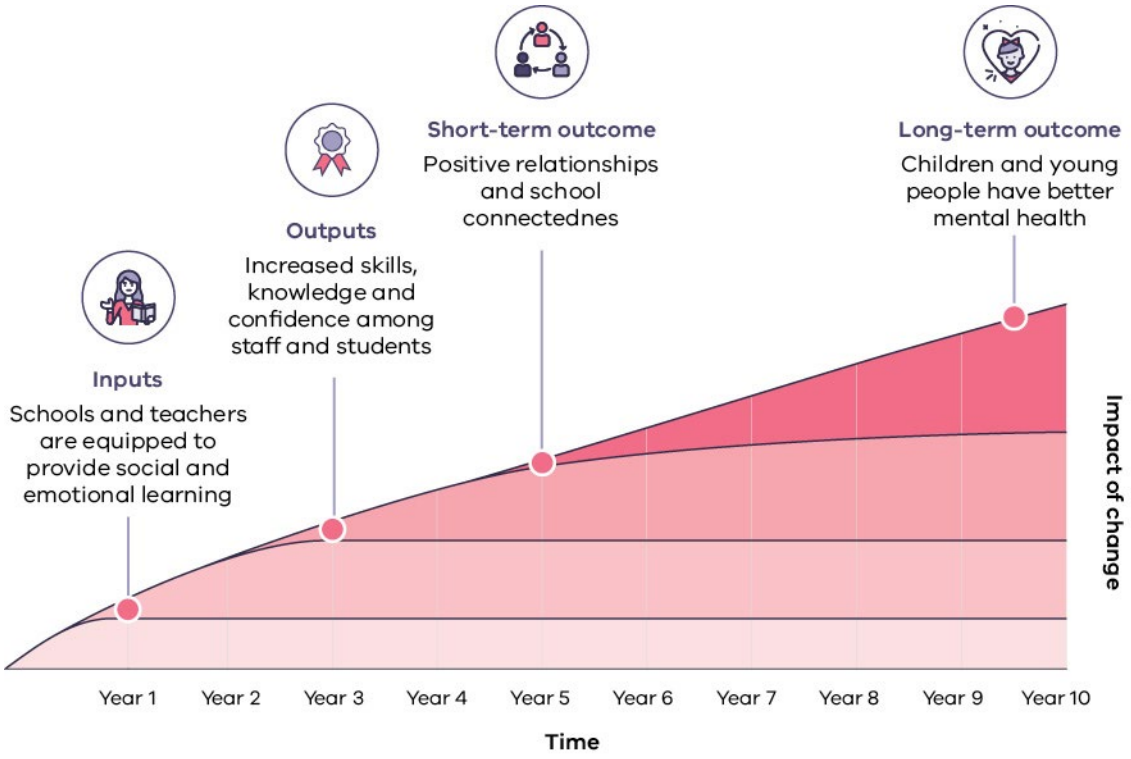
The challenge of measuring impact in the short term towards a reduction in prevalence in the long term is comparable with other areas of policy reform, including the prevention of violence against women. In a framework document for measuring the impact of prevention action over time, Our Watch stated:

> it may take ten years or more of multi-pronged and sustained prevention efforts to create quantifiable change against prevalence indicators.

Participants at the Commission's Public Health Roundtable agreed that the impact of prevention on mental health can be difficult to detect in the short term and therefore it is important to measure other outcomes and indicators.[151]

In this context, progress measures and medium- and long-term indicators are required to support monitoring of the impact of preventative measures over time. As an example, Figure 4.5 illustrates the long-term impact on the mental health of children and young people following investment in school-based prevention programs, with a focus on social and emotional learning. The Department of Education and Training's model, Rights, Resilience and Respectful Relationships, is used as the basis for this illustrative example to indicate how a variety of indicators can be used to measure the impact of prevention programs at different time points.[152]

Figure 4.5: Prevention indicators at different time points



In Chapter 3: *A system focused on outcomes*, the Commission proposes a new approach to setting and monitoring outcomes for the mental health and wellbeing of all Victorians. The outcomes framework will capture the broader determinants that influence mental health and wellbeing, to encourage 'whole of individual' and 'whole of community' approaches that draw on the intelligence and resources of multiple government portfolios.

There is emerging global research to support improved monitoring of mental wellbeing in Victoria. For example, the What Works Wellbeing Centre in the United Kingdom has highlighted a large range of evidence-based indicators at the population level across many domains such as social connection, social inclusion, resilience and subjective wellbeing.[153] In Canada the *Positive Mental Health Surveillance Indicator Framework* combines data on mental health outcomes with data related to the individual, family, community and societal determinants of mental health to provide a comprehensive assessment of population mental health.[154] In addition, some authors suggest that strengthened measurement of subjective wellbeing would help to assess the proportion of people who are 'flourishing' or experiencing good mental health, which is different to assessing the proportion of people who are experiencing mental illness.[155]

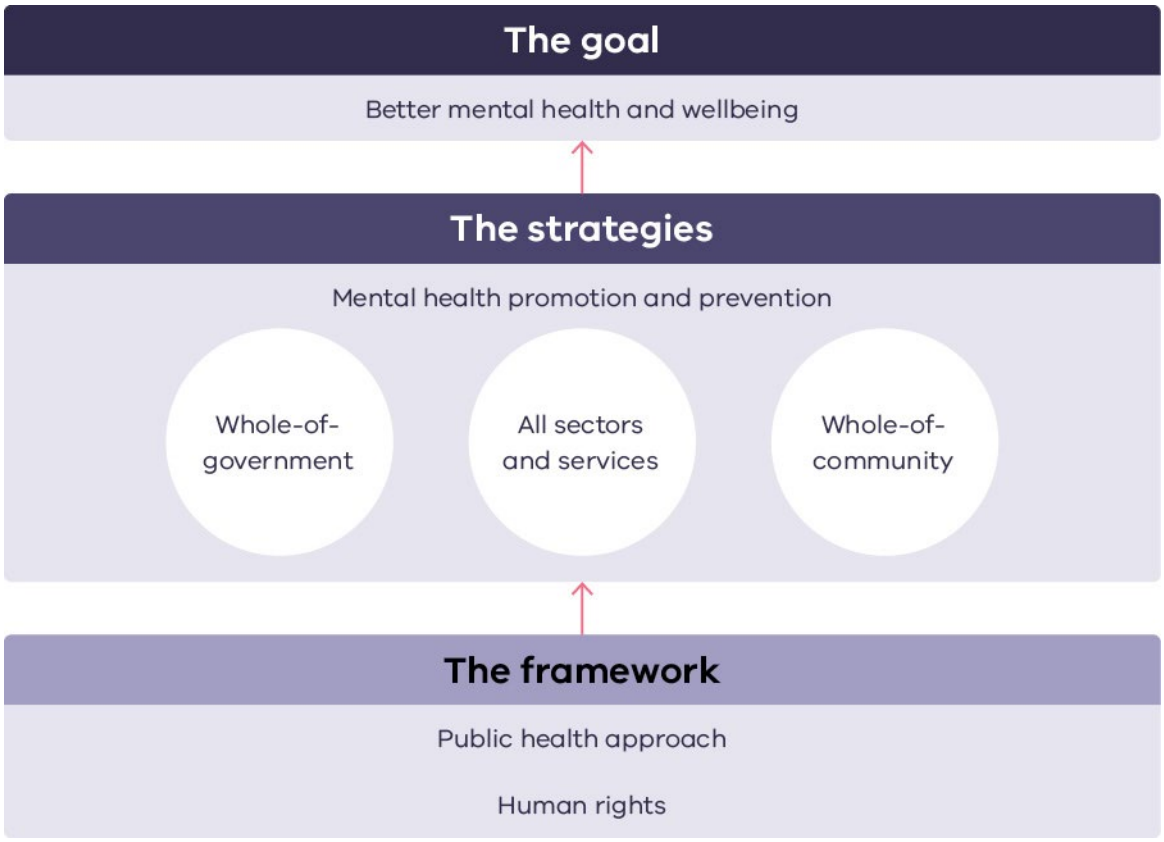
4.5 Transforming the approach to prevention and promotion

There is a significant opportunity in Victoria to establish a renewed public health approach to mental health and wellbeing as a core element of the future mental health and wellbeing system. Without this reform, it is less likely that the Victorian Government will make an impact on the prevalence of mental illness nor the costs associated with it. It will take enhanced investment into prevention and promotion, improved coordination of these efforts and strengthening the position of mental health in public health activity to make a significant difference.

As outlined in Figure 4.6, the Commission calls for the Victorian Government to adopt a public health and human rights approach to underpin mental health promotion and prevention activity. This should be done as a matter of priority. As Prevention United submitted:

> It's time to try something new. It's time to add prevention to the policy and funding mix because without greater investment and action to prevent mental health conditions from developing in the first place, we will never be able to 'shift the dial' in mental health in Victoria.[156]

Figure 4.6: A public health approach to improve mental health and wellbeing



4.5.1 Creating new leadership—a new Mental Health and Wellbeing Promotion Office

Victoria has a unique opportunity to build on a strong prevention and promotion history and establish a new leadership function to coordinate statewide cross-sector prevention efforts. The Commission acknowledges the importance of leadership, particularly in the context of the social and other trends described in Chapter 1: *The reform landscape*, and in the context of new and emerging challenges to mental health such as climate change and the impact of social disadvantage; indeed, some researchers suggest that the mental health impacts of COVID-19 may only be prevented or reduced through a cross-sectoral approach underpinned by strong coordination.[157]

The Commission recognises there are several agencies currently delivering prevention and promotion efforts across Victoria; however there is no one agency or office solely dedicated to coordinating those efforts.

The Commission recommends that the Victorian Government establishes a dedicated Mental Health and Wellbeing Promotion Office to lead a statewide approach to promotion and prevention. The goal of the office will be to improve mental health and wellbeing for the entire population including people who are experiencing mental illness.

In determining the optimal governance and leadership arrangements for mental health promotion and the prevention of mental illness, the Commission considered several models. The Commission has determined that the most suitable location for the new office is inside the new Mental Health and Wellbeing Division in the Department of Health, as described in Chapter 27: *Effective leadership and accountability for the mental health and wellbeing system—new system-level governance*. Locating the Mental Health and Wellbeing Promotion Office inside the government unit responsible for system-wide governance will (a) align with the department's responsibility for statewide coordination; (b) support integrated planning and delivery of prevention and promotion alongside other system functions; and (c) strengthen capacity to drive whole-of-government prevention and promotion activity.

The new office will be well resourced and led by a Mental Health and Wellbeing Promotion Adviser (the Adviser), a senior executive position reporting to the Chief Officer for Mental Health and Wellbeing in the Department of Health.

The Adviser will ideally have experience leading significant public health efforts, including in areas related to human rights and social justice, in change management and working across government portfolios. The Adviser's role will involve overseeing the office's operations and leading cross-sector and whole-of-government engagement in prevention and promotion. The Adviser will represent the office within the Department of Health and will work collaboratively with other offices and divisions to ensure prevention and promotion continue to be prioritised and aligned with broader mental health activity. External to the department, the Adviser will represent the office and its priorities in working with multiple government departments and agencies to support mental wellbeing activity.

The Adviser and office staff will also lead engagement across sectors and settings with the aim of working collaboratively and sharing their prevention and promotion expertise. A productive working relationship with Commonwealth Government agencies will also be essential for ensuring Victoria's approach to promotion and prevention coordinates with, and complements, the national mental health reforms. Finally, the office will be responsible for securing support for prevention and promotion across the political spectrum and through successive governments. Witnesses such as Professor Moodie described the importance of securing bipartisan support to sustain health and economic policies through successive governments in order to deliver mental health outcomes.[158]

Ultimately, the Adviser will assist the Secretary and the Chief Officer for Mental Health and Wellbeing to acquit their responsibilities for mental health promotion and prevention, as described in Chapter 27: *Effective leadership and accountability of the mental health system—new system-level governance*. Core functions and priority activities of the new office are outlined in Table 4.1, along with priority actions in each area.

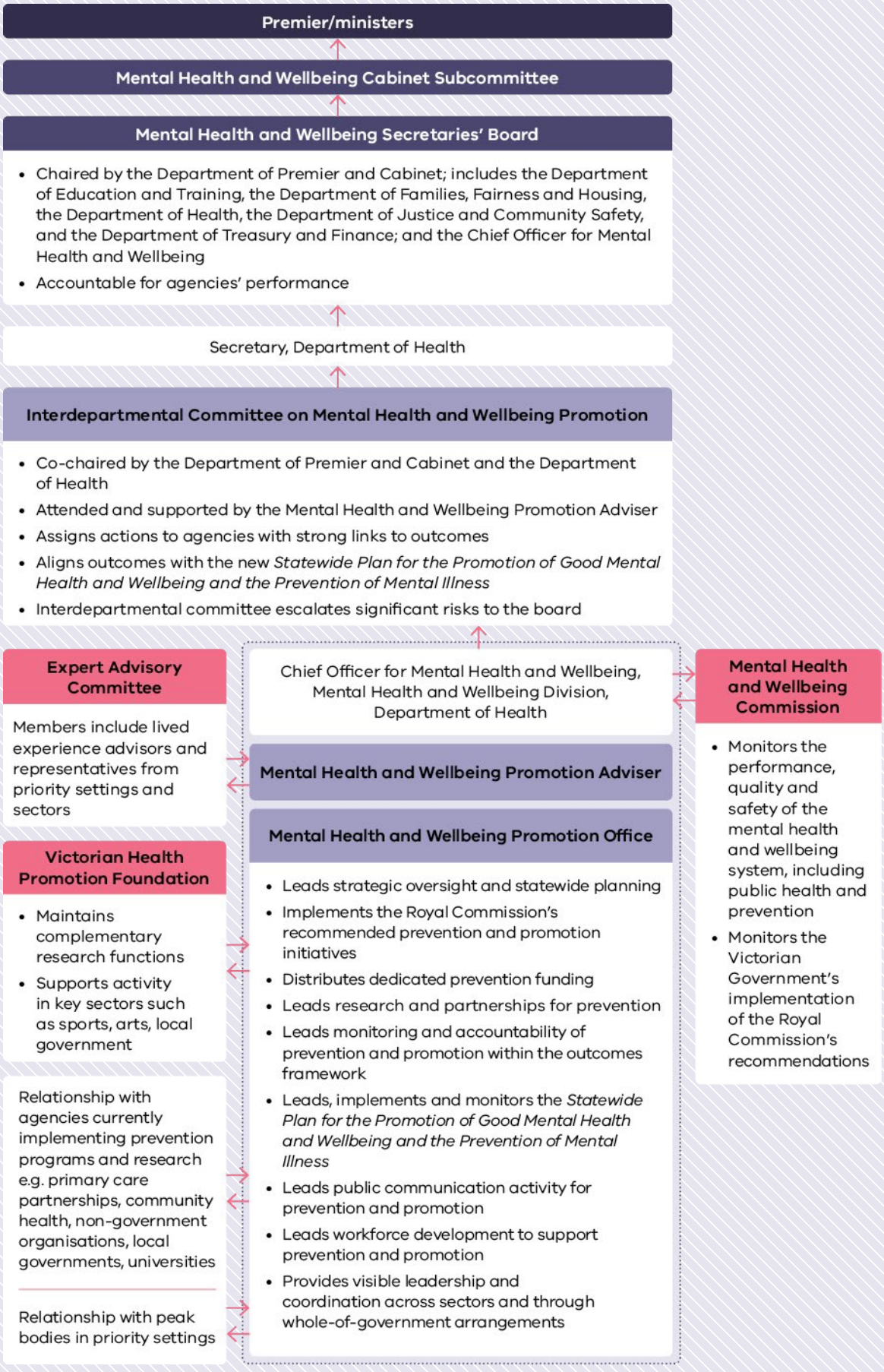
The proposed governance arrangements for prevention and mental health promotion, as shown in Figure 4.7, reflect a whole-of-government approach. The proposed Interdepartmental Committee on Mental Health and Wellbeing Promotion would include Deputy Secretary membership and report through the Secretary of the Department of Health to the Mental Health and Wellbeing Secretaries' Board. Other agencies on the Interdepartmental Committee will be required to ensure representation of expert bodies, sectors and subpopulation groups–for example, VicHealth, Commissioner for Gender Equality in the Public Sector, the Commissioners for Children and Young People, Commissioner for LGBTIQ+ Communities, the Victorian Multicultural Commission and WorkSafe. The Expert Advisory Group will include membership to reflect the priority settings and actions of the office, such as local government, education, workplaces and communities.

The Commission envisions the establishment of the new office will support a significant reduction in the prevalence of mental illness in the future and should position Victoria as a leader in mental health promotion and the prevention of mental illness. The Commission recognises that the establishment of new leadership and governance arrangements for prevention and promotion will take time. In order to move to delivery as quickly as possible, the Victorian Government will ideally identify priority actions to support a successful transition to the new arrangements and provide the resources to undertake those actions.

Table 4.1: Functions and priority actions of the Mental Health and Wellbeing Promotion Office

Function	Priority actions
Distribute dedicated prevention funding for programs and initiatives across the state	Establish and oversee the Community Collectives initiative in partnership with local councils as described in Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect*. Support delivery of the state's approach to supporting Mentally Healthy Workplaces as described in Chapter 11. Determine priority prevention programs for expansion and replication.
Coordinate research, evaluation and knowledge translation activity	In partnership with the Department of Education and Training, support development of a digital platform and validation of programs to support social and emotional wellbeing in schools as described in Chapter 11. In partnership with the Collaborative Centre for Mental Health and Wellbeing, universities and government agencies, develop research, evaluation and knowledge translation priorities for prevention and promotion.
Lead monitoring outcomes and measuring the impact of prevention and promotion activity	Contribute to development of the new *Mental Health and Wellbeing Outcomes Framework* as described in Chapter 3: *A system focused on outcomes*. Ensure prevention and promotion activity is monitored in alignment with the new framework.
Lead development and delivery of a whole-of-government *Statewide Plan for the Promotion of Good Mental Health and Wellbeing and the Prevention of Mental Illness*	Establish a new *Statewide Plan for the Promotion of Good Mental Health and Wellbeing and the Prevention of Mental Illness*, in partnership with key sectors and leaders with lived experience of mental illness or psychological distress. Work in close partnership with Aboriginal Victoria to identify opportunities to support the social and emotional wellbeing of Aboriginal communities in Victoria.
Lead public mental health promotion and prevention communication activity	Deliver public communication activity to provide a 'call to action' for all Victorians to support mental wellbeing. Conduct formative research to underpin mental health promotion activity (such as community attitudes, behavioural insights).
Lead, as part of broader workforce reforms, workforce development for promotion and prevention	Work with the Collaborative Centre for Mental Health and Wellbeing to support approaches to planning, professional development and wellbeing for the mental health workforce, including opportunities to strengthen prevention and promotion across sectors.
Provide visible leadership and coordination across sectors and through whole-of-government arrangements	Engage government agencies and departments in developing the *Statewide Plan for the Promotion of Good Mental Health and Wellbeing and the Prevention of Mental Illness*. Identify opportunities and strengthen efforts to drive collective responsibility and accountability across government departments for mental health and wellbeing prevention and promotion outcomes, as described in Chapter 3: *A system focused on outcomes*.
Support mental health promotion and prevention for Victoria's diverse communities	Work in collaboration with the Department of Families, Fairness and Housing to align approaches and efforts to reduce risk factors for mental illness for Victoria's diverse communities including racism and discrimination, and design strategies, in partnership with Victoria's diverse communities, to support equity of mental health outcomes for Victoria's diverse populations.

Figure 4.7: Governance arrangements for the Mental Health and Wellbeing Promotion Office



4.5.2 Dedicated funding for prevention and promotion

In delivering its new focus on mental health promotion and prevention, the Victorian Government should establish dedicated funding for mental health promotion and prevention efforts.

Prevention United drew on international evidence to highlight that, at the national level, funding for public health interventions (including health promotion) is substantially less in Australia compared with other countries. It suggested setting an increased target for the funding allocated to prevention within overall mental health expenditure and suggested improvements to the way prevention investments are measured and tracked over time.[159]

Similarly, the Victorian Council of Social Service outlined that there is scope to increase the investment in prevention programs and related research.[160] In determining the appropriate amount of funding, the Victorian Government should consider the burden of disease currently associated with mental illness. This should include the personal and economic costs of this burden and the potential impact of prevention investment.

The *Primed for Prevention Consensus Statement*, issued by a collection of mental health organisations, proposes several priorities for future investment in prevention, saying:

> **In the first instance, funding for prevention should focus on scaling-up existing evidence-based strategies that target the most influential or modifiable risk factors and/or priority populations … It also requires a dedicated program of research to create new and better approaches for preventing mental disorders.**[161]

These organisations suggested that the current spending on prevention as a proportion of the mental health budget is 1 per cent and that this should be increased to at least 5 per cent, in the context of an increased budget for mental health overall.[162]

In determining the appropriate proportion of funding for prevention, and a mechanism through which to protect funding, the Victorian Government should consider the merits of setting the funding amount in legislation. An alternate, although perhaps less sustainable option, would be to set, as a departmental output performance measure, a target for the proportion of the total mental health budget allocated explicitly to prevention activities via the Mental Health and Wellbeing Promotion Office. If the latter mechanism is employed, the Victorian Government should ensure this output measure is consistently incorporated through consecutive budget cycles and performance recorded in budget papers. This mechanism, if adopted, should align with the investment approach outlined in Chapter 3: *A system focused on outcomes*.

The funding should be sufficient to support universal and long-term strategies while also supporting activity that aligns with immediate Victorian Government priorities. This will enable long-term action on the determinants of mental illness, which can be complex and deeply entrenched. It will provide sufficient longevity to detect measurable change in the causes and determinants—and, ultimately, the prevalence—of some forms of mental illness.

The Mental Health and Wellbeing Promotion Office will distribute funding for mental health promotion and prevention activity, including in priority settings. However, funding will also be required to support delivery of other office functions such as coordination, communication and workforce development.

Three priority areas for funding are:

- prevention programs—to increase the scale, reach and longevity of evidence-based programs
- research, evidence and knowledge translation—including strengthening the evaluation and evidence base for prevention; conducting economic modelling; forecasting future trends that affect mental health and wellbeing; producing resources to guide practitioners and policymakers
- partnerships—engaging a range of partners in prevention across government, non-government and private sectors, brokering partnerships and leading collaborative projects.

4.5.3 Statewide Plan for the Promotion of Good Mental Health and Wellbeing and the Prevention of Mental Illness

A priority of the Mental Health and Wellbeing Promotion Office will be to lead development of a new *Statewide Plan for the Promotion of Good Mental Health and Wellbeing and the Prevention of Mental Illness*. The development of a new plan is intended to strengthen mental health promotion across all the settings and sectors that are outside the mental health and wellbeing system, acknowledging that some activity is already occurring in various places, settings and environments. The new plan will provide direction for a diverse range of peak bodies and key agencies to align to a common set of mental health and wellbeing objectives. It will describe how these settings and sectors can benefit from increasing their role in prevention and promotion and provide a framework for their approach within the timeframe that is required to make significant changes. The current *Prevention First* framework,[163] developed by Everymind in New South Wales, provides a useful example of a statewide cross-sector approach, as do past mental health promotion frameworks led by VicHealth.

The new plan will provide a foundation for the cross-sector approach to mental wellbeing. The plan will complement Victoria's *Public Health and Wellbeing Plan*, in that it will strengthen Victoria's capacity to meet the mental wellbeing objectives. It will also complement *Victoria's 10-Year Mental Health Plan* in that it will strengthen Victoria's capacity to meet prevention and mental health promotion goals for the entire population. The new *Statewide Plan for the Promotion of Good Mental Health and Wellbeing and the Prevention of Mental Illness* will also ensure cross-sector activity is aligned with whole-of-government activity. In addition, it will reflect input from and strengthen the role of regional networks and agencies in prevention and promotion. The plan will require specific allocation of resources for planning, partnerships, delivery and monitoring over its entire timeframe.

The plan should be underpinned by prevention and human rights frameworks and aligned with future Victorian public health and wellbeing plans. It should focus on mental health and wellbeing but also recognise the interdependencies of mental health and other public health issues such as physical activity and harm from alcohol and other drugs. It should focus on the priority settings identified by the Commission, such as communities, workplaces and education. Its timeframe should allow it to achieve tangible impact on the determinants of mental health and also to build foundations for emerging challenges to mental health and wellbeing. This may include the impacts of the COVID-19 pandemic, climate change, rising costs of living, housing affordability and other social trends.

In developing the *Statewide Plan for the Promotion of Good Mental Health and Wellbeing and the Prevention of Mental Illness*, the office should align goal-setting with the broader outcomes framework described in Chapter 3: *A system focused on outcomes,* and work closely with the Suicide Prevention and Response Office described in Chapter 17: *Collaboration for suicide prevention and response* to ensure activities are complementary and not duplicative.

It is essential that the new plan is monitored and reported on to overcome the limitations described earlier in this chapter. From the outset, the plan should include objectives and indicators that are specific to prevention and promotion and that allow progress towards, and alignment with, the new *Mental Health and Wellbeing Outcomes Framework*. The objectives and indicators within the plan should be developed with consideration of the timeframe required to impact on the prevalence of mental illness and the improvement of mental wellbeing across the population, as discussed earlier in this chapter; for example, it should include detail about the expected inputs, outputs, short-, medium- and long-term outcomes of the plan.

The Mental Health and Wellbeing Promotion Office should ensure appropriate procedures and resources are set up to monitor the plan. The office should lead its own monitoring activity and also ensure partners and funded agencies are equipped to conduct the required monitoring activity. This may include monitoring of:

- the budget that is allocated and spent on prevention and promotion and what it is spent on
- the impact of plan activities in the context of the plan's objectives and indicators
- the level of engagement with and delivery of prevention and promotion activity in all sectors—including within the mental health and wellbeing system, in the places, settings and environments outside the system, and across government departments and agencies
- significant social or other changes that affect prevention and promotion activity.

It is suggested that the Mental Health and Wellbeing Promotion Office publish biannual progress reports on the *Statewide Plan for the Promotion of Good Mental Health and Wellbeing and the Prevention of Mental Illness* , with oversight from the new Mental Health and Wellbeing Commission, to publicly report on expenditure, actions, impact and priorities going forward. The progress reports should complement rather than duplicate Victorian Government reporting in relation to the *Public Health and Wellbeing Plan* and *Victoria's 10-Year Mental Health Plan*, and should be seen as an important source of information about the state of mental health and wellbeing in Victoria.

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Chapter 5

A responsive and integrated system

Recommendation 3:

Establishing a responsive and integrated mental health and wellbeing system

The Royal Commission recommends that the Victorian Government:

1. establish a responsive and integrated mental health and wellbeing system, in which people receive most services locally and in the community throughout Victoria, close to their families, carers, supporters and networks.
2. establish service delivery across Victoria at local, area-based and statewide levels comprising:
    a. between 50 to 60 new Adult and Older Adult Local Mental Health and Wellbeing Services that operate with extended hours and are delivered in a variety of settings;
    b. 22 Adult and Older Adult Area Mental Health and Wellbeing Services delivered through partnerships between public health services or public hospitals and non-government organisations that deliver wellbeing supports;
    c. 13 Infant, Child and Youth Area Mental Health and Wellbeing Services delivered through partnerships between public health services or public hospitals and non-government organisations that deliver wellbeing supports; and
    d. statewide services that are delivered in a way that minimises the need for people to travel far to access services.
3. for planning and governance purposes, realign existing boundaries and organise mental health and wellbeing services across eight regions (refer to recommendation 4).
4. remove rigid boundaries (or catchments) for service delivery based on where people live.
5. establish the requirements for each service and the links between them through a 'service capability framework'.

Recommendation 4:

Towards integrated regional governance

The Royal Commission recommends that the Victorian Government:

1. by mid 2021, establish eight interim regional bodies to provide advice to the Mental Health and Wellbeing Division in the Department of Health as it plans, develops, coordinates, funds and monitors a range of mental health and wellbeing services in each region.
2. by no later than the end of 2023, replace interim regional bodies with legislated Regional Mental Health and Wellbeing Boards to:

    a. undertake workforce, service and capital planning for mental health and wellbeing services; and

    b. lead engagement with their respective communities.

3. from the end of 2023 and by no later than the end of 2026, enable each Regional Mental Health and Wellbeing Board also to:

    a. commission mental health and wellbeing services; and

    b. hold individual providers to account to improve the outcomes and experiences of people who use their services.

4. in parallel with the establishment process, ensure that Regional Mental Health and Wellbeing Boards:

    a. acquire and maintain the required skills and capabilities to perform the above functions;

    b. are accountable for the delivery of agreed outcomes through new accountability arrangements; and

    c. are skills-based and include at least one person with lived experience of mental illness or psychological distress and one person with lived experience as a family member or carer.

5. with the assistance of the interim regional bodies, establish a multiagency panel in each region to coordinate as required the delivery of multiple mental health and wellbeing services for people living with mental illness or psychological distress, including children and young people, who may require ongoing intensive treatment, care and support.

5.1 The need for a responsive approach to organising services

The Commission established in its interim report that systemic failures have meant that people are often unable to access services at a time when treatment, care and support would make the greatest difference.[1] There is a serious and often detrimental mismatch between what people seek and what the system offers.[2] As the Commission worked towards delivering its final report, these sentiments remained ever-present in the evidence collected.

Mr Kiba Reeves, a witness before the Commission, described the difficult experience of seeking help and being turned away from accessing services:

> I have tried a few times to voluntarily go into the emergency department and say: 'look I'm really not okay right now, I need to be admitted.' Most times I got told that there were no beds, or that they thought I could deal with the issues at home. There have been several times when I have looked the emergency department staff in the eye and told them that I was going to 'off myself' if they sent me home. Once or twice when they sent me home saying I was fine and I ended up trying to commit suicide. I then kind of gave up because, what was the point, if you're just going to be sent home.[3]

People describe being told they were not 'sick enough' or 'not suicidal enough' to access services, despite seeking help:

> Reaching out for help and admitting you believe you could have an issue is hard enough in itself. But going through that difficult process to then be turned away from treatment makes the anxiety about reaching out even worse for fear of being told you aren't worthy of treatment. Turning people away because they 'aren't sick enough' (rather than recommending an alternative which would still benefit their recovery) sends a message that there is a level that needs to be achieved before you're allowed to get better.[4]
>
> It is extremely difficult to find mental health help in Victoria. It seems that the only time you will receive attention or help is if you threaten suicide.[5]

Reflecting on the experiences of older adults, the Commissioner for Senior Victorians stated that '[o]ften appropriate supports only become available once a situation reaches crisis point',[6] and conveyed reports from a person with lived experience that, '[f]or 55–75-year-olds, you almost must be fully broken down before help is provided, and sometimes this is a complete family or financial loss.'[7]

Families, carers and supporters also told of the lengths they went to at times to help their loved ones to get services. Mr Michael Silva, a carer for his brother Alan and a witness before the Commission, explained:

> Over the years, our main dealings were with the [Crisis Assessment and Treatment Team]. Once the [Crisis Assessment and Treatment Team] got to be aware of Alan's history, we thought that this might give us an easier passage for getting help from someone, whom we could then inform that we were going through another episode of illness. However, we often felt that it wasn't getting easier to get help; it was almost as if we had to retell everything again to the team.[8]

Concerns have been expressed that the current service offering is overly focused on prescribing medication and that it fails to respond to a person's preferences or their broader needs. People have said there is a lack of effective wellbeing supports or approaches that respond to experiences of trauma or recovery-based responses.[9] Ms Julie Dempsey, a witness before the Commission, explained:

> Current psychiatric units were set up as attachments to mainstream hospitals as a move to integrate back into wider society, away from the isolation of the old asylums. However, what this has achieved is an intensification of the medical model at the cost of real person-centred recovery.[10]

The dominance of a clinical paradigm in the current service offering is also considered at odds with Aboriginal cultural understandings of mental health, which are based on beliefs about the inextricable connections between a person's physical, emotional and spiritual wellbeing, and their community and the environment.[11] As highlighted in the *Ways Forward* report, for Aboriginal people '[h]ealth does not just mean the physical well-being of the individual but refers to the social, emotional and cultural well-being of the whole community.'[12]

Structural problems, such as major supply problems and a crisis-driven approach, have adversely affected the workforce's ability to work effectively and deliver the types of services people seek.[13] Members of the current workforce often find themselves trying to do their best in a system that constrains them.[14] As the Royal Australian and New Zealand College of Psychiatrists highlighted, '[p]sychiatrists and other mental health workers, are facing moral distress: a desire and knowledge to do the right thing, but system constraints make it impossible to do so.'[15]

This chapter explores how the current organisation of mental health services can contribute to the challenges people encounter when seeking access to treatment, care and support, and impede the efforts of the workforce. It then outlines the Commission's vision for a responsive and integrated mental health and wellbeing system, founded on access to diverse, community mental health and wellbeing services, where people receive most services locally and in the community, close to their families, carers and supporters.

To realise this vision, the Commission has recommended creating new structures to ensure people have access to high-quality services that are compassionate, responsive to their needs, and respectful of their preferences. The Victorian Government will need to ensure these structures and the services that stem from them are well resourced so people have dependable access to mental health and wellbeing services.

To deliver the Commission's vision for a future mental health and wellbeing system, the Victorian Government will need to:

- invest in 50–60 new Adult and Older Adult Local Mental Health and Wellbeing Services that deliver community mental health and wellbeing services over extended hours and in a variety of settings (refer to section 5.5)
- establish 22 Adult and Older Adult Mental Health and Wellbeing Services to provide more intensive mental health and wellbeing services, delivering a range of treatment, care and support through service partnerships between public health services (or public hospitals) and non-government organisations that provide wellbeing supports (refer to section 5.6)
- establish 13 Infant, Child and Youth Area Mental Health and Wellbeing Services, delivering a range of treatment, care and support through service partnerships (refer to section 5.6)
- remove boundaries (or catchments) for service delivery so a person's place of residence no longer limits access to mental health services (refer to section 5.4.2)
- ensure statewide services are readily available in a way that minimises the distance people need to travel to connect with these services (refer to section 5.7)
- establish new links between statewide services and the Collaborative Centre for Mental Health and Wellbeing to leverage its capabilities in research and knowledge sharing (refer to section 5.7.2).

The Commission has also recommended organising mental health and wellbeing services around eight regions by realigning existing service boundaries. These boundaries will provide the frame for new regional governance structures, which will be known as Regional Mental Health and Wellbeing Boards. This will support mental health and wellbeing services to be planned and organised in a way that responds to community needs. These structures also provide a platform for greater integration across services beyond the mental health and wellbeing system, including both Victorian Government- and Commonwealth Government-funded services (refer to section 5.9).

5.1.1 Inadequate service capacity, unmet demand and inequities

The rationing of services and the high bar to access mental health treatment, care and support is a consequence of increasing demand and limited service capacity.[16] People are being turned away and experiencing long waits for mental health services, primarily because supply has not kept pace with demand.[17]

Many consumers described being unable to access public acute mental health inpatient services:

> So many people who are feeling suicidal are turned away from being admitted to a psychiatric unit because there isn't enough beds. It's hard enough for people in that mindset to open up and ask for help without then being turned away. Because then they feel it is worthless in asking for help.[18]
>
> I attended an emergency department on two occasions when acutely unwell. On both occasions I was sent home—once being told that it would be 'too disturbing' for me to be admitted. There is effectively no inpatient care in the public system unless a person is a threat to others—being acutely suicidal is not enough to be given care.[19]

This shortfall was also highlighted through submissions from the workforce, who described that the threshold to access services has increased, leaving service providers no choice but to give priority to admitting those who are the most unwell and for whom treatment cannot be delayed any longer.[20]

Ms Jennifer Williams AM, Chair of Northern Health and a former senior state government official who led deinstitutionalisation in Victoria, which dismantled standalone asylum-style mental health institutions and brought people into the community, shared similar concerns:

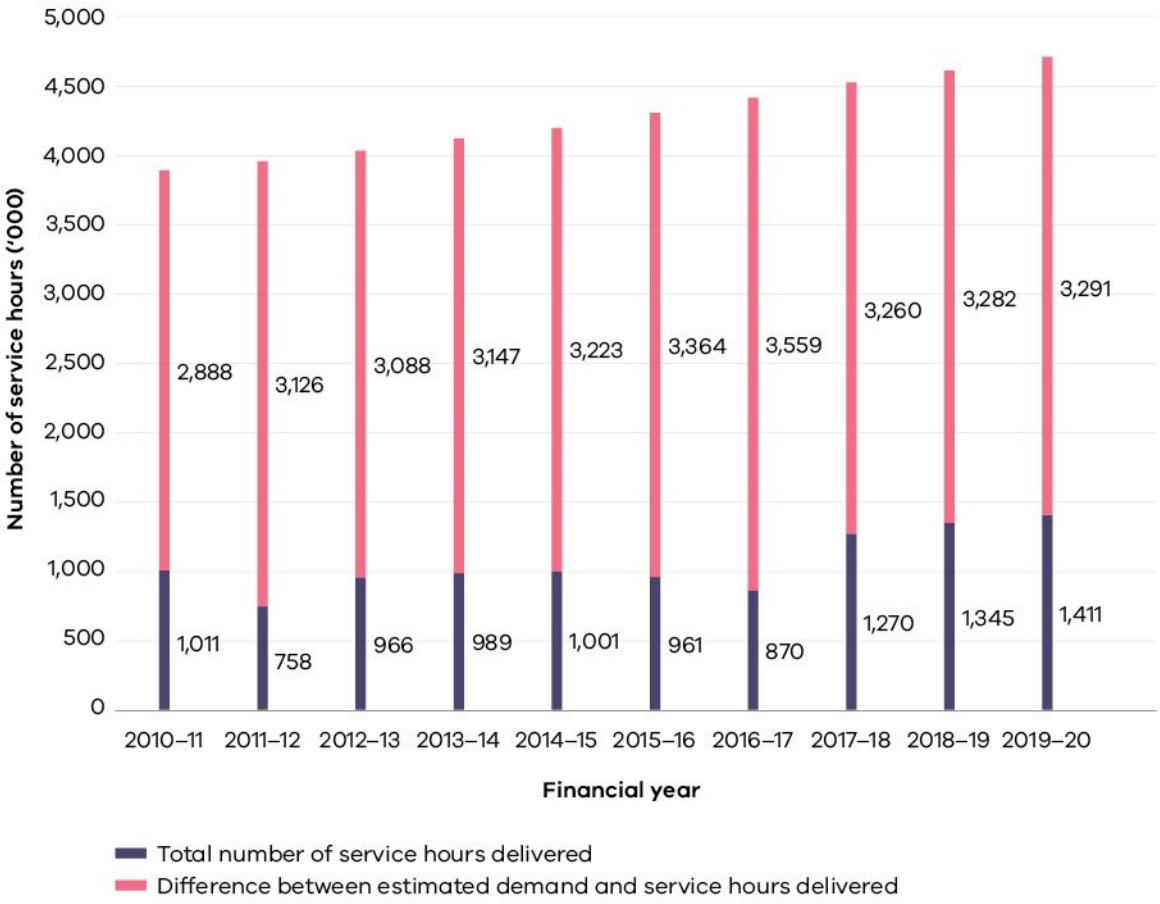
> One of the biggest problems is that demand for mental health services is greater than that with which services can cope. This results in difficulty accessing services, with the clinical threshold for admission to a hospital bed being very high, which results in patients being discharged too early or not admitted at all … [m]ental health services in Victoria have not grown to keep pace with population growth and patient demand putting all parts of the mental health system under stress such that the very urgent and critically ill are prioritised for treatment.[21]

The undersupply of community-based mental health services is particularly pronounced and also of concern. The minimalist level of service in community-based mental health services was acknowledged in the Victorian Government's submission to the Commission, which noted that consumers of Victoria's community-based mental health services receive a less-intense service offering than most of their counterparts in other Australian states and territories.[22] With additional investment the Commission notes that Victoria's annual provision of community based mental health services (or community contacts) have improved, but they are still lower than the national average and that of most other states and territories.[23]

When there are less-intensive services available in the community, people with ongoing needs, or those who face a situational crisis, are less likely to get the treatment, care and support they require.[24] Subsequently, people can become sicker and are more likely to present at emergency departments.[25]

Figure 5.1 shows the shortfall between the number of hours of community-based mental health services provided by Victorian public specialist mental health services and the estimated level of demand. In 2019–20 the system responded to less than one-third of the estimated demand for these services.

Figure 5.1: The difference between actual public specialist community service hours delivered and estimated demand, all ages, Victoria, 2010–11 to 2019–20



Sources: Calculation by the Commission based on Department of Health (Commonwealth), *National Mental Health Service Planning Framework*; Australian Bureau of Statistics, Australian Demographic Statistics, June 2020, cat. no. 3101.0, Canberra; Department of Health and Human Services, Client Management Interface/Operational Data Store 2010–11 to 2019–20.

Notes: 2010–11, 2012–13, 2015–16 and 2016–17 data collection was affected by protected industrial action. The collection of non-clinical and administrative data (public specialist mental health services) was affected, with impacts on the recording of community mental health service activity and client outcome measures.

Some of the estimated unmet demand (the difference between estimated demand and service hours delivered) may be met through services delivered in the private mental health system.

Consumer-related service hours are defined in the *National Mental Health Service Planning Framework* as time spent working with or for a client. This includes direct activity—for example assessment, monitoring and ongoing management, care coordination and liaison, respite services, therapies, peer work, review, intervention, prescriptions, pharmacotherapy reviews, carer peer work and support services and community treatment teams. It does not include administration, training, travel, clinical supervision and other activities that do not generate reportable activity on a consumer's record.

The Productivity Commission also identified insufficient availability of community-based mental health services, with their *Mental Health Inquiry Report* highlighting that funding for these services is 'a long way short of the level required'.[26]

> The large shortfall in community ambulatory services means that several hundred thousand people are either receiving only a fraction of the care they need, or are missing out on community ambulatory care altogether.[27]

Pressures on the system and the lack of dependable access to services can have negative impacts on people living with mental illness or experiencing psychological distress, families, carers and supporters.[28] One person said it was only after 'significant damage was done' that her brother was able to access treatment, care and support:

> Even though people may meet the criteria for needing mental health care, they can still be turned away … It was only after significant damage was done in several aspects of my brother's life and he became a lot more unwell that he was considered sick enough to warrant help.[29]

Tragically, in some cases a lack of access to treatment, care and support as a result of systemic failures has culminated in loss of life.[30] Reflecting on her experiences with her daughter, a mother shared:

> After she lost her job my daughter started having panic attacks, she became agoraphobic, [she] stopped eating and drank more and more. Over the next two years she spiralled down into a morass of physical and mental decline. We had many emergency trips to hospital, [intensive care unit], [community care unit] and long spells recovering merely to start the process again … (Unfortunately she was not able to get to the half way house as recommended as there was not a place). The family held meetings [where] we begged for a place in the mental health unit, we begged for a place anywhere she would be cared for, but all was denied … she haemorrhaged and died at home alone.[31]

These constraints on the system contribute to a range of unintended consequences including the default use of compulsory treatment.[32] As one participant at the workforce roundtable on compulsory treatment described:

> we use legislation to cover up the fact that we've actually got holes in our system that don't allow us to engage well with people. So we try and have a piece of paper that says you have to engage with us, rather than us engaging with them.[33]

Service gaps are more pronounced among people whose mental health needs are too complex and enduring for primary care services but not considered severe enough to meet the high access threshold to receive public specialist mental health services—often described as the 'missing middle'.[34]

Ms Amelia Callaghan, Director of Clinical Service Innovation at Orygen, providing evidence in a personal capacity, explained how the needs of young people in these circumstances can be overlooked:

> Many young people who can only access primary care currently, have a higher level of need than can be met in that system. This places significant pressure on the primary system. A lot of [clinicians'] time is also spent trying to get young people into tertiary systems that will not accept them. A young person may be referred from headspace to a tertiary provider and back to headspace without receiving any treatment because the services are debating where they should fit, and theoretically either system could provide the service if they had capacity. Currently access is a debate based on resource and service capacity and severity of symptoms, and not on needs of the young people. The services which can be offered by primary and tertiary care are limited by the funding available. This creates huge gaps in the services available to the missing middle.[35]

At the launch of the Productivity Commission's *Mental Health Inquiry Report*, the Prime Minister, the Hon. Scott Morrison MP, identified a need to respond to the service gaps that people in these circumstances experience, stating:

> this must be comprehensive and compassionate and provide the right care at the right time. … That means filling gaps in the system, particularly for those with mild and moderate needs in what's called … the missing middle …[36]

The considerable variability in the availability of mental health services exacerbates inequities some people and social groups experience when seeking access and support from the mental health system.[37] In a joint submission to the Commission, Mental Health Victoria and the Victorian Health Care Association described how poor experiences of care can be linked to 'variable access to quality services largely depending on where people live or their income'.[38] This variability in access can be confronting for those trying to navigate the system, including those trying to support their loved ones. As Dr Melissa Petrakis, the Chair of Tandem, giving evidence in a personal capacity, stated:

> Services are like franchises operating in different ways rather than a system—each mental health service has its own names for things.[39]
>
> In addition, carers in Victoria have spoken to me about each hospital or each access point within the system having its own triage processes; its own interfaces; and differently built environments—and carers have said they find this confusing and confronting.[40]

Accessing mental health services is challenging in rural and regional areas.[41] Following the deinstitutionalisation of Victoria's mental health services, some rural and regional health services missed out on important elements of the mental health system redesign.[42]

Dr Ravi Bhat, Divisional Clinical Director of Goulburn Valley Area Mental Health Service at Goulburn Valley Health, reflected on how a lack of access to services in rural areas may further compound people's experiences:

> Rural state-funded mental health services do not have local [child and adolescent mental health service inpatient units] and as a result, they are required to access metropolitan based [child and adolescent mental health service inpatient units]. This often results in children and adolescents with serious mental health problems being managed either in local emergency departments or paediatric inpatient units. The delay in access can exacerbate their mental health problems.[43]

Ms Karyn Cook, Executive Director of Mental Health Services at South West Healthcare, Warrnambool Community Health, made similar observations regarding the lack of community-based support for those living in rural areas of Victoria:

> The further away from larger centres a consumer is, the less options they have for support in the community mental health and primary health sector. In short, it is more challenging for a rural person to have all their needs met in relation to the social determinants of health.[44]

Others have shared similar views about inconsistency in getting treatment, care and support in rural and regional Victoria.[45] These perspectives are described further in Chapter 24: *Supporting the mental health and wellbeing of people in rural and regional Victoria*.

5.2 A difficult system to navigate

For those seeking services, it is often difficult to know or find out where to go for help, what eligibility criteria might apply, and which services are best suited to their needs. People conveyed the frustration and distress they felt when trying to identify the right mental health services for themselves, a loved one or someone else.[46]

Submissions also described how people have to 'jump through multiple, lengthy hoops to prove they meet narrow eligibility criteria',[47] sometimes to no avail. One consumer explained how rigid eligibility criteria meant they did not receive the treatment, care and support needed:

> when [I] was first looking for help, [I] was in much need of a residential support, [I] didn't fit into the eligibility criteria for hospital or rehab. [At] this time, therapy was not helping. [In] the end [I] didn't receive the help [I] needed, [I] ended up having a complete meltdown and lost my job. [I] think that there could have been some more preventative measures before it got too bad.[48]

Joanna Farmer, who has lived experience of mental illness and of caring for others experiencing poor mental health, agreed that the challenges of traversing the mental health system combined with rigid eligibility requirements unfairly place the burden of responsibility on people living with mental illness or experiencing psychological distress, leaving them to navigate the system alone:

> Online information on how to access specialist services is hard to navigate, links are often broken or outdated. While the [Department of Health and Human Services] website includes information on services as generally available, it is challenging to find information on specific services available in your area and service eligibility requirements. .... If the onus is on the consumer to navigate to a service and the system makes it too hard, consumers will simply not access the service.[49]

People who support a loved one and help them find treatment, care and support experience these challenges too. Leigh Garde explained the difficulties she faced when trying to seek support for her daughters from a fragmented system:

> As a single mother who had to work full time to keep a roof over my girls' heads, navigating the service system has been so difficult. This has taken a huge emotional and financial toll on me as I have not been able to progress my career due to my caring requirements, which will severely impact the amount of super I have to retire on. Disconnected, poorly promoted services with overly tight eligibility criteria meant that only some aspects of my girls' multiple and complex needs could be addressed.[50]

A lack of accessible information can also impede people's efforts to find services and make their way through the mental health system. In its submission, the Ethnic Communities' Council of Victoria stated that its consultation with member organisations revealed:

> the need for more mental health literature and documentation to be translated into community languages, especially those of new and emerging communities, who are generally most in need of support with their health literacy and understanding of the Victorian mental health system.[51]

In its submission, Deaf Victoria described the mental health system as 'inaccessible'[52] for people who are deaf and hard of hearing. It noted that this is a particular problem for people who use Auslan as their preferred language.[53]

People often rely on service providers such as GPs, teachers, housing support workers and social workers to refer them to mental health services. But the mental health system is so complex that many service providers—even those within the mental health system—are unaware of the full range of services available and how to connect people to them.[54] In this regard, the difficulties of navigating the mental health system are felt by consumers, families, carers and supporters, and the workforce.

Complexities of the current system are recognised by government. For example, the Prime Minister of Australia, the Hon. Scott Morrison MP said:

> the system is too complex and uncoordinated. … People who need help and their families are left to try and find and coordinate their own care without clear guidance about what is available, affordable and appropriate. And this happens at a point in their lives when they are most vulnerable and they will be finding it most difficult to try to access the services.[55]

5.2.1 The postcode lottery of the existing catchment structure

A further challenge is the current catchment structure that determines access to public specialist mental health services.

Public specialist mental health services are currently delivered by area mental health services that are age-based and location-based.[56] Established in the early 1990s, these services operate within geographic boundaries as:

- 13 child and adolescent mental health services for people up to the age of 18 or child and youth mental health services for people up to the age of 25
- 22 adult mental health services for people aged 16–64
- 17 aged persons mental health services for people aged 65 or older.[57]

While the Victorian Government defines 21 adult area mental health services, the Commission has been advised that Monash Health has operationally split the Dandenong catchment into two sub-areas.[58]

Unless a person is seeking a specialist service that is not provided or available in their catchment area, consumers of public specialist mental health services must attend the service within their catchment.[59]

While the catchments have remained largely unchanged, age groupings and services now vary across the system. For example, in some areas, child and youth services extend to people up to the age of 25, while other services only support children and adolescents up to the age of 18.[60]

While there are considerable differences in the types of services that public specialist mental health services offer, a person's age and postcode can place further limits on the services available to them because of these boundaries. As a result, there is great variability in access to community and bed-based mental health services.

One community consultation participant told the Commission:

> There are huge funding disparities for mental health services—there are differences between metro and regional areas, and differences region to region. If your lottery of birth wasn't enough, what services you get is also a lottery.[61]

Another person who is involved in mental health workforce training made similar observations:

> [The] current system is a postcode lottery, services are not evenly distributed across the state and in some cases the catchments are too rigid in regards to eligibility and access.[62]

These disparities in service offerings were also highlighted by Associate Professor Dean Stevenson, Clinical Services Director at Mercy Mental Health:

> Services are, I believe, funded differently, nobody's really aware of what other services are getting, so there's certainly a lack of transparency about what the department is providing to services in terms of funding to that particular area.[63]

Catchment boundaries have not substantially changed since they were introduced in the 1990s, and so they do not reflect demographic changes such as population growth and ageing. The Victorian Government acknowledges there is now misalignment between service levels and service types compared with the size and needs of the population in each catchment.[64]

Despite the department having received advice through several reviews[65] on the need to reconfigure the current approach to catchment areas for public specialist mental health services, they have remained unchanged.[66] In a personal story, a mother, Yolanda, shared her perspectives and experiences on how the current organisation of public specialist mental health services impacted on her daughter, Sonia.

Personal story:

Yolanda

Yolanda's* daughter Sonia* has been diagnosed with borderline personality disorder, depression, anxiety and anorexia, and had self-harmed since she was 13 years old. Sonia was receiving services from the child and youth mental health service in her catchment area. Yolanda reflects that this was a supportive service for Sonia's recovery.

> [Sonia] developed a strong therapeutic relationship with her therapist, and treatment ranged from mostly fortnightly to sometimes twice-weekly appointments when she was suicidal.

The service was walking distance from their home, which meant that Sonia could easily attend appointments—this was helpful when she needed more regular support.

When Sonia turned 18, she was told she was no longer eligible for services in the child and youth mental health service catchment that she lived in and instead had to move to the adult mental health service.

> [Sonia] now [falls] into a [different] hospital catchment area and the adult mental health services are located … a 20 km drive away.

Yolanda still does not understand why Sonia could not stay with the child and youth mental health service that provides treatment for young people up to the age of 25. The rigid catchment areas made it more difficult for Sonia to get to appointments and also meant that she needed to establish relationships with new clinicians.

> People with [borderline personality disorder] have significant trouble forming relationships at the best of times, and to force them to have to start therapy with a new therapist just because they turn 18 is detrimental to their mental health and set[s] them back in their treatment.

Yolanda reflects on her daughter's experience and would like to see changes to the way catchments are coordinated to ensure consistency for consumers, families, carers and supporters across an individual's life.

> What I would like to see is a review of hospital catchment areas for mental health services so that it is the same for children and adults, and some logic used in deciding where the boundaries are—if you are in walking distance to a service you should be in that catchment area, not made to drive 20 km to access services in another catchment area.

Source: Anonymous 478, *Submission to the RCVMHS SUB.0002.0024.0064*, 2019.

Note: * Names have been changed to protect privacy.

In the *Access to Mental Health Services* report, the Victorian Auditor-General found that catchments also cause 'practical problems that hinder service access'[67] such as:

- difficulty coordinating services because the catchment areas are not aligned with other health and human service areas or local government area boundaries
- misalignment of age-based service groupings (child and youth, adults and aged persons) meaning that people may have to transition to different health services, where they are unknown, as they become older
- a lack of coordination when consumers need access to services across catchment borders.[68]

Rigid boundaries mean that when a person moves outside a catchment, they need to find new services. Melbourne City Mission explained that this is particularly problematic for young people who are experiencing homelessness:

> Young people who are experiencing homelessness are regularly required to move across metropolitan Melbourne for temporary accommodation—forcing them to move between the area-based zones of clinical mental health services. The responsibility falls on homelessness services to coordinate area mental health supports for young people across different catchment areas.[69]

The misalignment of catchment boundaries for different age groups can be disruptive for young people as they move into adulthood.[70] In the metropolitan area, catchment boundaries for child and youth, adult and aged persons mental health services do not align. Some young people access or transition into adult public specialist mental health services at a relatively young age.[71] Depending on the young person's place of residence, this can occur as early as 16 years old.[72]

This experience can be disruptive, as explained by Ms Nicole Juniper, a witness before the Commission, who started going to an adult clinic at age 21:

> Not what I—I guess, not what I was expecting, but at the same time I'd heard other people's experiences, and I—I'll admit, I wasn't the most hopeful going to an adult service. You know, family and friends of mine have tried to get support and sometimes you just—you just hit a wall and nothing happens. I was very lucky to get into the service that I did. Again, I've always felt like, you know, my problems are—they're not severe enough to be—I'm not severe enough to be in hospital, but quite often I am struggling. It's—I need support. I can function, I can work, I can volunteer, I can study, but I still need support. And going to this adult service, I felt like they weren't really prepared for somebody that can function like I do, and they weren't able to give me what I needed. [73]

The boundaries of these catchments are not aligned with other Victorian health and human service areas, local government area boundaries or Primary Health Network boundaries. This causes access and navigation problems for people living with mental illness or experiencing psychological distress, families, carers and supporters. It also makes it difficult for governments and service providers to plan integrated services for communities across the state that support people at all stages of their lives.

5.2.2 Disjointed services within the mental health system

As described earlier, the onus is often on the individual to navigate and connect with different parts of the mental health system. As it is currently structured, the mental health system is complex, with little continuity between providers, settings and types of treatment, care and support.[74]

The Commission was told about how the insufficient integration of services had negatively affected people's lives:

> We found the 'siloed' nature of the mental health system to be unhelpful. It was like a full-time job trying to link up the school, after school care, and the psychologist.[75]
>
> In the reality of people's lives fragmentation translates to a significant time constraint as well as lost opportunities for better outcomes. … And these services can't deliver on their potential because they are fragmented rather than set up in a coordinated way that optimises the outcome for the person accessing them. In my experience, fragmentation exhausts people. It's like running on a treadmill using all your energy just to keep going.[76]

In its submission the Victorian Government recognised the complications that arise for individuals because of this fragmentation between different parts of the mental health system:

> Victoria's mental health system includes services funded by the Commonwealth and delivered largely in private settings, as well as an array of Victorian Government services. Fragmentation between these primary and specialist systems also inhibits local connection and creates a complicated pathway for people who need help, with the onus on the individual to navigate themselves towards the service that meets their needs.[77]

Connections to statewide services is another area that the Commission was called on to consider.[78] Several statewide services provide highly specialised treatment, care and support to a small proportion of people who access mental health services.[79] In Victoria, statewide mental health services, include, for example, parent and infant units, eating disorders services, dual-diagnosis services (for people living with both mental illness and substance use) and services for people living with a personality disorder.[80] Forensic mental health services that provide treatment, care and support to people living with mental illness who have come into contact with the criminal justice system are another example of statewide services.[81]

People accessing statewide services are also likely to seek treatment, care and support from other parts of the mental health system. This can include primary care services (such as GPs), wellbeing or psychosocial supports, which provide assistance for people to live well in the community, and public specialist mental health services.

There are, however, limited connections and unclear pathways for people to access statewide services. In its submission, Eating Disorders Victoria stated:

> There are few community based supports to assist people [to] transition between systems (i.e. primary care to inpatient and specialist) or to provide psychosocial support to maintain or reintegrate with work, education, family and community.[82]

Eating Disorders Victoria called for a 'seamless and integrated pathway from primary health care into the specialist system'[83] to respond to this problem.

Underinvestment in the mental health system extends to statewide services, with limited service capacity resulting in people experiencing long wait times and service gaps.[84] At a community consultation, a carer advised of the long wait to access statewide services:

> but when I started looking I found there was no services for people under 18 years of age with gender issues, especially this side of the city. I couldn't get her into any counselling services to help her talk about her sexuality … or her eating disorder. There is one service but there was a three-month waiting list and it was on the other side of the city.[85]

Service capacity constraints were also reported by Monash Health, which described the lack of specialist services for asylum seekers and refugees:

> There are however, considerable capacity constraints on [the two current specialist service providers] with very limited funded clinical time. This restricts direct service provision, does not permit a flexible out-reach model, and does not allow more extensive primary and secondary consultation services across the State.[86]

Inadequate planning to understand the need for statewide services has seen inequities in how these services are distributed and accessed.[87] Barwon Health highlighted these inconsistencies, advising:

> At the moment, consumers who reside in the Barwon region area can only access certain specialist services via defined referral pathways. Many of these specialist services are available locally in similar sized catchment regions.[88]

Barwon Health named a range of challenges people face when they cannot access statewide services locally. These challenges can include, for example, people expressing reluctance to access services outside their local community because it can separate them from local support networks.[89] The lack of local access can create inefficiencies and risks. It can lead to essential treatment, care and support being substituted or skipped entirely.[90]

Spectrum, the Personality Disorder Specialist Service for Victoria delivered by Eastern Health, explained how limited resourcing and poor structures to connect with specialised services can contribute to negative experiences and outcomes for people:

> The current care for people with [personality disorder] is chaotic, uncoordinated and may unintentionally contribute to mental illness. There is no clearly articulated care pathway or model of care for people with [personality disorder]. When care is provided, it is frequently in response to a crisis, leading to expensive and, in most cases, unnecessary hospitalisations, polypharmacy and [emergency department] care. People with [personality disorder] are, at best, *managed* rather than *treated* with evidence-based psychological interventions that have proven to result in remission and recovery for most people.[91]

Poor planning, underinvestment and the lack of connections between statewide services and other parts of the mental health system mean that people do not have dependable access to treatment, care and support from these highly specialised services.

5.2.3 Poor connections with other service systems

Some people will seek services from a range of organisations and sectors so they can attend to all aspects of their mental health and wellbeing. Victoria's mental health services, however, are not well connected with each other, with other health services, or with other vital support systems.[92]

People who require ongoing intensive treatment, care and support experience considerable challenges in accessing and coordinating services from multiple providers. At times, there can be limited coordination between elements of the same clinical service.[93]

The Mental Health Tribunal described at least two hurdles when responding to people with higher levels of need:

> First, the service that has responsibility for a … consumer usually has to grapple with a lack of clear processes for bringing together the various agencies that need to be involved in developing and implementing a comprehensive support plan. Secondly, even when they can be brought together, impasses between agencies can result and presently no entity has clear authority to resolve these matters, if necessary, by directing what is going to happen. The result is that individuals can languish.[94]

One model that attempts to assist people with diverse support needs across agencies is the Multiple and Complex Needs Initiative.[95] This model uses area-based panels to help provide more collaborative and coordinated treatment, care and support. It involves agencies working together in a person's local community to provide services that meet their diverse needs and preferences,[96] although Multiple and Complex Needs Initiative services are only available to a limited number of people at any one time.

In some instances, artificial boundaries between the mental health system and other service systems can mean that people who have multiple needs experience service gaps. For example, differences between disability and mental health services, stemming from historically different service delivery approaches, can be a major barrier to access.[97]

As noted in a 2013 review of Victorian disability services:

> **Currently, mental health and [intellectual disability] services tend to have competing paradigms which manifest in philosophical, operational and systems differences … Not only does this create confusion over issues of clinical and financial responsibility, but ultimately impacts on the quality and accessibility of each of these services.**[98]

The 2019 Victorian Auditor-General's Office report, *Child and Youth Mental Health*, highlighted difficulties in access to mental health services for children and young people living with neurodevelopmental disabilities in the residential care system.[99] The report noted that it is difficult or impossible to obtain clinical services through regular child and adolescent mental health services, with private practitioners stating '[t]hese young people represent a 'blind spot' or service gap, with high morbidity and cost.'[100]

At times, resource limitations can mean that service providers take limited responsibility for coordinating services, or indeed take no responsibility at all, in responding to the needs and preferences of people living with acquired or neurodevelopmental disabilities and mental illness, which can result in people staying longer in mental health services.[101]

This matter was also highlighted in the Victorian Auditor-General's report, which described how '[y]oung people are routinely getting 'stuck' in [child and youth mental health services] inpatient beds when they should be discharged'[102] because they are unable to access family or carer supports or other services including disability accommodation and out-of-home care services.[103]

Systemic issues mean that mental health and disability services are not able to effectively support people living with dual disability. Of note, people living with acquired brain injury are over-represented in the prison system, with some estimates suggesting 42 per cent of male prisoners and 33 per cent of female prisoners in Victoria show evidence of an acquired brain injury.[104] Forensicare identified that current arrangements do not include a 'consistent process to identify, assess or support this group of vulnerable prisoners', and there is 'a lack of available services both within prison and in the community'.[105]

Despite reviews suggesting that treatment should be integrated and holistic,[106] Dr Vinay Lakra, Clinical Director of North West Area Mental Health Service at Melbourne Health, told the Commission the separation of mental health services and alcohol and other drug services can be particularly challenging for people who seek support from both types of services.[107]

A carer who attended one of the Commission's community consultations described how a lack of integration in the delivery of these services was problematic:

> **There is no integration for people with mental health issues and [alcohol and other drug] issues. There's no facilities, there's no referral points and the constant refrain I got from her mental health team was that until she recognises she has a problem with alcohol, there is nothing we can do. If something had been done years ago, maybe we won't be here at this stage.**[108]

Turning Point, a national addiction treatment centre, highlighted similar concerns, noting that people seeking both alcohol and other drug and mental health services can be disadvantaged when seeking help.[109] It reported people being turned away from mental health services or being told to 'address their alcohol and other drug use before any mental health treatment can be offered, even when other services do not have the skills or capacity to offer suitable treatment'.[110]

The Commission was also told that older adults in residential aged care facilities face barriers to accessing mental health services. In a joint submission, Mental Health Victoria and the Council on the Ageing Victoria described that people in aged care facilities have little access to mental health services, other than through GPs, saying '[b]oth levels of government need to work harder and work together to ensure that older adults do not fall through the gaps.'[111]

Connections between the mental health system and housing supports are also lacking. The 'multi-directional link' between mental health and housing and homelessness means housing affects mental health, and mental health also affects a person's housing arrangements,[112] but pressures on both systems result in negative experiences for people. This can mean consumers have a prolonged stay in an inpatient unit or are discharged into inadequate living arrangements, or into homelessness, which can compromise recovery.[113]

The negative impacts of the disconnection within the mental health system and with other service systems, including service gaps and poorly coordinated services, are felt deeply by people living with mental illness or experiencing psychological distress, and by families, carers and supporters.

5.3 A system at odds with a true stepped care model

Every day, a range of providers offer mental health services to people living with mental illness or experiencing psychological distress. These services may be provided by GPs, psychologists, non-government organisations, psychiatrists, specialist mental health services, or emergency first responders such as Ambulance Victoria.

Beyond those directly involved in providing mental health services, many other providers offer various supports to people living with mental illness or experiencing psychological distress. These include a range of health, social and community services such as general health, advocacy, employment and housing services. People do not only seek help from service providers, however. Personal resources—for example, support from families, friends and communities, as well as self-care—also play a crucial role.[114]

Responsibility for funding and oversight of mental health services and their respective providers is primarily shared between the Commonwealth and Victorian governments. Traditionally, the Victorian Government has described its role as the 'steward and system manager of the public mental health system', a role that includes providing clinical treatment and non-clinical support services in hospital, residential and community-based settings.[115]

The Commonwealth Government considers its main role is to fund mental healthcare services primarily through the Medicare Benefits Schedule, the Pharmaceutical Benefits Scheme, the Repatriation Pharmaceutical Benefits Scheme and the National Health Reform Agreement.[116] These funding responsibilities see the Commonwealth Government leading, with Primary Health Networks, the commissioning of primary care services, and providing subsidised access to GPs and other health professionals, including psychiatrists, psychologists, some social workers and occupational therapists.[117] The Commonwealth also oversees the private health insurance sector.

On paper, mental health services are said to be organised around a framework of 'stepped care'.[118] The *Fifth National Mental Health and Suicide Prevention Plan*, agreed by the Commonwealth and all state and territory governments, adopts a stepped care approach (refer to Figure 5.2).[119] This approach defines 'the various levels of need, based on best available epidemiological evidence, along with the services required at each level', taking into account 'linkages between clinical and non-health supports'.[120]

Stepped care relates resource use to individual need, beginning with a focus on self-care and individual wellbeing, with resourcing changing as the level of need increases.[121] As described in the *Fifth National Mental Health Plan*, '[w]ithin a stepped care approach, a person is supported to transition up to higher-intensity services or transition down to lower-intensity services as their needs change.'[122]

Figure 5.2: A stepped care model for mental health, where services are matched to individual need, as outlined by the *Fifth National Mental Health and Suicide Prevention Plan*, 2017

Source: Department of Health (Commonwealth), *Fifth National Mental Health and Suicide Prevention Plan*. Canberra: Commonwealth of Australia, 2017.

According to Mr Bill Buckingham, Director of Buckingham Consulting, providing evidence in a personal capacity, successful implementation of a stepped care model depends on:

> an organised system that allocates people to the right level of care; informed referrers (mainly GPs) who understand how to use self-management and low intensity options, and who trust that those options can meet an individual patient's needs; an effective system of self-management and low intensity assistance options; and community acceptance and trust.[123]

While Victoria's mental health system may have some features of a stepped care model, there are large gaps between different types of services—meaning that consumers frequently experience poorly coordinated and discontinuous care.[124] Many of the successful features of this model are not yet evident, and Victoria's mental health system has not yet achieved a real model of stepped care.[125]

There are a number of deficiencies and barriers that put Victoria's mental health system at odds with a true stepped care model. First, the system's heavy focus on inpatient and crisis responses means opportunities to intervene early are missed.[126] Second, 'unclear referral pathways and inadequate coordination can result in [people] being bounced around the system—or missing out on the care they need altogether'.[127]

The lack of coordination, different funding approaches, unaligned service leadership and poor delineation of responsibilities between primary care services and specialist mental health services have also been identified as barriers to achieving a stepped care model.[128]

Some contributors have advised that a stepped care model has limitations and advocate instead for a staged care approach that seeks to give priority to providing the right care the first time.[129]

Professor Patrick McGorry AO, Executive Director of Orygen and Professor of Youth Mental Health at the University of Melbourne, providing evidence in a personal capacity, advised that a deficiency of a stepped care model is that the approach is not proactive:

> Stepped care only offers the opportunity to progress to the next step in the ladder if a patient has failed, deteriorated or become more severe at the previous stage of their illness. The model is not proactive; it does not try to pre-empt progression of the disease or illness where staged care in cancer and other illnesses does.[130]

Professor Ian Hickie AM, Co-Director of Health and Policy at the Brain and Mind Centre at the University of Sydney, is also a critic of stepped care models. Giving evidence in a personal capacity, he stated:

> Under these models, all patients receive the same form of generic initial care. If that initial form of care is not successful, patients are progressed to the next level of care; the process then continues throughout multiple levels. The result of this approach is that people with the most severe mental health problems tend to wait the longest amount of time to receive the appropriate care.[131]

While descriptions in government strategies and frameworks may imply an organised and cohesive system, the experiences outlined in this chapter, throughout this report and in numerous inputs to the Commission show there are a number of deficiencies and missing steps in the continuum of care.

5.4 A new architecture to respond to need

Given the wide impacts that mental illness has on the Victorian community,[132] the future mental health and wellbeing system must be equitable and responsive to the broad needs and preferences of Victorians. International evidence suggests there is also a need to strike a balance between care in the community and bed-based services.[133]

Achieving this balance will require a fundamental shift in the role and structure of the mental health system. The types of treatment, care and support offered will need to evolve and be organised differently to provide each person with dependable access to mental health and wellbeing services and links to any other supports they may seek.

Importantly, the future mental health and wellbeing system must recognise that a person's experiences of mental health and wellbeing, and their recovery, is highly individual and often nonlinear.[134] Consequently, the types of treatment, care and support they seek will change.

In recognition of the dynamic nature of mental health and wellbeing, the Commission has purposefully chosen to focus on strengths and needs, rather than labels, which can be stigmatising and discriminatory.[135] The five streams shown in Figure 5.3 are based on evidence that the intensity of mental health and wellbeing services should be matched to people's strengths and needs.[136]

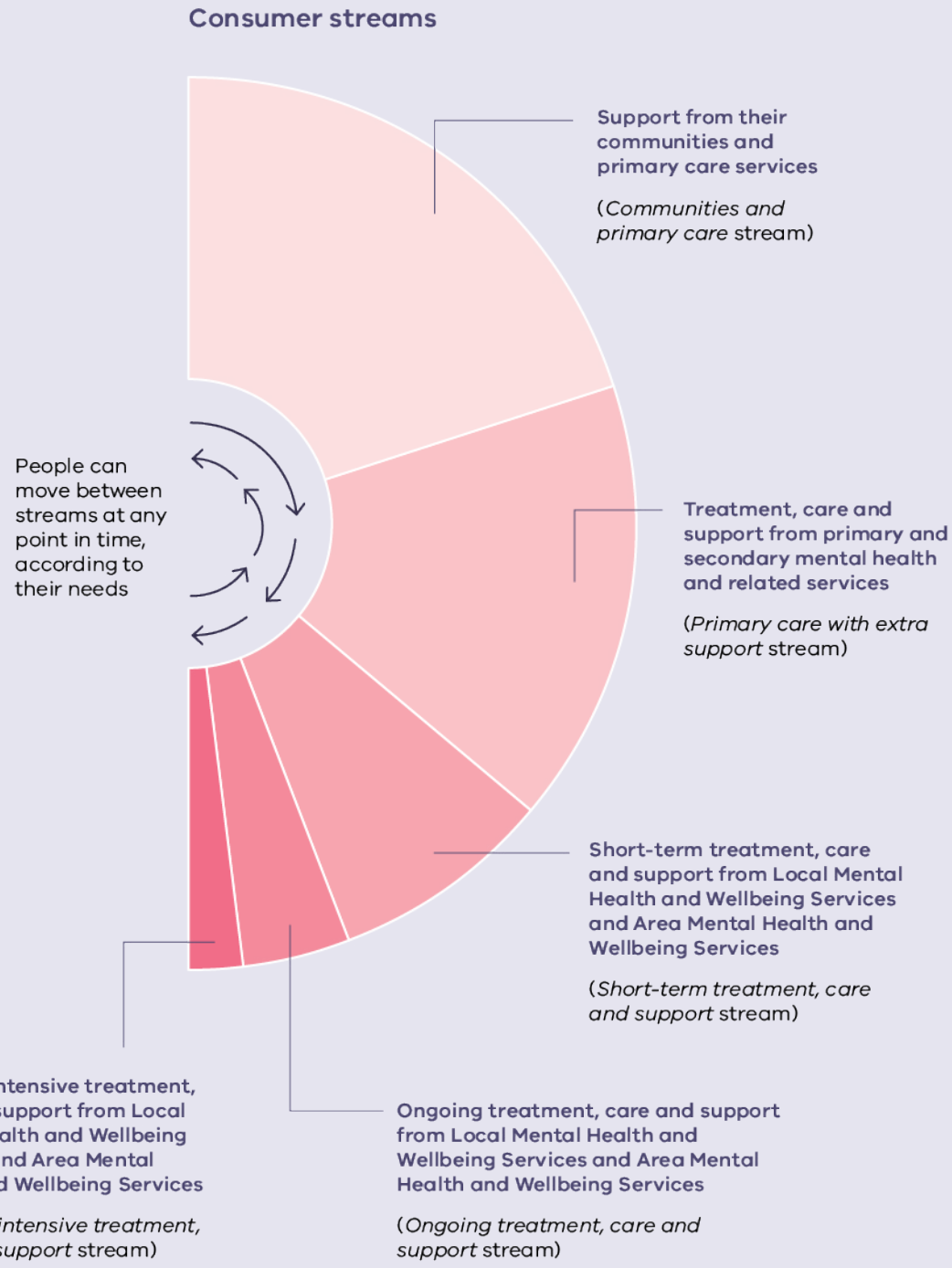
While services will always respond to people's immediate, high intensity needs, pathways between streams will support people back into services in lower intensity streams as their needs stabilise. Many people will continue to be supported by lower intensity services, such as their GP, even when accessing services from higher intensity streams.

These streams are further explored in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*, which describes how people at a given point in time may need:

- support from their communities and primary care services ('Communities and primary care' stream)
- treatment, care and support from primary and secondary mental health and related services ('Primary care with extra support' stream)
- short-term treatment, care and support from Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services ('Short-term treatment, care and support' stream)
- ongoing treatment, care and support from Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services ('Ongoing treatment, care and support' stream)
- ongoing intensive treatment, care and support from Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services ('Ongoing intensive treatment, care and support' stream).

Figure 5.3: Five consumer streams

At any given point in time, a person living with mental illness or experiencing psychological distress will need:



5.4.1 Concepts of 'stepped' and 'staged'

The new system will ensure a person's strengths are recognised and that each person is able to receive services that are proportionate to their needs at any point in time.

As described earlier, a model of stepped care is the major framework for mental health systems in Australia today. However, a stepped care model has been criticised for only progressing services when a person deteriorates.

A limitation of how the stepped care model is currently implemented relates to its reported inability to respond appropriately to individual need. The initial step offers everyone the same care, and those who do not recover following the care they get are then progressed to the next step, and so on. Witnesses have stated this may relate to a lack of understanding of how to use the model, or insufficient guidance on how to assess the level of care needed.[137]

An alternative to stepped care is staged care, or 'staging'. Staging models attempt to understand what 'stage' of illness people are experiencing at a particular point in time and how this may progress in subsequent 'stages'. This approach emphasises the need for more preventive services delivered in earlier stages of illness. Professor David Coghill, Financial Markets Foundation Chair of Developmental Mental Health at the Royal Children's Hospital, told the Commission that staged care 'is different to stepped care where one wants to see whether a less intensive intervention fails before moving to the next level'.[138]

The staging model was first developed for cancer care.[139] The experience of a person with cancer is typically staged: with a medical referral, the person is assessed by a multidisciplinary team, and a care plan is developed based on the likely progression of the illness and the person's preferences. Treatment is provided at a local centre or more specialised service, based on the person's needs and treatment requirements.

Staging models can support intervention at earlier stages, if this is likely to result in positive outcomes.[140] Staging models are appropriate for diseases such as cancer, which have clear markers for each 'stage' of illness. However, additional research is required to test and refine staging models for mental health and wellbeing.[141]

The Commission has drawn on the merits of both stepped care and staged care models. The Commission's reforms reflect:

- a stepped care approach to system design through five streams of treatment, care and support that respond to an increasing intensity of need
- staged care for service delivery that emphasises prevention, early intervention and support for people to recover and stay well.

In the future system, a person will be able to access a mix of services that respond to their needs and preferences. People will not be turned away on the grounds that they are not sick enough. By focusing on responding to needs, the Commission has sought to ensure the system no longer leaves people to get more unwell before they can get the treatment, care and support they seek.

It will be easier to get help earlier through welcoming and inclusive Local Mental Health and Wellbeing Services. In the new system, everyone will be able to have an initial support discussion, often over the phone or online. This discussion will seek to ensure a person is matched with treatment, care and support that responds to their needs and preferences. In most cases, the outcome of the discussion will be low-intensity treatment, care and support in a Local Mental Health and Wellbeing Service, which are described in section 5.5.

Where a person has higher levels of need, a medical practitioner or Local Mental Health and Wellbeing Service will be able to refer them directly to an Area Mental Health and Wellbeing Service, or they may be offered a comprehensive needs assessment and planning discussion. In this discussion, a multidisciplinary team, together with the person, will agree on the treatment, care and support that person will receive over an agreed timeframe. The types of treatment, care and support will be drawn from across the core functions outlined in section 5.5.2 and Figure 5.5, and matched to the person's intensity of need.

Assessment processes are the gateway to the tertiary services delivered by Area Mental Health and Wellbeing Services, and are described in detail in Chapter 8*: Finding and accessing treatment, care and support*.

Assessment processes will combine with a revised approach to care planning and coordination to ensure efficiencies as people enter, re-enter and move between services. Consumer-centred care planning and coordination is the 'glue' that organises and connects the treatment, care and support described in the core functions.

As Professor Suresh Sundram, Head of Department of Psychiatry, School of Clinical Sciences at Monash University and Director of Research at Monash Health Mental Health Program, providing evidence in a personal capacity, described these functions of care planning and coordination ensure 'that when people require support and services, they know how and where to access those services'.[142] Care planning and coordination will ensure consumers' needs and preferences at any given time determine the intensity of the supports they receive.[143]

The Commission intends that this combined approach to assessment and coordination will help to ensure people receive services that are proportionate to their needs. In the new system, Local Mental Health and Wellbeing Services will respond to a large amount of the current demand that is placed on area mental health services. Looking ahead, new Area Mental Health and Wellbeing Services will have resources freed up. Coupled with greater investment in service delivery, this will mean that Area Mental Health and Wellbeing Services will be able to offer more responsive and intensive services to people with higher levels of need, with greater flexibility to support people as their needs and strengths change.

5.4.2 Breaking down rigid boundaries for service delivery

Consumers, families, carers and supporters have consistently expressed their frustration with the rigidity of current catchments, which limit access and choice, and create inequities. For example, Ms Lynda Watts, a witness before the Commission, shared how catchments made it difficult for her son to get care:

> Attempts to get [my son] follow-up care at the appropriate [area mental health service] resulted in a volley of 'it's not our catchment, it's yours,' resulting in *no* follow-up treatment for weeks on end, two more [emergency department] presentations (with 3am discharges), and no information sharing between [the emergency department, two area mental health services], and the [National Disability Insurance Scheme] accommodation service.[144]

Leaders of mental health services have also called for greater flexibility in area-based boundaries to support consumer choice and preference.[145] Professor Sundram submitted that:

> geographical catchments are antithetical to family and consumer choice. In my view, the choice of hospital that a person presents to should be consumer or family driven, such that patients can be admitted to whichever hospital they wish to go to.[146]

Current catchments for delivering mental health services do not accord with typical arrangements for other health services. Dr Margaret Grigg, CEO of Forensicare, highlighted that:

> While catchments are useful, there needs to be more options for individuals to choose the service they want to receive care from so as to provide consumer choice that is equivalent to that available in acute physical health care—that is, individuals should be able to decide which mental health service they want treatment from, and they are not forced to receive care from a service because of their home address. This could also provide an opportunity for greater subspecialisation, with mental health services developing specific services in response to consumer demand.[147]

St Vincent's Hospital Melbourne stated that rigid catchments cause challenges for both providers and consumers, explaining that it 'can lead to capacity issues for the providers, but also result in the consumer being treated some distance from their network of family and friends'.[148]

The Victorian Government also acknowledged that rigid boundaries can create inequities in service access.[149] In its 2013 consultation paper, the then Department of Health and Human Services stated, '[i]n some cases, strict application of eligibility has created access difficulties and contributed to discontinuities in care.'[150] Recent analysis of Victorian mental health data shows that some flexibility already exists in the system, with approximately 25 per cent of all acute mental health adult bed-based admissions being out of the person's area of residence.[151]

Achieving accountability was an argument put forward for retaining catchments for service delivery. It was suggested that designating a provider to be accountable for a local population establishes clarity and certainty that consumers will receive services.[152] Dr Grigg acknowledged that '[t]he catchment approach provides a strong basis for population planning and creates a safety net for vulnerable consumers to ensure that there is clarity on which service is responsible for providing care.'[153]

The department also pointed to accountability. Ms Kym Peake, then Secretary of the former Department of Health and Human Services, noted that '[catchment] arrangements also enable clear clinical accountability for all patients, especially involuntary patients'.[154]

Arguably, given the extent of unmet need, it is difficult to conclude that catchments are achieving the accountability stated.

Increased investment and new funding approaches that account for people's needs can be used to ensure service providers offer treatment, care and support to people with higher levels of need, without the adverse impacts of catchments.[155]

Associate Professor Ruth Vine, Director of Forensicare, advised:

> **Services should be rewarded for providing consistent care, and the level of complexity of consumers' needs should be reflected in additional funding to the services—this would be an incentive for the service to provide treatment regardless of a person's place of abode.**[156]

Given that strategies such as the one advised by Associate Professor Vine, which links funding to need and actual service delivery, can be used to create accountability, fixed boundaries for the purposes of service delivery are no longer required. The Department of Health must abolish the existing catchment structures for accessing public specialist mental health services. While boundaries may remain for planning and guidance and as a frame for referral, service providers will never turn people away on the basis of where they live.

5.4.3 Developmentally tailored services

Given the mix of age eligibility arrangements in Victoria's public specialist mental health services, the Commission has proposed a number of reforms that will mean that age and developmentally appropriate treatment, care and support is provided. The following age-based systems are recommended:

- ages 0–25: a single infant, child and youth mental health and wellbeing system with common governance, including clinical governance and commissioning, with two separate service streams:
  - ages 0–11: infant, child and family mental health and wellbeing service stream
  - ages 12–25: youth mental health and wellbeing service stream

- ages 26 and older: adult and older adult mental health and wellbeing system with a dedicated service stream for:

  – Older Victorians: comprising older adult mental health and wellbeing specialists within a dedicated older adult mental health and wellbeing service stream, which will be delivered through Adult and Older Adult Area Mental Health and Wellbeing Services for people with complex and compounding mental health needs generally related to ageing.

As noted earlier in the chapter, across child and youth mental health services, and child and adolescent mental health services, some current services respond to young people up to the age of 25, while for other services, the age limit is 18. This discrepancy is due to a change in Victorian Government policy, where the then Department of Health and Human Services began increasing service eligibility to 25 but stopped the rollout midway through when the government changed.[157]

Conflicting age boundaries across the state contribute to disruption in treatment, care and support when children and young people are referred between services and catchments. In these circumstances, children and young people, and their families, are then faced with retelling their experiences, different service models and provider practices that do not always meet the needs of young people.[158]

There are also risks for young people who transfer to adult mental health services at the age of 18, given this can be a vulnerable time as they transition to adulthood. According to the National Institute for Health Research in the United Kingdom, a 'transition' is more than simply moving from one service to the next; a young person requires tailored support to move towards a new stage of life.[159]

Orygen described the transitional 18-year age point as 'one of the significant challenges in delivering youth-appropriate and evidence-based care for young people with more severe conditions'.[160] The structural divide between the youth and adult systems also falls within an age range where the incidence of new mental illnesses can peak, meaning that 'the system is at its weakest where it should be strongest'.[161]

The different service models and eligibility criteria in the adult system compound the risk of disrupted treatment, care and support.[162] Some young people receiving treatment for a specific illness may not meet the criteria or have access to the same treatment in the adult mental health system.[163]

The current service demarcation at the age of 18 years was characterised by Professor McGorry as a 'fatal design flaw', where young people are an 'afterthought'.[164] The Commission supports this notion and recommends that the future youth mental health and wellbeing service stream (current child and youth mental health services, and child and adolescent mental health services) are supported and resourced by the Victorian Government to consistently lift their age eligibility so they can respond to young people up until a person's 26th birthday.

The Commission considered whether to establish two separate systems: an infant and child mental health and wellbeing system, and a youth mental health and wellbeing system. The majority of participants at the Commission's Youth Mental Health Roundtable advised against this separation, on the basis that it would:

- create an age-related transition barrier at a vital developmental period and crucial transition stage from primary school into high school
- restrict the flow of resources to respond to changes in demand, especially in smaller services
- require both systems to establish new relationships, pathways and connections to other services, with relationships in adjacent sectors essentially being doubled
- be problematic for professional training requirements; for example, child and adolescent psychiatrists would be unable to practice across the broader age range
- very likely make the cost of treatment, care and support in both systems more expensive.[165]

Conversely, it was also put to the Commission that separation from youth services could raise the profile and prioritisation of services for infants and children. At the same roundtable, one participant remarked that this separation could have the benefit of preventing resources from being pulled out of child and infant services into youth services, and would allow for more targeted services for each cohort to be fostered.[166]

Dr Neil Coventry, Victoria's Chief Psychiatrist, observed that age-based streaming led to fewer services being made available to preschool and primary school–aged children. Dr Coventry also suggested that the focus of service providers was drawn to cohorts with the highest levels of need, particularly adolescents.[167]

It is difficult, however, to establish to what extent the described 'pull' of resources towards children and young people in the 12–25-year-old age group reflects the system's constraints and under resourcing, and whether the reported imbalance could be fixed with additional resourcing.

Experiences of services that have lifted their age eligibility to 25 years suggest this may be the case. Ms Lynne Allison, Associate Program Director of Eastern Health, Child, Youth Mental Health Service, explained that initial challenges of expanding Eastern Health's service to cater for 0–25-year-olds largely related to underfunding.[168] Ms Allison explained how the lack of priority given to infants and children was reflected in funding arrangements:

> Initial evaluation indicated an under-representation of infants and children under 12 years of age, as compared to what might be expected for a specialist mental health service based on epidemiology and population data. This followed demand for [child and youth mental health services] increasing by upwards of 30% without sufficient increase in resourcing. This has since been addressed through targeted and 'reserved' appointments for children under 12 years, and through the establishment of the [Specialist Child Team] and Infancy Access Project, following [Department of Health and Human Services] Specialist Child Initiative funding.[169]

On balance, the Commission considers the main goal of age-based streaming—to provide developmentally appropriate services that respond to the needs of infants, children and young people—can be achieved within a single system, with consistent governance of infant, child and youth mental health and wellbeing services across 0–25-year-olds, rather than establishing two separate systems.

Accountability mechanisms, coupled with the Commission's proposals to reform and increase funding and service capacity, will ensure services within the future infant, child and family mental health and wellbeing service stream are not left behind.

The infant, child and family mental health and wellbeing service stream will start at birth and continue through to infancy and childhood. It will conclude at 12 years, typically coinciding with the transition from primary school to secondary school.

As outlined in Chapter 12: *Supporting perinatal, infant, child and family mental health and wellbeing*, infants and young children require treatment, care and support that is suitable to their stage of development, and closely tied to their family or carer context.[170] Services for this age group will adopt a developmental and relational approach.[171] This means that treatment, care and support will be matched to the infant or child's developmental stage, and respond to individual, situational and family and carer factors that might be impacting on an infant or child's development, with the objective of supporting them and their families to thrive.[172]

For young people, the youth mental health and wellbeing service stream will begin at 12 years of age. Young people will generally transition to adult mental health and wellbeing services on their 26th birthday. Where a young person's developmental and biological age differ, clinicians and consumers will have flexibility to make decisions about the best age to transition to other services, and to allow treatment cycles to be completed.

As detailed in Chapter 13*: Supporting the mental health and wellbeing of young people*, there will be a strong focus on supporting young people's connection with mental health and wellbeing services, and on building services that respond to their needs in these formative years.[173]

Age eligibility must not be rigid. It has been impressed on the Commission that the design of the future infant, child and youth mental health and wellbeing system must have flexibility to recognise and respond to the different ways and different paces at which children and young people grow and develop.

Ms Callaghan cautioned:

> **Regardless of the criteria used, any grouping needs to not be overly concrete. It must be flexible in response to how people present. If age streamed, there needs to be flexibility at the ends of the age ranges to allow for exceptions in some scenarios where an argument can be made to begin care in this system earlier for pre-12 years or extend it later for post-25 years.[174]**

Similarly, Associate Professor Alessandra Radovini, Director of Mindful at the University of Melbourne and Consultant Psychiatrist at Orygen, advised that services need to be able to consider the child's or young person's development needs, not just their chronological age. Associate Professor Radovini, providing evidence in a personal capacity, favoured a more nuanced approach, rather than strict, age-based streaming.[175]

Professor Louise Newman AM, Professor of Psychiatry at the University of Melbourne and Practising Perinatal and Infant Clinician, stated that the rigid age-based streaming of services does not necessarily benefit infants, children and young people.[176] Professor Newman warned that '[s]uch an approach is unnecessary and risks neglecting some of the complexities around developmental periods and issues.'[177] The Commission concluded that flexible age boundaries will be critical to achieving its ambition of a responsive service system.

The Commission has also turned its attention to the impact of strict age-based streaming on older Victorians. Currently, older Victorians are not provided with the same range of mental health services that other adults are. Older Victorians are often required to attend a specific aged persons mental health service even when this does not align with their preference or needs.[178]

The current application of age-based criteria can create problems for adults and older adults for whom ageing-related mental health impacts can vary markedly across chronological age.[179] Wintringham, an aged care service that supports older Victorians with long-term experiences of homelessness, mental health difficulties and addictions, submitted that:

> in one Western municipality, mental health services for people under the age of 65 have refused to provide assistance to a long term mental health patient as he is living in a nursing home. At the same time, the aged care mental health team have refused service due to his age. The fellow is 62 [years] old. Is this type of red tape really necessary? What has resulted is a person in desperate need unable to access services, yet, in another Southern based suburb, mental health services are freely available, from the appropriate service, for those under 65 years living in a residential aged care service.[180]

In the new system, older Victorians (including people aged 65 years or older) will be able to access and receive mental health and wellbeing services in the same way as adults. In addition, people with complex and compounding mental health needs generally related to ageing—irrespective of their chronological age—will have access to services delivered by older adult mental health and wellbeing specialists, a service stream within an Adult and Older Adult Area Mental Health and Wellbeing Service. Crucially, people will not be 'kicked out' of services on their 65th birthday; they will be supported to transition to new services on a case-by-case basis, depending on their needs, strengths and preferences.

The above changes to age-based services and the removal of rigid age-based eligibility criteria will mean mental health and wellbeing services are more flexible and deliver programs and services that respond to the strengths, needs and preferences of people at any stage of their life.

5.5 Local services in the community as the backbone of the system

In considering responses to mental health and wellbeing needs, the Commission has determined that the future mental health and wellbeing system will be founded on an approach that provides people with services in the community; recognises an individual's strengths; and provides holistic responses in line with their needs and preferences.

The Victorian Mental Illness Awareness Council's declaration emphasises the importance of choice and the need for more options about the kinds of actions or supports sought, the places and services consumers want to access that support, and how they access it.[181] Similarly, Ms Mary O'Hagan MNZM, Manager of Mental Wellbeing at Te Hiringa Hauora in New Zealand, giving evidence in a personal capacity, advocates for a shift towards a 'Big Community' system in which people have access to a broad menu of comprehensive community-based resources and services extending beyond the mental health system to sustain and restore their wellbeing.[182]

5.5.1 Community services as the prominent feature

In setting its direction for the future, the Commission has taken an expansive view of what makes up community mental health and wellbeing services.

This reflects international evidence that community mental health services:

> includes the community in a broadly defined sense. … it emphasizes not just the reduction or management of environmental adversity, but also the strengths of the families, social networks, communities and organizations that surround people who experience mental illnesses.[183]

The Commission proposes that community mental health and wellbeing services should encompass a broad range of local informal supports and providers including public health services, public hospitals, non-government organisations, community health services, private providers, new consumer-led providers and a range of primary and secondary services. People will access services by attending site-based services, through digital platforms and via home and community visits.

Figure 5.4 sets out the view of the system as a series of levels where the top level engages with each subsequent level aimed at a decreasing proportion of the population.

Figure 5.4: Six levels in a responsive and integrated system

At the broadest level are whole-of-population responses that promote good mental health and wellbeing for all individuals, families and communities.[184] Families, friends, carers, colleagues or acquaintances provide people with considerable support.[185] As one community consultation participant in Mildura told the Commission, '[s]ometimes people don't realise their best support is their family and friends.'[186] In contrast, the amount of time that people spend with the professionals who work in mental health and wellbeing services can be limited.

When people start to experience mental illness or psychological distress, the first people they often turn to are friends and families, neighbours and their communities. People's mental health is heavily influenced by a range of social determinants and therefore may involve a multitude of different supports, including informal community connections.[187]

The first level of the system comprises of social supports—*families, carers and supporters, informal supports, virtual communities and communities of place, identity and interest*—which provide social connections that are critical for good mental health and wellbeing.[188] The case study on the Big Feels Club shares the experiences of how peer-led resources can support people experiencing long-term psychological distress.

At the next level, there is the *broad range of government and community services* outside the mental health system that help people to remain well and flourish. These include services that meet universal needs like education or health, as well as those that meet specific needs like housing, legal assistance services or help dealing with family violence.[189] Universal and specialised service sectors play an important role in the primary prevention of some mental illness and psychological distress.[190] They are crucial for helping people to live well in the community.[191]

There is also growing recognition that mental health systems should work closely with a broad range of government and community services. As the Productivity Commission *Mental Health Inquiry Report* states:

> creating a person-centred mental health system requires coordinated reform beyond health. It requires the health system to work together with community and Indigenous services, social security, public housing, education, justice and employment relations.[192]

At the third level, *primary and secondary mental health and related services* are the widely distributed services that also offer mental health treatment, care and support. GPs play a central role at this level, providing mental health services, along with other primary care services like community health services.[193] These combine with psychologists and other allied health practitioners, paediatricians, maternal and child health nurses, and alcohol and other drug support providers.

The remaining three levels—*Local Mental Health and Wellbeing Services*, *Area Mental Health and Wellbeing Services* and *statewide services*—have been earmarked for reform by the Commission in various parts of this report. They comprise services that deliver a range of specialised mental health and wellbeing responses to a progressively smaller number of people (the most targeted at the statewide level). Responsibility for commissioning these services initially rests with the Victorian Government, noting that they may be funded from a range of different sources, including from the Commonwealth Government, and over time may be jointly commissioned by Victorian and Commonwealth governments.

At each level, from local through to area and statewide services, multidisciplinary teams will operate with increasing specialisation.

Local Mental Health and Wellbeing Services, delivered in a variety of settings, will be where people first access and receive most of their services. They will be supported by some tertiary-level responses.

Area Mental Health and Wellbeing Services, the fifth level, will provide tertiary-level, high-intensity and complex support responses, with multidisciplinary teams. Area Mental Health and Wellbeing Services will be responsible for delivering all of the core functions (refer to Figure 5.5) of community mental health and wellbeing services for those requiring a higher intensity of treatment, care and support than can be provided through local services alone.

Statewide services, the sixth level, have multiple roles. First, to respond to people with higher levels of need, their expertise will be shared with Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services so these service providers can deliver treatment, care and support to people close to home. Second, statewide services and Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services may work together to deliver treatment, care and support to a person, for example, through shared-care arrangements. Finally, statewide services may provide services to people directly. In some instances, statewide services may undertake more than one of these roles simultaneously.

While the system will be based in the community, it will be complemented by treatment, care and support through hospital and other residential services. This system design reflects domestic and international evidence in favour of a balanced system that spans community-based services and inpatient care.[194]

Case study:

The Big Feels Club

Co-founded by Graham Panther and Honor Eastly in 2017, the Big Feels Club creates spaces for people with 'big, scary feelings' to hear from others who share similar experiences.

The Big Feels Club provides peer-led resources, including articles, podcasts, peer discussion spaces and digital self-help tools, for people experiencing long-term psychological distress.

Mr Panther describes the Big Feels Club as primarily for people who have tried to get support from the mental health system but found it has not been as helpful as they expected.

> The Big Feels Club is for the people who are doing all the things that are supposed to help. The people who have been asking for help for years, who have tried all the things the system has to offer, often multiple times, but still don't really feel any better.

Both Mr Panther and Ms Eastly said they have had this experience and found it very isolating.

> All the mainstream mental health spaces, the main message seems to be 'go see your GP', and it's like, 'yeah well, thanks but I've tried that a few times actually, what now?' We started to wonder, wouldn't it be great if there was somewhere we could talk about this with people who get it?

The Big Feels Club started as a small meet up in Mr Panther and Ms Eastly's living room and now has more than 6,000 community members and more than one million downloads of its podcasts and articles. It was a finalist at the VicHealth Health Promotion Awards in 2019.

Mr Panther noted that despite the main offerings of the Big Feels Club being 'light touch' and often one-way, 'for many this is enough to feel part of something bigger, to feel their pain is no longer a private burden, but an opportunity to feel connected to others going through similar things'.

Mr Panther and Ms Eastly often speak to Big Feels Club members to understand how the platform is supporting them. In response, the members regularly speak about the importance of understanding they are not alone in how they feel:

> I have never felt so understood in all my life. I had given up hoping I might ever hear it spoken from another person.

> The Big Feels Club was a profound part of my own experience of clawing for life. And it continues to sustain me through current struggles.

Mr Panther said this gets to the core of what the Big Feels Club offers and the importance of peer support.

> It is one of the few spaces that people can go and not feel that anyone is trying to fix them. In my experience, this is a sacred thing. Our services are not like clinically led services which aim to reduce symptoms. The Big Feels Club is more about helping people find meaning in those tough experiences.

Mr Panther and Ms Eastly set up the Big Feels Club to be an example of ways to meet previously unmet community needs, outside of the traditional services available. They would like to see more opportunities for peer-led initiatives to grow and become sustainable through funding pathways and development opportunities so that peer-led solutions become a core part of Victoria's wider response to people in distress.

Source: Graham Panther, *Correspondence to the RCVMHS*, 2020; Graham Panther, *Radical Connections: the real future of digital mental health*, Keynote address at E-Mental Health Expert Forum, Auckland University of Technology, October 2018.

5.5.2 Addressing the need for diverse community-based services

Diverse community mental health and wellbeing services, such as those the Commission recommends, are clearly preferred by consumers:

> create alternatives to the current system. There should be places for people to go when they are having breakdowns. Mental healthcare should be taken out of hospitals so that these can be places of care and healing.[195]

> I want the Royal Commission to remake the system into healing and respite centres: mental health services should be taken out of the hospital and put onto natural grounds, where you can have natural healing and therapies.[196]

> focus on community based support for those who can manage in the community, rather than institutionalisation. Holistic care programs such as art therapy, group programs, involving nature and bush work in a mental health setting …[197]

Ms Indigo Daya, Consumer Academic in the Centre for Psychiatric Nursing at the University of Melbourne, giving evidence in a personal capacity, described the importance of community-based services to her personal recovery:

> A community support worker (an art therapist by occupation) supported me to find hope again, and to connect with a creative consumer/survivor community of fellow artists. This belief that my life could change, that my future could hold something positive, was a critical beginning, and aligns with the hope and connectedness elements of recovery-oriented practice.[198]

High-quality, community-based mental health and wellbeing services are pivotal to meeting demand and to lowering the high bar to access services. One submission from a member of the mental health workforce suggested:

> Greatly increase community based mental health services to allow them to support people and their families in becoming socially and economically involved with the community. Move the focus away from acute and inpatient based services towards community services, this will reduce the strain on [emergency departments] and offer more treatment options for people, rather than basing access on acuity.[199]

Another contributor asserted:

> Community based interventions are essential and need to focus on reconnection and integration. Interventions within society (not behind the closed walls of a psychiatric facility) will facilitate a cultural shift whereby people in distress are embraced and understood right there within the community in which they live.[200]

Community mental health and wellbeing services will not just expand in volume and reach. To support a consistent and responsive service offering, as well as dealing with current inequities and variability in the services that are available, mental health and wellbeing services will offer three core functions (refer to Figure 5.5).

Requiring the delivery of three core functions provides a number of advantages. First, articulating a consistent approach to community-based service provision will deal with inconsistencies across the state in how people can access help, what they can access, and the quality of the treatment, care and support provided. It responds to calls from people living with mental illness or experiencing psychological distress, families, carers and supporters, and service providers, for greater consistency in the types of services that are funded and available.[201]

Second, a consistent approach can help to minimise fragmentation and confusion when seeking to access services. Professor Hickie commented that increasing the number of programs operating across a system comes with financial and opportunity costs because each program requires its own administrative structure and leadership.[202] Professor Graham Meadows, Professor of Psychiatry at the Monash University School of Clinical Sciences at Monash Health, who gave evidence in a personal capacity, suggested that without consistency, a proliferation of service models can cause confusion and inefficiency.[203]

Adopting a set of core functions also supports associated funding and resourcing approaches. Lessons from international community-based mental health reforms highlight that there is a need to '[d]esign a system that directly relates required service components and financially reimbursable categories of care'.[204] The core functions aim to achieve exactly this.

The Commission has recognised, however, that some variation is necessary within any complex system to avoid stifling innovation.[205] As such, implementation of the core functions will be adapted to meet local community needs and preferences while retaining a consistent service offering across the state.

The delivery of these core functions will be consistent across age groups, with some tailoring—for example, to support the delivery of developmentally appropriate services to children and young people. Chapter 7: *Integrated treatment, care and support in the community for adults and older adults* outlines the core functions in further detail.

The Commission's recommendations focus on establishing a responsive and integrated mental health and wellbeing system comprising:

- Local Mental Health and Wellbeing Services: These will be delivered in a variety of settings where people first access services and receive most of their treatment, care and support. People will access these services either directly or via referral, and services will operate with extended hours. Services will deliver the Commission's recommended core functions. The delivery of Local Mental Health and Wellbeing Services may involve Area Mental Health and Wellbeing Services.
- Area Mental Health and Wellbeing Services: These are where all of the Commission's recommended core functions and more intensive services will be made available. Services will be delivered through a partnership between a public health service (or public hospital) and a non-government organisation that provides wellbeing (or psychosocial) supports. Area Mental Health and Wellbeing Services will operate with extended hours, and also respond to crisis calls from anyone in the community, 24 hours a day, seven days a week.
- Statewide services: These are where highly specialised services will be concentrated for high-quality and safe service provision.

Figure 5.5: Community mental health and wellbeing services: core functions

Wherever possible, all consumers, irrespective of their level of need, will be supported to receive services through Local Mental Health and Wellbeing Services close to their support networks. Because formal pathways between different types of services will be established, people will have planned and dependable access to services. These pathways will also support people to access more integrated services that respond to their individual needs and preferences.

Consumers will only access a service within a higher level when their level of need or the specialisation required is too great to use Local Mental Health and Wellbeing Services—for example, when they are experiencing a crisis. Services within that higher level will support the person to return to their Local Mental Health and Wellbeing Service for continuing services, as soon as is practical. Figure 5.6 explains the role of Local Mental Health and Wellbeing Services, Area Mental Health and Wellbeing Services and statewide services. As described in section 5.8, clear pathways will also be established between services so that people have planned and dependable access to more specialised services.

Figure 5.6: The role of Local Mental Health and Wellbeing Services, Area Mental Health and Wellbeing Services and statewide services

50 to 60 Adult and Older Adult Local Mental Health and Wellbeing Services

- Support adult and older adult populations of up to 100,000
- Where people first access and receive many of their services
- Delivered by a range of service providers
- Offer all core functions
- Consumer-led supported care planning and coordination for all (except consumers with the highest level of need at a point in time)
- Comprehensive, coordinated multidisciplinary teams working in a service
- Operate at extended hours (to recognise peak periods and also reduce pressure on Area Mental Health and Wellbeing Services)
- Platform for delivering Area Mental Health and Wellbeing Services and statewide services
- Pathways to higher levels of services
- Pathways to other social services
- Community bed-based care (such as respite services)

Dedicated Youth Local Mental Health and Wellbeing Services (for example, headspace)

Dedicated Infant, Child and Family Local Health and Wellbeing Services (intially three new hubs)

22 Adult and Older Adult Area Mental Health and Wellbeing Services and 13 Infant, Child and Youth Area Mental Health and Wellbeing Services

- Support adult and older adult populations of approx. 200,000 to 300,000 in Melbourne and approx. 100,000 to 200,000 in rural and regional communities
- Support infant, child and youth populations of approx. 200,000 to 300,000 in Melbourne and approx. 50,000 to 100,000 in rural and regional communities
- Partnership between a public health service or public hospital and a non-government organisation that delivers wellbeing supports
- Multidisciplinary response across all core functions
- Community-based care
- 24/7 crisis response
- Support assessment and planning discussions and care coordination
- Assertive Community Treatment teams
- Consultation liaison and inreach to Local Mental Health and Wellbeing Services
- Coordination of services for people with the highest level of need at a point in time
- Pathways to and platform for the delivery of statewide services
- Requires a referral from a medical practitioner or Local Mental Health and Wellbeing Service
- Hospital bed-based care, emergency departments and urgent care centres provided by public health services and hospitals

Statewide services

- Support a very small number of consumers
- Require a high degree of specialisation
- Whenever feasible and safe, delivery of statewide services in Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services
- Centrally coordinated by the Collaborative Centre for Mental Health and Wellbeing in partnership with other research organisations
- Require a referral from an Area Mental Health and Wellbeing Service

5.5.3 The role of Local Mental Health and Wellbeing Services

Access to local, community mental health and wellbeing services is the foundation of the Commission's reforms. In line with the latest available evidence, these reforms seek to ensure Victorians have access to a mental health and wellbeing system they can rely on, with most people able to access the majority of their treatment, care and support in their community, close to their local support networks.[206]

There are a range of definitions and interpretations of local services. The following examples illustrate the variety of forms that a local service can take:

- headspace centres: Each headspace centre strives to be 'deeply embedded within the local system and community'.[207] The populations served by each headspace centre differ. Some headspace centres in urban areas have youth populations of more than 100,000 within a 10 kilometre radius, whereas a number of regional headspace centres have total service populations of less than 5,000.[208]
- GP practices: These are local services where most people access mental health treatment, care and support. GPs are often the first point of contact for people experiencing mental health challenges.[209] Each GP practice supports around 4,200 people in urban areas and around 3,200 people in rural areas.
- Community health centres: These typically have a strong connection to the local area in which they are based.[210] The location of these services and the size of the communities they service differ. cohealth's community health centre at 365 Hoddle Street, Collingwood works with two nearby sites to support around 12,000 consumers, with a focus on the Collingwood public housing sites. '365' is one of 37 sites operated by cohealth across 10 local government areas.[211]
- The Walwa Bush Nursing Centre: This supports local rural communities in North East Victoria. In 2019 the centre supported around 1,300 people, and those providing the service travelled more than 18,000 kilometres annually to service their local community.[212]

The above examples illustrate that the concept of 'local', as it relates to the delivery of services, can mean different things for different communities, depending on how long and far people need to travel, how frequently they may access services, the level of urgency that may be involved, and the workforce skills or specialist capabilities that may be required.

Victorian Government-funded mental health services are typically configured towards population sizes of 200,000–300,000 adults and older adults in metropolitan Melbourne and 100,000–200,000 adults and older adults in rural and regional communities.[213]

Yet there are inconsistencies. Existing catchments for Victorian Government–funded public specialist mental health services vary substantially in terms of current and predicted population size and spread. Some selected catchments are currently very large in volume and densely populated, and rapid growth is forecast. For example, the adult Mid-West catchment services a population of 218,000 adults and older adults.[214] Conversely, other catchments are very small in volume and dispersed, and little growth is forecast. For example, the adult Northern Mallee catchment services a population of 42,000 adults and older adults, with little growth forecast.[215]

The Commission considers that the organisation of mental health services in this manner does not support the consistent provision of a responsive local community-based service offering across Victoria. In a highly constrained system, and in the absence of clear policy and funding direction from the Victorian Government, service providers have had little choice but to concentrate the delivery of services away from local community-based services, instead focusing on crisis responses and acute inpatient services.[216]

To move away from this approach, the Commission recommends that the Department of Health centres the delivery of treatment, care and support in Local Mental Health and Wellbeing Services. Each Adult and Older Adult Local Mental Health and Wellbeing Service must support a population of up to 100,000 adults and older adults, whether in metropolitan Melbourne or in a rural or regional community. In the first instance, 50–60 Adult and Older Adult Local Mental Health and Wellbeing Services will be established to deliver community-based mental health and wellbeing services with extended hours of operation.

Every Local Mental Health and Wellbeing Service will deliver the Commission's recommended core functions of community-based mental health and wellbeing services.

Local Mental Health and Wellbeing Services will also be used as a face-to-face or digital delivery platform for people to access more specialised services that may be delivered by Area Mental Health and Wellbeing Services or statewide services.

Demand modelling will inform the precise locations of Local Mental Health and Wellbeing Services. Over time, to respond to population growth and changes in need, sound planning must inform when and where Local Mental Health and Wellbeing Services are expanded. In some rural areas, where distance can be a challenge, the department should pursue additional ways to support Local Mental Health and Wellbeing Services to ensure equitable access to treatment, care and support, including through digital and online technologies.

The Commission has developed service standards to assist in the selection of providers, including non-government organisations and new providers such as consumer-led providers, to deliver mental health and wellbeing services. To help create a diverse service offering, providers of Local Mental Health and Wellbeing Services should be selected in accordance with these standards, which are outlined in Chapter 28: *Commissioning for responsive services*.

Together, these changes represent a profound shift in the organisation of mental health and wellbeing services. The focal point of service delivery will move to early responses in local communities through diverse and responsive types of treatment, care and support, away from the current crisis-driven system.

5.6 Establishing Area Mental Health and Wellbeing Services for infants, children and young people, and adults and older adults

In determining the scope and size for the operation of Area Mental Health and Wellbeing Services, the Commission was encouraged to aim for sufficient 'critical mass' to support a full range of services, without areas being so large that they become spread over long distances and removed from local communities.

Associate Professor Steven Moylan, Clinical Director for Mental Health, Drug and Alcohol Services at Barwon Health, suggested:

> Constraining the geographic size of a catchment is … important for maintaining strong partnerships with community organisations and primary care providers—as catchments increase [in size] the nature of these partnerships can be harder to maintain. The catchments must be designed around the particular characteristics of the geographic areas to service the natural flow of people.[217]

The importance of maintaining connections to communities when determining the size of areas was also emphasised by numerous contributors. Ms Julie Anderson, Senior Consumer Advisor in the Office of the Chief Mental Health Nurse and the Office of the Chief Psychiatrist, who gave evidence in a personal capacity, warned that '[t]he risk of larger catchments is that the services become dehumanised.'[218]

In 2013 the then Department of Health and Human Services released a catchments discussion paper that set out a number of principles and criteria to guide change. Although the reforms did not progress, the discussion paper included a principle on the optimal service size that stated:

> The size of consolidated whole-of-life public mental [health] services should optimise efficiencies, allow for capacity to provide a full range of functions at an appropriate level of safety and quality, and be viable and sustainable.[219]

In terms of the size of an area, the views and evidence presented, including from past Victorian Government reviews, point to a minimum viable population size of around 500,000 to support a full complement of service functions across all ages.[220] In selected areas of the state where populations are highly dispersed (most notably in rural areas), this threshold is lower, at around 250,000–300,000, with recognition that the service mix may not always be comprehensive.[221]

The Commission concurs with these inputs and recommends that the future mental health and wellbeing system comprises 22 Adult and Older Adult Area Mental Health and Wellbeing Services and 13 Infant, Child and Youth Area Mental Health and Wellbeing Services across Victoria. Taking socioeconomic disadvantage into account, these areas should respectively service:

- adult and older adult populations of approximately 200,000–300,000 in metropolitan Melbourne, and approximately 100,000–200,000 in rural and regional communities
- infants, child and youth populations of approximately 200,000–300,000 in metropolitan Melbourne, and approximately 50,000–100,000 in rural and regional communities.

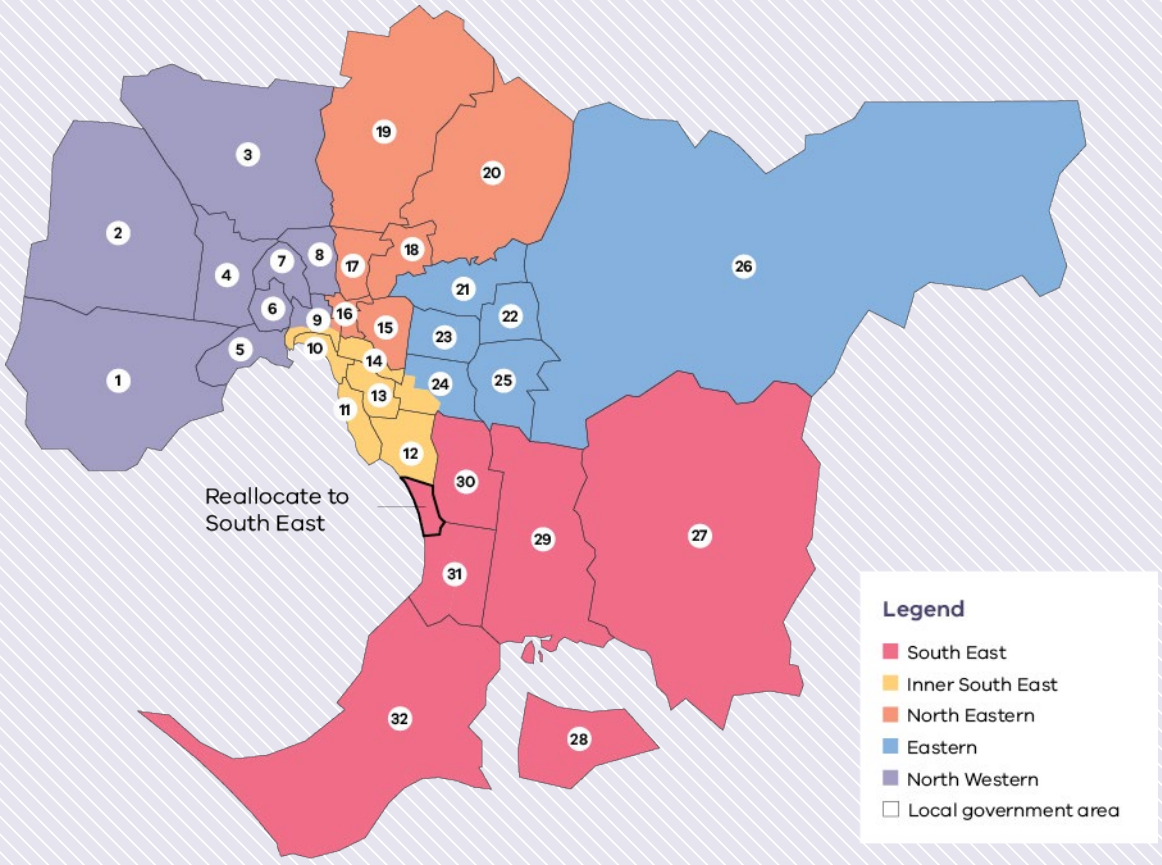
The areas recommended by the Commission broadly map to the existing adult catchment structures for public specialist mental health services. The Commission adopts a cautious approach to reconfiguring boundaries, given the failures of past attempts, the cost of reform and the risk of diminishing the strengths of existing arrangements.

To support planning and commissioning efforts that take a 'whole-of-life' approach, however, the Commission does recommend changes to some boundaries:

- For future Infant, Child and Youth Area Mental Health and Wellbeing Services, the suburbs in the statistical local area of Kingston South should be moved from Inner South East Area Mental Health and Wellbeing Service to South East Area Mental Health and Wellbeing Service (refer to Figure 5.7).
- For future Adult and Older Adult Mental Health and Wellbeing Services, the suburbs in the statistical local area of Frankston East should be moved from Peninsula Area Mental Health and Wellbeing Service to Dandenong Area Mental Health and Wellbeing Service (refer to Figure 5.9).

Flexibility in relation to these boundaries and age eligibility will ensure minimal disruption to consumers, families, carers and supporters in these suburbs. It means that current consumers of those services can continue to access either existing or different services, and future consumers will have choice as to which services they access. Figures 5.7–5.10 describe the changes required in metropolitan Melbourne and the arrangements for rural and regional Victoria. The arrangements in rural and regional Victoria are a continuation of existing arrangements, although catchments will no longer be rigid.

Figure 5.7: Future Infant, Child and Youth Area Mental Health and Wellbeing Service areas, metropolitan Melbourne



Metropolitan Melbourne

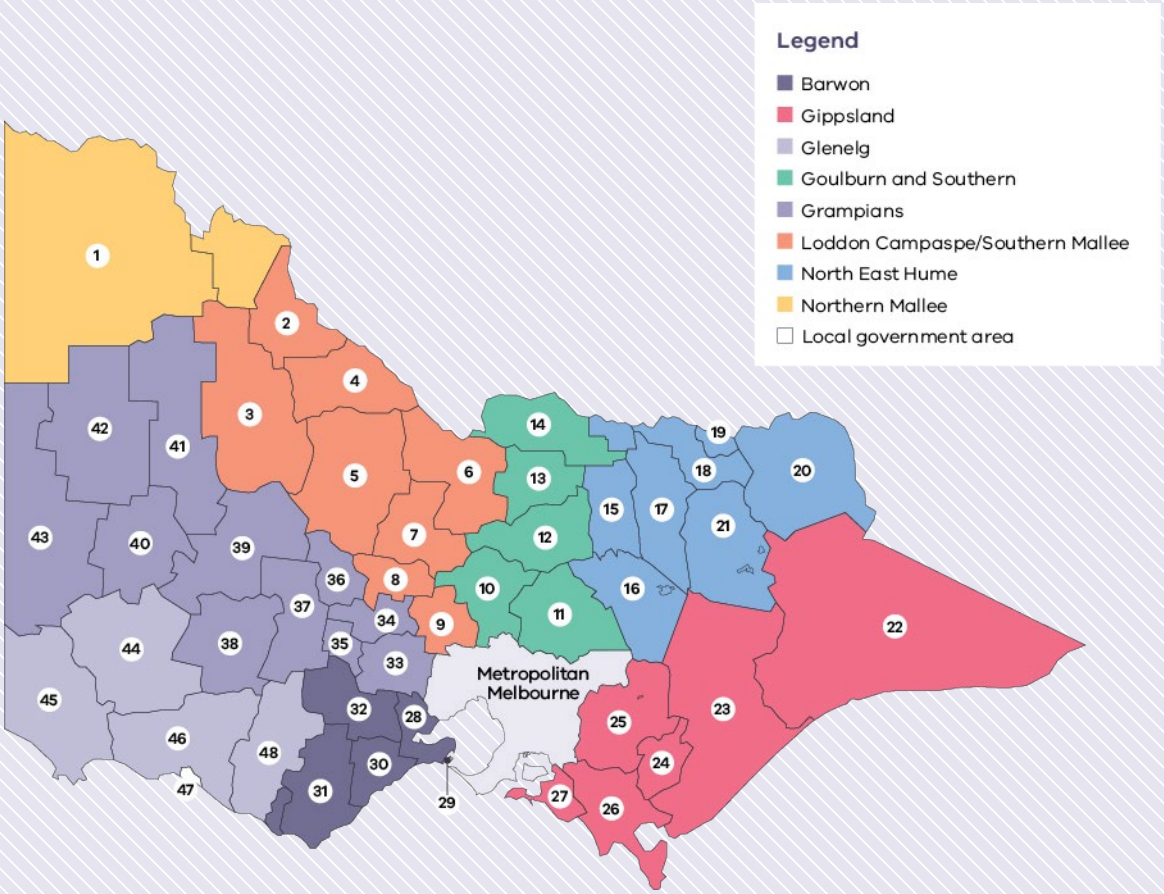
Local government areas

1 Wyndham
2 Melton
3 Hume
4 Brimbank
5 Hobsons Bay
6 Maribyrnong
7 Moonee Valley
8 Moreland
9 Melbourne
10 Port Phillip
11 Bayside
12 Kingston
13 Glen Eira
14 Stonnington
15 Boroondara
16 Yarra
17 Darebin
18 Banyule
19 Whittlesea
20 Nillumbik
21 Manningham
22 Maroondah
23 Whitehorse
24 Monash
25 Knox
26 Yarra Ranges
27 Cardinia
28 French Island (unincorporated)
29 Casey
30 Greater Dandenong
31 Frankston
32 Mornington Peninsula

Source: Adapted from Department of Health and Human Services, *Mental Health Service Areas—Maps*, 2015, <www.health.vic.gov.au/mentalhealthservices/maps/index.htm>, [Accessed 27 October 2020]; *Correspondence from Melbourne Health*, January 2021.

Note: Catchments names are based on what is currently listed on the Department of Health website. Names may be amended in the future.

Figure 5.8: Future Infant, Child and Youth Area Mental Health and Wellbeing Service areas, rural Victoria



Rural Victoria

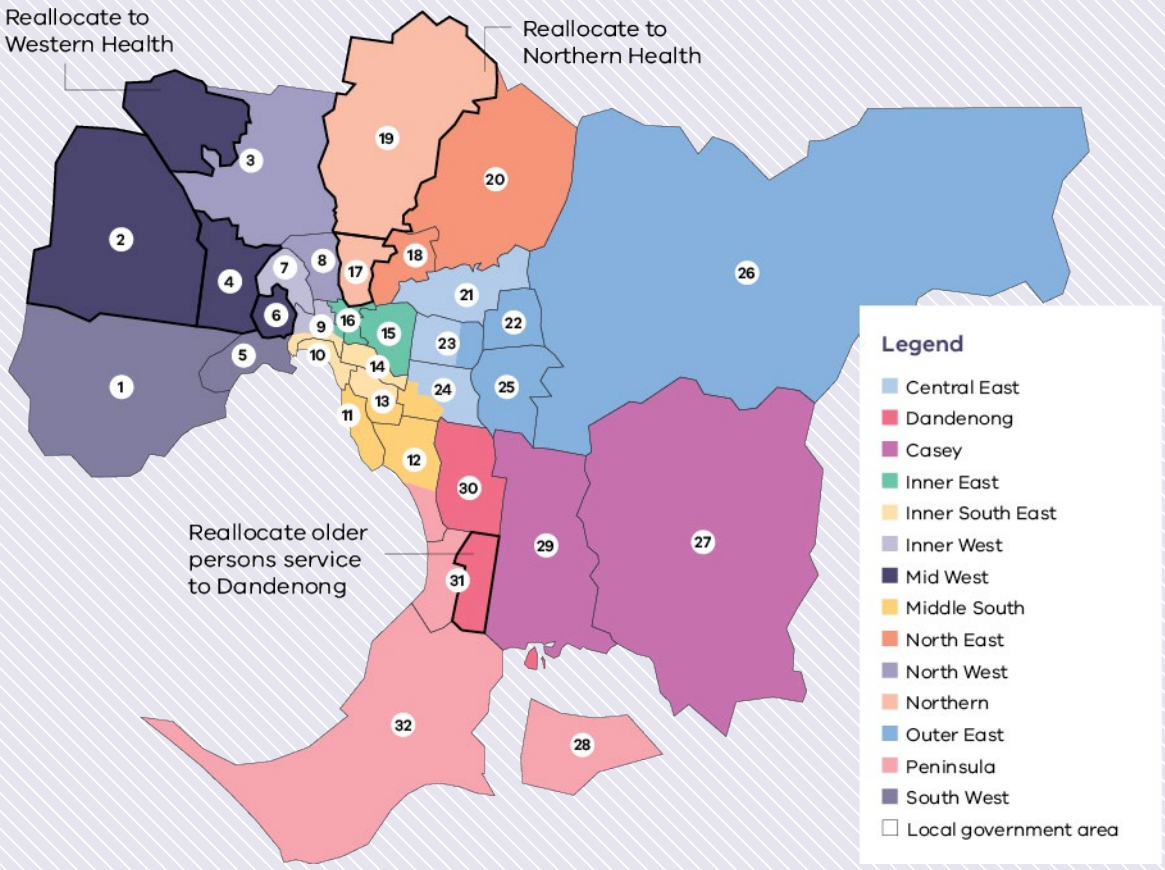
Local government areas

1 Mildura
2 Swan Hill
3 Buloke
4 Gannawarra
5 Loddon
6 Campaspe
7 Greater Bendigo
8 Mount Alexander
9 Macedon Ranges
10 Mitchell
11 Murrindindi
12 Strathbogie
13 Greater Shepparton
14 Moira
15 Benalla
16 Mansfield
17 Wangaratta
18 Indigo
19 Wodonga
20 Towong
21 Alpine
22 East Gippsland
23 Wellington
24 Latrobe
25 Baw Baw
26 South Gippsland
27 Bass Coast
28 Greater Geelong
29 Queenscliffe
30 Surf Coast
31 Colac–Otway
32 Golden Plains
33 Moorabool
34 Hepburn
35 Ballarat
36 Central Goldfields
37 Pyrenees
38 Ararat
39 Northern Grampians
40 Horsham
41 Yarriambiack
42 Hindmarsh
43 West Wimmera
44 Southern Grampians
45 Glenelg
46 Moyne
47 Warrnambool
48 Corangamite

Source: Adapted from Department of Health and Human Services, *Mental Health Service Areas—Maps*, 2015, <www.health.vic.gov.au/mentalhealthservices/maps/index.htm>, [accessed 27 October 2020].

Note: Catchments names are based on what is currently listed on the Department of Health website. Names may be amended in the future.

Figure 5.9: Future Adult and Older Adult Mental Health and Wellbeing Service areas, metropolitan Melbourne



Metropolitan Melbourne

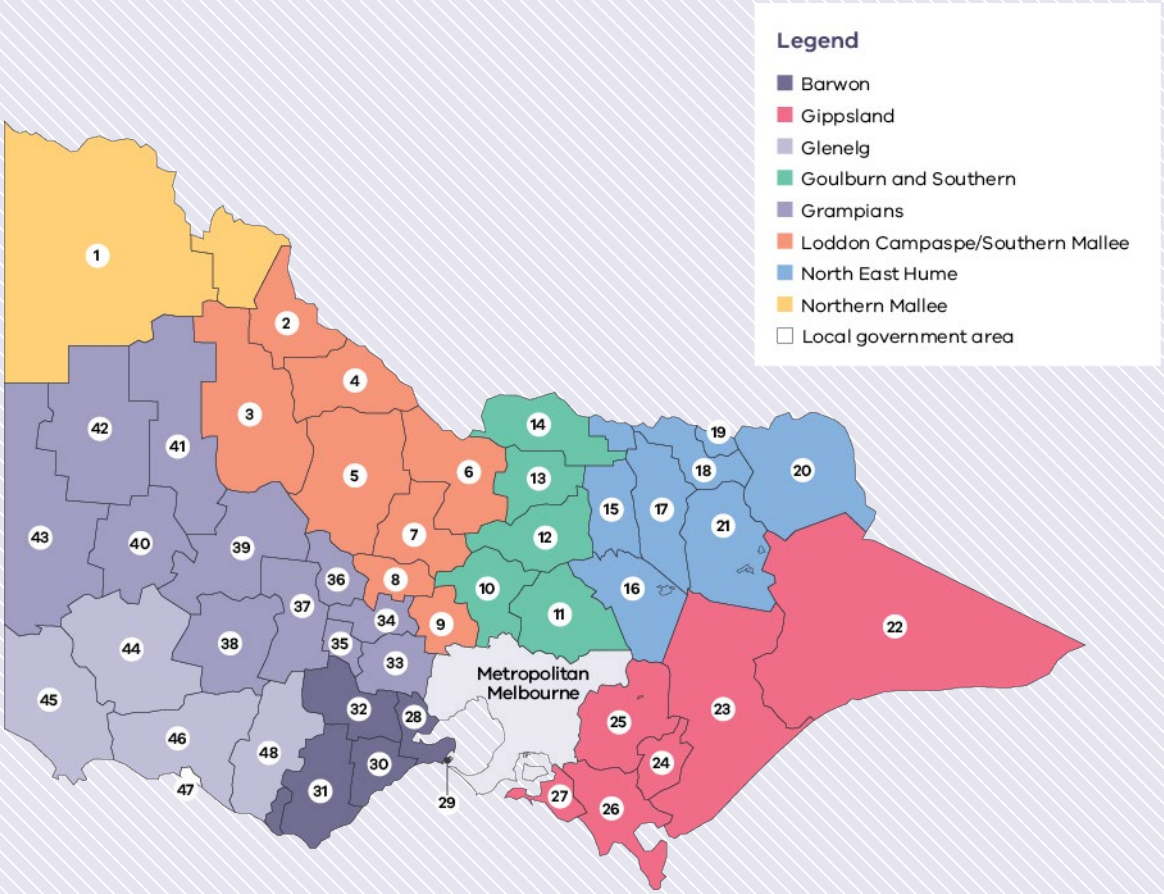
Local government areas

1 Wyndham
2 Melton
3 Hume
4 Brimbank
5 Hobsons Bay
6 Maribyrnong
7 Moonee Valley
8 Moreland
9 Melbourne
10 Port Phillip
11 Bayside
12 Kingston
13 Glen Eira
14 Stonnington
15 Boroondara
16 Yarra
17 Darebin
18 Banyule
19 Whittlesea
20 Nillumbik
21 Manningham
22 Maroondah
23 Whitehorse
24 Monash
25 Knox
26 Yarra Ranges
27 Cardinia
28 French Island (unincorporated)
29 Casey
30 Greater Dandenong
31 Frankston
32 Mornington Peninsula

Source: Adapted from Department of Health and Human Services, *Mental Health Service Areas—Maps*, 2015, <www.health.vic.gov.au/mentalhealthservices/maps/index.htm>, [accessed 27 October 2020]; *Correspondence from Andrew Stripp*, 8 December 2020; *Correspondence from Melbourne Health*, January 2021.

Note: Catchments names are based on what is currently listed on the Department of Health website. Names may be amended in the future.

Figure 5.10: Future Adult and Older Adult Mental Health and Wellbeing Service areas, rural Victoria



Rural Victoria

Local government areas

1 Mildura
2 Swan Hill
3 Buloke
4 Gannawarra
5 Loddon
6 Campaspe
7 Greater Bendigo
8 Mount Alexander
9 Macedon Ranges
10 Mitchell
11 Murrindindi
12 Strathbogie
13 Greater Shepparton
14 Moira
15 Benalla
16 Mansfield
17 Wangaratta
18 Indigo
19 Wodonga
20 Towong
21 Alpine
22 East Gippsland
23 Wellington
24 Latrobe
25 Baw Baw
26 South Gippsland
27 Bass Coast
28 Greater Geelong
29 Queenscliffe
30 Surf Coast
31 Colac–Otway
32 Golden Plains
33 Moorabool
34 Hepburn
35 Ballarat
36 Central Goldfields
37 Pyrenees
38 Ararat
39 Northern Grampians
40 Horsham
41 Yarriambiack
42 Hindmarsh
43 West Wimmera
44 Southern Grampians
45 Glenelg
46 Moyne
47 Warrnambool
48 Corangamite

Source: Adapted from Department of Health and Human Services, *Mental Health Service Areas—Maps*, 2015, <www.health.vic.gov.au/mentalhealthservices/maps/index.htm>, [accessed 27 October 2020].

Note: Catchments names are based on what is currently listed on the Department of Health website. Names may be amended in the future.

5.6.1 Service partnerships to support integrated Area Mental Health and Wellbeing Services

Collaboration is a central theme of the Commission's reform agenda. Partnerships between service providers is a fundamental way in which the Commission is seeking to foster collaboration across the mental health and wellbeing system as a means of achieving well-integrated and coordinated services that respond to a person's whole needs.

Dr Alice Andrews, Director of Education, Value Institute for Health and Care and Assistant Professor, Department of Medical Education, Dell Medical School, University of Texas, described how partnerships between providers can improve outcomes for people:

> Organising around patients with shared needs and demonstrating better value in care creates opportunities to expand partnerships and improve health outcomes for more people. This may include partnerships among clinical organisations as well as partnerships with other community organisations, such as employers.[222]

Partnerships can also support organisations to move away from competition towards more collaborative approaches. As Mr Tass Mousaferiadis and Mr Kent Burgess, Chair of the Board of Star Health and Acting CEO of Star Health respectively, explained:

> There are many service providers that are highly competitive. Some people would argue that some competition is useful, but in fact the rise in competition has fragmented our health service system, and especially our community-based service system. We should be looking for much more collaborative approaches.[223]

Currently, there are separate and often localised examples of providers entering into partnership arrangements to provide mental health services. For example, one of the principles underpinning the delivery of Prevention and Recovery Care (PARC) services is collaboration—clinical services and psychosocial support providers work together to provide short-term residential treatment and support, with a person and their recovery as the central focus.[224]

PARC services are well regarded by consumers:

> The PARC stay was good. I felt like it did what it was supposed to in that it settled me and I felt okay.[225]

> I can only speak good things about this place [the PARC], it had a tremendous affect on my recovery in fact it changed me for good. [W]ithout this facility [I] would be back in the same place [I] was before. … [I] highly recommend more [PARCs] to be opened around regional areas or more information for intake [be given] to GPs.[226]

Area mental health services and non-government organisations providing psychosocial supports have also established collaborations to deliver the Early Intervention Psychosocial Support Response Service.[227] As just one example, Austin Health and Mind Australia have collaborated to provide additional psychosocial supports (or wellbeing supports) to consumers, particularly people who either do not qualify or are awaiting to access the National Disability Insurance Scheme.[228]

The integration of primary and clinical specialist services at Alfred Health for children and young people is another example of effective collaboration that brings together state and Commonwealth Government funding to integrate headspace centres and the child and youth mental health service, to support local communities in south-eastern metropolitan Melbourne.

In its submission to the Commission, Alfred Health highlighted the value of collaboration:

> **A model of care that allows for collaboration of private practitioners and community services delivering drug and alcohol, employment and vocational, specialist mental health and primary care medical services has much to teach [the] [Victorian mental health system] about the value of breaking down silos of practice to bring together clinical and psychosocial services. Future developments of community adult and aged mental health should consider this approach to service delivery.**[229]

Provider partnerships are increasingly a feature of health and social service delivery. The Commission considers that partnerships between providers must be a defining feature of Victoria's future mental health and wellbeing system. Effectively responding to the needs and preferences of people living with mental illness or experiencing psychological distress, families, carers and supporters means collaborative approaches are needed. Bringing together the strengths of individual service providers supports more holistic responses to people's needs and preferences.

The Commission recommends that a service partnership between a public health service (or public hospital) and a non-government organisation that provides wellbeing supports is established in each area for Infant, Child and Youth, and for Adult and Older Adult Area Mental Health and Wellbeing Services.

These partnerships are critical to realising the Commission's ambition for a system that offers holistic responses, where the relationship between social factors and a person's mental health and wellbeing is recognised. These partnerships will see public health services and non-government organisations that provide wellbeing supports work in a coordinated way to improve access to a mix of high-quality and safe treatment, care and support that is well integrated.

To fulfil these aims, service partnerships for Area Mental Health and Wellbeing Services will be responsible for providing:

- multidisciplinary responses across all core functions of community-based mental health and wellbeing services that have extended operating hours
- a centrally coordinated 24-hour, seven-day-a-week telephone and telehealth crisis response service accessible both to service providers and the public, including crisis assessment and immediate support; mobilisation of a crisis outreach team or emergency service response where necessary; and referral for follow-up by other services
- Assertive Community Treatment teams that work with other providers through new coordinating structures in the form of Regional Multiagency Panels, to support people who need to use multiple services (refer to section 5.9.4)
- community bed-based care
- consultation liaison and inreach to local services so that expertise from service partnerships can be shared with Local Mental Health and Wellbeing Services
- assessment and planning discussions, as well as care coordination
- pathways to, and a setting for the delivery of statewide services.

Separately, public health services and hospitals will continue to be responsible for providing acute inpatient services and responding to people who present to emergency departments or urgent care centres with mental health-related needs.

The Department of Health and new Regional Mental Health and Wellbeing Boards described in section 5.9 will take on a leading role in establishing these service partnerships and the continuing efforts that are required to maintain them. New accountability arrangements will also need to be established to provide clarity to service partnerships about what they are expected to achieve in terms of service delivery and improvements in people's experiences and outcomes.

5.6.2 Governance reforms in northern and western metropolitan Melbourne

There are some complex arrangements between public health services that govern the delivery of public specialist mental health services to people living in northern and western metropolitan Melbourne. These arrangements—which were established 20 years ago and continue today—see Melbourne Health responsible for delivering mental health services at the three public health services of Melbourne Health, Northern Health and Western Health.

Ms Williams believes the centralised model, in which Melbourne Health governs four mental health catchments extending into the north and west metropolitan Melbourne, has 'had some unintended consequences'[230] at Northern Health including:

> (a) Northern Health has poor visibility over mental health provided within its facilities;
>
> (b) The separation of mental health means that Northern Health has little or no influence over how the mental health resources are allocated or prioritised as this is done by Melbourne Health;
>
> (c) Coordination of care for patients is made more complex and difficult given the dual responsibility; and
>
> (d) Patients, families and the community assume that Northern Health is the provider of these mental health facilities given they are in our facilities. When complaints arise they must be referred to Melbourne Health for response, as Northern Health has no knowledge of mental health incidents or events occurring in the mental health facilities at Northern Health.[231]

Ms Williams argued that, while this model was fit for purpose at the time of establishment some 20 years ago, the capabilities of Northern Health have matured and it is 'no longer appropriate that another health service (Melbourne Health) be responsible for services provided within Northern Health facilities and elsewhere that services the Northern Health community'.[232]

With regard to these arrangements, Associate Professor Vine stated that:

> at the time of their creation, the smaller outer metropolitan services were probably not ready to run an area mental health service. This position has changed and now the limiting factor as to whether Northern Health and Western Health should manage their own mental health service is not the lack of corporate capability to do so, but rather the lack of capacity to manage their local demand.[233]

Western Health has advised the Commission of its preference to be the single mental health service provider for its population area.[234] Melbourne Health also advised of its support for the disaggregation of direct clinical care services within NorthWestern Mental Health.[235]

In light of this, the Commission proposes that the governance of adult and older adult mental health services currently delivered by NorthWestern Mental Health across the current catchments of Inner West, Mid West, North West and Northern is altered as follows:

- The current Northern adult mental health catchment will be governed by Northern Health.
- The current Mid-West catchment and the local government area of Maribyrnong, a small part of the existing South West adult mental health catchment (currently governed by Mercy Health), will be governed by Western Health.
- The North West and Inner West adult catchment will continue to be governed by Melbourne Health.

Service partnerships will be established between the public health service nominated above and a non-government organisation that provides wellbeing supports for each future area.

As part of these changes, governance arrangements for Orygen will also evolve. Orygen Clinical Services is a part of Melbourne Health and is the current provider of youth public specialist mental health services for young people aged 15–25 years in north-western metropolitan Melbourne. Orygen runs youth mental health inpatient services at Footscray Hospital. It also provides specialist services, such as eating disorders services and neurodevelopmental disorder services, as well as operating the Forensic Youth Mental Health Service for the custodial sites at Parkville and Malmsbury.[236]

In this area, The Royal Children's Hospital provides outpatient (community-based) mental health services to infants, children and young people aged 0–15 years and inpatient services to children, adolescents and young people aged 0–18 years. The Royal Children's Hospital also provides a number of specialist services including eating disorders services and a gender service.[237]

Also in this area, NorthWestern Mental Health provides mental health services to young people aged 18 years and older.

Young people have access to five headspace centres, which are provided by Orygen and commissioned by the North Western Melbourne Primary Health Network.

Age-based eligibility for child and youth mental health services are ill defined in northern and western metropolitan Melbourne, with implications for children and young people, as well as their families, carers and supporters. An example of this complexity relates to the follow-up care for young people after a hospital stay. The Royal Children's Hospital provides an inpatient service for adolescents aged 13–18 years. Their community programs, however, cease at 15 years.

For young people aged 15 years who access inpatient services at the Royal Children's Hospital and live in the North Western metropolitan catchment, follow-up community-based services are provided by Orygen. The Victorian Auditor-General noted that problems of communication during the discharge process are made worse in this catchment because service delivery is shared by the two organisations.[238]

This is a fragmented and complex approach to the organisation and delivery of child and youth services. The Commission considers that changes are required so that the Royal Children's Hospital delivers community mental health and wellbeing services to children up to the age of 12 years and Orygen delivers community mental health and wellbeing services for young people aged 12–25 years, noting that the age-based eligibility should not be strict and instead respond to a child or young person's development and circumstances. The Royal Children's Hospital will also deliver acute inpatient care to young people aged 13–18 years through its existing Banksia ward, which has a statewide role, admitting young people from across Victoria.

To support the Commission's vision for the infant, child and youth mental health and wellbeing system, the Department of Health will work with Orygen and the Royal Children's Hospital to implement changes that better define age-based arrangements so there is a consistent provider across inpatient and community-based services for children and young people in these areas. This will provide an integrated service between community-based responses and inpatient services. It is imperative that changes are put in place to maximise service continuity for children and young people, their families, carers and supporters, in particular for children transitioning from the Banksia ward to community-based services.

These arrangements are the only exception to the Commission's recommended approach of having a single system with common governance for infants, children and young people aged 0–25 years.

The Commission also considers that Orygen's clinical services should be separated from Melbourne Health, with arrangements made to integrate these services with headspace services and Orygen's research and innovation capabilities. Professor McGorry believes that '[w]ithout such integration the patient experience is less optimal and major barriers exist',[239] adding that '[a]s the world's leading translational youth mental health research centre, it is essential to integrate and operate both the specialist services and the primary care services.'[240]

The Commission is aware that the governance changes outlined above will need to be informed by deep consultation. It will also need to be accompanied by thorough and long-term change management strategies that minimise disruptions to consumers, families, carers and supporters, communities, the affected workforce and service providers.

These changes are expected to necessitate a redistribution of funding between services, the transfer of infrastructure, workforce changes, and major effort to articulate and coordinate roles and responsibilities between services—all of which will occur at a time of great change to the whole mental health and wellbeing system. With the removal of the catchment structure for accessing services, some people may also choose a different service provider or to stay with their existing service provider. These changes, however, are long overdue and are necessary to achieve the Commission's ambition for a future service system that is organised to support people to access services locally.

5.7 Role and coordination of statewide services

Highly specialised services that are delivered on a statewide basis are an essential part of the mental health and wellbeing system. The expertise these services offer should be fostered and supported to work in a coordinated manner that provides people, and other parts of the mental health and wellbeing system, with established pathways to highly specialised treatment, care and support. While not all consumers will seek these types of services, it is vital that there is clarity about the role statewide services play in the future system.

The Victorian Government defines a number of service types as 'statewide services':

- the Koori Statewide Inpatient Service at St Vincent's Mental Health Service
- the Brain Disorders Unit at Mary Guthrie House at Royal Talbot Rehabilitation Centre
- the Victorian Dual Disability Service run by St Vincent's Mental Health and NorthWestern Mental Health
- the Mood and Eating Disorders Unit at Austin Health
- Parent and Infant Units (or 'mother-baby services')
- Psychiatric Intensive Care Services at Alfred Psychiatry
- the neuropsychiatric unit at the Royal Melbourne Hospital
- personality disorder services run through Spectrum
- services from Victorian Transcultural Mental Health.[241]

It is not clear, however, on what basis these services are classified as statewide, nor is it clear when this list was determined and when it was last updated.

A clear definition of the role of statewide services is absent in the architecture of the current system. Barwon Health told the Commission:

> **Currently, there is no definition of which services should be locally available, irrespective of population size, versus those that should be accessed in a different area or across a region via referral pathways. As [a] consequence, access to tertiary level mental health and [alcohol and drug] services across Victoria varies depending on a consumer's residential address.[242]**

Regardless of how they are defined, highly specialised services are not always accessible to people living with mental illness or experiencing psychological distress, families, carers and supporters. Ms Anderson told the Commission, 'if I had lived in a different catchment, my children could have accessed the Family and Parents with a Mental Illness program (FAPMI). But, that was not possible because FAPMI wasn't in my catchment'.[243] Ms Anderson believes it would be an advantage if highly specialised services were 'open to all'.[244]

Several witnesses to the Commission have suggested ways to determine which services should be designated as statewide. For example, Associate Professor Moylan believes:

> The key criteria for determining which services are offered on a centralised state-wide basis, compared to a local basis should be the relative specialisation of the service, the demand level, and how the service interacts with other key systems.[245]

A similar view was put forward by Professor Bruce Bonyhady AM, Executive Chair of the Melbourne Disability Institute at the University of Melbourne, who gave evidence in a personal capacity:

> streaming is likely to be beneficial where the degree of specialist knowledge required for the delivery of services is particularly high. The size of the relevant population may also determine whether streaming will be optimal, i.e. whether the group is sufficiently large such that it would be best supported through a separate stream. There may also be cultural factors that will determine whether streaming is appropriate.[246]

A report on health service commissioning also asserts that service volumes are a factor influencing what services may need to be centralised, stating:

> complex, specialist or expensive services may need to be considered across a larger footprint to allow for sensible allocation of scarce resources. Decisions about the level at which commissioning should take place should be driven by the nature of the service, for example the level of demand or the number of places where the service can be delivered efficiently.[247]

The 2016 review of hospital safety and quality assurance in Victoria, *Targeting Zero*, noted that streaming based on service volumes supports better outcomes.[248] While centralising care is necessary where demand is low and the specialised knowledge needed is high, it is paramount that the needs and preferences of consumers are also considered when defining services as statewide. The *Targeting Zero* report suggested that '[d]ecisions should always be for the overall benefit of the community, taking all aspects of quality into account.'[249]

Based on the evidence presented, the Commission characterises statewide services as those that usually involve:

- a workforce with a high level of expertise and knowledge
- a dedicated research focus
- the provision of treatment, care and support to a proportionately small number of people, often with higher levels of needs.

Statewide services might also involve new and emerging areas of knowledge and practice. Consistent with this approach, the Commission has identified a need for statewide services to be established to support improved services for people with lived experience of trauma, people living with mental illness and substance use or addiction, and children and young people in contact with, or at risk of coming into contact with, the youth justice system.

5.7.1 Dependable access to statewide services through established pathways

While it is critical to define what services should be statewide and the expectations of their role in the future system, it is also critical to define their relationship with the broader system. Barwon Health recognises that not all services can be made available locally but asserted that, '[w]here these units are not available locally, they should be made available to consumers from other areas via defined specialist pathways.'[250]

Associate Professor Moylan stated:

> The model needs to be flipped from prescribing services based on what is available within a region, to facilitating access to the required care for people utilising local and specialist networks across the state, whenever and wherever they need it.[251]

Wherever possible, all consumers, regardless of their level of need or complexity, will be supported to receive services in Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services. This decision is informed, in part, by evidence the Commission has heard about the importance of making mental health and wellbeing services available close to where people live.

Ms Georgia Harraway-Jones, a witness before the Commission, said 'I found it difficult to get support close to home, which inhibited my recovery'.[252] Similarly, Dr Claire Gaskin, Forensic Adolescent Psychiatrist at the University of New South Wales, who provided evidence in a personal capacity, told the Commission that it is preferable to keep people as close to home and their community as possible.[253]

For people living in rural and regional Victoria, distance can be a barrier to accessing statewide services. A person at a community consultation held by the Commission in Shepparton explained the impact this can have:

> People are vulnerable and then you add the complexity of them having to travel to get access to a service … this is removing people from an environment familiar to them and away from family and friends and what they know.[254]

In a joint submission from rural and regional area mental health services, service providers explained:

> Whilst there is a reasonable range of statewide specialist services within the Victorian mental health system, the vast majority of these are Melbourne based. As a result, these services, including Eating Disorder, Forensic, Personality Disorder, Neuropsychiatry and [child and youth mental health services] inpatient beds, are often in high demand resulting in delayed access and a limited ability to provide early intervention. In addition, geographical distance further compounds access issues for patients and their family/carers living in rural and remote areas of Victoria.
>
> For example, a patient living in Barham (located within the catchment area of Albury Wodonga …) who requires an inpatient admission to a Melbourne based specialist service will require travel of up to four hours one way. If the admission occurs via Albury Wodonga Health services, travel increases to seven hours to facilitate admission to an appropriate specialist facility.[255]

In the future, there will be clear pathways for providers to access statewide services and their expertise.

Established pathways between services are also critical to managing demand for statewide services. Access to statewide services will require a referral from an Area Mental Health and Wellbeing Service. This will often be undertaken after assessment processes are complete. The Department of Health, in conjunction with statewide services, will need to establish clear access policies that provide clarity about how referrals will be managed. These policies will need to be monitored and periodically updated to reflect changes in need, demand and expectations among people living with mental illness or experiencing psychological distress, families, carers and supporters.

In developing these policies, it will be crucial to emphasise that in most circumstances, people will need short-term access to statewide services. The former *Blueprint for Mental Health Services in New Zealand* says that specialist services should provide assessments, treatment planning and coordination and only short-term treatment, care and support:

> **The intention is that this should be a specialist resource to assist general mental health services and would not have long-term users.**[256]

The Commission agrees with this sentiment and considers that pathways back to Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services are pivotal in most circumstances. In the same way that consumers require clear pathways into statewide services, they also need clear pathways back to Local Mental Health and Wellbeing Services. As noted earlier in this chapter, consumers will only access a higher level of care for as long as their level of need is too great to be cared for locally.

Wherever feasible and safe, statewide services will be delivered through Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services, rather than through a model of service provision that requires consumers, families, carers and supporters to travel away from their home and support networks. This will include through virtual and onsite consultations.

To make statewide services easier to access, the pathways between providers in Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services to these statewide services will be clearly articulated through the service capability framework described in section 5.8.1, and there will be sufficient resourcing to enable providers to collaborate.

These approaches are well established in other service systems. For example, the 2016 *South Australian Clinical Services Capability Framework* provides a tool for statewide strategic planning, defines the criteria and capabilities required of services, and identifies interdependencies between services.[257] This means providers who deliver the most complex level of mental health services are responsible for specialist consultation liaison, providing their expertise to other services.[258]

Statewide services in the future system will be delivered using a mix of service delivery models. Some statewide services may use a combination of approaches—for example, supporting other providers to improve their capabilities while also directly providing services through a hub-and-spoke model. Figure 5.11 outlines some examples of how statewide services can be delivered.

Figure 5.11: Different approaches to service delivery for statewide services

	 Capability uplift	 Direct service provision	 Hub and spoke	 Satellite model
Examples	**Victorian Transcultural Mental Health Service** This service supports mental health service providers to improve their capabilities in the delivery of culturally responsive services.	**Brain Disorder Program** This service, located at Austin Health, provides services directly to people from across the state experiencing a combination of cognitive impairment and mental illness.	**Forensic Mental Health and Advice Response Service** The 'hub' is the community forensic mental health services run directly by Forensicare, the statewide provider of specialist forensic mental health services, and the 'spoke' services are mental health clinicians embedded in eight metropolitan courts, providing clinical mental health advice within the court.	**Eating disorders services** There are three acute hospitals in Victoria that provide specialist tertiary eating disorders services. Mental health services are also provided to people with eating disorders at area mental health services, with referrals through to specialist services where required.

Sources: Victorian Transcultural Mental Health, What we do, <vtmh.org.au/what-we-do/>, [accessed 5 November 2020]; Austin Health, About us, <www.austin.org.au/bdp/about>, [accessed 5 November 2020]; Department of Health and Human Services, Eating disorders – clinical services, <www2.health.vic.gov.au/mental-health/practice-and-service-quality/specialist-responses/eating-disorders/eating-disorders-clinical-services>, [accessed 5 November 2020]; Forensicare, *Correspondence to the RCVMHS: CSP.0001.0108.0001*, Forensicare Service Plan, 2020, p. 28.

5.7.2 The Collaborative Centre for Mental Health and Wellbeing as the coordinator of statewide services

The level of expertise associated with statewide services necessitates links to continuing research, workforce training and education opportunities. These endeavours help statewide services to continuously improve, and other parts of the system and statewide services to adapt to new ways of working.

The Commission has heard of a lack of support for both the statewide workforces and workforces in other parts of the system to support people with higher levels of need. For example, as Dr Coventry explained:

> [There is] a lack of capability within area mental health services to adequately assess, treat and manage consumers with complex disabilities. There is a shortage of trained professionals with relevant experience and qualifications, and existing inpatient environments are often inappropriate. The Mental Health and Intellectual Disability Initiative (MHIDI) program is currently only available in two services, which report increasing referrals, and the Victorian Dual Disability Service—the statewide service located at St Vincent's Hospital Melbourne which works with specialist mental health services across Victoria to assess, treat and support people with a dual disability—has limited capacity to provide support.[259]

Another example of this limited workforce capacity was highlighted by Monash Health, which noted that treating teams in current area mental health services have limited knowledge to support refugees who have experienced trauma.[260] While acknowledging that there are cost and efficiency barriers to training all clinicians in highly specialised areas, Monash Health considered that there is a need to respond to the capacity constraints that limit the distribution of expertise held by statewide services to other parts of the system.[261]

There are also examples of shortcomings in the development of skills and access to a suitably trained workforce to staff statewide services. Dr Coventry advised that services can experience difficulties recruiting forensic mental health workers, including to staff forensic youth mental health programs. Dr Coventry pointed to delays in the opening of further bed capacity at Thomas Embling Hospital as a consequence of these workforce shortfalls.[262]

Turning Point submitted, '[t]his knowledge and skills gap within the health system has been further exacerbated by the absence of funding for a Victorian tertiary specialist workforce'.[263]

Links between statewide services and research institutions are critical to ensuring emerging knowledge is rapidly translated into high-quality and evidence-informed services that are available to people. Yet, among statewide services, links to research differ and there is often little funding available to support these endeavours.

Forensicare and the Centre for Forensic Behavioural Science at Swinburne University of Technology explained:

> Despite the legislative mandate that Forensicare conduct research, Forensicare has received very little government funding to further this responsibility. From its inception, Forensicare has worked with a range of universities to develop a research capacity in forensic mental health and related fields. The relationships have ensured that Forensicare attracts academics and research funding to undertake research relevant to Forensicare's clinical work. The [Centre for Forensic Behavioural Science] operates under the auspices of [Swinburne University of Technology] in collaboration with Forensicare. The [Centre for Forensic Behavioural Science] serves as the research arm of Forensicare, conducting independent research and facilitating the research enterprises of Forensicare.[264]

The Collaborative Centre for Mental Health and Wellbeing, recommended in the interim report, will respond to these challenges, bringing people with lived experience of mental illness or experiencing psychological distress, families, carers and supporters together with researchers and service providers.[265]

The collaborative centre's functions make it ideally placed to support and, where appropriate, coordinate the delivery of statewide services for adults and older adults. In relation to statewide services, the collaborative centre's functions will include translational research, supporting workforce skill development and training, as well as establishing and coordinating pathways between statewide services and Area Mental Health and Wellbeing Services and Local Mental Health and Wellbeing Services. For some statewide services, this function may be performed in partnership with other research organisations including, but not limited to, Orygen and the Murdoch Children's Research Institute.

The collaborative centre and statewide service providers will be responsible for building the service and workforce capabilities of Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services. Professor Sundram spoke of the need to develop and promote specialisation in the workforce, '[f]or the team to develop such skills requires streaming or specialisation. There is a desperate need to promote excellence in the sector to foster the expertise required.'[266]

In establishing and monitoring pathways to statewide services, the collaborative centre, will play a critical role in coordinating access to statewide services. As Professor Robert Thomas OAM, Deputy Chairperson of the Victorian Comprehensive Cancer Centre, said in his personal capacity:

> The collaborative centre could have a role for a few years setting up the ground rules for pathways of care. There is time to be invested in getting the broad pathways and inspiration right first. The control of referrals for example needs time to be developed and implemented and the collaborative centre should prioritise this at the outset.[267]

The role of the collaborative centre in supporting statewide services is not to fracture existing relationships that may exist between statewide services and research institutions. As James Ogloff AM, Executive Director at Forensicare and Distinguished Professor of the Centre for Forensic Behavioural Sciences at Swinburne University, recommended, in a personal capacity:

> It is my view that [the Centre for Forensic Behavioural Science], considering its relationship with Forensicare and [Swinburne University of Technology], should be formally established as a partner or 'node' of the Collaborative Centre to further the important work in forensic mental health. Indeed, the aims of the Collaborative Centre to close the knowledge translation gap and to establish models for knowledge sharing are as important—if not more important—in forensic mental health than general mental health given the 'double stigma' people living with mental illness experience when they also come into contact with the criminal justice system. Working as part of the Collaborative Centre, the [Centre for Forensic Behavioural Science] would continue to develop academic and clinical excellence in forensic mental health which drives best practice. Such a partnership would enable the shared vision of the [Centre for Forensic Behavioural Science] and Forensicare as an innovation hub in forensic mental health and forensic behavioural science for Victoria and Australia.[268]

The collaborative centre will partner with established mental health service providers such as Forensicare to harness these existing relationships. Having this close link to the research arm of the collaborative centre will allow new and emerging areas of need that might warrant a statewide response to be monitored and responded to through innovative service models.

Bringing together statewide services offers a number of benefits that stem from increased collaboration. This includes opportunities for greater sharing of knowledge, research and support, as well as avenues to coordinate the delivery of programs, such as training programs for the workforce. The need to coordinate statewide services in the context of dual disability services is explored in Box 5.1.

Box 5.1: Dual disability services

The Commission has heard that diagnostic overshadowing (attributing symptoms of mental illness to disability), and a lack of understanding of differences in the way mental illness may present in people with acquired or neurodevelopmental disabilities, are barriers to accessing care. Alfred Health, which has a specialist youth mental health and intellectual disability service, identified a range of challenges in identifying mental illness in children and young people with intellectual disabilities, including communication, behavioural and emotional challenges, that can mask or complicate presentation of mental health symptoms.[269]

Self-aggression, self-injury and destruction of property may be seen as behaviours related to acquired or neurodevelopmental disability, rather than signs of mental illness or psychological distress. Given that public specialist mental health services seldom provide services for people presenting with behavioural problems in the absence of mental illness, attributing behaviour to disability, rather than mental illness, reduces the chances of a person receiving appropriate mental health services.[270]

The Commission for Children and Young People shared the personal account of Jamie, a child living in residential care with a lengthy history of child protection involvement. It described how Jamie experienced high levels of self-harming and suicidal behaviour, multiple hospital presentations, police attendances and admissions to secure welfare services. When Jamie sought help, 'a lack of shared understanding by mental and non-mental health services about the 'cause' of Jamie's presenting issues resulted in a disjointed service response that failed to consistently support his safety, wellbeing and development'.[271]

There is a mix of supports available to support people with a dual disability. The statewide Victorian Dual Disability Service, which is a consultation service, offers supports to other service providers. The Centre for Developmental Disability Health Victoria, now within Monash Health, provides assessment and limited psychiatric intervention to support GPs. Two Mental Health Intellectual Disability Initiatives—one adult initiative based in the Monash Health catchment and one youth initiative in the Alfred Health catchment—provide assessment, diagnosis and intervention within their catchment populations. The Commission has heard that these services currently only provide care for a small proportion of people living with dual disability in Victoria; for example, the adult service cannot keep up with demand.[272]

The Victorian Government's *Intellectual Disability Mental Health 10-year Plan Technical Paper* states, '[t]here are limited specialist services for dual disability in Victoria and Australia and the needs of this population are not adequately acknowledged and integrated with mental health and disability service policy and strategy.'[273]

Evidence suggests clinicians lack sufficient training in the management and care of clients with dual disabilities.[274] The Victorian Dual Disability Service and the Centre for Developmental Disability Health Victoria are important sources of secondary advice for clinicians. However, these services typically lack an after-hours crisis service, and can have restrictive acceptance criteria.[275]

The Commission has been told there is a need for specialist dual disability training and higher qualifications in dual disability for paediatric and adult psychiatry and psychology, and across the disability sector. There is also a need to promote greater expertise and training in dual disabilities in the wider mental health workforce.[276]

It is the Commission's view that there is a need for greater, structured investment in statewide dual disability services to support the functions of specialist assessment, diagnosis and intervention (including after-hours support) and in consultation and liaison, to ensure the broader workforce has sufficient dual disability training and decision support.

5.7.3 Planning and funding for statewide services

As the capacity of the system increases, the capabilities of Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services to support people with higher levels of need will improve.

This means the mix of statewide services that are delivered today are likely to change, and new services may emerge that will be delivered as a statewide service. As a result, the Department of Health will need to have a dynamic approach to planning statewide services, regularly assessing what services should be delivered as a statewide service, and what service model is most appropriate for each service.

There is currently limited information to help estimate and monitor demand for statewide services. A contributing factor may be that some statewide services do not report to the department's main data store, the Client Management Interface/Operational Data Store, and there is missing information from others.[277]

There is also limited available information about demand for statewide services. While the *National Mental Health Service Planning Framework* estimates demand for some statewide services (for example, parent and infant units),[278] most statewide services are not captured.

The Commission has been presented with data for the prevalence of some types of need that may require a statewide mental health service, such as eating disorders,[279] but it is not always possible to use this to determine demand for statewide services. For example, not everyone living with an eating disorder requires a statewide service response, and many people can be supported by a local provider.[280]

These challenges in gathering meaningful information limit planning approaches to statewide services. Currently, some statewide service providers undertake planning for their individual services. These efforts are often undertaken separate to broader system planning, with limited data or understanding of how statewide services connect within the wider mental health system or with other services.

The absence of a regular and rigorous planning approach for statewide services can disadvantage requests to government for additional investment, and contribute to people missing out on services. A new approach to the way that statewide services are planned, funded and monitored is required. Chapter 28: *Commissioning for responsive services*, outlines the way mental health services, including statewide services, are to be planned in the future. As part of this, the *National Mental Health Services Planning Framework* will be adapted to support planning approaches, including for statewide services.

As described earlier, statewide services have also been constrained by long periods of underinvestment. Several service providers have told the Commission that insufficient funding was a barrier to meeting demand.[281] For example, Spectrum advised that 'access to evidence-based treatment for people with [borderline personality disorder] is extremely limited'.[282]

According to the Commission's analysis, there has been a decrease in the number of hours of community mental health services (or community contacts) delivered by statewide services over the 10 years to 2019–20. In 2010–11 there were approximately 30,000 community service hours, including contacts where the consumer was not present. In 2019–20, despite some increases in the previous two years, there were only approximately 25,000 community service hours, which is a decrease of 17 per cent. By comparison, over the same period, adult community service hours increased by 45 per cent, infant, child and youth by 44 per cent and aged persons by 25 per cent.[283]

In the immediate term, the Victorian Government will need to deal with underinvestment plaguing many statewide services. The expansion of statewide services should be informed by the new planning approach to ensure additional resourcing goes to the areas of greatest need.

While funding approaches are largely explored in Chapter 28: *Commissioning for responsive services* it is noted here that, given the unique position statewide services hold, they will need to be funded through block funding in the immediate term. Block funding, also known as input-based funding or grant funding, involves providers receiving a fixed sum of funding to deliver a particular service or function.[284] This is the most appropriate way to fund these services, given their specialised nature and relatively small volume of activity.

The department's funding policy options paper states that some services should be funded through a specified grant to achieve efficiency in terms of scope and scale for services that are small in volume, high cost or involve statewide provision.[285] This will require the department, for example, to provide block funding to Aboriginal community-controlled health organisations with the flexibility to support self-determination in funding decisions, so that the distribution of funding is led by Aboriginal communities.

Block funding gives providers certainty and stability, as well as allowing the flexibility to innovate. This is particularly important for statewide service providers that deliver services to a small number of consumers when compared with other parts of the mental health system. It will support providers to take a leadership role, disseminating knowledge and research, supporting consumers from across the state to access statewide services, and helping providers in Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services to build capacity.

In the longer term, once the statewide services have solidified their place in the new mental health and wellbeing system, additional investment could be delivered through a fee-for-service model. Under this arrangement, funds should be held regionally, with Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services purchasing services from statewide providers.

Quarantined funding, role delineation and oversight from the department would need to be in place to prevent Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services developing their own statewide services, in lieu of purchasing these services from statewide service providers. These arrangements would create an approach whereby statewide services would be encouraged to continuously improve the quality of their service provision to receive additional funding, and would arguably increase the responsiveness of the system.

5.8 Dependable access to the most appropriate level of service

To ensure consumers can access the most appropriate level and intensity of treatment, care and support that responds to their needs, and is delivered safely by an appropriately skilled workforce, the Department of Health will clearly explain the roles of each part of the mental health and wellbeing system through role delineation.

Role delineation is used to describe the minimum workforce, infrastructure, equipment, clinical support and governance requirements for each service level.

Service capability frameworks are useful tools for describing and implementing role delineation. They also support clinical governance and considerations regarding the level of need a service, its workforce and infrastructure can support.[286] Rather than delineating a hospital or health service as a whole, service capability frameworks delineate the level of services.[287] Essentially, these frameworks can assist a service provider to determine who they should be referring or linking to other services, rather than offering treatment, care and support themselves.[288]

Service capability frameworks are typically cumulative in design. This means service providers will meet the requirements outlined for lower levels, with additional requirements for each advancing level identified within the service capability framework.[289]

Service capability frameworks have long been used to describe and plan health service delivery in Victoria and other jurisdictions across Australia. In Victoria, at the time of writing this report, there are several frameworks in various stages of implementation, including for maternity and newborn services, emergency and trauma services, subacute services and cardiac, renal and surgical services. In 2016 the *Targeting Zero* report found there had not been a consistent approach for assessing and monitoring adherence to existing capability frameworks in Victoria.[290]

Other jurisdictions, such as New South Wales, South Australia and Queensland, already have frameworks for a wide range of health service streams, including mental health. Each jurisdiction has its own service requirements in relation to capability frameworks. For example, in Queensland, health service agreements between Queensland Health and the health service CEO requires a health service to undertake a baseline self-assessment against the capability framework, and notify Queensland Health when there is a change. Under legislation, the Queensland Chief Health Officer has statutory responsibility for monitoring private hospital compliance with the capability framework.[291]

The former Department of Health and Human Services committed to the staged introduction of role delineation, underpinned by capability frameworks, in the *Statewide design, service and infrastructure plan for Victoria's health system 2017–2037*.[292] This commitment includes agreeing referral networks between multiple providers, with referral thresholds and pathways, to ensure people can access care across the state.[293]

The development of a service capability framework for mental health and wellbeing services is critical for achieving the Commission's aspiration of clarifying the roles and responsibilities of different parts of the mental health and wellbeing system, and providing people with dependable access to the most appropriate level of treatment, care and support for their needs.

5.8.1 Critical features of a service capability framework

There is no agreed blueprint for how mental health services and the associated workforce, equipment and infrastructure capabilities should be organised. Nor is there a single, optimal configuration.

Experiences from other services suggest that developing a service capability framework requires extensive research and consultation, drawing on a range of resources, including policies and procedures issued by professional associations, published peer-reviewed literature, reports and recommendations from a range of bodies including the Coroners Court, and inputs from consumers, families, carers and supporters, clinical networks and service providers.[294]

Recognising this, the Commission has not sought to develop a mental health and wellbeing service capability framework. Instead, it has developed a set of service features to be used by the Department of Health to guide development of a service capability framework for mental health and wellbeing services. These features have been informed by witness statements, public submissions, expert advice and the wider academic literature.

Using the service features listed in Box 5.2, the Commission recommends that the Department of Health develops a service capability framework that outlines how mental health and wellbeing services should be organised to respond to the varying needs and preferences of people living with mental illness or experiencing psychological distress, families, carers and supporters. The service capability framework should have age-based subcomponents.

Box 5.2: Service features of a service capability framework for mental health and wellbeing services

- Care in the community is the fundamental principle.
- Services should be arranged around areas large enough that people receive most services within the area, but areas should not be so large as to cause loss of local connection.
- Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services should be supported with specialist input and support, through liaison and support models, consultation and care provision, and established referral pathways.
- Services offered on a statewide basis should be based on the:
  - degree of specialist knowledge and dedicated research required
  - complexity of need
  - size of the relevant population, and the relationship between service volumes and outcomes.
- Services should be embedded within a network so that people have planned and dependable access to higher-level services when needed.
- Each service level will include a service description and requirements with minimum thresholds related to:

  service descriptions
  - service setting and hours of service
  - intensity (and response times) of services, based on need at a given point in time

  service requirements
  - the types of services to be provided (linked to the Commission's core functions and available evidence)
  - the pathways and relationships between service providers and levels
  - workforce requirements (linked to the Commission's workforce capability framework)
  - infrastructure requirements.
- Services should be resourced to provide sufficient access to treatment, care and support, in accordance with the size and spread of the relevant population.
- Access to Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services should be flexible and should not require providers or consumers to rigidly adhere to boundaries for service delivery.

Usually, but not always, service capability frameworks are organised around six levels, with level one managing the lowest level of need, and level six responding to the highest level of need. As mentioned previously, as a general rule, each successive level builds on the last. This means that as a person's needs increase, they are referred to a higher-level service for care. This approach recognises that a person's mental health needs often change throughout their life.

As Ms Christine Morgan, CEO of the National Mental Health Commission, stated:

> **individuals' needs may be fluid, moving both up and down in intensity, with ongoing needs for support to lead a healthy life socially and emotionally (including recovery support) throughout their journey.**[295]

Importantly, service capability frameworks can support shared care arrangements that delineate the roles and responsibilities of multiple service providers, and can clarify pathways for referral between providers. This means a person can receive most of their care in their local community, close to home, but when they have a critical need (for example, following a suicide attempt or a crisis that cannot be managed through their usual services), they can be referred to a higher-level service. Once a person has been supported with their critical needs, they can be referred back to their local provider.

An example of this is found in the *Capability Frameworks for Victorian Maternity and Newborn Services*, where routine pregnancy care ('level-one' maternity services) can be provided through a GP or midwife shared care arrangement. Because level-one services do not support birthing and intrapartum care, however, the framework requires the provider to plan with the woman and her family for the most appropriate place to birth, before a woman can return to the community for postnatal care.[296]

Like the maternity framework, the mental health and wellbeing service capability framework will also support a person to receive different types of treatment, care and support from different providers, including establishing clear pathways to access, and then return from, more specialised services.

Once the service capability framework is available, Regional Mental Health and Wellbeing Boards (refer to section 5.9), working with the Collaborative Centre for Mental Health and Wellbeing, will be responsible for coordinating providers in their region to assess their respective services. Regional Boards will also be responsible for validating the outcomes of the assessment process, and working with providers to respond to any identified risks, as well as supporting providers to reassess their services as the framework is updated.

To support a connected and responsive system and timely referrals, the Department of Health will be responsible for disseminating information on the outcomes of assessment. The department will also be responsible for maintaining the service capability framework and updating it to ensure it remains contemporary.

The collaborative centre, in partnership with other research organisations, will provide leadership and coordination for delivering statewide services, which are likely to be designated the highest level in a service capability framework, supporting research and knowledge translation, and workforce education, training and support.

5.9 A new regional approach

The Commission was encouraged to consider regional approaches to the way decisions about mental health services are made. This includes regional commissioning—decisions related to the way mental health services are planned, resourced and monitored.

Regional commissioning approaches typically move away from centralised decision-making structures towards more localised approaches, with the aim of achieving service responses that are tailored to the needs of local communities. They can also support efforts to achieve collaboration between Commonwealth and Victorian government-funded services.[297]

Mr Shane Solomon, Partner of Caligo Health, providing evidence in a personal capacity, advocated to the Commission for localised decision making and principles of subsidiarity, stating that effective health services require the devolution of accountability and authority to support freedom to respond to community needs and innovation.[298]

Mr Terry Symonds, former Deputy Secretary, Health and Wellbeing, of the then Department of Health and Human Services, concurred that the principle of subsidiarity should be applied when commissioning services, suggesting that the department's operational commissioning responsibilities might be better conducted by more 'local actors working together'.[299] Mr Symonds stated:

> **While it is critical that government retains a strong statewide strategic commissioning role to ensure accountability to the community, and alignment and consistency of regional approaches; we should also work towards a system where regional operational commissioning is done as close to the community as possible while still retaining efficiencies of scale.**[300]

Locating these functions closer to communities is a major departure from current arrangements, where the Department of Health centrally plans, funds and monitors the delivery of Victorian government-funded mental health services.

Even so, a push towards creating regional bodies to achieve collaboration, and services that are responsive to local communities, is not a new concept. The *Fifth National Mental Health and Suicide Prevention Plan* nominates achieving integrated regional planning and commissioning as one of eight priority areas, with a view to setting 'an enabling environment for regional action instead of dictating change from the top down'.[301]

The Productivity Commission's *Mental Health Inquiry Report* confirms that the approach put forward in the *Fifth National Mental Health and Suicide Prevention Plan* is suitable, but noted that the guidelines for developing joint regional plans are insufficiently prescriptive and too narrowly focused on clinical services.[302]

The Productivity Commission *Mental Health Inquiry Report* highlighted that cooperation between Primary Health Networks and public health services is essential and that, ideally, a grouping of the two 'would act as though it were a single entity, holding a single pool of mental health funds that could be held singularly accountable for mental health service commissioning in its region'.[303] However, in recognition of differing arrangements among the states and territories, the Productivity Commission proposed a flexible approach where each jurisdiction can determine how planning and service delivery can cooperatively occur between Commonwealth and state governments. This includes an option for state government regional commissioning authorities that could work with Primary Health Networks.[304]

More localised decision making and regional commissioning could form part of the solution to a number of problems that consumers, families, carers and supporters as well as the workforce encounter with Victoria's mental health system. As a submission from a member of the workforce described:

> **We need to build holistic solutions that are not run in silos—working together across medical professions such as GP, medication, psychologists or psychiatrists … At the moment the majority of treatment options and services operate in silos—this needs to end—there needs to be greater collaboration, communication and the building of a thorough support network.** [305]

Regional commissioning can contribute to achieving these aspirations. In particular, the service gaps and disjointed responses from different providers that people experience can be repaired by approaches to planning and resource allocation that respond to local needs and show awareness of local arrangements. As a participant at the Commission's Primary Health Network Roundtable described, 'the whole beauty of regional commissioning is about fixing issues, allocating resources to where they need it, and taking, I hope, a consumer centric approach to the way in which we do it'.[306]

5.9.1 Achieving the right balance

Successful regional commissioning approaches depend on government stewardship that balances the need for adherence to evidence-informed service models, and flexibility for local innovation.[307] Mr Frank Quinlan, former CEO of Mental Health Australia, advised in a personal capacity that 'local commissioning without national oversight and standards is likely to fail dismally, but similarly national commissioning without appropriate engagement with local communities is also likely to fail'.[308]

The Commission has heard that separating out the commissioning of mental health services from the commissioning of other health and social services runs the risk of increasing the 'fragmentation and silos that separate mental health from other areas, such as physical health, housing and homelessness'.[309]

Another related consideration for the Commission has been the relationship between the governance of mental health and other health services. The mainstreaming of mental health with other health services means there are shared governance arrangements in place for delivering public specialist mental health services. This dual focus, where governance arrangements cover both mental health and other health services, has obvious benefits but can sometimes lead to mental health being a lower priority.

While still favouring the continuation of shared governance for mental health and other health services, Associate Professor Simon Stafrace, Chief Adviser at Mental Health Reform Victoria, observed in a personal capacity that mental health services can struggle to be given priority:

> Despite the advantages of integrating the governance of public health and mental health services, risks emerge because the process and context of mental health care can be difficult to define and measure, and the needs of the health service more broadly can dwarf those of the mental health component. This combination of factors means that it can be easy to lose sight of and exercise meaningful mental health governance at a board level.[310]

In an attempt to deal with longstanding challenges related to the lack of priority given to mental health, the Victorian Government's 2009 *Because Mental Health Matters* strategy proposed creating mental health boards or committees under the broader governance structures of public health services.[311] Although these changes did not eventuate, the expectation was that these changes would 'support a more collaborative and holistic response to mental health care'.[312]

More recently, Associate Professor Stafrace proposed changes to improve the oversight of mental health services within local health services through creating a mental health subcommittee of a health service board, advising:

> This would have a skills-based membership that would include people with clinical and lived experience and members of the community with any one of a range of related skills such as communication, digital technologies, system design and thinking, implementation science, leadership and culture, and community development, to name a few, all underpinned by a passion for mental health and mental illness. The subcommittee would report directly to the health service board. By virtue of its greater subject matter expertise, it will be able to advise local public health service boards about strategy, financial and clinical performance, organisational culture and risk, community partnerships and participation and will be able to ensure transparency of reporting to the local community.[313]

Similarly, Mr Solomon suggested creating a subsidiary of public health service boards with responsibility for mental health to provide both expertise and some assurance that funds allocated to mental health will be spent on mental health.[314] Mr Solomon highlighted examples from the commercial world, noting that such arrangements could have a number of benefits including opportunities for mental health services to innovate.[315]

The Commission has also considered in parallel the emergence of eight clusters of Victorian health services incorporating public and private hospitals that were formed in response to the COVID-19 pandemic.[316] This includes three metropolitan clusters and five regional clusters.

This formation of clusters has created opportunities for collaboration, demonstrating that clusters can be used within geographic areas to coordinate services and flexibly use service capacity. It is understood the health services have identified further opportunities to collaborate in cluster arrangements, beyond immediate COVID-19-related planning and responses.

Ms Peake advised of the considerable potential of these arrangements:

> We are now consulting on how to sustain and build on the remarkable collaboration we've seen across the system. We intend to make the clusters permanent and, as an integrated commissioner, this would provide the foundations for cross-sector collaboration to deal with multi-morbidity, dual diagnosis and the underlying social determinants of health. It is an opportunity to build a governance structure that helps acute care, primary care, mental health and social care all work together—the vision that the Royal Commission outlined in its interim report.[317]

Any future regional commissioning structures will need to be designed and implemented in a way that allows for collaboration between mental health and wellbeing and other health services, as well as other service systems, with a view to encouraging integration that is centres on a person's needs.

5.9.2 Establishing new Regional Mental Health and Wellbeing Boards

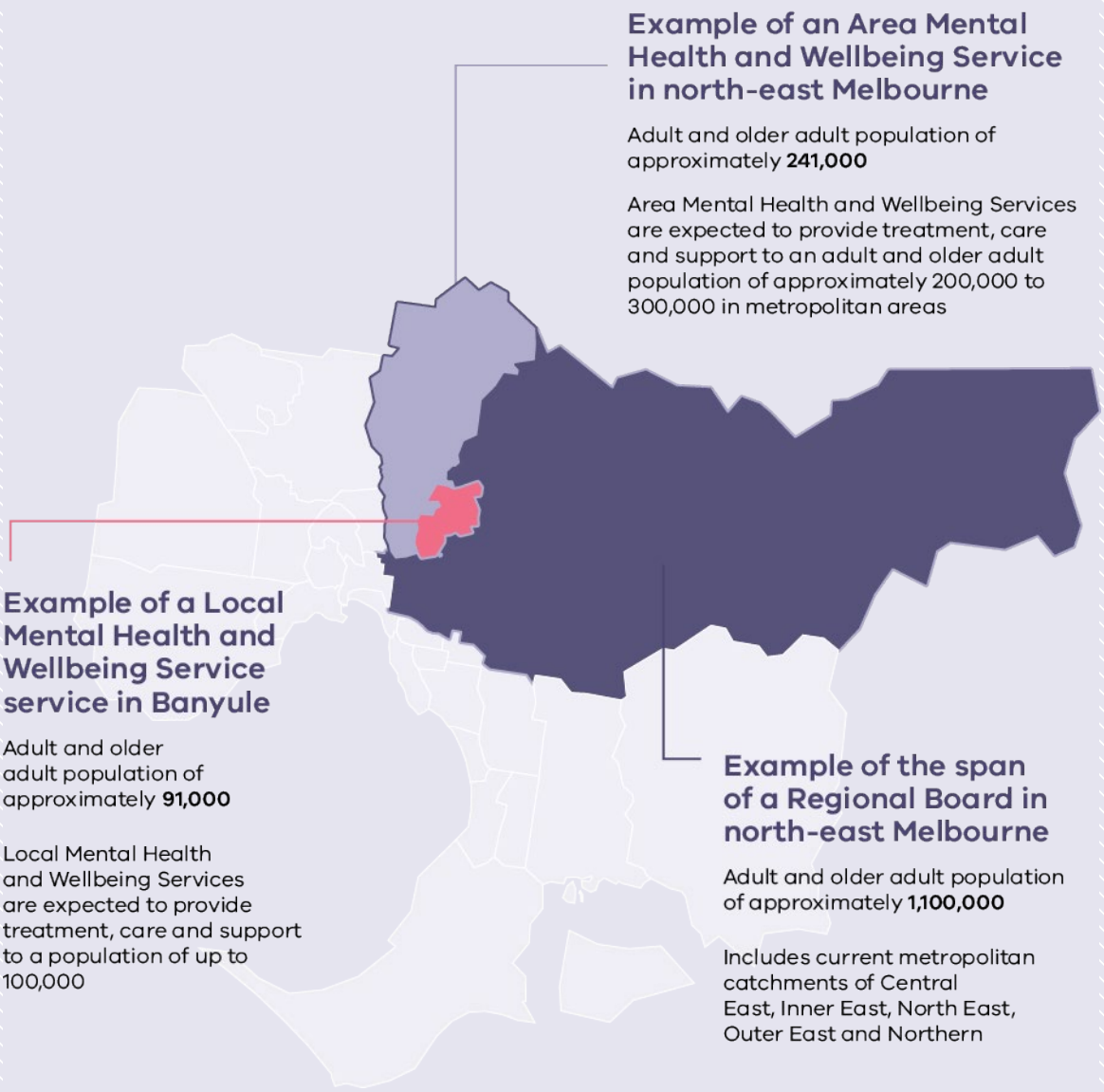
The Commission recommends that eight Regional Mental Health and Wellbeing Boards (Regional Boards) are established throughout Victoria. The boundaries in which Regional Boards operate will span the aggregation of multiple Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services, with alignment across age-based services, so that a range of decisions on mental health and wellbeing services, including how they are planned, funded and monitored, can occur across the life span.

The Commission has purposefully chosen to give the task of determining the precise boundaries for these Regional Boards to the Department of Health. This will allow the department to consider in detail the types of services that are best brought together under these arrangements. As much as possible, the planning and flexible service delivery boundaries for Regional Boards must align with planning and service delivery boundaries for health and other social services.

In light of the need for continued collaboration between mental health and wellbeing services, other health services and social services, the precise boundaries for Regional Boards must align with other existing boundaries such as Primary Health Network boundaries and alcohol and other drug service catchments.

Figure 5.12 shows examples of a Local Mental Health and Wellbeing Service, an Area Mental Health and Wellbeing Service and the span of a Regional Board.

Figure 5.12: Example of a Local Mental Health and Wellbeing Service, an Area Mental Health and Wellbeing Service and the span of a Regional Board



The Commission believes that new Regional Boards are warranted in Victoria's future mental health and wellbeing system. As described earlier, the Commission's aspiration is for Victorians to have access to a diverse service offering that is responsive to their needs and preferences. Establishing Regional Boards furthers this ambition, allowing for treatment, care and support to be planned and resourced in a way that recognises and responds to the needs of different communities.

Rather than embedding these responsibilities within existing public health services or as part of health structures, the new Regional Boards will have a dedicated focus on supporting mental health and wellbeing needs. Given the sweeping reforms proposed by the Commission, a dedicated focus on mental health and wellbeing is needed. Embedding these responsibilities within existing structures risks taking attention away from mental health and wellbeing, which may hamper the goal of improving outcomes and experiences for people living with mental illness or experiencing psychological distress, and for families, carers and supporters.

The Commission considered whether existing providers could partner to make funding decisions but felt this may create a risk of real or perceived conflict of interest, and was therefore considered undesirable by the Commission. For example, this arrangement could mean the service provider that holds funds is less inclined to invest in services that are outside its own organisation. To foster collaboration between service providers and avoid questions arising about the objectivity of decisions made by a regional commissioning body, an independent governance arrangement is preferred.

The Commission's preference for regional governance reflects evidence it received about the importance of joint planning. Professor Shitij Kapur, the Dean of the Faculty of Medicine, Dentistry and Health Sciences and the Assistant Vice Chancellor for Health at the University of Melbourne, who gave evidence in a personal capacity, reflected on arrangements in the United Kingdom that support providers to come together around a common population, noting that the current organisation of the National Health Service 'allows for a greater integration of primary, secondary and mental health care in defined geographies'.[318]

Associate Professor Moylan echoed this sentiment, advising that clear boundaries can assist services with planning and help encourage different services that share boundaries to coordinate.[319]

Regional Boards are to be governed by a skills-based board (rather than a representative board) and will include people with lived experience of mental illness or psychological distress, and people with lived experience as a carer. Members should be appointed by the Governor-in-Council on recommendation by the relevant minister, following a competitive process.

There will be opportunities to engage with local communities through community advisory committees. Regional Boards will seek to support communities to achieve the highest attainable standard of mental health and wellbeing through achieving the following objectives:

- Services are responsive to the needs of local communities.
- Services respond to individual needs and preferences, with a focus on community-based service provision.
- Services are integrated.
- Services are given incentives and support to be safe.

- Resources are allocated to improve outcomes.
- Resources are allocated in a way that maximises value.

To fulfil these objectives, Regional Boards will have the following functions:

- **Understanding need and planning services:** Working with mental health and wellbeing service providers (including those operating Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services), other commissioning bodies, consumers, families, carers and supporters, and their local community to understand need and demand across the life span. This includes understanding the diversity and current and anticipated demographics of communities and developing regional service and capital plans for publication and review by the Victorian Government every three years.
- **Supporting collaboration:** Working with other agencies to support an integrated approach to the planning and delivery of mental health and wellbeing services and other health, disability, alcohol and other drug, and community support services that may support people to obtain good mental health and wellbeing. Regional Boards will also establish integration demonstration projects that bring together multiple providers to support people who need ongoing intensive treatment, care and support, and people who need short-term mental health care and are in the 'missing middle'. Regional Boards will also support Regional Multiagency Panels (refer to section 5.9.4).
- **Funding providers:** Selecting providers and allocating them funding in line with the Commission's standards and to achieve the best possible outcomes for their community. This includes selecting a range of mental health, prevention and early intervention, and suicide prevention and response services, for delivery by Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services.
- **Monitoring providers:** Monitoring and evaluating the performance of service providers and intervening as necessary to sustain services that are responsive to consumer, family, carer and supporter expectations.
- **Workforce readiness:** Undertaking workforce planning and leading localised educational and training pathways and recruitment strategies.
- **Innovation:** With support from the Collaborative Centre for Mental Health and Wellbeing, facilitate research translation and innovation efforts of Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services. This function will support Regional Boards to evaluate, identify and scale valued practices and initiatives.
- **Support access and navigation:** Establishing, coordinating and maintaining service directory information to help people find and access services. Commissioning and organising services in line with a future service capability framework to provide people with planned and dependable access to services.
- **Community involvement:** Engaging with local communities to promote good mental health and wellbeing, and to carry out the above functions.

To discharge these functions, the new Regional Boards will need to be enshrined in legislation. The relevant provisions will be part of the new Mental Health and Wellbeing Act that the Commission has recommended, which is discussed further in Chapter 26: *Rebalancing mental health laws—a new Mental Health and Wellbeing Act*.

5.9.3 Implementing new Regional Mental Health and Wellbeing Boards

The functions described in section 5.9.2 represent the full complement of responsibilities for the new Regional Boards. The implementation of these functions, however, should be staged because they represent a considerable shift in the governance and operating structures for the system.

At the same time, the Department of Health should continue reforming Victoria's mental health and wellbeing system, including the Commission's recommended changes to community mental health and wellbeing services. Establishing these boards is not, in the Commission's view, a precondition to service expansion and reform.

Successful implementation of new regional governance structures will require new capabilities and skills to be acquired. This will take time and dedicated effort. In addition, relationships and trust will need to be established. *All Together*, a report developed by the Sydney Policy Lab from the University of Sydney, said the first principle of commissioning human services in New South Wales should be putting relationships first, stating that the core challenge 'is changing from transaction governance and models of operating to ones that are relational'.[320]

In a contribution to a recent review of the Australian public service, Janine O'Flynn and Gary Sturgess similarly described that commissioning public services needs to emphasise community participation:

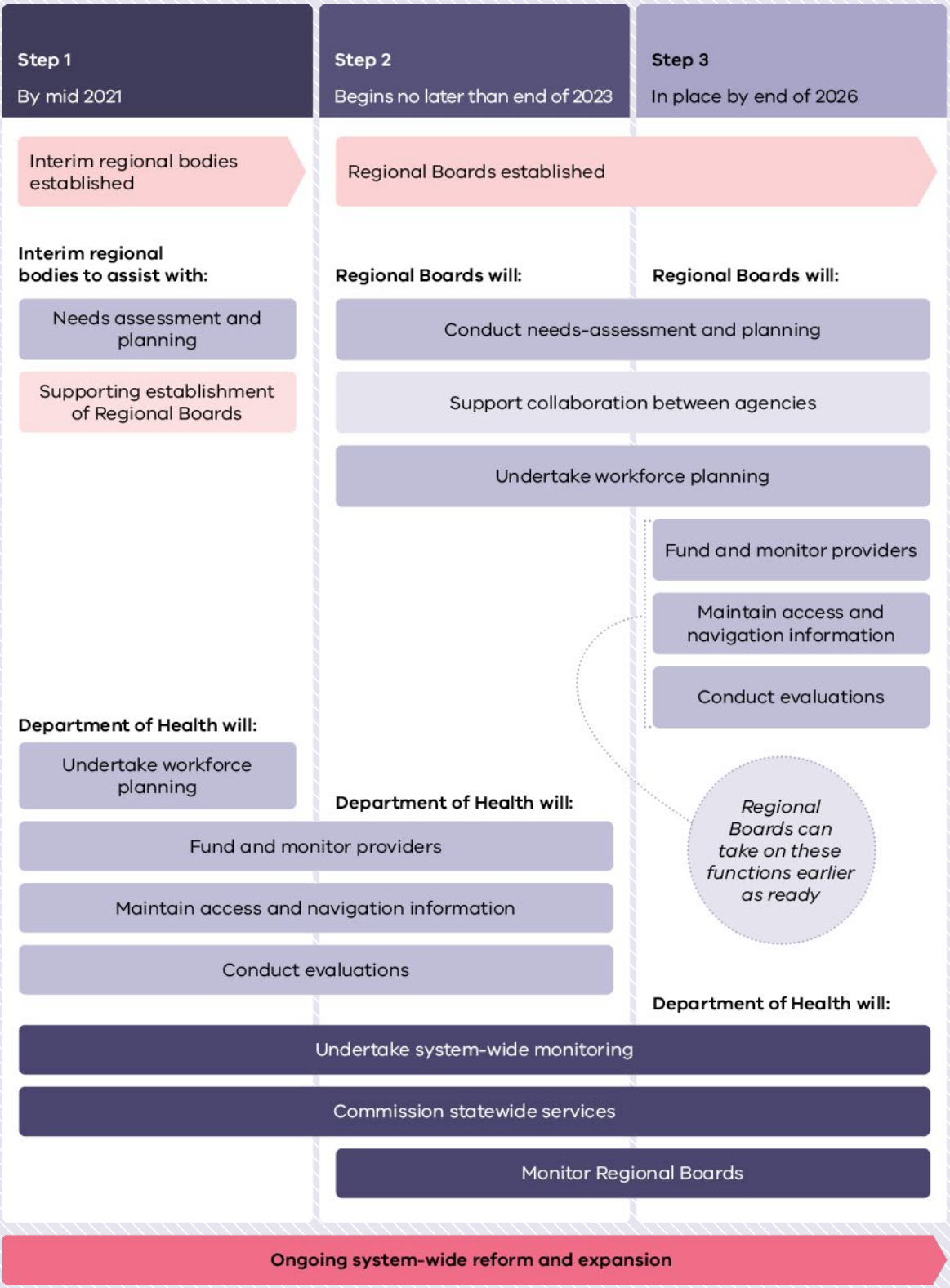
> Commissioning should be anchored to community needs and aspirations, not decisions made by government for communities, and may well be a catalyst for more local solutions rather than central decisions; partnership rather than paternalism.[321]

Continuous communication and developing trust are identified as conditions of collective success:

> Developing trust among nonprofits, corporations, and government agencies is a monumental challenge. Participants need several years of regular meetings to build up enough experience with each other to recognize and appreciate the common motivation behind their different efforts. They need time to see that their own interests will be treated fairly, and that decisions will be made on the basis of objective evidence and the best possible solution to the problem, not to favor the priorities of one organization over another.[322]

A staged approach to implementing the functions of the new Regional Boards will allow for trusting partnerships to be developed between the department, these new entities and service providers, as well as their respective communities (refer to Figure 5.13). This includes relationships with public health services and public hospitals, which will continue to be accountable for delivering health services.

Figure 5.13: Transition of functions from the Department of Health to Regional Boards



As an intermediary step towards establishing Regional Boards, the department will establish eight time-limited interim regional bodies, one in each region, to perform two critical roles by mid-2021. Interim regional bodies should comprise a chair and five members who are appointed based on their skills and understanding of community needs in their respective regions. Interim regional bodies should include a person with lived experience of mental illness or psychological distress and a person with lived experience as a carer.

Interim regional bodies will have two important roles. First, each interim regional body will be responsible for laying the groundwork to support the establishment of their respective Regional Board. This includes building relationships with service providers and establishing strong community participation processes—two preconditions that are critical to the success of regional commissioning.

Second, until Regional Boards are established and have the required skills and capabilities to discharge the above functions, the department will perform their intended functions, with advice from interim regional bodies. This approach will help decisions to be informed by local perspectives until they can be fully performed by decision-makers who have first-hand knowledge of their communities.

As part of this arrangement, chairs of the interim regional bodies will work with the department to put in place a framework to transition to these arrangements. This may include establishing the scope of a future standard operating agreement between the department and each Regional Board—that is, the pathway by which funds will flow between the department to the Regional Board, and then on to service providers—and the associated accountability arrangements.

This collaboration between chairs of the interim regional bodies and the department will also establish the broad parameters for how future Regional Boards will work with other entities such as the new Mental Health and Wellbeing Commission, the Chief Psychiatrist and the new Office for Mental Health Improvement within Safer Care Victoria (discussed in Volume 4).

As part of this transition, the department will work with the Commonwealth Government to maximise the Commonwealth's contribution to mental health and wellbeing services under the *National Health Reform Agreement*.

Once established, Regional Boards are to make functions related to service, workforce and infrastructure planning a priority. As a Regional Board matures, the department will transfer the functions outlined above to the respective Regional Board, and put arrangements in place to hold the Regional Board to account.

The Commission recognises that each Regional Board will mature differently depending on local circumstances and the extent of existing relationships. While all Regional Boards will be performing all of the Commission's desired functions within five years, the pace at which the Regional Boards are established may differ. Early adopters—those Regional Boards that already have the skills needed—must not be held back from realising the full extent of the Commission's reforms. Through an assessment process, the department will need to work with and support those Regional Boards identified as still in development to obtain the desired capabilities so they can eventually take on all desired functions.

The department will also need to invest in supporting the capabilities of Regional Boards, with dedicated, continued investment in the leadership and operation of each Regional Board.

The Commission has purposefully adopted a cautious approach to implementing regional governance structures. Regional commissioning approaches are still maturing, and the risks to implementation that come with such large-scale changes were front of mind. The recommended approach sets the overall ambition of regional governance and puts forward a pathway for implementation that recognises that the full potential of these changes will only be realised if the new arrangements are given time, focus and the structures to mature. For existing service providers, this approach will also smooth and minimise any impacts of transitioning to these structures.

5.9.4 Regional Multiagency Panels

People who seek treatment, care and support from multiple service agencies can experience considerable challenges in finding responsive and coordinated services. To respond to these unmet needs, the Commission has recommended introducing new coordinating structures called Regional Multiagency Panels within each region, supported by Regional Boards. In parallel, the Commission has also recommended an increase in the availability of services, including Assertive Community Treatment, for people living with mental illness who need ongoing intensive treatment, care and support, and for some people who need ongoing treatment, care and support.

Chapter 7: *Integrated treatment, care and support in the community for adults and older adults* sets out the coordination and care planning core function, and the requirements to assist people who have needs for the highest intensity supports.

The primary purpose of Regional Multiagency Panels is to bring different service providers together to support collaboration and accountability in providing services to consumers. As a comparable example, a greater diversity of clinical and other multidisciplinary services are delivered under an Assertive Community Treatment model than may previously have been provided together—including services delivered by alcohol and other drug support workers, vocational specialists and peer workers.[323]

The new system will result in much better coordination of supports without the need for Regional Multiagency Panels—for example, coordination of physical health needs and wellbeing supports. But some supports, such as those relating to housing, National Disability Insurance Scheme packages and the justice system, will often require responses from many other agencies and services.

The core role of Regional Multiagency Panels is to monitor outcomes and service and agency accountability for the proportion of people, or 'shared clients', in a region using services provided by multiple agencies. Through system monitoring, panels will identify service gaps and the actions needed to respond to them. If required in difficult or complex circumstances, panels will support individual consumers by reviewing and discussing those circumstances and engaging in problem solving, where appropriate, in partnership with the person, as well as family, carers and supporters, in the context of performing a caring role.

In the case of adults and older adults with ongoing treatment, care and support needs, Regional Multiagency Panels will support and assist Assertive Community Treatment teams. In the case of children and young people, they will assist mobile assertive outreach teams and the Intensive Mobile Youth Outreach Service. They will do so by providing a forum where Assertive Community Treatment teams and service providers, meeting in a room together, hold each other accountable for providing integrated services to consumers.

Regional Multiagency Panels will find, and then support, consumers in each area to obtain access to the supports they require. An important aspect of the role is examining data provided by service providers to ensure people requiring treatment, care and support do not 'fall through the gaps'. Regional Multiagency Panels' support for individual consumers will be less common where the mental health and wellbeing services in the region, and the other services and agencies providing support in the region, are working well.

As forums for collaboration and accountability, Regional Multiagency Panels will help improve communication between services. They will ensure services are delivered in a way that reduces the barriers and challenges associated with delivery of services from diverse agencies and support service integration.[324] The recommended collaborative, region-based approach also reduces the potential for people to lose connection with treatment and support services and, in turn, reduces the potential for people to 'languish' when multiple agencies do not come together to support people's needs.[325]

The collaborative element of the Regional Multiagency Panel model also ensures:

- appropriate information sharing through building trusted relationships
- sharing of information to deal with service gaps
- collaboration between providers and agencies operating locally
- support for those delivering services to consumers
- clear definition of roles and responsibilities for multiagency support, services and treatment teams (with all roles valued and understood by service providers, treatment team members and members of Regional Multiagency Panels).

In considering how best to support multiagency collaboration, the Commission considered in detail other multiagency collaboration and oversight models currently operating in Victoria. These included the:

- Orange Door (multiagency leadership groups providing oversight and support for family violence support and safety hubs)[326]
- Royal Children's Hospital's Victorian Forensic Paediatric Medical Service SCAN (suspected child abuse or neglect) multiagency panel process[327]
- Multiple and Complex Needs Initiative (MACNI).[328]

Important elements derived from these models are set out in Box 5.3. The Victorian Government must take these elements into account when establishing Regional Multiagency Panels.

Box 5.3: Features of Regional Multiagency Panels

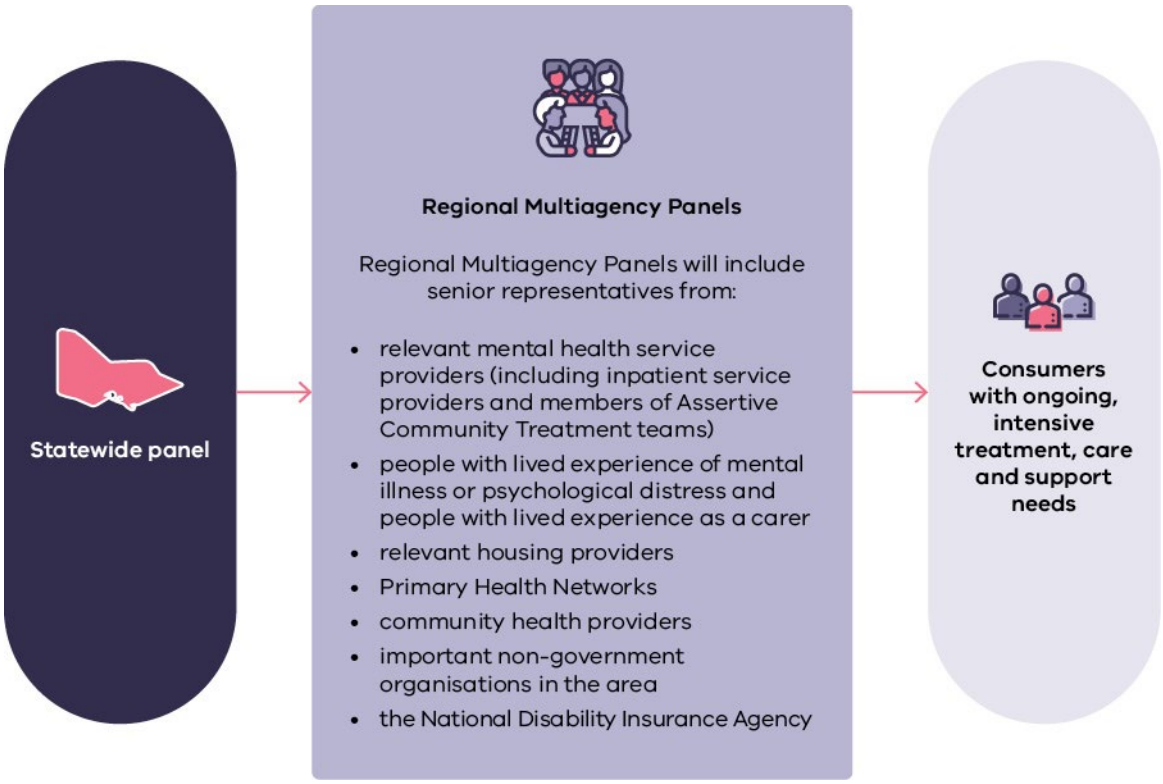
Features required to ensure the effectiveness of Regional Multiagency Panels include the following:

- There are multiple entry pathways for referrals (for example, from acute settings, community settings and other services and agencies).
- Centres of excellence and experts are involved early to shape processes and panel meetings. Multidisciplinary, multiagency approaches ensure expertise and services are mobilised quickly and efficiently.
- The mechanism sits within a policy and procedure framework that commits each agency to the process, and ensures actions are clearly defined and followed up.
- Those involved must understand the respective roles of each of the agency representatives in meetings, and the multiple perspectives and multiple purposes of the arrangements. Representatives accept their roles and the limits of their expertise.
- There is early and continued information sharing with key parties, including sharing of regional data to identify those who need services and may be missing out.
- Panels have both a consumer service delivery oversight and system improvement element.
- Panels have a link to central government to help ensure system-wide lessons are cascaded to Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services.
- The model can be adapted to best use local resources (for example, knowledge, skills, available experts).

In the new model, there will be one Regional Multiagency Panel in each of the eight regions. Regional Multiagency Panels will be supported by Regional Boards to manage requirements across their respective regions, including responding to relevant local needs. Each region will have a well-resourced secretariat to help manage work across the region. While administration and governance will sit at the regional level, Regional Multiagency Panels will have the capacity to hold meetings across their respective regions so they can support local communities and individual consumers, families, carers and supporters.

The group of agencies involved will be diverse and will vary across Victoria. Regional Multiagency Panels will ensure local service delivery conditions and requirements are taken into account, recognising there are variations across the state, and that every person has specific needs. Figure 5.14 outlines the context of Regional Multiagency Panels.

Figure 5.14: Regional Multiagency Panels



Regional Multiagency Panels will include clinical, housing and wellbeing support service providers. The composition of a panel may change each time it meets. Panel composition may depend, for example, on local needs and services, and the needs of individual consumers (including their age).

At a minimum, members of Regional Multiagency Panels will include senior representatives, as outlined in Figure 5.14.

Other people will be invited as needed. For example, Victoria Police or representatives of the Victorian Fixated Threat Assessment Centre (VFTAC) will participate where necessary. VFTAC supports coordination between multiple agencies and services in cases of potential and serious threats of violence. Mr Peter Kelly, Director of Operations at NorthWestern Mental Health, Melbourne Health, Royal Melbourne Hospital, acknowledged the increasing referrals from VFTAC to secure extended care units,[329] a potential rehabilitation pathway for people who will be supported by Regional Multiagency Panels. In cases where Regional Multiagency Panels are supporting children and young people, representatives may be drawn from services such as child protection, out-of-home care providers, education providers and family services.

In line with the features described in Box 5.3, there is an interface between Regional Multiagency Panels and MACNI—consumers may at different times require consideration and support from one or both, and may transfer between them. For example, consumers may be supported through cross-referrals, or continuous and coordinated participation in Regional Multiagency Panels, during and after leaving MACNI.

Where necessary, Regional Boards will commission one of the service providers involved to establish, coordinate and support Regional Multiagency Panels, including secretariat and administrative functions. Otherwise, Regional Boards will undertake these support functions. Regional Boards will also fund these activities and give strategic support to Regional Multiagency Panels where necessary.

Regional Multiagency Panels will also have two broader roles.

The first is providing advice to Regional Boards and the Department of Health regarding broader policy or service delivery matters. Panels will analyse systems and trends to influence strategic thinking. This type of thinking will ensure better support for people requiring the highest-intensity supports from multiple agencies. This role equates to the advice and strategy function of the 17 MACNI area panels.[330]

The second broader role is to provide a governance link between Regional Multiagency Panels and the Department of Health. This governance link is a statewide panel, comprising the chairs of each of the Regional Multiagency Panels chaired by the Chief Officer for Mental Health and Wellbeing from the department, that will resolve complex issues requiring a system-level response.

As with the MACNI model, Regional Multiagency Panels and the statewide panel should be established legislatively under the new mental health and wellbeing legislation recommended by the Commission. This will help ensure the reform endures, and is funded, as a continuing function in the redesigned system. In the interim, the model should be implemented administratively using existing legislative powers in the *Health Services Act 1988* (Vic).

5.9.5 Strong stewardship from the Department of Health to support regional governance

There are a number of potential weaknesses of devolving functions of government to regional entities. These weaknesses include the tension between devolving responsibility and maintaining public accountability, as well as the difficulties of spreading effective practices between regions.[331] Strong stewardship from the Department of Health will be pivotal in this regard.

The Commission is mindful of not further fragmenting Victoria's mental health system, or contributing to disjointed experiences of treatment, care and support, or variable access to services between areas. In particular, the department will need to set clear expectations of all Regional Boards about the standards they must demand of services they are commissioning. It will also need to signal that collaboration and the achievement of integrated services and outcomes must be a priority, rather than a secondary consideration.

A number of submissions have emphasised the importance of the department in the success of regional commissioning models.[332] Reflecting on New Zealand's experience, the New Zealand Productivity Commission explained:

> **Government cannot delegate some important roles. It is the major funder of social services; and only Parliament, led by the Government of the day, can legislate and assign regulatory powers. Government has responsibility for creating and maintaining the 'enabling environment' for the social services system.[333]**

The department recognises that a program of sustained development is required to achieve the full potential of regional commissioning. Mr Symonds believes that an 'expanded set of skills and knowledge' would be required to fulfill changed roles and improve service outcomes.[334] Beyond the generic commissioning skills of needs assessment, contracting, performance monitoring, accounting and budget management, Mr Symonds advised that 'specialist knowledge is required to make coherent decisions and assist with technical aspects', including predicting what demand will be through modelling, as well as assessing service quality and outcomes.[335]

The Commission considers that at the same time as it builds the capabilities of Regional Boards, the capabilities of the department will also have to evolve. In particular, the department will need to take on the role as a strategic commissioner of the mental health and wellbeing system.

Strategic commissioning has been defined as '[a]ll the activities involved in assessing and forecasting needs, linking resource allocation to agreed desired outcomes, considering different options, planning services, and working collaboratively to put these in place.'[336] Strategic commissioning can encourage governments to focus on the role of 'steward of a complex system', helping to sustain a diverse service offering.[337] It allows government to 'better connect purpose and action … because … public sector organisations rarely have control over the whole process of deciding and producing what needs to be done to achieve desired outcomes'.[338]

For the department, becoming a strategic commissioner of mental health and wellbeing services will require new skills and capabilities to:

- assess the needs of the whole population
- set broad directions for the mental health and wellbeing system, such as desired outcomes and the standards of quality, safety and access that must be adhered to
- resource Regional Boards to fund services based on needs in their respective regions
- monitor performance by measuring progress against statewide outcomes, monitoring quality and safety, and holding Regional Boards to account for agreed indicators
- fund and hold statewide services to account.

Building these new structures and capabilities will require concerted focus and investment. Nonetheless, these structures will hold Victoria in good stead to enter into new formalised partnerships with Primary Health Networks and other organisations because they will encourage more coordinated approaches to mental health and wellbeing services, regardless of who funds them. The opportunities such partnerships present, including for pooling budgets, co-commissioning and coordinated approaches to planning, are outlined further in Chapter 29: *Encouraging partnerships*.

Importantly, these structures support efforts to achieve improved outcomes for consumers, families, carers and supporters, and the workforce—a matter that is fundamentally important to the Commission's reform agenda. The Commission has outlined a new *Mental Health and Wellbeing Outcomes Framework* for Victoria in Chapter 3: *A system focused on outcomes*, which will support multiple areas of government to make policy and investment decisions based on the greatest impact.

In the context of the mental health and wellbeing system, the structures proposed in this chapter are a pivotal part of efforts to achieving improved outcomes. In particular, they provide the frame to move towards a stronger focus on value-based commissioning approaches, which seek to create value for consumers by focusing on the outcomes that matter to them, rather than reducing the costs of service delivery or resourcing service providers on a historical basis, or solely for the volume of services they provide.[339]

By positioning the Department of Health as a strategic commissioner, and allowing for localised decision making through Regional Mental Health and Wellbeing Boards, the Commission has established system-wide architecture that enables a focus on improving outcomes.

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Chapter 6

The pillars of the new service system—community-based mental health and wellbeing services

6.1 A new system anchored in community-based services

Chapter 5: *A responsive and integrated system*, introduced the Commission's vision of a mental health and wellbeing system that is reoriented towards community-based treatment, care and support. This requires more than an expansion of existing community-based mental health services. It is a commitment to offering consumers genuine community-based alternatives to hospital or crisis care. It recognises the benefits of care for people in their own communities and close to their homes, families, carers and supporters.

Each person has unique mental health and wellbeing support needs. To improve consumer outcomes, community-based mental health and wellbeing services will recognise and respond to the rich diversity of the Victorian community and the unique backgrounds and experiences of each person.

The need for such reform was highlighted by the Honourable Professor Kevin Bell AM QC, Director of The Castan Centre for Human Rights Law, Monash University, who in giving evidence in a personal capacity, described his professional and personal experiences as a judge and as a father supporting his daughter, Jessica:

> [The system] is too often based upon an essentialised and discriminatory notion of who a person with mental illness is and what they need: once the person is diagnosed with mental illness, that is how they are seen, and they receive the treatment that people like them receive in the system. In my personal, professional and judicial experience, people with mental illness present with various (and sometimes fluctuating) levels of illness and symptoms, susceptibility to treatment, capability strengths and weaknesses, social and family supports etc. They are as diverse as the richness of humanity itself, to which they contribute, as Jessica did.[1]

Community-based mental health and wellbeing services in the future will offer the full range of supports that people living with mental illness or psychological distress need to recover and lead contributing lives. This is a major change to the way that mental health treatment, care and support is delivered in Victoria.

Box 6.1: Wellbeing supports

As part of the shift to a more balanced system, the Commission has chosen to use the word 'wellbeing' in place of the word 'psychosocial'. This is because the term 'psychosocial' is highly technical, with limited meaning in plain English. It is also heavily associated with the disability-based language of the National Disability Insurance Scheme (NDIS).

Instead, the Commission uses the term 'wellbeing supports' rather than 'psychosocial supports'. The Commission envisages 'wellbeing supports' encompassing a broad range of supports that build community connection and social wellbeing, as well as practical life assistance.

6.1.1 Community-based mental health care in the future mental health and wellbeing system

Chapter 5: *A responsive and integrated system* sets out the whole-of-system architecture to guide reforms to Victoria's mental health system. This chapter focuses on what the new system architecture and the Commission's reforms mean for community-based mental health and wellbeing services. Figure 6.1 is an overview of the major components and organising concepts of the future community-based mental health and wellbeing system.

Consumer streams

The left-hand side of Figure 6.1 sets out the five 'consumer streams' that the Commission has developed. These streams broadly define the needs of people across a spectrum of intensity of mental health and wellbeing treatment, care and support. Individual consumer needs will often change over time, meaning that people move between streams. As the complexity or intensity of a consumer's mental health and wellbeing needs increase, they are more likely to be in a higher stream. The streams are explained in section 6.5 of this chapter.

Two age-based systems

The top-right corner of Figure 6.1 sets out the two age-based systems of the future mental health and wellbeing system. In the future system, mental health and wellbeing services will be divided into two distinct age-based systems. The first is an infant, child and youth system for those aged 0–25 years old. It will have two age-based service streams, one for those aged 0–11 years old (for infants, children and families) and one for those aged 12–25 years old (for youth). The second age-based system is for adults and older adults for those aged over 26 years old. This adult system will have a service stream for people with mental health needs generally related to ageing (older adults).

An age-based approach to treatment, care and support recognises that people have different mental health and wellbeing needs related to their stage of life and their development. The future system will deliver developmentally and age-appropriate treatment, care and support.

Six levels in a responsive and integrated system

In the middle right of Figure 6.1 are the six levels of the future responsive and integrated system. As described in Chapter 5: *A responsive and integrated system*, the six levels of the future mental health and wellbeing system show the continuum of treatment, care and support for people with different levels of need, for people of all ages. This chapter focuses on levels three to six. This includes primary and secondary care and related services, Local Mental Health and Wellbeing Services, Area Mental Health and Wellbeing Services and statewide services.

Core functions of community mental health and wellbeing services

At the bottom right of Figure 6.1 are the core functions that Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services will deliver. These have been recommended by the Commission so that there is consistency in treatment, care and support delivered across Victoria. These core functions are:

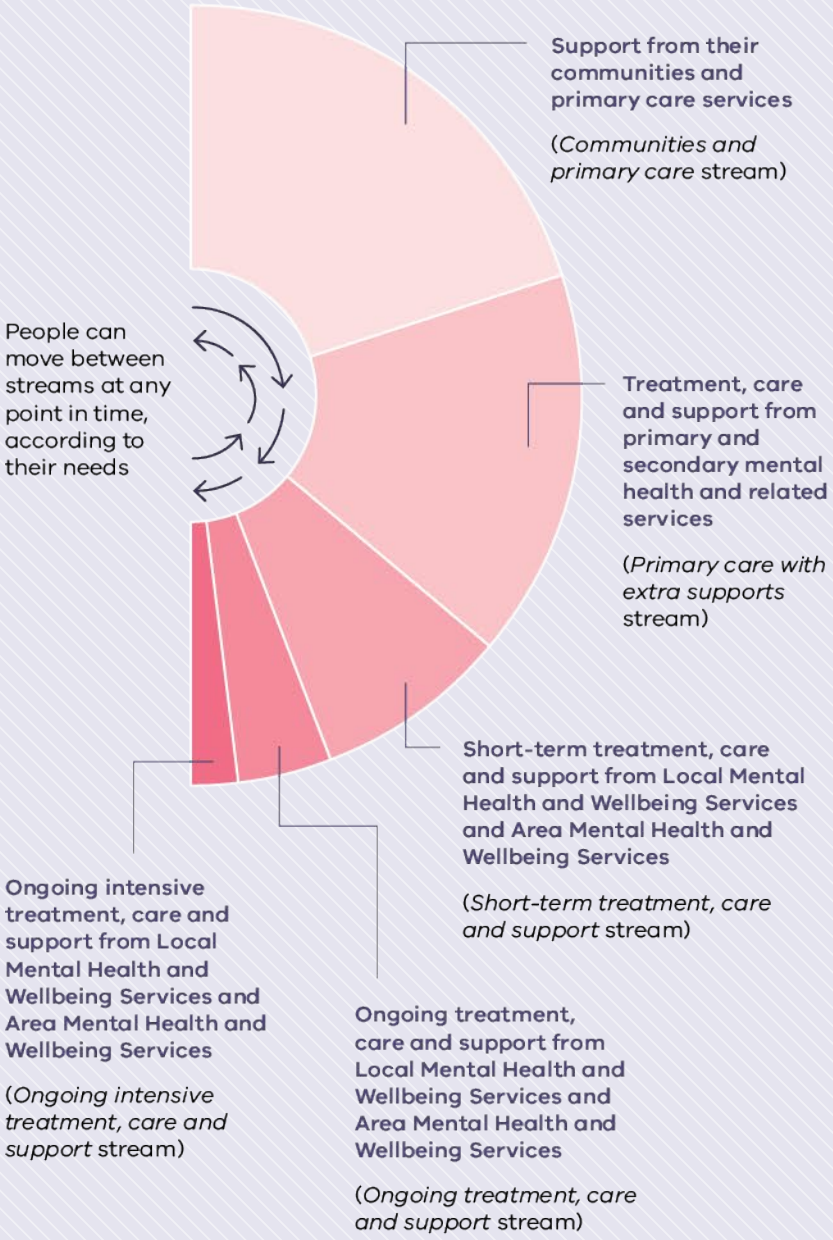
- integrated treatment, care and support across four components:
  - treatments and therapies, including physical health and substance use and addiction support
  - wellbeing supports, including community connection and social wellbeing, life skills, housing, training and employment
  - education, peer support and self-help, including recovery colleges
  - care planning and coordination, so that care is proportionate to need and for continuity of care
- supports for finding and accessing treatment, care and support and to respond to mental health crises
- supports for primary and secondary services, including shared care.

The core functions are explained in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*, Chapter 12: *Supporting perinatal, infant, child and family mental health and wellbeing*, Chapter 13: *Supporting the mental health and wellbeing of young people*, and Chapter 14: *Supporting the mental health and wellbeing of older people*.

Figure 6.1: Community mental health and wellbeing system: consumer streams, age-based streams, services within each level and core functions

At any given point in time, a person living with mental illness or experiencing psychological distress will need:

Consumer streams

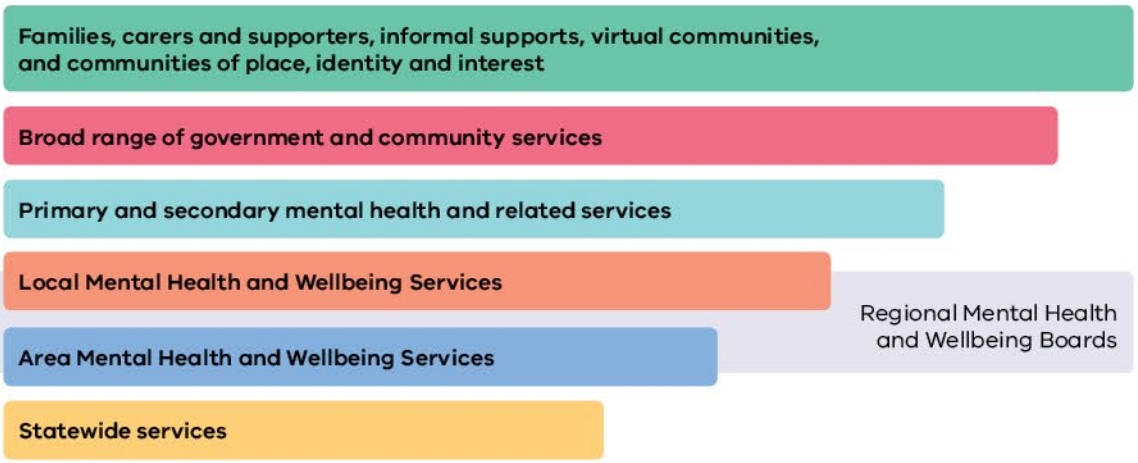


Services provided across two age-based systems

Six levels in a responsive and integrated system

Community mental health and wellbeing services delivering three core functions

Developmentally appropriate transitions will be applied between age-based systems and service streams



Core functions of community mental health and wellbeing services

Core function 1: Integrated treatment, care and support across four components:

- (a) **Treatments and therapies**
- (b) **Wellbeing supports**
- (c) **Education, peer support and self-help**
- (d) **Care planning and coordination**

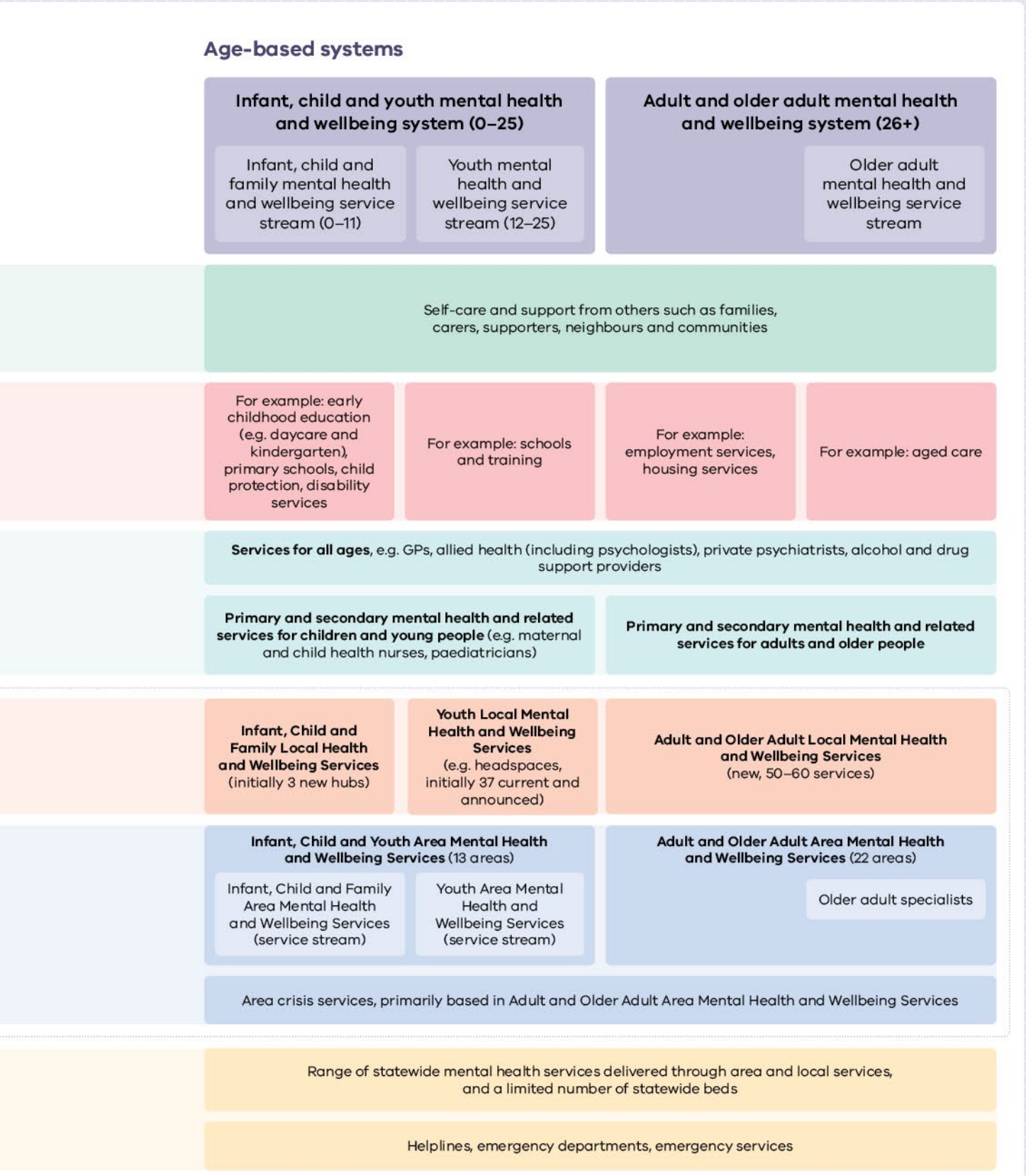
Core function 2: Services to help people find and access treatment, care and support and, in area services, respond to crises 24 hours a day, seven days a week.

Core function 3: Support for primary and secondary services through secondary consultation with providers of those services, primary consultation with their consumers, and a formal model of comprehensive shared care.

These services will be delivered across a range of modes (telehealth and digital technologies; in centres and clinics; and in visits to people's homes or other settings, including through assertive outreach) and will be accessible and responsive to the diversity of their local community.

Figure 6.2: Community mental health and wellbeing system: Levels of services within age-based systems

Developmentally appropriate transitions will be applied between age-based systems and service stream.


Age-based systems
Infant, child and youth mental health and wellbeing system (0–25)
Infant, child and family mental health and wellbeing service stream (0–11)
Youth mental health and wellbeing service stream (12–25)
Adult and older adult mental health and wellbeing system (26+)
Older adult mental health and wellbeing service stream
Self-care and support from others such as families, carers, supporters, neighbours and communities
For example: early childhood education (e.g. daycare and kindergarten), primary schools, child protection, disability services
For example: schools and training
For example: employment services, housing services
For example: aged care
Services for all ages, e.g. GPs, allied health (including psychologists), private psychiatrists, alcohol and drug support providers
Primary and secondary mental health and related services for children and young people (e.g. maternal and child health nurses, paediatricians)
Primary and secondary mental health and related services for adults and older people
Infant, Child and Family Local Health and Wellbeing Services (initially 3 new hubs)
Youth Local Mental Health and Wellbeing Services (e.g. headspaces, initially 37 current and announced)
Adult and Older Adult Local Mental Health and Wellbeing Services (new, 50–60 services)
Infant, Child and Youth Area Mental Health and Wellbeing Services (13 areas)
Infant, Child and Family Area Mental Health and Wellbeing Services (service stream)
Youth Area Mental Health and Wellbeing Services (service stream)
Adult and Older Adult Area Mental Health and Wellbeing Services (22 areas)
Older adult specialists
Area crisis services, primarily based in Adult and Older Adult Area Mental Health and Wellbeing Services
Range of statewide mental health services delivered through area and local services, and a limited number of statewide beds
Helplines, emergency departments, emergency services

Levels of the future mental health and wellbeing system across age-based streams

Figure 6.2 focuses on the specific services that will make up the future community-based mental health system, across the six levels of the responsive and integrated system, and the two age-based systems. It shows that many settings and services are responsible for providing mental health and wellbeing support. Some settings are universal, such as schools, whereas others are specialised, such as bed-based or emergency mental health services.

At the top of Figure 6.2 and as described in Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect*, are the first and second levels of the mental health and wellbeing system. The first level comprises supports including self-care and support from others, such as families, carers and supporters. It includes virtual communities, such as online supports and places, such as those where people work. The second level includes a broad range of government and community services outside the mental health and wellbeing system. These include early childhood education and schools for children and young people, and services for adults and older adults, such as employment services and aged care.

At the third level are primary and secondary mental health care and related services. These include services for people of all ages, such as general practitioners (GPs), psychologists or alcohol and other drug support providers. Certain services at this level are age-specific, for example, maternal and child health nurses or paediatricians.

The final tiers of the system in Figure 6.2 are the three services at the centre of the Commission's reforms: community-based Local Mental Health and Wellbeing Services, Area Mental Health and Wellbeing Services and statewide services. Primary and secondary mental health care and local and area services will be the backbone of Victoria's new mental health and wellbeing system. Local and area services will consist of age-based services for children, infants and families and young people, and for adults and older adults. Where age groups are specified, these will be applied with some flexibility so that people receive the services most appropriate to their developmental needs.

The most specialised level of care is comprised of statewide services, which are described in Chapter 5: *A responsive and integrated system*. Those services will also increase the responsiveness of local and area services to the needs of these consumers.

The reforms the Commission recommends for community-based services align with, as much as possible, the Commonwealth Government's recent strategic directions and investments in mental health. These include the Commonwealth Government's investment in Adult Mental Health Centres.[2] The Commission's reforms also share common features with the establishment of the HeadtoHelp mental health services in Victoria, introduced in response to the COVID-19 pandemic.[3] To fully realise the Commission's vision of a predominantly community-based mental health and wellbeing system, support from the Commonwealth Government is needed to strengthen primary and secondary care.

Box 6.2: Key definition—community-based mental health and wellbeing services

The Commission uses the term 'community-based mental health and wellbeing services' to describe those future services provided outside a hospital setting. These include primary and secondary care, as well as Local Mental Health and Wellbeing Services, Area Mental Health and Wellbeing Services and statewide services.

In the future these services will be delivered in a range of community-based ways. These include site-based services (where people visit a centre, clinic or other service site), telehealth (videoconferencing and phone calls), digital technologies, and home and community visits. For a small number of people with the most complex support needs, this will include assertive outreach.

Community mental health and wellbeing services recognise the relational context in which people living with mental illness are situated; that is, their families, social networks and communities.[4]

In the current system these services include mental health services provided in community settings such as clinics, including outpatient or day clinics, centres, in people's homes or other places, or delivered by phone or videoconferencing, or online.[5]

It also includes wellbeing supports (formerly called 'psychosocial supports'), which are provided in the community by a wide range of non-government organisations.

Some bed-based services—such as Prevention and Recovery Care services—are also provided in the community, rather than in a hospital, and are discussed in Chapter 10: *Adult bed-based services and alternatives*.

The Commission notes that the term 'community ambulatory mental health services' is sometimes used to describe services provided in the community in places such as outpatient or day clinics.[6] An 'ambulatory service' in this context is defined as '[a] specialised mental health service that provides services to people who are not currently admitted to a mental health admitted or residential service.'[7] The Commission is not emphasising the term 'community ambulatory' in this report. This is because the community-based system recommended by the Commission contains far broader services than those currently delivered through 'community ambulatory mental health services'.

6.2 Community-based mental health and wellbeing treatment, care and support

As set out in Chapter 5: *A responsive and integrated system*, the Commission's approach to responding to the needs of consumers is one that prioritises providing treatment, care and support in the community. This approach recognises the need to achieve a balanced system of mental health and wellbeing that recognises individual consumer strengths and preferences.

This section sets out the evidence and rationale for reorienting the focus of mental health and wellbeing treatment, care and support to a community-based model. Specifically, this section focuses on:

- the evidence for a balanced model of community-based mental health and wellbeing care
- a renewed focus on wellbeing
- the evidence for a community-based model of mental health and wellbeing treatment, care and support.

The Commission received a broad range of evidence about the need to rebalance the mental health system towards community-based care. These reasons are well summarised by witness Ms Mary O'Hagan MNZM, Manager Mental Wellbeing, Te Hiringa Hauora, New Zealand, who gave evidence in a personal capacity and explained to the Commission that community is where care is oriented towards improving health and life outcomes for people across multiple domains and over their lifespan.[8] The choice to locate most consumer care in the community is one of 'ethics, evidence, cost-effectiveness and the wishes of people who [use] services'.[9]

6.2.1 A balanced system anchored in the community

The Commission envisages a balanced future system—with a careful mix of hospital and community care, where most care is provided close to people's homes and in their local communities.[10]

Mental health system design expert Sir Graham Thornicroft states that this approach is based on the evidence about what makes mental health systems work:

> there is no strong evidence that a comprehensive system of mental healthcare can be provided by hospital-based care, but nor is there strong evidence that it can be provided by community-based services. Rather, a balance is necessary which includes both hospital and community components.[11]

While the capacity of the system to provide treatment, care and support in bed-based services remains important, only a relatively small number of people will need the highest intensity level of care that bed-based services provide. As Mr Tass Mousaferiadis, Chair of the Board of Star Health and Mr Kent Burgess, Acting CEO of Star Health, told the Commission, 'everything other than psychiatric care for acute [mental] illness could be effectively delivered in a community-based environment'.[12]

Witnesses have told the Commission that achieving a balanced mental health and wellbeing system is required because in an unbalanced system, pressures in one area can adversely affect other areas. For example, Associate Professor Ruth Vine, now Deputy Chief Medical Officer for Mental Health, then Executive Director of NorthWestern Mental Health, Melbourne Health told the Commission:

> As the system came under pressure, component parts put up barriers to access or delay in acceptance … For example, inpatient units are more reluctant to accept patients unless there is a clear rationale or the risk issues are critical. The impact of this includes an increase in caseloads in community settings, and difficulties in consumers accessing beds in a timely way. This impedes our ability to provide person-centred care.[13]

A wide range of stakeholders told the Commission that to achieve a balanced system in Victoria, more mental health care must be delivered through community-based services.[14] This means that community mental health and wellbeing services should be 'genuine alternatives to hospitalisation',[15] with a more integrated approach, where community mental health and wellbeing services are closely linked with primary and secondary care, as well as bed-based care. The National Mental Health Commission explained in a submission to the Productivity Commission that:

> There is a growing international [expert] consensus that mental health services should be placed in the centre of their communities, closely linked or co-located where possible with primary health care and functionally integrated with hospital-based services.[16]

6.2.2 A balanced system with a renewed focus on wellbeing

The guiding principles for reform that the Commission set out in the interim report included respecting the 'inherent dignity of people living with mental illness … and [ensuring they are provided with the] necessary holistic support … to ensure their full and effective participation in society'.[17] This requires an increased focus on social and emotional wellbeing.

In a major structural and cultural change, the Commission is renaming the mental health system the 'mental health and wellbeing system' in recognition of the range of supports that are required for people living with mental illness to live full and contributing lives. So that this change is more than in name only, the Commission has recommended that the mental health and wellbeing sectors, including non-government organisations that provide wellbeing supports, are brought together in partnership. As set out in Chapter 5: *A responsive and integrated system*, this will involve partnerships between public health services or public hospitals and non-government organisations that provide wellbeing supports.

These partnerships are necessary so that there is a more balanced focus on mental health and wellbeing needs. It will reflect that mental health challenges occur within, and are aided or exacerbated by, a person's social context.[18] A person's social context includes safe and stable housing, employment or engagement in education, skills to live independently and connection to others. A stronger focus on them is fundamental to improving consumer outcomes.

Social and emotional wellbeing

People's communities, neighbourhoods and environments affect their health and wellbeing. The Commission has already acknowledged the evidence that 'mental health is shaped by the social, cultural, economic and physical environments in which people live'.[19]

This knowledge has been long held by Aboriginal peoples and is now formalised in Aboriginal approaches to social and emotional wellbeing.[20] The Aboriginal concept of social and emotional wellbeing takes a holistic view of mental health that is 'not limited to connections between the mind and the body'.[21] This concept 'captures Aboriginal people's connections to land, to spirit, spirituality and ancestors, to culture, and to community, family and kinship'.[22]

Building from its work in the interim report, the Commission acknowledges there is much to be learned from the Aboriginal social and emotional wellbeing model. This includes the importance of connecting dimensions of wellbeing: people's bodies, emotions, families and communities, spirit and culture.[23] Consistent with the social and emotional wellbeing model, the Commission acknowledges the important role of experiences of 'safety and security, sense of belonging, control or mastery, self-esteem, meaning making, values and motivation, and the need for secure relationships'.[24]

Ms O'Hagan presented a similar way of understanding mental health and wellbeing when she described the *Wellbeing Manifesto for Aotearoa New Zealand*.[25] The development of the Wellbeing Manifesto was led by people with lived experience of mental illness, with input from their allies and experts. It calls for a wide range of services and supports for people experiencing mental distress that are accessible to everyone, with one central principle, 'we must work together for the wellbeing of all.'[26]

The Wellbeing Manifesto calls on the New Zealand Government to fund 12 'responses' from the 'Big Community wheel of responses and workforces', as shown in Figure 6.3.[27] The figure refers to whānau, a Māori word that is often translated to English as 'family', however, the meaning of whānau has a more complex meaning.[28] '[Whānau] includes physical, emotional and spiritual dimensions' and is 'multi-layered, flexible and dynamic … [t]here are roles and responsibilities for individuals and for the collective. The structure of whānau can vary from immediate family to much broader collectives'.[29]

Figure 6.3: The Big Community wheel of responses and workforces

Source: Witness statement of Mary O'Hagan MNZM, 16 June 2020, p.42.

Note: The response represents a focus of attention and are not necessarily separate services. Many people will only need one or two of the responses. For instance, everyone needs wellbeing promotion but very few people in the population need crisis support. For more information please see the Wellbeing Manifesto, <www.wellbeingmanifesto.nz/brochure-page-03>.

An important feature of the 'Big Community wheel of responses and workforces' is the sense of balance. The wheel reflects the diverse ways people with mental illness or psychological distress can get help to live well.[30] Psychiatric treatments and medications, talking therapies, education and employment supports, stable housing and income supports are all important.[31] As Ms O'Hagan told the Commission:

> **Big Community needs to replace Big Psychiatry at the hub of the system and position psychiatry as one of its many spokes, so that everyone with mental distress and addiction has open access to a comprehensive range of responses.**[32]

This means placing value on clinical expertise as well as other expertise, and creating a system in which different and varied expertise is highly valued and supported.

Rebalancing to a more holistic approach to treatment, care and support

The Commission's vision for community-based mental health and wellbeing support is for a system that approaches treatment, care and support holistically. This means reorienting the current approach, which too often emphasises a 'biomedical model' of understanding mental illness and focuses on physical illness, to one that is more holistic.[33]

Such an approach is sometimes referred to as a 'biopsychosocial approach'.[34] The biopsychosocial approach is not new to mental health. It was advocated for in the 1970s by George Engel as an alternative to the biomedical model.[35] He criticised the then prevailing biomedical model as 'reducing' the understanding of complex human experiences to physiological processes and brain 'dysfunction', and treating people's experiences of mental illness and psychological distress solely with medicines and other physical interventions.[36] Engel argued that mental illness is both a cause and effect of complex and interacting psychological, social and biological processes. Accordingly, it should be treated holistically and account for the 'biopsychosocial' factors relevant to the individual's experience.[37]

A biopsychosocial approach also recognises the central role of consumers as active participants in recovery and good mental health and wellbeing.[38] The biopsychosocial approach is widely acknowledged now as a way to respond to the multidimensional nature of mental health and the influence of interactions between biological, psychological and social factors.[39]

In the course of its inquiries, the Commission has heard about the need to transform current approaches to a biopsychosocial approach. For example, Ms Sandra Keppich-Arnold, Director of Operations and Nursing, Mental and Addiction Health, Alfred Health, stated:

> **At present, mental health services are primarily based on a medical model, and treatment has a strong biological approach, including medication management … If mental health services are serious about providing proper mental health care, they need to embed into routine practice a range of evidence-based therapies to ensure consumers are provided with resources that build resilience and capacity to self-manage … The kinds of therapeutic interventions that support recovery will support the consumer in reducing symptoms (or the impact of symptoms) through structured psychological therapies, promote wellness through exercise, relaxation, mindfulness and other activities, encourage and enable community connection and social participation through group activities, and build skills and knowledge to promote independence. Therapeutic interventions for families and carers are also essential.**[40]

Associate Professor Simon Stafrace, Program Director of Alfred Mental and Addiction Health, Alfred Health at the time of giving evidence, stated that this required a shift from a focus on a 'disease-based intervention' model to a 'supportive health' model.[41] This means having a greater role for consumers and their families, carers and supporters in setting the priorities for service delivery.[42] Consumers also described the need to 'create a culture of change and address medicalisation of human experience'.[43] One consumer said:

> 'You're mentally ill. It's an illness. You have a mental illness.' This is all they say because they don't understand me. Just because you don't see, feel and hear the things I do, doesn't mean I'm not right. I have my own truth and see the world differently.
>
> God gives you tears, laughter and sighs. I don't believe tears are a form of weakness. It is a form of strength. If people who want to cry for 50 years. You don't give women who have lost their child, electrocutions to their brain. When people cry. They cry because they're sad and overawed. Why not cry? We're only human beings. Not computers.[44]

As the Commission heard from one participant at a roundtable on community integrated mental health services, 'part of the way forward is letting go of partisan ways of thinking—individual or institutional; medical or person-centred care'.[45] Another said that the new system must 'avoid dichotomies' between medical and wellbeing approaches.[46]

Taking a more holistic view of the biological, psychological and social factors that are influencing people's lived experiences can guide services to offer more comprehensive responses to people's needs.[47] The need to consider the social factors in mental health and wellbeing was put forward by many witnesses with lived experience of mental illness and recovery. For example, one witness said:

> I think we need to look at the social determinants of health, at economic participation, and at social participation. We need to understand why people want to live, and how people can build a meaningful life. We need to look at whether people have the resources to build a meaningful life, and whether they have the support to do so. For me, it's about far more than the absence of symptoms or the treatment of a medical condition. With or without symptoms, it's about living a meaningful life.[48]

The Commission's expectation is that the future mental health and wellbeing system will adopt this more balanced approach. Such an approach retains an important role for medical perspectives. This can include maintaining a suitable place for the use of diagnoses.

Typically, medicine understands and defines different presentations of mental health issues in terms of 'diagnoses' (for example, depression or schizophrenia), which are intended to reflect clusters of behavioural, cognitive and emotional symptoms, syndromes or observable traits.[49] Diagnosis is useful for identifying treatments that may be effective.

For some consumers, a diagnosis or label can provide clarity about previously misunderstood feelings or experiences, and open pathways to treatment and recovery.[50] It can provide a clinical language to frame certain experiences and feelings of distress. It can give people terms that may legitimise their feelings and enable them to talk about them in ways that are commonly understood.[51]

As one consumer told the Commission:

> After years … I was diagnosed with ADHD. This was both a shock—in particular to my self image as someone who was very organised and efficient—and also a relief—something could finally explain my struggles and help me better manage my life.[52]

Witness Ms Nina Edwards told the Commission:

> I believe [my GP's] ability to engage in critical diagnostics and the need to engage with allied health services outside his own skill-sets and clinical discourse ultimately started my recovery. I recognise the role of psychosocial, spiritual and personal tools I had developed over the years, but my illness and its symptoms outweighed the remedy they could provide. A type 1 diabetic may recognise the importance of monitoring insulin and caloric and carbohydrate intake, however the baseline and inherent pathology cannot be addressed without underpinning diagnostics and a management plan.[53]

However, critiques of the *Diagnostic and Statistical Manual of Mental Disorders* (the DSM)—the manual commonly used to diagnose mental illness—include that it holds too much power.[54] Critics also say it privileges medical opinion and imposes language in a way that '[divests] people's experiences of their personal, social, and cultural significance'.[55] Diagnostic labels can affect the way consumers are perceived and treated by mental health practitioners, and the Victorian Mental Illness Awareness Council argues that labelling can lead to more restrictive forms of treatment.[56]

Given these limitations and challenges, the Commission has been told that alternative frameworks for understanding mental illness may be appropriate. For example, there is interest within Victoria's mental health sector in collaborative or integrated formulation approaches. Integrated formulation approaches involve the consumer and clinician working together to understand the consumer's history, challenges and needs.[57] In its submission, the Royal Australian and New Zealand College of Psychiatrists described a formulation approach as 'more like a story [that] … gathers up all the biological, psychological and social factors that have led to a person becoming unwell and considers how these factors interconnect'.[58]

While the value of professionals being able to hear and understand the holistic lived experience of consumers and their families has been well recognised for some time, psychiatrists told the Commission that '[t]he high pressure, overloaded nature of the current [public mental health system] is eroding the capacity of psychiatrists and psychiatrists-in-training to develop these capacities and expertise.'[59] Consequently, this approach is not yet embedded across mental health services. A participant in the Commission's human-centred design workforce focus group noted:

> My aspiration, I think, would be around a greater focus within the workforce being able to stop and think about what the experience is of the people who are seeking care and how it is that our services may be able to work with them in a way that promotes their wellbeing and doesn't get in the way of things getting better for them … for me a key thing is the use of the core basis of formulation and making that really strongly embedded within all of the work that we do.[60]

The future community-based mental health and wellbeing system will deliver a more balanced, biopsychosocial approach to treatment, care and support. Key enablers of this include the future workforce and approach to partnerships. As discussed in Chapter 33: *A sustainable workforce for the future*, the future system will support multidisciplinary teams where professionals with different skills and perspectives collaborate to provide coordinated, holistic responses that consider the strengths and aspirations of individual consumers.[61] Chapter 28: *Commissioning for responsive services* and Chapter 29: *Encouraging partnerships*, describe approaches that will support partnerships between mental health and wellbeing services.

6.2.3 Community-based services enable connection, healing and recovery

The Commission's support for community-based mental health and wellbeing services recognises the importance of enabling consumers to stay connected to their community and social networks. Communities are where people have relationships, resources and tools that they can draw on to help them manage their levels of distress and move towards recovery. For example, Mr Dave Peters, a lived experience worker and mental health advocate, told the Commission about the benefits of community-based mental health and wellbeing services:

> Being part of a community can have a positive effect on mental health and emotional wellbeing. Community involvement provides a sense of belonging and social connectedness. It can also offer extra meaning and purpose to everyday life. Communities can exist or be created from a shared location, hobbies, lived experiences and backgrounds, or a common cause. For many people, communicating with others—through online forums, social media, or in person—can help them to have a healthier mindset, improved self-worth, and greater enjoyment of life. In my experience, when consumers and carers talk about community-based services, they are looking for this broad spectrum of services.[62]

Community connectedness is important for supporting recovery and healing. As Ms Julie Anderson, Senior Consumer Adviser in the Office of the Chief Mental Health Nurse and the Office of the Chief Psychiatrist in Victoria, giving evidence in a personal capacity, told the Commission:

> Staying connected is a principle of recovery, therefore, a person may get what they need from a community hub while maintaining a local community connection through volunteering with the local council, being connected with neighbours, local gyms and sporting clubs.[63]

Community-based mental health care can increase social connectedness of people of all ages, including older people, who may be at risk of social isolation or loneliness.[64] Dr Claire Gaskin, Forensic Adolescent Psychiatrist, University of New South Wales, giving evidence in a personal capacity said, '[i]t is best practice to keep people as close to home as possible and keep them connected to their community'.[65]

Professor Graham Meadows, Professor of Psychiatry, Monash University School of Clinical Sciences at Monash Health, giving evidence in a personal capacity, cited research from the Netherlands which described contemporary mental health services in the following terms:

> The mental health service of the 21st century may be best conceived of as a small-scale healing community fostering connectedness and strengthening resilience in learning to live with mental vulnerability, complemented by a limited number of regional facilities.[66]

Witnesses and consumers identified connection to community as a critical component of healing and recovery. For example, witness Ms Sandy Jeffs OAM stated:

> The best thing about providing such a community [a therapeutic community] is for people to have their mad comrades around them to offer support to each other … The problem is that there's nowhere for people to gather to tell their war stories – there are no drop-in centres, no art studios or places for people with mental illness to actually congregate and talk to each other, or support each other.[67]

Witness Professor Alan Rosen AO, Professorial Fellow, Illawarra Institute for Mental Health, University of Wollongong and Clinical Associate Professor, Brain and Mind Centre, Sydney Medical School, University of Sydney, also described community as a place where people heal.[68] This reflects international literature suggesting that local mental health services should focus on integration and connectedness, and 'have an authentic "look and feel" of a local healing community'.[69] Australia's *A National Framework for Recovery-Oriented Mental Health Services* states:

> Most of a person's recovery occurs at home, so their family, friends, neighbours, local community, church, clubs, school and workplace have an important part to play. Recovery oriented services can facilitate and nurture these connections, so people gain the maximum benefit from these supports.[70]

6.2.4 Community-based services are preferred by many consumers

Throughout the Commission's various engagements with the community, many consumers, families, carers and supporters stated a preference to be supported in their home or in the community. Research on consumer preferences indicates that this can be because community-based care is less disruptive, more familiar and less stigmatising than care in a hospital setting.[71] For some people, the experience of care in hospital can be intimidating and upsetting.[72]

One consumer described the jarring transition from community mental health services to hospital care:

> People go from a [community] environment like headspace to a very clinical, unpleasant environment like the hospital.[73]

Another consumer described how a well-designed community mental health service can act as a powerful source of community connection after a disaster:

> We see this during the bushfires, when those community hubs get called in … the underpinning thing that keeps people going is the camaraderie. It is the connection to people and no, it doesn't work for everyone. But again, you're creating a network, a web of people … it's a safety net … the community is actually the safety net that supports people … it's not the mental health system. It's the community system.[74]

Another consumer explained the benefits of community-based care that is focused on recovery:

> Mental health community support services work well. You see the impact of not being in a strictly clinical service—it's more person-centred, focused on recovery, and with access to peer workers and group work.[75]

6.2.5 Community-based services involve families, carers and supporters

The Commission acknowledges the role of families, carers and supporters in supporting the mental health and wellbeing of the person they care for and the significance and importance of this role—to individuals and to the system. Everyone lives in a social context. Regardless of the type, diversity and closeness of peoples' relationships, they are often a source of comfort, support and strength. As Ms Marie Piu, CEO, Tandem, told the Commission, '[m]ost people with mental health issues live in the community with family and friends supporting them.'[76]

A community-based system brings treatment, care and support closer to people's homes and families, carers and supporters than is possible in many bed-based settings. This recognises that:

> people live their lives in the community. That the community is probably the biggest influence of somebody's mental health … We should be focussed on activating the community support[s] that are actually going to help somebody live their life in the community. Now, clearly, we have to access professional care and different spokes … Some of which will be healthcare, and some of it, which will be a much broader kind of series of supports and relationships in somebody's community, that's going to enable them to build a thriving life in the community.[77]

A community-based mental health and wellbeing system is one that should consider consumers' social contexts.[78] Accordingly, the system should encourage family, carer and supporter involvement.[79] There is an opportunity for mental health services for people of all ages to integrate a family-centred approach that is currently most common in child and adolescent mental health services.[80]

Through expert roundtables, the Commission heard about the importance of 'activating' the supports that consumers derive from their communities and their families, because these were highly influential recovery factors:

> good community based, community driven mental health is about recognising that people live their lives in the community. That the community is probably the biggest influence of somebody's mental health, that community connection linking to mainstream and supporting people to do that is probably the critical piece. The first question we should ask for people who are your friends and family that actually help you support your mental health, rather than going into a mental health kind of … risk assessment. We should be focused on activating the community support that are actually going to help somebody live their life in the community.[81]

For others, the inability to access community-based services close to home means a detrimental separation from support networks. For example, witness Ms Georgia Harraway-Jones told the Commission that the lack of accessible and appropriate local services meant that when she was a teenager, she needed to arrange a private inpatient stay and travel for hours on her own to get there.[82] She told the Commission:

> During my inpatient stay in Geelong I felt isolated as my family couldn't visit me and neither could my friends. This made my treatment difficult. I was also far away from my local treatment team.[83]

Families, carers and supporters emphasised the need for community-based mental health and wellbeing services that welcomed them and supported them. One consumer suggested that a welcoming approach for family members could encourage consumers to engage with services:

> I have this imagining of a community place where I might turn up to get, you know, a pathway forward. As a carer, I might turn up initially on my own. But then if I was welcomed and felt safe, I might bring my kids in next … and if … my kids were happy, we might be able to convince, you know, dad to come in as well … I think part of the understanding of having a community response is to recognise that it's not only the person going through the addiction that gets limited in their capacity.[84]

The Commission's vision for a new approach to families, carers and supporters is detailed in Chapter 19: *Valuing and supporting families, carers and supporters*.

6.2.6 Community-based services enable early intervention and can be cost effective

Community-based treatment, care and support better enables early intervention. As described in the Commission's interim report, early intervention in mental health can involve equipping people to deal with the signs and symptoms of illness or distress and 'helping people as soon as possible once mental distress is identified'.[85] The Commission has heard much about the need to focus the attention of the mental health and wellbeing system on early intervention.[86]

Evidence suggests that early intervention programs can be effective in delaying and reducing the impact of mental illness.[87] However, early intervention is often difficult to access or unavailable in the current system. Systemic failures mean that consumers are often unable to access services at a time when treatment, care and support would make the greatest difference. People often have to wait until their needs escalate to enable a diagnosis of mental illness, or to the point of crisis, before they get help.[88]

Importantly, early intervention should be available at any stage of life.[89] This means that the mental health and wellbeing system should offer opportunities for people to receive treatment, care and support early in the onset of mental illness regardless of age. In the current system, early intervention is particularly lacking in current services for adults and older people. As one person told the Commission:

> **Early intervention … is missing within current adult community funded programs due to reduced capacity and resources to respond to early warning signs or those considered sub threshold for current inclusion criteria for services.[90]**

Rebalancing the system to offer more community-based treatment, care and support will mean that people are helped earlier in the onset of mental health and wellbeing challenges. Primary and secondary mental health and related services in the community are critical for achieving this. Primary care practitioners often form ongoing relationships with individuals and families. These relationships can make it easier for primary care staff to identify people's emerging mental health needs and monitor their physical and mental health and wellbeing.[91]

Service providers told the Commission that opportunities for early intervention can arise from strong collaboration between primary care and specialist mental health services.[92] For example, community health provider cohealth told the Commission that there is an opportunity to:

> **invest significantly in community-based early intervention and support services to shift the orientation of the mental health system towards keeping people well and reducing the need for acute care. This needs to include significant re-investment in community-based psychosocial rehabilitation, based on recovery-oriented practice, for those who need it.[93]**

A focus on early intervention can be particularly powerful for young people, as detailed in Chapter 13: *Supporting the mental health and wellbeing of young people*.[94] It can, for example, enable intervention at an early stage when behaviours are first emerging and before they advance to the stage of a diagnosis of mental illness.[95] Evidence indicates that early intervention can have substantial long-term benefits for a young person's development and wellbeing.[96] The Commission heard that early intervention in emerging mental health problems during childhood and youth can be particularly powerful in preventing or reducing the severity of mental illness in adulthood.[97]

The Commission heard repeated calls for increased investment from state and federal sources in community mental health and wellbeing, including wellbeing supports.[98] The Productivity Commission also found that psychosocial support (or wellbeing support) programs can be cost-effective because they prevent mental illness getting worse and therefore reduce demand for more resource-intensive services.[99]

There is some evidence to suggest that integrated, community-based mental health and wellbeing services, which provide lower-intensity forms of treatment, care and support, can be cost-effective.[100] There have been several analyses of the cost savings from investment in community mental health services in Australia, including most recently in the Productivity Commission's *Mental Health Inquiry Report*.[101] The historical experience in Victoria also indicates savings through reductions in inpatient services and increased investment in community mental health.[102] However, as the Commission highlighted in its interim report, over time the effectiveness of Victoria's community mental health system was undermined by inadequate funding as priorities shifted away from mental health.[103] As Ms Kym Peake, the then Secretary of the Department of Health and Human Services observed, growth in funding has not been consistent over the last decade, and has often been used to fill gaps, rather than increase service capacity.[104]

There is some evidence that in health systems where investment in community mental health has been sustained, overall costs of care in the community can be comparable to those of bed-based services for long-term patients, depending on the models of care.[105] However, even in those contexts where costs may be comparable, the quality of life and satisfaction of people receiving care in the community have been found to be consistently higher compared to people receiving treatment in hospital.[106] As such, investment in community mental health can be seen as more cost-effective because it delivers better outcomes.[107]

For example, Assertive Community Treatment may reduce people's need for bed-based services.[108] One study of 31 consumers who participated in an Assertive Community Treatment program in Victoria indicated that there was a substantial reduction in the number of days the consumers spent in bed-based services. In the 12 months before participating in the treatment program the consumers had a total of 2,128 days in bed-based care, but this reduced to only 305 days during the program.[109] A cost analysis estimated that this saved the health service a total of almost $430,000 per annum, equating to almost $14,000 per consumer.[110]

The Productivity Commission noted that community-based mental health care is associated with substantial cost savings and improved consumer outcomes.[111] It also found that if a consumer is accommodated in supported housing and receives 'community ambulatory' care instead of bed-based care, there may be substantial cost savings.[112]

Making sure people get the help they need as early as possible is also good for the mental health and wellbeing system as a whole. Evidence suggests that 'spending a higher proportion of funds from within existing resources on keeping people well and in the community by focusing on prevention, early intervention and recovery [may] help tackle both the growth in costs and overall expenditure'.[113] As Professor Rosen and Professor Maree Teesson AC stated, '[e]arly intervention is a good investment. It can be progressively implemented in conditions at every phase of the life cycle, and in every stage of most mental and substance use disorders.'[114]

Early intervention can also apply to wellbeing and other life supports, which can better enable people to lead contributing lives. Wellbeing supports will involve connecting people to other services such as legal, disability, financial and income supports, family violence, housing, migration and refugee services, culturally specific services, employment, education and training, and gambling support. As the Victorian Government submitted to the Commission, these services can play a key role in early intervention.[115] The Commission expects that strengthening connections between community mental health and wellbeing services and other services will improve their ability to identify early signs that people may need help and connect them with relevant services.

In addition, reducing the need for consumers to visit emergency departments or be admitted to inpatient units to access treatment, care and support is consistent with a human-rights based approach to non-coercive options provided through community-based service offerings. Treatment, care and support provided to people earlier, and in the community, may reduce the likelihood of a person experiencing compulsory treatment, seclusion and restraint.[116] This responds to broader concerns that consumers have about human rights issues in clinical mental health environments, leading many to suggest community-based care as a less restrictive option.[117]

Chapter 5: *A responsive and integrated system* describes the Commission's vision for a system that is informed by a staged model of care for delivery of services to individuals. This will support prevention, early intervention and enable more people to stay well and live life on their own terms.

6.3 Diverse and varied delivery of treatment, care and support

This section outlines two of the defining features of the Commission's vision for the future community-based mental health and wellbeing system:

- community-based mental health and wellbeing services will deliver treatment, care and support through a range of modes
- community-based mental health and wellbeing services are accessible and responsive to the diversity of the Victorian community.

6.3.1 Community mental health and wellbeing services delivered through a range of modes

In order to be responsive to the needs of consumers across Victoria, community mental health and wellbeing services will offer treatment, care and support across the three core functions and through a range of delivery modes. These delivery modes include:

- site-based care (where people visit a centre, clinic or other service site)
- telehealth (videoconferencing and phone calls)
- digital technologies
- home and community visits and, for a small number of people with the most complex support needs, assertive outreach.

This range of delivery modes is important because the Commission's aspiration is for consumers to have more flexibility in how their treatment, care and support is provided, so that it responds to their needs, strengths and life circumstances. Wherever possible and appropriate, it should be easier for consumers to access treatment, care and support in a mode and location that makes them feel safe and comfortable. Expanded use of telehealth or videoconferencing, as well as digital services, will increase efficiency and extend the reach of services, especially in rural and regional areas.

Clinics and centres

The default and predominant mode of delivery for most services will be site-based care, where people travel to the service site—a mental health clinic, multiservice centre or any other building in which services are based. This will allow those physical spaces to become centres of activity and community in the mental health and wellbeing system.

The sites will be designed to be welcoming and comfortable environments that normalise the experience of visiting a service. They will be places where activities can happen (for example, group supports) and where people may be more likely to feel like they belong to a community. Local Mental Health and Wellbeing Services will have walk-in access, meaning consumers can 'drop in', as well as extended hours, giving people greater flexibility and opportunity to get the help they need.

The headspace model provides an example of a welcoming and pleasant community-located mental health environment. As Mr Jason Trethowan, CEO of headspace, told the Commission:

> **Service access is facilitated by ensuring that the centre has a welcoming environment, in both its physical setting, and a non-judgemental and personalised staff response and orientation process. The service must be youth-friendly, and socially and culturally inclusive.**[118]

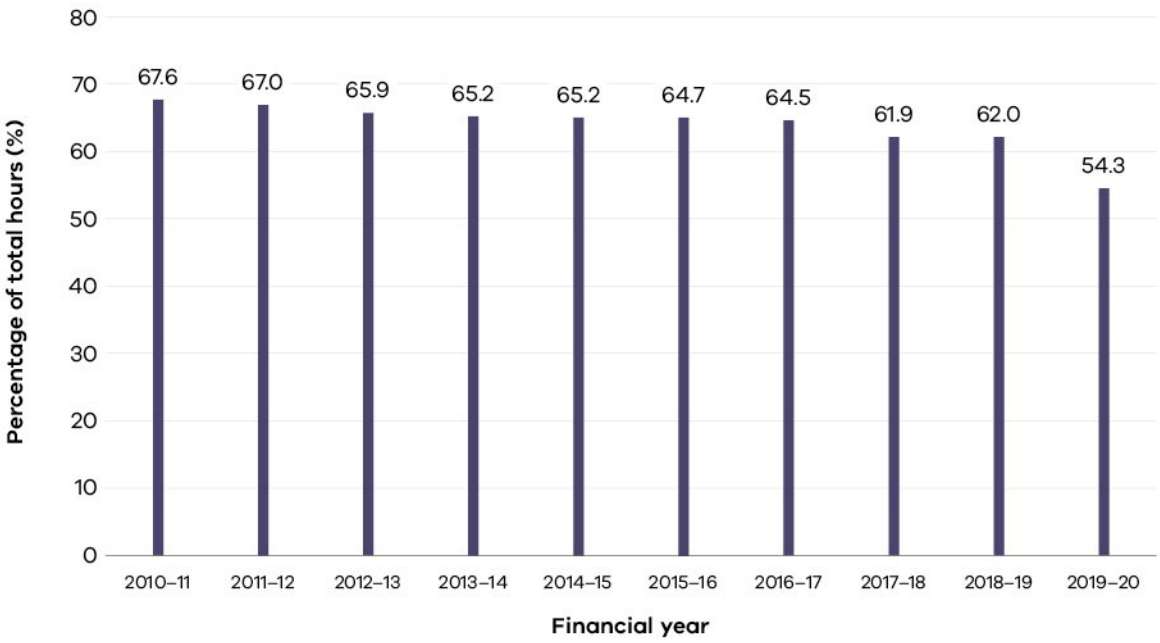
In designating site-based care as the default and predominant mode of delivery, the Commission emphasises the important role of face-to-face treatment, care and support. Data analysed by the Commission indicates that in the 10 years from 2010–11 to 2019–20, the number of face-to-face hours of community mental health treatment, care and support steadily decreased (refer to Figure 6.4). The more marked decrease in 2019–20 is as a result of the COVID-19 pandemic. The Productivity Commission also noted the gap in the provision of community mental health services compared to demand for services and suggested that the hours staff spend on consumer-related activities were insufficient.[119]

Telehealth

Some forms of mental health care and wellbeing supports can be provided via telephone or video calls—collectively known as telehealth. Telehealth can also play a critical role in providing greater equity of access to services for people who live in remote and regional locations. Experts informed the Commission about the need for more investment in telehealth to improve service access in regional and rural areas.[120]

The increased adoption of telehealth services due to social distancing requirements during the COVID-19 pandemic has shown that, although it is not suitable for everyone, this mode of service delivery can give consumers more choice over how and when they receive help.[121] By way of illustration, Figure 6.5 sets out the increase in telehealth items under Temporary Medicare Benefits Schedule items for different practitioners and clinicians—including GPs and psychologists—between March and September 2020. The increased use of telehealth in March and July corresponds with Victoria's first and second waves of COVID-19 and related lockdown measures.

Figure 6.4: Direct community contact hours (face-to-face contact) as a proportion of total community contact hours for public specialist registered clients, all ages, Victoria, 2010–11 to 2019–20



Source: Department of Health and Human Services, Client Management Interface/Operational Data Store 2010–11 to 2019–20.

Notes: 2011–12, 2012–13, 2015–16 and 2016–17 data collection was affected by protected industrial action. The collection of non-clinical and administrative data was affected, with impacts on the recording of community mental health service activity and client outcome measures.

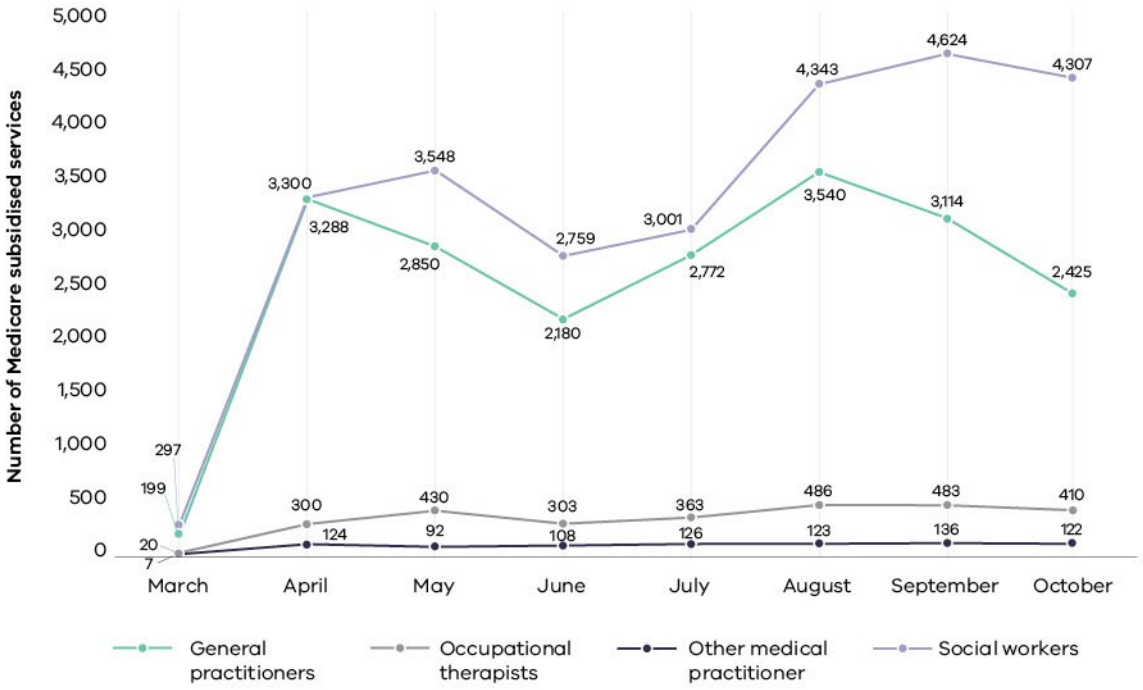
Digital technologies

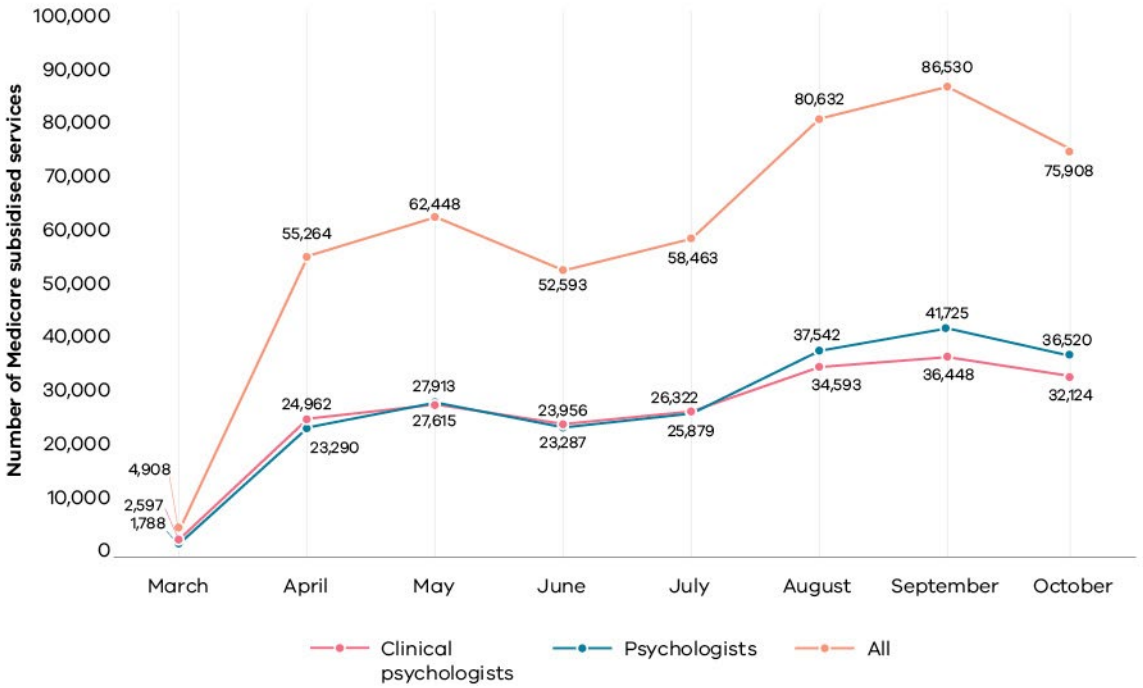
Digital technologies are now well-established modes for mental health service delivery and have been shown to be effective in a range of situations, from ongoing care through to crisis responses and helplines. Some forms of treatment, care and support have been specifically designed for delivery over a digital platform. This might be preferred by consumers who cannot attend a physical location, or because it is what works best for them.

Using technology to deliver mental health services is increasingly considered a way to focus on prevention, early intervention and to deliver more integrated and person-centred care.[122] There are several evidence-based digital interventions available that appear to be as effective as face-to-face therapy of the same nature.[123]

One example of a digital intervention is Orygen's Moderated Online Social Therapy (MOST) platform, which was launched in July 2020.[124] The platform offers a range of face-to-face and digital mental health supports to young people and is staffed by professionals, including peer workers. It provides a range of tools, including personalised therapy programs, a digital toolkit to build resilience and coping skills, and a safe, virtual support network to provide meaningful social connections.[125]

Figure 6.5: Number of COVID-19 Temporary Medicare Benefits Schedule telehealth services processed, by occupation, Victoria, 2020





Source: Australian Government Services Australia, Medicare Statistics: Medicare Item Reports, <www.medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp> [accessed 14 November 2020].

Notes: COVID-19 – Temporary MBS telehealth items: General practitioner telehealth items–92112, 92113, 92114, 92115, 92116, 92117, 91818, 91819, 92210; Other medical practitioner items–92118, 92119, 92120,9 2122, 92123, 91820, 91821; Occupational therapist items–91172, 91173; Social workers items–91175, 91176; Clinical psychologists items–91166, 91167; Psychologists items–91169, 91170.

For further information, see COVID-19 Temporary MBS Telehealth Services <www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-TempBB>.

Through the Commission's consumer engagements, young people aged 16–25 years old, and who have recent lived experience of child and youth mental health services, told the Commission that they wanted alternatives to phone-based or in-person mental health care:

> You shouldn't have to talk on the phone to be accepted into services.
>
> Access is less phone based with more contact via email or text.
>
> Use multiple channels to reach me—text, phone, app, web, email.[126]

The application of digital platforms to mental health is described fully in Chapter 34: *Integrating digital technology*.

Services provided in people's homes and other settings

As noted earlier, the Commission anticipates that attendance at a site-based service will be the main mode of service delivery for many people. However, for some consumers, site attendance will be supplemented by home and community visits.

Four types of services will be offered in homes and other settings:

- crisis outreach services, as described in Chapter 9: *Crisis and emergency responses*
- hospital in the home services, as described in Chapter 10: *Adult bed-based services and alternatives*
- home and community visits, as described below
- assertive outreach, as described below and detailed further in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*.

Home and community visits

The future mental health and wellbeing system will have more capacity to provide services, on an as-needed basis, by visiting people in their homes or out in the community. This can include, for example, visits in parks, cafes, or other service settings such as accommodation services or residential aged care settings. This will also allow for on-site provision of integrated treatment, care and support in supported housing, as outlined in Chapter 16: *Supported housing for adults and young people*.

Consumers and family members explained to the Commission why some people may need contact through home and community visits. For example, one consumer described experiencing agoraphobia (a fear of entering open or crowded places or of leaving one's own home) which was a barrier to attending clinic-based services. The consumer said that home-based services would have helped them earlier in the illness.[127]

A carer spoke about the benefits of home visits for her mother:

> Staff come to our home. This is working really well and we are seeing improvements in our mum. They come and check on her and make sure she is taking her medications. They come to talk and have a coffee with her. But there needs to be more of it.[128]

Ms Keppich-Arnold advised the Commission that it is important for mental health practitioners to see some consumers in their own homes:

> The ability to assess consumers in their home environment or elsewhere in the community is vital … We have a far better capacity to assess someone in their home environment. For example, we may see that a consumer lives in poor conditions, or does not have food in their fridge which allows us to understand their illness in context. It enables us to build a strong relationship with consumers.[129]

These models of home and community visiting can be given in a person's home or community setting for a limited period, before moving to clinic-based care when the person is ready. For example, some mental health services in the United Kingdom offer support where '[s]taff … visit for a few hours per week, providing practical and emotional support, with the aim of reducing support over time to zero'.[130]

Some home and community visiting programs focus on specific issues. For example, NorthWestern Mental Health offers a medication management program that provides evening home visits for a limited period to help people manage their own medication. It delivers 'phased' support—from intensive support involving multiple visits per week, through to independence.[131]

It is more challenging to implement home visiting and other outreach models in rural and regional areas, but it is not impossible. Ms Karyn Cook, Executive Director of Mental Health Services at South West Healthcare, Warrnambool Community Health, told the Commission, however, that current funding models do not support outreach models in rural areas:

> many [services] do not provide outreach (home visits) into rural areas. AMHS [area mental health services] on the other hand will see people at home, including farms and residential care facilities. This can involve hours of travelling for clinicians, limiting clinician availability to others and often means that only a small percentage of people are seen … The current … funding methodology does not adequately account for providing access to people isolated in rural areas, leading to a number of vulnerable persons in rural settings simply missing out on clinical mental health services and crisis responses.[132]

The Commission also heard from a range of people that regional and rural models of outreach should involve a mix of telehealth and in-person approaches.[133]

In the Commission's view, home and community visiting approaches could be enhanced through the addition of lived experience workforces. This can be important for consumers in all areas, however, it can be especially important in regional and rural areas. This is because consumers can benefit from the involvement of people with lived experience who are local residents and who understand the unique perspectives, culture and challenges of rural life.[134]

Assertive outreach

In addition to the services described earlier, Area Mental Health and Wellbeing Services will offer a specific model of outreach, called assertive outreach. Assertive outreach will be available to consumers in the ongoing intensive treatment, care and support stream, as a major feature of the Assertive Community Treatment model of care.

Within the Assertive Community Treatment model, assertive outreach recognises that when people experience significant mental health challenges, there may be periods when they are unable to attend services in clinics and centres.[135] Assertive outreach aims to provide the necessary treatment, care and support to people in their homes, or another community setting, for a period of time, after which consumers may be able to engage in site-based services. Assertive outreach aims 'to reduce hospital admission, increase continuity of care and improve psychosocial outcomes'.[136]

It is recognised that for a very small number of consumers, assertive outreach for extended periods may be required. As this is a highly resource-intensive model of care, it will be targeted to people with the most complex support needs.

6.3.2 Community-based mental health and wellbeing services that meet the diverse needs of communities and individuals

All people should feel confident that when they access mental health and wellbeing services, their specific needs will be met in a safe and appropriate way, regardless of their cultural, religious, social, sexual and gender identities or first or preferred language. This means that services must have a deep knowledge of the specific needs of their local communities. These include culturally diverse communities, LGBTIQ+ communities, Aboriginal people, people experiencing family violence or homelessness, people living in rural and regional communities, victims of crime, refugees and asylum seekers, and people who have common conditions that can coexist with mental illness, such as physical or intellectual disability.[137]

Chapter 21: *Responding to the mental health and wellbeing needs of a diverse population*, describes how certain communities in Victoria are disproportionately impacted by mental illness. For example, high levels of harassment and discrimination from strangers towards LGBTIQ+ people and experiences of racism among people with diverse faith or cultural backgrounds are linked to psychological stress and other mental illnesses.[138] Diverse communities also face barriers to accessing appropriate mental health care.

This means that services will need, to the greatest extent possible, to be responsive to the needs of diverse consumers, including those related to language and communication, culture, gender and gender identity, sexuality, and physical and intellectual disability. The Commission expects that this is core business for mental health and wellbeing services. Furthermore, because no two communities in Victoria are alike, services will be expected to offer specific programs for their local communities *in addition* to offering treatment, care and support that responds to diverse needs within its community. Both of these are elaborated below.

Treatment, care and support that responds to diverse needs

Victoria's 10-Year Mental Health Plan, released in 2015, set out a clear expectation that all mental health services will provide:

> equitable access and safe and inclusive services for people with diverse cultural, religious, racial, linguistic, sexuality and gender identities … This does not mean that everyone receives the same response, but rather that all people have their mental healthcare needs met equally well.[139]

Despite that plan, the Commission has heard from many consumers, families, carers and supporters whose experiences do not meet that aspiration.

In the future system, Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services, supported by the Department of Health and in time Regional Mental Health and Wellbeing Boards, will need to develop, fund and implement specific plans to ensure a greater level of accessibility and responsiveness in their services. It is expected that services will develop an in-depth understanding of their local communities, and the needs and strengths within them. They will work with a diverse range of consumers, families, carers and supporters to better understand the challenges to the accessibility and responsiveness of their services, and then codesign the solutions.

There are a range of ways in which services might strengthen their responsiveness to diverse communities, including through a reinvigorated workforce that has the necessary capabilities and competencies to work with people who have had diverse experiences. Representative workforces—such as bicultural workers, Koori Mental Health Liaison Officers and peer navigators (meaning people with a lived experience who assist consumers to find and access services) and increased access to professional translation services could strengthen the cultural responsiveness of services.

Specific services to meet the needs of local communities

As noted earlier, community mental health and wellbeing services will also be expected to deliver programs that provide tailored treatment, care and support to their local communities. That is, that they will have an in-depth understanding of what community-specific services currently operate in their area. Through appropriate planning processes, local and area services will identify, develop and deliver programs or supports for specific groups in their local community. Such programs or supports will typically be for people whose needs are not being met in mainstream services, and who are at risk of developing mental illness.

For example, a mental health and wellbeing service would benefit the community by delivering a specific program to refugee and asylum seekers because of a high representation of this community in its area. Mental health and wellbeing services may develop and deliver these programs through creating partnerships with Local Mental Health and Wellbeing Services that provide services to specific communities.

Chapter 21: *Responding to the mental health and wellbeing needs of a diverse population*, describes the Commission's recommendations for reform relating to meeting the mental health and wellbeing needs of Victorians from diverse backgrounds.

Community health provider cohealth offers an example of how a health service is currently offering responsive services. This includes providing a culturally safe environment, workforce diversity and strong links and partnerships with local services that provide community-specific supports.

Case Study:

cohealth

Melbourne-based community health service cohealth uses an integrated model of care for people living with mental illness. Using a person-centred and strength-based approach, the organisation provides services that include mental health nursing, individual support, mentoring, residential programs, homeless outreach and complex-care coordination.

Ms Nicole Bartholomeusz, cohealth's Chief Executive, said their focus is on providing integrated care for the most marginalised people in the community.

> We have a particular focus on the most vulnerable and marginalised people in our community. Our focus is on integration, so that when an individual walks in to access care, they get care for what they present with, and then we work with them to identify other health care and social support, and actively refer them across a broad spectrum of services.

Benefits of the integrated approach include the ability to make referrals and have trusted workers accompany consumers to physical health appointments, for example, with GPs, dentists, allied health, alcohol and other drug services, and group programs. Where appropriate, cohealth also works closely with the Aboriginal, and refugee and asylum seeker health programs.

Ms Bartholomeusz notes that providing a culturally safe environment is central to breaking down barriers between clients and care providers, and is critical to achieving better outcomes.

> At cohealth, we attempt, as much as possible, to ensure that our workforce reflects the communities that we serve to bring a level of cultural safety into the workplace. For example, if a client from a diverse background attends one of our clinics, engagement and outcomes are improved if they see one of their own people. Or, if someone who has been unemployed long term, has alcohol and drug issues, walks into a clinic, they should work with a peer worker who has the same kind of social experience or background.

One example of the integrated care service that cohealth offers is the Homeless Outreach Mental Health Service (HOMHS), which is a service that responds to consumers with intersecting homelessness and long-term serious mental health needs.

Ms Caz Healy, cohealth's Executive Lead, Services, said HOMHS demonstrates the importance of multidisciplinary teams working in partnership to provide integrated supports to consumers, as well as the benefits of physical co-location of mental health, physical health and social support functions.

> HOMHS works because when needed, a psychiatrist can come out, at sometimes short notice from Melbourne Health, and people can engage with a psychiatrist to assist to stabilise their mental health. It works because we have a multidisciplinary team enabling easier access to the support people need.

Ms Healy pointed to another example of integrated care through the Indigo program, which provides assessment and care plan coordination for consumers with multiple and complex needs.

> Care coordination is a key success factor in multidisciplinary teams for people with complex issues. The care plan allows highly skilled individuals to work with a range of providers, to work as one at the directions of a client. The multiple and complex needs model provides assessment over many months, and clients have seen significant success to achieve their goals and live well and safely.

Source: cohealth meeting with Commissioner Armytage, 16 April 2020; *Witness Statement of Nicole Bartholomeusz*, 9 June 2020; Nicole Bartholomeusz, *Correspondence to the RCVMHS*, 2020.

6.4 Community-based mental health and wellbeing services grounded in primary and secondary care

6.4.1 Primary and secondary care

In its interim report, the Commission identified the need for reforms so that mental health services could operate 'seamlessly with primary care services at one end and acute services at the other so that people no longer fall through cracks between different levels and types of services'.[140] As described in Chapter 5: *A responsive and integrated system*, the Commission's model of a responsive and integrated mental health and wellbeing system identifies widely distributed primary and secondary mental health and related services as the third of six main levels where consumers access treatment, care and support.

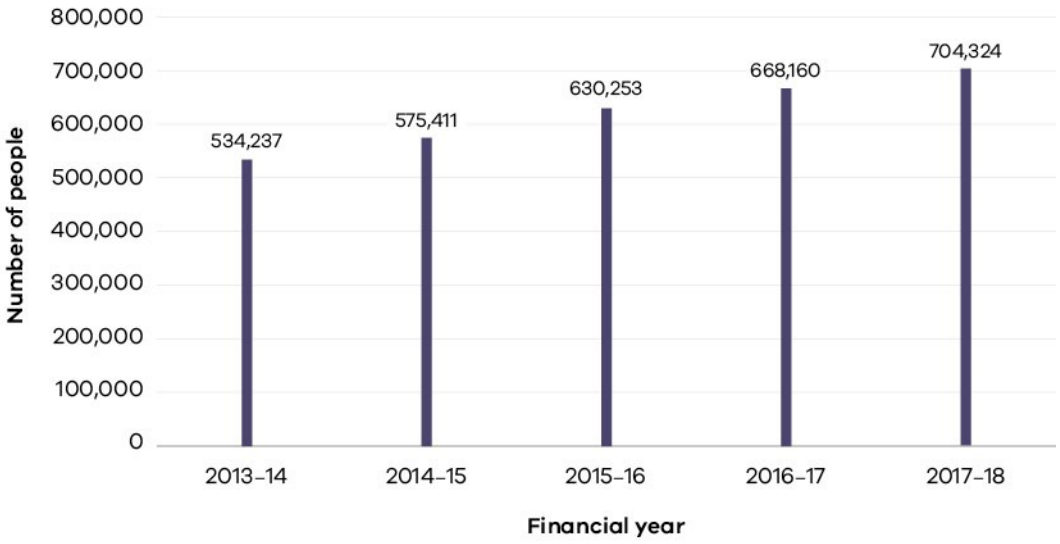
Primary care services are those where consumers access treatment, care and support without needing a referral or having to meet eligibility criteria, and so are a very accessible form of health care. They are provided in most local communities across Victoria. Primary care providers include GPs and allied health professionals, such as social workers or mental health nurses. Secondary care and related services are generally those that consumers can only access through a referral from a GP. This can include a wide range of professionals, including psychologists, paediatricians and geriatricians.

Strong primary and secondary care systems are the Commonwealth Government's responsibility.[141] This is because most primary care, such as that delivered by GPs, and much secondary care, such as the Better Access program for rebated psychological therapies, is funded by the Commonwealth Government through the Medicare Benefits Schedule (MBS).[142] The Commonwealth Government is also responsible for subsidising prescribed medication under the Pharmaceutical Benefits Scheme (PBS), which includes medication prescribed for mental health reasons.

Primary care is, and will continue to be, where most Victorians access support for their mental health and wellbeing. In their statements to the Commission, expert witnesses have emphasised the central role of primary care in Victoria's mental health system, including Professor Rob Moodie, Deputy Head of School and Professor of Public Health, University of Melbourne, who asserts, '[t]hese services are incredibly important, because they are often the first port of call.'[143]

This is consistent with data about the use of MBS-subsidised primary and secondary mental health care analysed by the Commission. Figure 6.6 sets out the number of Victorians over the five-year period from 2013–14 to 2017–18 who accessed any MBS-subsidised mental health care. This shows that there was a 32 per cent growth in the number of people using any MBS-subsidised mental health services in Victoria during that period (in comparison to a 10 per cent growth in population) from 2013–14 to 2017–18, with more than 700,000 Victorians accessing those services in 2017–18.[144]

Figure 6.6: Number of people accessing Medicare-subsidised mental health services, Victoria, 2013–14 to 2017–18

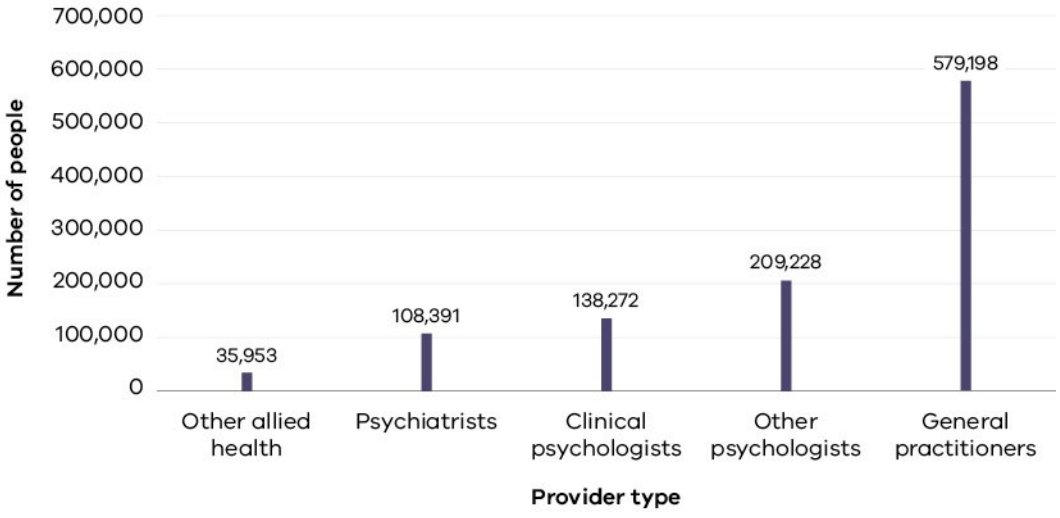


Source: Australian Government Services Australia, Medicare Benefits Schedule 2013–14 to 2017–18.

Note: Data includes people with Victorian postcodes and if the patient's address is unknown, service providers with a Victorian postcode are included.

Figure 6.7 gives a breakdown of these MBS-subsidised mental health services by provider type in 2017–18. The majority of such mental health services in Victoria in that year were provided by GPs, followed by psychologists and clinical psychologists.

Figure 6.7: Number of people accessing Medicare-subsidised mental health services, by service provider, Victoria, 2017–18



Source: Australian Government Services Australia, Medicare Benefits Schedule 2017–18.

Note: Data includes people with Victorian postcodes and if the patient's address is unknown, service providers with a Victorian postcode are included.

Personal story:

Pru Howell-Jay

From the age of 18, Pru experienced severe anxiety and depression. Pru said she became suicidal and made three separate attempts on her life during a 12-month period. After the second attempt she saw a private psychiatrist and began medication.

> I felt that the medication made me almost numb, I still felt distress on the inside, but I couldn't express it on the outside. I used to ask my friends to try and make me cry because I desperately wanted to cry and I couldn't.

Pru felt like no one listened when she told them the medication was not working for her.

> I started to think I was crazy because I was blacking out all the time and nobody was really believing me.

Pru said she does not recall her third suicide attempt, after which she was admitted to a private inpatient unit. During her stay in the unit she stopped taking her medication.

> I just refused to take them. The psychiatrist did try to get me back on them, explaining that I need to wean off them for my health. But at this point, I just didn't trust them and I was really scared of the medication. I was convinced it was the reason that I blacked out and tried to take my life. They all just kept telling me that's not how it is, and I was like that's how I feel it is.

A few years later, Pru said, she began to experience symptoms of depression again. Her psychologist suggested she speak to her GP, whom she trusted, about medication. This time, her experience was more positive.

> I was quite hesitant because of my experience when I was younger. I expressed to my GP that I was really afraid of side effects and was worried that I'd get pressure to stay on them. She really heard my concerns. She said that we could try a different medication from last time and explained to me actually how the medications work, which I found really helpful.
>
> We made a plan for a few different options and she told me what the side effects may be. If I started something and I felt like I was having a side effect she promised to believe me, because I had so much fear that I wouldn't be believed. I felt like I had so much more control over this situation.

Pru added that her GP and psychologist worked closely together but were fully transparent in their communication about her.

> If they sent letters to each other, they would both let me proof read to check that it was true to my experience.

Pru found her second experience with medication much more positive than the first. She said it helped her 'get out of bed and get motivated' and attend her psychologist appointments, and ultimately come off the medication.

As someone who experienced mental health challenges as a young adult, Pru initially chose not to involve her parents. Pru believes that young people should have access to GPs in schools who can assist them to seek mental health support.

Pru is now a peer work team leader at a Melbourne hospital, where she has access to both clinical management and external lived-experience support. Pru thinks it is important for peer workers to have managers with lived experience, who can understand their experiences and reduce the risk of stigma in the workplace.

> There is a different understanding I have of my team, as someone with lived experience. My boss would have a different understanding of what it's like to be coming to work with mental health challenges and to be using those challenges in your work all day, every day, going over your trauma.

Source: RCVMHS, *Interview with Pru Howell-Jay*, September 2020.

Personal story:

Dr Sara Renwick-Lau

Sara is a GP based in Mallacoota in East Gippsland, with more than 20 years' experience working with regional and rural communities.

Sara says that communities in regional and rural areas are often more engaged with their local GPs as a familiar and trusted way to access health care.

Throughout her career, Sara has seen how important GPs can be in local communities. She says they are often required to fill the gaps to provide the kind of specialised health support that would normally exist in bigger centres.

> A lot happens in rural General Practice to ensure access to the full breadth of health services that rural and remote patients need, including acute, preventative and emergency general mental health care.

Sara talks about some of the challenges that regional and rural communities like Mallacoota face, such as their limited access to hospital services and allied health. She also notes that applying models of care can be more difficult across greater distances.

> Ultimately, our access to tertiary services is dependent on the goodwill or a motivation by those services to provide access to rural patients. We are at the mercy of those services as to whether or not they feel it is necessary to support rural patients.

When talking about access to mental health care, Sara explains that some of the current commissioning and funding arrangements can be detrimental to the viability of local GPs being able to meet the needs of their communities.

> I think the important thing for health agencies to understand is that if you support GPs and doctors with a broad scope of practice, and you support the viability of private general practices in small communities, then you are supporting a breadth of treatments in the community … GPs are gap fillers and can be podiatrists, paramedics and psychologists.
>
> In my view, if you want to provide any sort of primary health care, you need to actually have clinicians on the ground to do it. If you don't have a clinician visiting in the town, you don't have the service; it simply doesn't exist as far as our community is concerned.

Following the 2019 bushfires, which deeply affected Mallacoota and other areas in East Gippsland, Sara says she saw the impact of trauma on the local community. She notes that initially, many people with treated mental illness were coping well, and others with untreated mental illness came forward to seek help, but that some of the mental health consequences for the community will become more apparent in the longer term.

> In Mallacoota, we are beginning to see more serious mental health issues come to the fore. I am now seeing people with reactivated serious mental illness; for example, people with previous psychosis or long histories of PTSD who are now re-traumatised. Three months after the bushfires, these people are requiring services. We also anticipate that depression will present six to 12 months after a traumatic event.

Sara believes that one of the most important parts of helping a community that has experienced crisis is to provide ongoing and consistent support.

> Providing a service regularly is far more effective than providing a service twice.

Source: *Witness Statement of Dr Sara Renwick-Lau*, 19 May 2020.

In addition to the volume of people accessing primary and secondary mental health care in Victoria, there are other compelling reasons to strongly link primary care to Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services.

First, research suggests that mental health is the most common reason for people in Australia to see a GP.[145] Although stigma and discrimination remain common issues for Victorians with mental illness, accessing primary care can carry less stigma for some,[146] because primary practice offers integrated care for health and wellbeing, rather than focusing solely on mental health.[147]

Second, primary care practitioners often provide mental health care to consumers in their communities over many years, increasing the capacity for longer-term and more therapeutic relationships.[148] The role of a supportive GP is described by Ms Pru Howell-Jay in her personal story.

A third reason to have a strong primary care foundation in the future mental health and wellbeing system is that primary care practices and community health centres are uniquely placed to respond to the needs of their local communities.[149] Because they are based in communities and have local knowledge, they can connect people to wellbeing supports near to where they live[150] or to an allied health provider close to home.[151] Their local knowledge can also help a GP to understand more quickly what is happening for a consumer, as the GP can consider the consumer's mental health and wellbeing challenges in the consumer's social context.

Dr Mariam Tokhi, a GP who works at community health centre DPV Health in Broadmeadows and who gave evidence in a personal capacity, spoke about this:

> **GPs have a special role in our healthcare system because, unlike a lot of specialists, we get to see someone multiple times over a period of time, and we can bring people back more easily than a lot of specialist healthcare services can. We have reasons to engage from lots of different aspects … as a GP you're trying to provide whole-person care and understand health holistically, we have an ability to say, "Hey, how does your sexuality impact on your health?" and "How does your age impact on your health?" and "How is your mental health being impacted by these recent changes?" On our best days, GPs really do try and understand people. And because we build up trust over those various encounters, people open up.**[152]

This leads into a fourth reason: GPs are well placed to provide a person with holistic care, as they understand both their physical and mental health needs. This is important as research suggests that four out of every five people living with mental illness have a coexisting physical illness.[153] A coexisting mental and physical illness is also associated with a shorter life expectancy of potentially 10–32 years than people in the general population.[154] As described in the personal story of Dr Sara Renwick-Lau, the holistic care that GPs can offer is important in working towards closing this gap.

Dedicated GPs, who provide extensive mental health treatment, care and support to consumers in their communities, have contributed to the Commission's work through its engagement activities. Many have expressed a desire for primary care to be strengthened and supported, so that more consumers can access mental health support in a primary care setting.[155] For example, Dr Gerard Ingham, a GP working in the regional Victorian town of Daylesford, described the role of GPs as 'the glue' for consumers across the entire spectrum of need, providing care attuned to the needs of consumers, families, carers and supporters in a community setting.[156] Dr Ingham explained:

> I see GPs as both the gap-fillers and glue of the mental health system … We see patients who will not be managed by the regional psychiatric service because the problems fall outside the types of mental health issues that they manage even though the problems can be very complex and challenging … I will provide counselling when the patient can't afford a psychologist or because I have known the patient for many years and have built up the trust to enable me to be best placed to help. If a patient needs to be seen today our practice will see them today … We turn nobody away in an emergency and we provide a '24/7' service … GPs provide cohesion between health professionals and between episodes of care over time.[157]

The Commission expects that mental health and wellbeing services will proactively connect people of all ages they are helping to general practice, including GPs and practice nurses available in community health centres. The Commission also encourages all services to consider the value of employing physical health clinicians in their teams. Service expansion also provides an opportunity for co-location with other services people use, such as general practice, which would further encourage integration between mental and physical health. An example of an integrated service model is provided in the case study on the Cranbourne Integrated Care Centre.

Case Study:

Cranbourne Integrated Care Centre

With a key role in helping people with chronic diseases, Monash Health's Cranbourne Integrated Care Centre provides a wide range of acute medical and same-day surgical services, primary health care, mental health and rehabilitation, as well as family violence and housing services.

Cranbourne Integrated Care Centre also has a range of community health services where there are programs such as child, youth and family programs, and an Aboriginal health program that works with an Aboriginal Community Controlled Health Organisation.

Mr Andrew Stripp, CEO of Monash Health, is a strong advocate for the integration of primary mental health and specialised services to improve outcomes for patients.

> There are far too many experiences of unnecessary struggles due to lack of integration. This can be a lack of both vertical integration with services from primary care through to highly specialised tertiary services, and horizontal integration of different service types such as mental health and dental.

Mr Stripp said the broad range of functions provided in one centre enables internal referrals to other services, including mental health.

> A large proportion of consumers have mental health needs and Cranbourne Integrated Care Centre's integrated model has a range of benefits for those people. This includes the experience of coming to a health service that doesn't say 'mental health' in its title, where people can access treatment and support for a wide variety of health needs including mental health treatment.

Specifically, the mental health program supports consumers accessing the specialist mental health continuing care and mobile support teams, as well as those accessing shared care with a GP. The GP liaison coordinator can provide additional advice to GPs who are treating someone for a mental illness, if needed.

The mental health team comprises consultant psychiatrists, registrars, occupational therapists, psychologists, dieticians, a clozapine nurse and nurse practitioners.

Photo credit: Monash Health

For services not provided at the Centre, the team has established connections to community programs that are helpful for mental health consumers, as well as collaborations with not-for-profit community organisations that provide a range of medical, health and support services at subsidised cost, to improve the health and wellbeing of people in Melbourne's east and south east suburbs.

Due to a large growth in population in the area and the feedback on the very positive experience, Monash Health will replicate the Cranbourne model in a new community hospital in Pakenham.

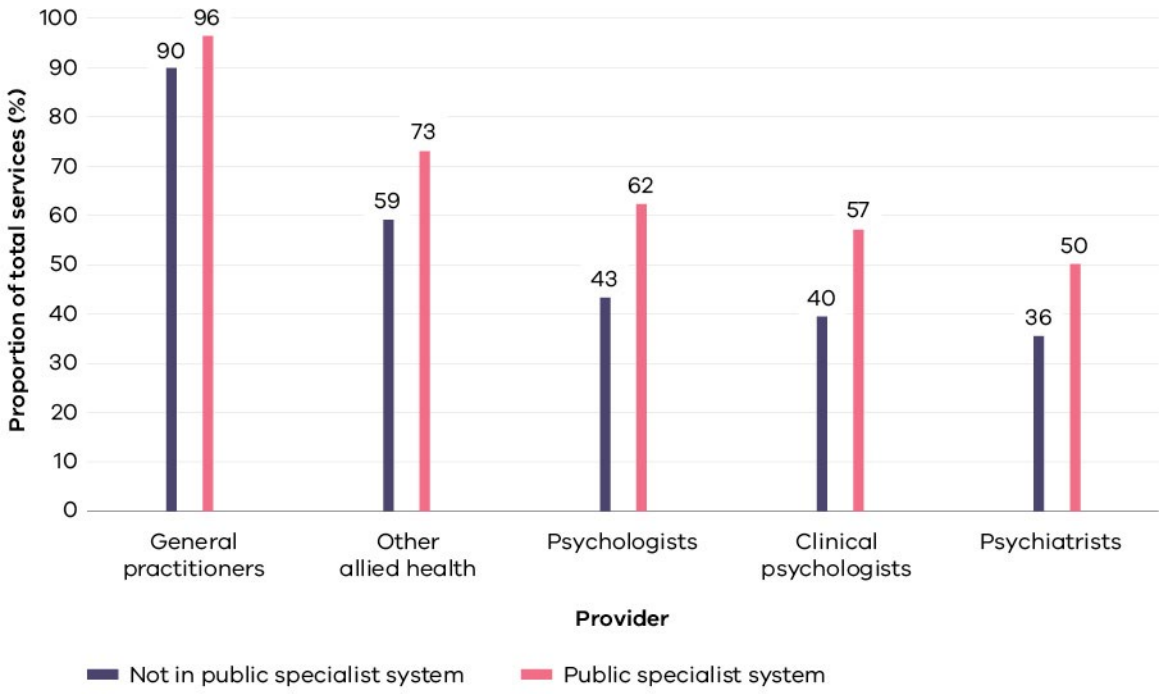
Source: Monash Health meeting with Commissioner Armytage, 1 April 2020.

6.4.2 Current challenges to accessing primary care

There are currently challenges to accessing primary and secondary care services for consumers. These include the cost of primary and secondary mental health care. Data analysed by the Commission indicates that an estimated 83 per cent of people who accessed any MBS-subsidised mental health care in 2017–18 were bulk-billed *at least once*. However, just over half (55 per cent) of all mental health care *services* were bulk-billed.[158]

Figure 6.8 shows the proportion of MBS-subsidised mental health services that were bulk-billed in Victoria in 2017–18, by different providers. The figure shows what proportion of these services were bulk-billed for consumers who were registered with a public mental health service, and those who were not.

Figure 6.8: Proportion of services bulk-billed for Medicare subsidised mental health services in the community by public specialist consumer status, by provider type, Victoria, 2017–18



Source: Department of Health and Human Services, Client Management Interface/Operational Data Store 2017–18; Australian Government Services Australia, Medicare Benefits Schedule 2017–18.

Notes: Only includes Victorian patients and Victorian service providers.

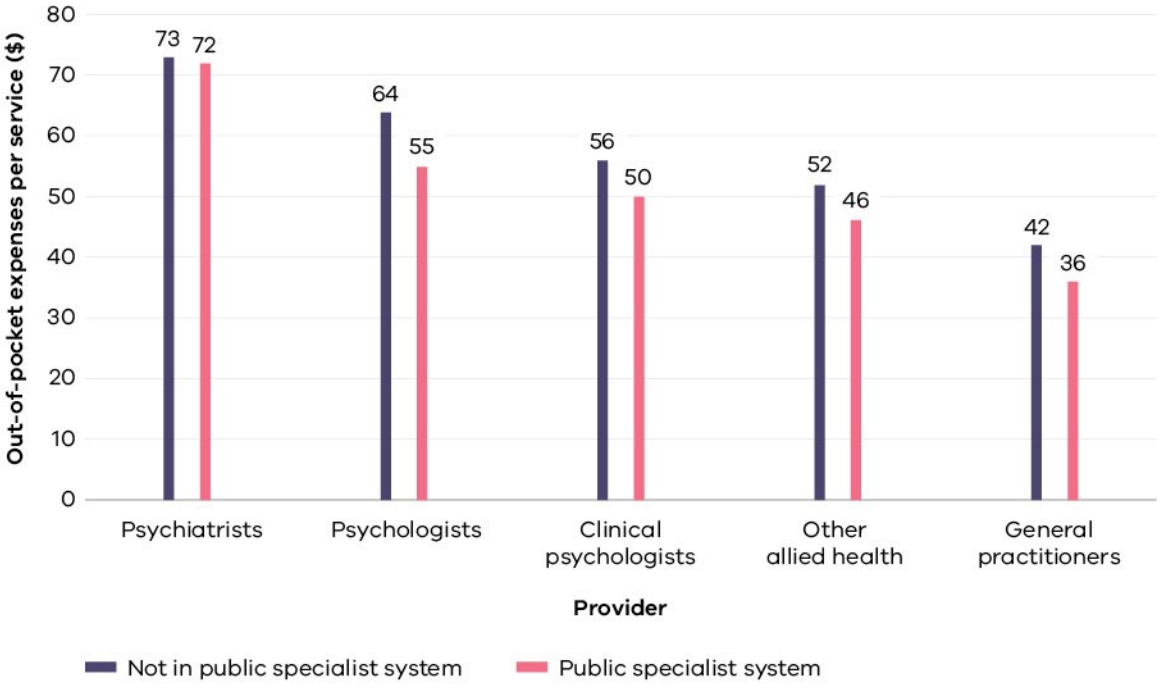
The data show that the vast majority of MBS-rebated services delivered by GPs were bulk-billed. This was slightly higher for consumers who were registered with a public mental health service. For all provider types, consumers who were registered with a public mental health service had a greater proportion of MBS-rebated mental health services bulk-billed than consumers who were not.

The data support the Commission's view that primary care, as a highly accessible setting for mental health care, will form the setting where the majority of consumers access treatment, care and support for mental health and wellbeing in Victoria.

The average gap fee (or out-of-pocket expenditure) for visits to these practitioners is relatively inconsistent across provider types. While these gap fees for different providers for a single visit may be feasible for some consumers, the Commission noted concerns that gap fees may be barriers to care for some consumers. For example, the Commission was told that for people on low incomes, the out-of-pocket costs associated with private psychologists or psychiatrists could be a barrier to access.[159] Dr Ingham noted that:

> 70–80 per cent of my patients are pensioners or health care card holders and the proportion is even higher among those with a major mental health disorder. Accessing a psychiatrist who will bulk bill is a significant challenge … for access to a bulk billing or community psychologist, the waiting time fluctuates but is typically around 2–3 months … for access to the public health system for psychiatry … access is limited to only those with a major mental health disorder.[160]

Figure 6.9: Average out-of-pocket expenditure ($) per service for Medicare subsidised mental health services in the community, by provider type, Victoria, 2017–18



Source: Department of Health and Human Services, Client Management Interface/Operational Data Store 2017–18; Australian Government Services Australia, Medicare Benefits Schedule 2017–18.

Notes: Only includes Victorian patients and Victorian service providers. Excludes bulk-billed services.

Gap fees can also be a substantial challenge when a consumer has support needs that mean they need more visits or sessions. Witness Ms Rachel Bateman told the Commission that the benefits of the positive relationship she had established with a social worker in private practice were limited by the number of sessions available in her mental health care plan:

> I will continue to see her, [my social worker] because I need therapy, but I can't afford to see her as much as I need her.[161]

Furthermore, not all consumers receive the mental health care they need from a GP or psychologist. For example, consumers described instances where their expectations for compassionate and responsive mental health care were not met, or where they were dismissed. One person who attended a community consultation stated that, 'When I was 16, I tried to complete suicide. One GP said I was just attention-seeking and wouldn't refer me to any supports.'[162]

Other people also told the Commission that their experience of primary care fell short of their expectations because it focused too narrowly on medication, rather than a more holistic or integrated care approach.[163] One consumer told the Commission how GPs did not understand the mental health system well enough to support her:

> I think there is a lack of mental health awareness in the community and amongst GPs, especially as it relates to young people. When I spoke about my mental health issues, my GP hadn't even heard of [clinical youth mental health service]. GPs need to know what services are out there and what treatment options there are.[164]

These limitations create barriers to people accessing support for their mental health and wellbeing. They will need to be addressed if the future mental health and wellbeing system is to be effective. The Productivity Commission's *Mental Health Inquiry Report* found that primary care needs to be strengthened in key areas, including by addressing a number of financial disincentives imposed by the current arrangements for GP reimbursement, and the lack of knowledge and skills in mental health for some GPs.[165] The Productivity Commission's recommendations in relation to primary care included 'referral tools' that can be used by GPs, and a Medicare Item (the individual Medicare services subsidised by the Commonwealth Government under the Medicare Benefits Schedule) to enable GPs and paediatricians to obtain advice from a psychiatrist relating to a consumer in their care.[166]

The Commission intends that future mental health and wellbeing services will provide support to primary care and secondary care so they can deliver high-quality and compassionate mental health care to more consumers, more consistently. A core component of this will be supporting primary and secondary care providers to access mental health expertise in a timely way. This is described in detail in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*.

In Chapter 29: *Encouraging partnerships*, the Commission describes the challenges arising from different parts of the mental health system, such as primary care and tertiary care services, not working well together. People and their mental health and wellbeing needs do not fit neatly into Commonwealth Government or state-funded service systems. For example, a person may be receiving treatment, care and support from a Commonwealth-funded primary care service through their GP, but might also at times require the support of a state-funded crisis service.

Primary and secondary care services are largely the responsibility of the Commonwealth Government. However, there are opportunities for the Commonwealth Government and the Victorian Government to work together to achieve shared goals. A more coordinated mental health and wellbeing system, including one that has strong links between primary and secondary Commonwealth Government-funded services and state-funded community mental health services, is likely to benefit more consumers.

As described in Chapter 29: *Encouraging partnerships*, a new National Mental Health and Suicide Prevention Agreement is to be finalised by November 2021.[167] The upcoming negotiations of this agreement provide an opportunity to reach national consensus on opportunities to improve treatment, care and support in primary care. The Commission encourages the Victorian Government to work collaboratively with the Commonwealth Government towards this end.

There are opportunities to build on the Commonwealth Government's commitment in its 2015 response to the National Mental Health Commission report *Contributing Lives, Thriving Communities* to better connect primary care, health services and the NDIS.[168] A new National Mental Health and Suicide Prevention Agreement represents a unique opportunity to build on the work of the Royal Commission and the Productivity Commission's *Mental Health Inquiry Report* and identify joint priorities to improve mental health and wellbeing outcomes.

6.5 Resourcing the community system to meet consumer needs

The Commission's vision for the future community mental health and wellbeing system is one where consumers receive the right treatment, care and support that is proportionate to their needs. To do this, the future mental health and wellbeing system must be organised in a way that 'meet[s] the spectrum of [consumer] needs from low to high'.[169] A system that delivers care proportionate to need is one that:

> allocates people to the right level of care; [has] informed referrers (mainly GPs) who understand how to use self-management and low intensity options .... [has] an effective system of self-management and low intensity assistance options; and [has] community acceptance and trust.[170]

It is clear that a substantial investment in, and reforms to the community-based mental health system in Victoria are needed. Matching consumers with the right care to meet their mental health needs is critical to improve consumer outcomes. It is also essential for investments in community mental health and wellbeing services to be sustainable. Good use of mental health and wellbeing resources means that treatment, care and support is delivered proportionate to need. The Productivity Commission's *Mental Health Inquiry Report* found that at present:

> many people are not accessing services that are right for them ... For example, close to half of people accessing MBS-rebated psychological therapy use three or fewer sessions (rarely enough to enable recovery, in those for whom psychological therapy is the most appropriate intervention) ... [and there is] a large gap in the utilisation of low cost, low risk and easy to access services.[171]

It further found that carefully targeting treatment, care and support to meet individual needs:

> is vital for ensuring that people with low needs are receiving low intensity care and the scarce resources at the high end of the spectrum are reserved for those with the highest needs.[172]

In order to plan and resource the community-based mental health services required to meet the needs of consumers, clarity about broad levels of treatment, care and support is required. This clarity will mean that the right treatment, care and support is provided, and enable services and the Department of Health to appropriately allocate and target services. In this section, the Commission highlights why the current system is currently not meeting demand for community mental health services. Then it outlines five consumer streams with different levels of need for treatment, care and support.

6.5.1 Insufficient investment in community-based mental health and wellbeing

In its interim report, the Commission highlighted that Victoria has not achieved its vision of a 'deinstitutionalised' mental health system that reoriented mental health care away from hospitals and into the community.[173] 'Deinstitutionalisation' describes the movement away from standalone asylum-style institutions towards integrated, community-based care backed by specialist hospital services that occurred in Victoria in the 1980s and 1990s.[174]

Services based in the community were seen as the preferred way to help consumers who were once patients of institutions to live well in the community, as well as to stabilise, rehabilitate and to support them to continue their recovery.[175] *Victoria's Mental Health Service: the Framework for Service Delivery (1994)* was the guiding document for these reforms, and outlined the full range of services to be delivered for Victorians following the closure of the psychiatric institutions.[176]

The framework specified that for those who needed more help, there would be more outreach, long-term residential care in the community and shared-care programs with GPs.[177] To complement community care, there would also be a range of hospital-based care for people to access during times of acute care and support need.[178]

Victoria today is a different state to what it was in the 1990s.[179] The population and its mental health needs, as well as Victoria's health services, are not the same. However, the principle of community-based mental health and wellbeing services and the need for investment in them has been a strong focus of the evidence presented to the Commission. For example, one respondent to a mental health workforce survey conducted by ORIMA Research on behalf of the Commission in 2020, when asked about their aspirations for the mental health system, stated:

> Community services would have greater resources to be able to assist consumers to remain in community and therefore not require acute services as much.[180]

Another respondent stated:

> Increase community mental health service resourcing for an adequate workforce. Robust community resourcing could reduce demand for inpatient services.[181]

The Commission heard that some community-based services have been defunded and this has resulted in consumers missing out on the treatment, care and support that they need to live well in the community.[182] For example, Dr Margaret Grigg, CEO, Victorian Institute of Forensic Mental Health (Forensicare), explained:

> It is possible to deliver complex, specialist services to people at home. However, this relies on rebuilding a comprehensive community-based service that is able to deliver intensive acute treatment to people in the community. In the early 2000s, Victoria's network of crisis assessment and treatment services that were available in the community were the envy of many jurisdictions. Reduced funding and increasing demand for acute care has resulted in the demise of this service model in most areas.[183]

Noting changes in the available resources, and the impact this has had on the system that was initially envisaged, Ms Gail Bradley, Interim Operations Director at NorthWestern Mental Health Service, Melbourne Health, stated:

> The lack of resources has also resulted in: (a) a re-focus of treatment to acute presentations of mental distress; and (b) the prominence of pharmacological treatment and minimal provision of psychosocial treatment … Brief 'episodic' care and rapid referral out to primary care and private services (for those who can afford it) has become the norm, which does not match the need for ongoing treatment and support required for treatment of severe mental health conditions, especially those with a frequently relapsing course.[184]

Other witnesses told the Commission that where certain community-based mental health programs were once strong, reduced funding and increased demand had resulted in programs such as outreach, primary mental health teams and a range of 'psychosocial' supports—for example, group programs—being defunded and lost from much of the system.[185]

These challenges are not unique to Victoria. As acknowledged by the Productivity Commission's *Mental Health Inquiry Report* in 2020, the lack of investment in community-based specialist care is a national problem:

> The large shortfall in community ambulatory services means that several hundred thousand people are either receiving only a fraction of the care they need, or are missing out on community ambulatory care altogether. This shortfall represents a substantial part of the missing middle. Addressing this would also help address the barriers to care that are due to locational mismatch and out-of-pocket costs.[186]

Chapter 5: *A responsive and integrated system* presented data analysed by the Commission that indicated the substantial gap between the estimated need for community-based specialist service (in terms of 'service hours') and the number of hours being delivered. The analysis showed that the difference between actual number of hours delivered (by public specialist services) and what was required in the financial year 2019–20 was around 3.3 million hours. This measure of unmet demand emphasises that there are substantial gaps in the comprehensiveness of treatment, care and support being delivered, even for those consumers who do access services. This data does not include the gaps in access to sufficient wellbeing supports.

6.5.2 Tailoring levels of treatment, care and support through consumer streams

Each person has different strengths and treatment, care and support needs. People's strengths and needs are influenced by their backgrounds, experiences and life contexts, and can change over time.[187] The intensity of mental health and wellbeing treatment, care and support, and where and how it is delivered, will vary for different people. No two individuals—nor their mental health and wellbeing needs—are the same. The Commission's aspiration is for a mental health and wellbeing system that embraces diversity and will deliver mental health and wellbeing care that responds to individual strengths and needs.

However, in order to plan and deliver treatment, care and support that supports people to lead contributing lives, there must be clarity about what intensity of treatment, care and support is required broadly for consumers with comparable needs. This is a critical component of offering the right care at the right time, and providing treatment, care and support that is proportionate to people's needs.

To achieve this clarity and guide the planning and delivery of services, the Commission has—as outlined earlier—developed five consumer streams, which are set out in Figure 6.10. These streams broadly describe the settings for, and kind and intensity of treatment, care and support that consumers will be offered in the reformed mental health and wellbeing system. Further, use of these streams to understand demand means that resources are optimally and efficiently targeted.

To inform the development of the five consumer streams, the Commission considered a range of existing tools and sources, including national frameworks, recent and past national inquiries, and evidence presented to the Commission, such as submissions and the advice of experts.[188] The five streams are applicable to consumers of all ages.

As set out in Figure 6.10, most people with mental health and wellbeing support needs are in the two lowest intensity consumer streams: the communities and primary care stream, and primary care with extra supports stream. A relatively smaller group of consumers have mental health and wellbeing needs consistent with the higher intensity consumer streams. These are the short-term treatment, care and support stream, the ongoing treatment, care and support stream and the ongoing intensive treatment, care and support streams. As the intensity of treatment, care and support *increases*, the number of consumers who require that level of intensity *decreases*.

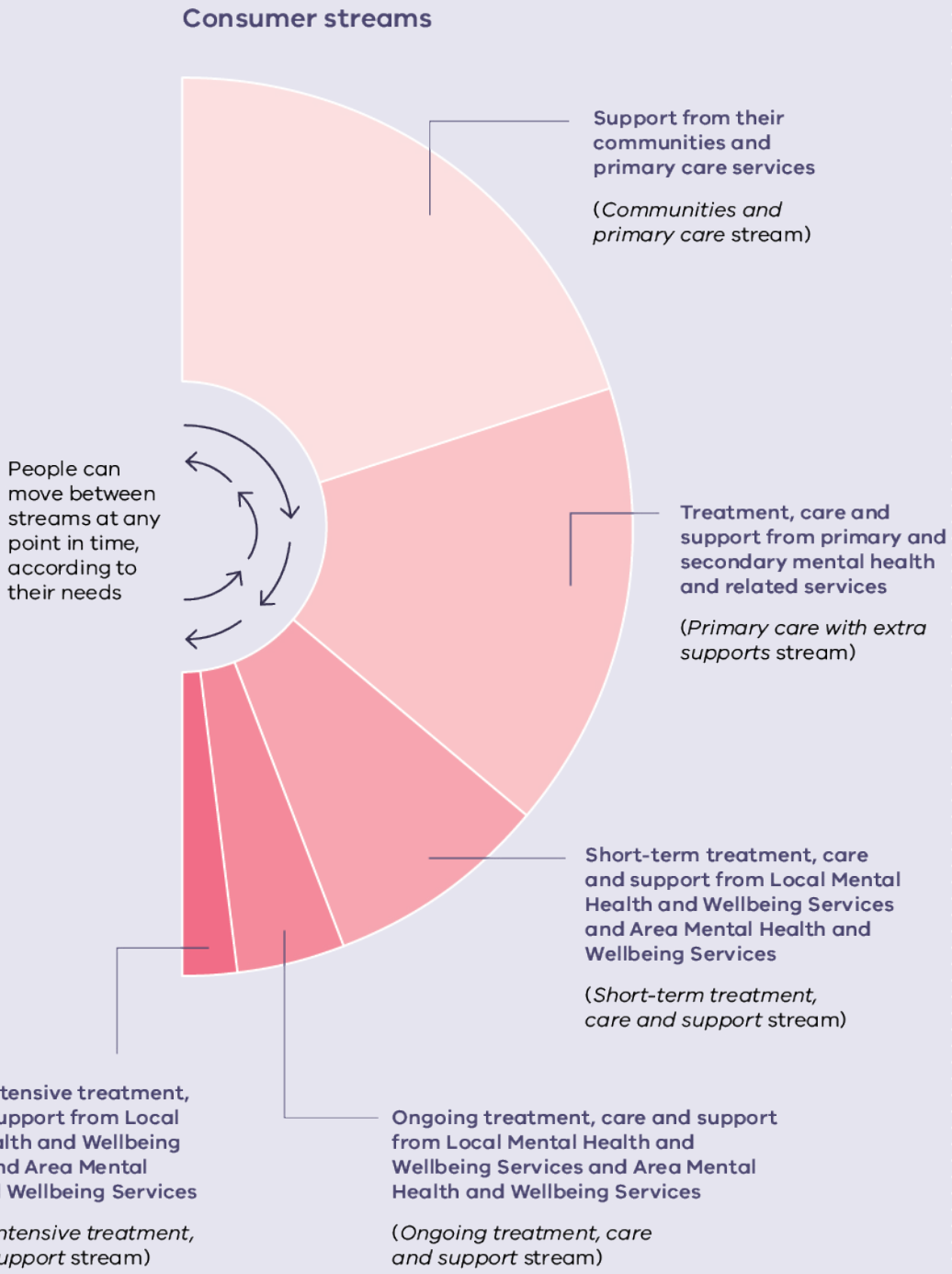
The Commission intends that assessment and care planning and coordination will be central to proportionately meeting these needs. Assessment has two main components:

- *initial support discussions*, which provide initial support and determine a person's need. This is similar to the current role of triage clinicians in area mental health services. However, this new process will provide a higher level of therapeutic support and more proactively support access to necessary mental health services and/or other services—including GPs, mental health services available through the Better Access Scheme, community-based organisations—or self-help tools.
- *comprehensive needs assessment and planning discussions*, which are designed for consumers who would benefit from an opportunity to intensively work through their treatment, care and support needs. These will be held for people with more complex support needs, including those likely to require further support from Local Mental Health and Wellbeing Services or Area Mental Health and Wellbeing Services. This assessment will use a biopsychosocial approach.

A detailed description of initial support discussions and comprehensive needs assessment and planning discussions is contained in Chapter 8: *Finding and accessing treatment, care and support*. Care planning and coordination, which will provide ongoing support to consumers, is described in detail in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*.

Figure 6.10: Five consumer streams

At any given point in time, a person living with mental illness or experiencing psychological distress will need:



Box 6.3: A note on the language used to describe the consumer streams

Each consumer stream has been given a name that is clear and straightforward, and broadly describes the support needs for consumers in that stream. In developing the name of each stream, the Commission has attempted to use language and terminology that is as non-stigmatising as possible.[189] Accordingly, the Commission has chosen not to use language commonly used in other mental health frameworks, literature or policy documents used to describe consumer streams and needs, such as:

- 'mild, moderate and complex mental illness'
- 'severe, severe episodic, severe and persistent mental illness'.[190]

This is for several reasons. First, such language narrowly focuses on mental illness, without acknowledging a person's wellbeing needs. Second, terms such as 'chronic', 'relapsing', 'complex' or 'severe' and 'persistent' when used to describe a person's mental health can contribute to the stigma about mental illness or effectively reduce a person to their mental health status.[191]

Third, feedback to the Commission from people with lived experience of mental illness indicated that this language can be disempowering.[192] For example, it can reflect paternalistic (or overly protective) approaches that may contribute to excluding consumers from decision making about their care.[193] Research indicates that many consumers do not use this language to describe themselves or their care needs, but instead often use language focused on 'recovery and wellbeing, rights, peer support and trauma-informed services'.[194]

However, the Commission acknowledges that the common terms cited earlier are widely used and inform a variety of mental health policy making. Accordingly, the sections that follow, which describe each consumer stream in detail, use this language and terminology where necessary.

The Commission has developed initial estimates of how many people in each age group are likely to need to access each consumer stream at any given point of time in the 2020–21 financial year. The Commission's indicative estimates are outlined in Figure 6.11. These are based on the *National Mental Health Service Planning Framework*.[195]

Figure 6.11: The estimated number of people requiring mental health treatment, care and support over a 12-month period, by age groups, Victoria, 2020–21

At any given point in time, a person living with mental illness or experiencing psychological distress will need to be able to access treatment, care and support in one of five intensity-based streams:	Estimated number of people aged 0–11 in 2020–21	Estimated number of people aged 12–25 in 2020–21	Estimated number of people aged 26–64 in 2020–21	Estimated number of people aged 65+ in 2020–21
Communities and primary care stream	**147,000**	**190,000**	**573,000**	**111,000**
Primary care with extra supports stream	**36,000**	**45,000**	**135,000**	**35,000**
Short-term treatment, care and support stream	**22,000**	**19,000**	**73,000**	**11,000**
Ongoing treatment, care and support stream		**10,000**	**23,000**	**19,000**
Ongoing intensive treatment, care and support stream		**7,000**	**22,000**	**6,000**

Sources: Commission analysis of the Department of Health (Commonwealth), *National Mental Health Service Planning Framework*; Department of Environment, Land, Water and Planning, Victoria in the Future 2019.

Notes: Streams are adapted from Harvey Whiteford and others, 'Estimating the Number of Adults with Severe and Persistent Mental Illness Who Have Complex, Multi-Agency Needs', *Australian and New Zealand Journal of Psychiatry*, 51.8 (2017), 799–809. Care profiles from the *National Mental Health Service Planning Framework* have been mapped to the streams.

The Commission considers the *National Mental Health Service Framework* to be a useful starting point for estimating how many people may need different types of treatment, care and support in a given year because this framework is founded on estimates of prevalence, rather than historical data on service use.[196] However, as discussed in Chapter 28: *Commissioning for responsive services*, there are a range of limitations to the framework. The Commission recommends that the Victorian Government establishes a process for assessing the Victorian population's need for mental health and wellbeing services by initially using a substantially adjusted version of the *National Mental Health Service Planning Framework*.

Adjustments will include updating the data on the prevalence of mental illness or psychological distress, including updated prevalence estimates from national and international literature and population surveys, and consideration of social factors influencing mental health and wellbeing. Further, work will be undertaken to align the *National Mental Health Service Planning Framework's* service models with the core functions of the future community mental health and wellbeing system. Given this, the estimates in Figure 6.11 should only be viewed as a starting point.

While these figures are not a definitive guide, they are an important way for the Victorian Government to understand how many people are estimated to need mental health services in a given year. They are also not static and will change over time with changes to population size, population demographics and the mental health profile of Victorians. It is also important to note that these estimates speak only to the number of people per consumer stream. It is essential that people are able to access the necessary intensity and duration of treatment, care and support.

As recommended in Chapter 28: *Commissioning for responsive services*, the Department of Health will be working with Regional Mental Health and Wellbeing Boards to determine the optimal longer-term funding levels for mental health and wellbeing services through a needs assessment, demand modelling and planning process. This will include formalising a process to regularly update the numbers that underpin the consumer streams. The department and Regional Boards will be responsible for estimating demand and updating estimates over time based on new information.

6.5.3 Explanation of consumer streams

The five consumer streams developed by the Commission apply to consumers of all ages. In developing these five streams, the Commission does not suggest that people fit neatly into one stream and stay there. Within each stream are diverse consumers, with equally diverse mental health and wellbeing needs and strengths. Further, recovery is a human process, and often does not progress in a linear way.[197] Movement between streams can occur over the course of a mental illness or can also occur over the course of a lifetime. The Commission aims to reform the system so that it responds to people's changing needs over time. The core functions of community mental health and wellbeing services include needs assessments and care planning and coordination in order to facilitate and support necessary transitions for consumers.

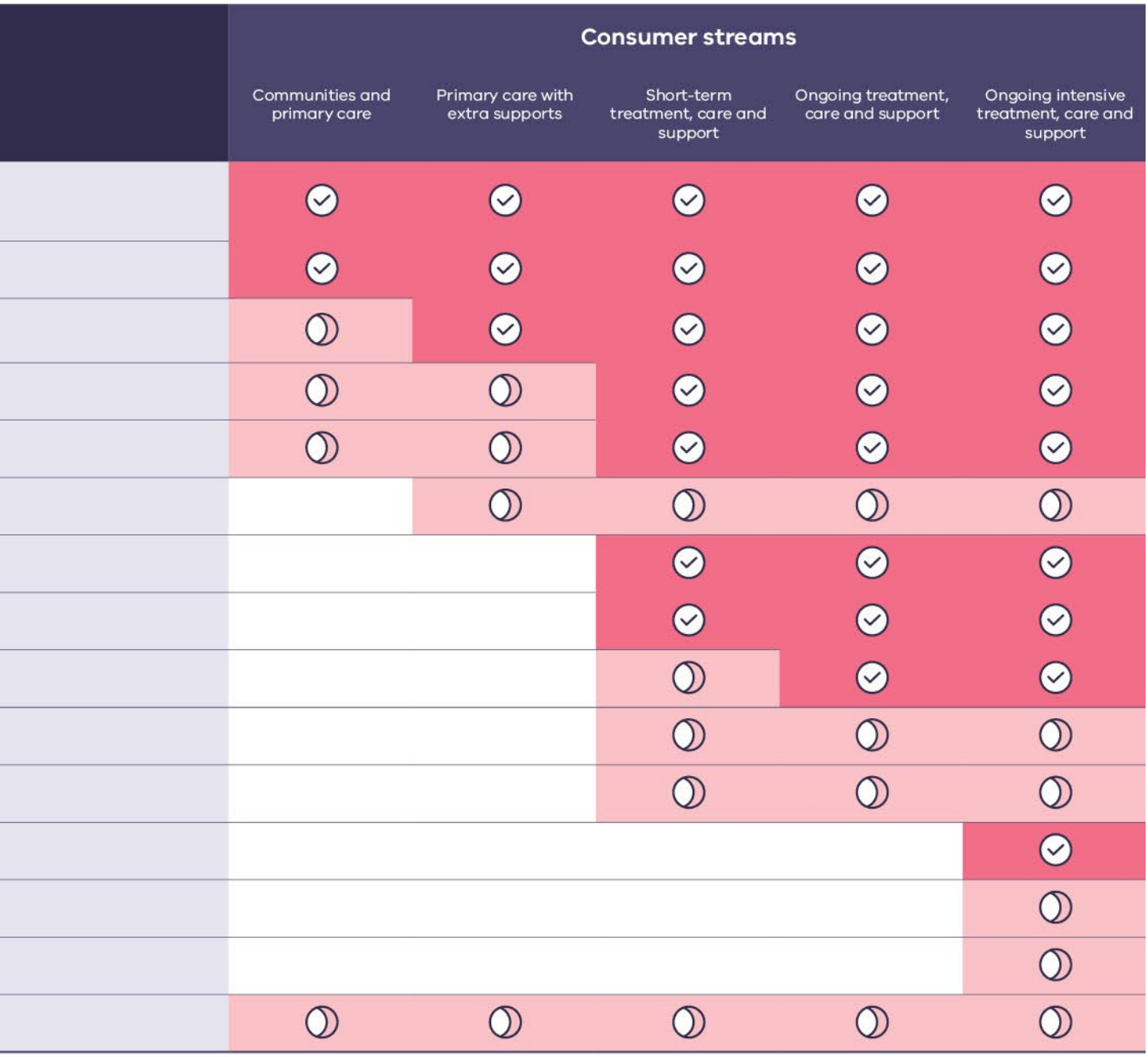
Figure 6.12 illustrates, at a general level, the kinds of treatment, care and support options that consumers across the five streams are likely to access as needed. The figure highlights that some supports, such as those provided by families, carers and supporters and primary care have a role for all consumers, regardless of which stream they are in.

Low-intensity supports are for all consumers, and may include a 'mix of self-help resources including digital mental health and low intensity face-to-face services, [with] psychological services for those who require them'.[198] Self-help could be through online resources, such as the Raising Children Network operated by the Department of Social Services, which includes information and resources on issues such as antenatal and postnatal depression.[199] Mental health apps are another low-intensity support that connect people to accessible and convenient resources.

Figure 6.12: Indicative mental health and wellbeing supports, proportionate to need, for consumers of all ages

Categories of treatment, care and support by consumer stream	
Families, carers and supporters; communities and places; government and community services; telehealth, digital and self-help	
Primary and secondary mental health and related services	Primary care (e.g. general practice)
	Secondary care and related services (e.g. psychology)
Local Mental Health and Wellbeing Services, Area Mental Health and Wellbeing Services and statewide services	Access and navigation support; Initial support discussions
	Education, peer support and self-help
	Primary and secondary consultation and shared care
	Care planning and coordination
	Treatments and therapies
	Wellbeing supports
	Home and community visits
	Bed-based services
	Assertive Community Treatment
	Supported housing
Regional Multiagency Panels	
Crisis responses (statewide and area)	

Text underlined refers to the core functions of community mental health and wellbeing services, explained in depth in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults.*



Sources: Informed by and adapted from a range of sources, including: National Mental Health Commissioner, *Vision 2030: Blueprint for Mental Health and Suicide Prevention*, 2020, p. 26; Elizabeth Leitch and others, *Implementing a Stepped Care Approach to Mental Health Services with Australian Primary Health Networks* (The University of Queensland, 2016), p. 18; Commonwealth Department of Health, *The Fifth National Mental Health and Suicide Prevention Plan*, 2017, p. 20; *National Mental Health Service Planning Framework, Introduction to the NMHSPF*, 2019, pp. 9–10 and 19–20.

Note: This figure indicates the broad areas of treatment, care and support available to consumers in each stream in the future mental health and wellbeing system—it is not a comprehensive list of available supports or services.

Another form of care that is available to all consumers is that provided by primary care services. Depending on their needs and preferences, people across all streams may also access treatment, care and support from clinicians who work in primary mental health and related services, such as GPs, paediatricians, geriatricians, and maternal and child health nurses, for example, for a mental health assessment.

Consumers in higher streams have more intensive support needs. Accordingly, treatment, care and support provided in Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services is targeted at consumers in the highest three consumer streams. The most intensive supports, such as wellbeing supports, housing supports, bed-based services and Assertive Community Treatment are targeted to a small group of consumers in the two ongoing care streams. In this way, the consumer streams are designed to assist in the efficient allocation of resources, so that the most intensive forms of treatment, care and support are provided to those who need them most.

Communities and primary care stream

People in this stream are often described as having 'mild' mental health challenges at that point in time.[200] This means that they will access support from their communities and from primary care services. Relative to other streams, the care and support they need is of the lowest intensity, and will be provided by families, carers and supporters and their communities, as well as low-intensity online support. The Productivity Commission stated that:

> Many Australians experiencing psychological stress or mild mental illness are able to manage their mental health without formal clinical intervention and without significant impact on their relationships or engagement in activities. What is needed to allow this is access to relevant information and the capacity to act on that information (such as by adjusting sleep patterns or diet, exercising, or learning stress management techniques).[201]

Some consumers may at times need support from a primary care clinician, such as a GP. The Commission estimates that across all age groups approximately 1,021,000 Victorians will be in this consumer stream in 2020-21. It is by far the largest of the consumer streams.

Primary care with extra supports stream

Consumers in this stream are often described as having 'moderate' mental health challenges at that point in time.[202]

In addition to support from families, carers, supporters and communities, consumers in this stream will get treatment, care and support from primary and secondary mental health and related services. GPs, paediatricians and geriatricians will offer mental health assessments, physical health care and, if appropriate, prescribed medication. Many people in this stream will also receive sessions of structured psychological therapy following a referral from a GP, subsidised through the Better Access scheme.

For a small group of consumers in this stream, an extra layer of support may be needed. There are two main ways that this will be provided: secondary or primary consultations from clinicians from Local Mental Health and Wellbeing Services or Area Mental Health and Wellbeing Services, for example, a medication review or a comprehensive needs assessment and planning discussion.

The Commission estimates that across all age groups there will be approximately 251,000 consumers in this stream in 2020-21. It is the second largest group of consumers.

Short-term treatment, care and support stream

Consumers in this stream need intensive mental health and wellbeing support for a limited time. Consumers in this stream are often referred to as having 'episodic' or 'severe episodic' treatment, care and support needs that are of a short duration—where that may mean several months. Short-term treatment, care and supports may include:

- high-frequency intensive therapy sessions over a short period (for example, less than three months)
- care coordination, as needed
- practical supports, such as help to find housing or employment, legal assistance or financial counselling
- working with the consumer to understand what is driving their distress and strategies to decrease it
- a short stay at a residential respite service or Prevention and Recovery Care service.

Consumers in this stream will access care primarily in Local Mental Health and Wellbeing Services or Area Mental Health and Wellbeing Services, or both, during their period of need.[203] Consumers will also be supported to transition back to primary or secondary care once they are travelling well.

People in this stream often experience high levels of psychological distress and timely access to support is important to respond to and help them reduce this distress. Treatment, care and support that is provided by multidisciplinary teams of specialised mental health clinicians and support workers from different disciplines is required to respond to their needs.[204]

Providing high-intensity treatment, care and support to consumers in this stream for a relatively short period can support consumers to reduce their distress. This can in turn prevent mental health challenges or distress from escalating to the point of crisis, or minimise the risk that longer-term mental illness is experienced. Some consumers in this stream may also at times need to access, for a brief period, bed-based services. This might include, for example, short stays at a residential respite service or Prevention and Recovery Care service.

The Commission estimates that in this stream in 2020–21 there will be approximately 19,000 consumers aged 12–25 years old, 73,000 consumers aged 26–64 years old and 11,000 consumers aged 65 years old and older.

Infants and children needing more intensive mental health and wellbeing supports are a far smaller group than adults. Accordingly, the Commission has combined the estimated number of consumers aged 0-11 years old for the top three consumer streams. The Commission estimates that there will be approximately 22,000 consumers aged 0-11 years old in the top three consumer streams, the short-term, ongoing and ongoing intensive treatment, care and support streams.

Ongoing treatment, care and support stream

Consumers in this stream are often described as having 'severe' or 'persistent' mental illness.[205] Like the stream above, people accessing services in this stream have more complex support needs and need high-intensity treatment, care and support from multidisciplinary specialised mental health clinicians and support workers. In contrast to consumers whose needs may be intensive but short term, consumers in this stream require this specialised support for longer periods of time.

The Commission expects that treatment, care and support for this stream will involve supporting more people, more frequently and for longer periods of time in the community than is currently the case. Their care will focus on a range of supports, including those related to wellbeing, clinical treatment, housing, employment, physical health care, and substance use or addiction. This will be provided in Local Mental Health and Wellbeing Services or Area Mental Health and Wellbeing Services, or both.

Consumers in this stream will be supported with ongoing care planning and coordination.[206] This may include transitioning into a less-intensive consumer stream in time as needed.[207] Multidisciplinary teams will offer continuity of care as the consumer transitions between settings, including bed-based services, and will assist them to get and coordinate care from other systems, such as the NDIS.

The Commission expects that in the future, many of those in this stream will be eligible for, and should successfully access, the NDIS. Those consumers who access the NDIS will need to be coordinated with the rest of their treatment, care and support. Unfortunately, the Commission notes that many of the people who fit the description of this stream in the current system have struggled to access the NDIS despite the nature of their support needs.[208]

Some consumers in this stream may at times require treatment, care and support in a bed-based service. Bed-based services and alternatives, such as Hospital in the Home are described in Chapter 10: *Adult bed-based services and alternatives*. The Commission expects that when consumers in this stream have access to treatment, care and support in the community that is effective and comprehensive, it may reduce their need to access bed-based services.[209]

In this second smallest stream, the Commission estimates in 2020-21 there will be approximately 10,000 consumers aged 12–25 years old, 23,000 consumers aged 26–64 years old and 19,000 consumers aged 65 years old and older.

Ongoing intensive treatment, care and support stream

Consumers in this stream are sometimes described as living with 'severe and persistent mental illness … and complex multiagency needs'.[210] As described above, this language does not focus on 'rights and wellbeing' and is not 'recovery-oriented'.[211] Accordingly, the Commission has chosen to use the term 'ongoing *intensive* treatment, care and support.'

Consumers in this stream require ongoing treatment, care and support from Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services and extra supports from other services or agencies.

Several factors determine if consumers are within this stream, including levels of wellbeing and distress, and symptom intensity and duration, as well as clinical needs, current and prior service use, and the impact of these on the person's functioning.[212] Data analysis by the Commission across health, human services, police and corrections data indicated that use of mental health services and services for substance use and addiction often coincides with homelessness services, family violence services and instances of engagement with Victoria Police, whether as victims or alleged offenders.[213] Consumers in this stream frequently have instability in multiple aspects of their life, such as housing, employment, relationships, legal and financial, and engagement with criminal law.[214] People often have co-occurring problems with substance use or addiction and can be frequent users of crisis and bed-based services and emergency departments.[215]

Consumers in this stream need treatment, care and support from specialised, multidisciplinary mental health and wellbeing clinicians and support workers. Many in this stream may also have experienced trauma, which is discussed further in Chapter 15: *Responding to Trauma*.[216]

As with the previous stream, the Commission expects that into the future many, if not all, people in this stream will be eligible for and should successfully access the NDIS. This will mean that the wellbeing supports they receive should be funded through the NDIS and will need to be coordinated with the rest of their treatment, care and support.

In this smallest stream, the Commission estimates in 2020-21 there will be approximately 7,000 consumers aged 12–25 years old, 22,000 consumers aged 26–64 years old and 6,000 consumers aged 65 years old and older.

As this stream is the group of consumers who need and benefit from the highest intensity and volume of services, the Commission has developed a reformed service response targeted to this stream, including:

- community-based treatment, care and support based on Assertive Community Treatment
- bed-based extended rehabilitation services (including future intensive rehabilitation models and community rehabilitation models)
- supported housing
- Regional Multiagency Panels.

This reformed service response is explained in the following section.

6.5.4 Reformed service response for people needing ongoing, intensive treatment, care and support

Research conducted by mental health experts at the University of Melbourne for the Commission about the needs of consumers in this stream suggested that:

> [Consumers who need ongoing, intensive treatment care and support] are often neglected by research and innovation efforts. Often a paternalistic and 'best interests' approach may exclude them, and minimal efforts are made to overcome barriers to inclusion … This group of people are highly likely to be living lives constrained by involuntary treatment … and yet are not experiencing access to the highest standard of care and support.[217]

This, and other evidence before the Commission, has highlighted the urgent need for a new approach to treatment, care and support for consumers in this stream.[218] For example, Professor Dan Lubman, Executive Clinical Director of Turning Point, Eastern Health and Professor of Addiction Study and Services, Monash University, stated in a personal capacity that:

> there is an urgent need to create a new service model for consumers with complex needs (typically involving co-occurring severe substance use disorders) … Ideally, this integrated service model would incorporate tertiary specialist expertise from both the [alcohol and other drug] and mental health sectors working within one team and one philosophy, spanning both outpatient and inpatient care, with access to community housing, employment support, peer support and integrated long-stay residential rehabilitation.[219]

In the 1990s, Victoria's mental health system was recognised for providing substantial support to people who had the most complex support needs.[220] However, decreased funding to community mental health has compromised the treatment, care and support for these consumers.[221] The Commission heard from consumers about the lack of longer-term treatment, care and support that is available to them:

> All services now are time-limited and people are being told in 18 months or 2 years you are going to be discharged because you now meet their criteria. We don't acknowledge that mental health problems are life-long … and the culture doesn't acknowledge that.[222]

Limited resources available to clinicians and practitioners working in community mental health with these consumers means that:

> Clinical community teams carry high caseloads and provide generic, more acutely oriented case management. This has not allowed staff to build or practice more specialised rehabilitative and recovery-oriented skills and undermined therapeutic practice across all disciplines … Staff churn is also an issue reducing the continuity and skills to support [these consumers].[223]

Continuity of care, including establishing relationships of trust and connection between consumers and mental health practitioners, can be beneficial for consumers with ongoing intensive support needs.[224] Currently, however, consumers often experience disjointed transitions between services.[225] Community health service leaders told the Commission that the current system often prevents them from offering continuity of care throughout a person's recovery journey.[226]

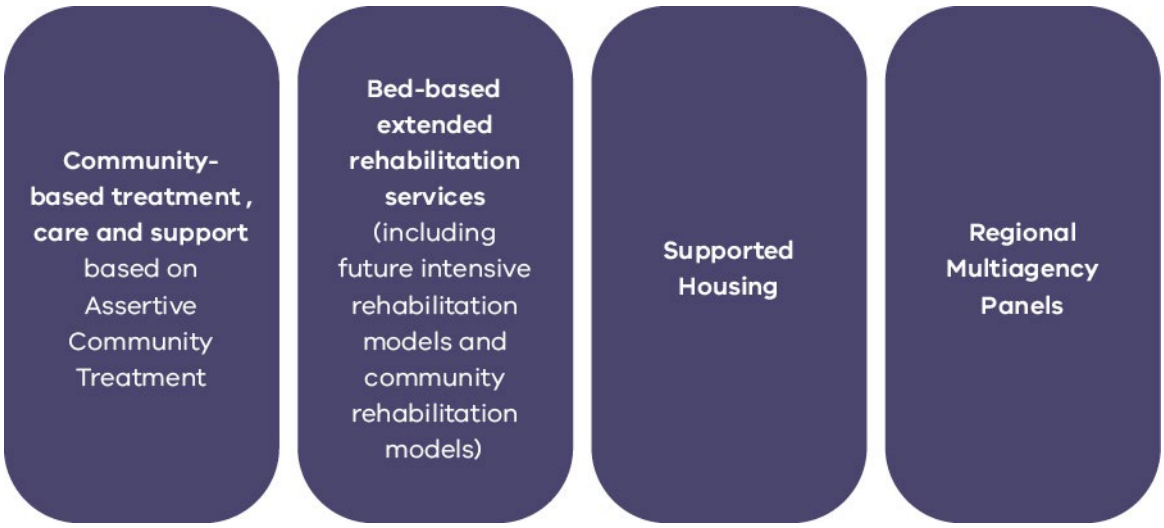
Consumers in this stream typically receive support from multiple agencies or services outside mental health and wellbeing, such as housing, justice or family violence. However, as highlighted in the submission from the Mental Health Tribunal, currently there are major barriers to collaboration and coordination of support:

> the situation of individuals with complex needs not only demonstrates how difficult it is to achieve collaboration across different services, it suggests that services will at times actively avoid collaboration. The response to individuals whose complex needs arise from the severe and enduring nature of their mental illness also highlights, and is arguably partly driven by, the tragic reality that in some cases, there are no truly satisfactory options available within the current system.[227]

Consumers in this stream frequently experience challenges in engaging with mental health or other services, for a range of reasons, including the skills and resources of services. As Mr Adam Burns, Senior Mental Health Clinician at Wadamba Wilam, Melbourne Health, stated, '[a]ppointment-based services are a type of systemic barrier for many people'.[228] Barriers to accessing mental health treatment in the community can have substantial and adverse effects; for example, in some instances resulting in people's incarceration. As Dr Emma Cassar, Commissioner of Corrections Victoria at Department of Justice and Community Safety, told the Commission, 'the corrections system is too often acting as a mental health provider of last resort because people are unable to access mental health services in the community'.[229]

To resolve these current challenges, the future system will have an interconnected set of approaches to support people in this stream, as summarised in Figure 6.13. Together, these supports create a reformed service response that will enable people with ongoing intensive treatment, care and support needs to achieve and maintain their greatest level of independence and better mental health outcomes.

Figure 6.13: Features of reformed service response for people needing ongoing intensive treatment, care and support



For adults and older adults, Area Mental Health and Wellbeing Services will provide treatment, care and support based on the Assertive Community Treatment model, including through 'assertive outreach' when necessary.[230] As described in the Commission's interim report, assertive outreach is a term that can apply to a broad range of models of care that are delivered in different service contexts. Generally, assertive outreach recognises that some people may require services to be more proactive in engaging or following up with them. A variety of assertive outreach models are now in operation in Australia and internationally.[231] Assertive Community Treatment is an evidence-based model of assertive outreach that includes multidisciplinary staffing, highly individualised approaches to treatment, care and support, coordination and integration of services across agencies, assertive outreach, and wellbeing supports focused on everyday living.[232]

Research on the benefits of the Assertive Community Treatment model has indicated positive outcomes for people and systems.[233] Diverse experts have also described to the Commission the weight of evidence behind the effectiveness of Assertive Community Treatment where appropriately made available. For example, Professor Rosen explained that:

> **Ample existing evidence replicated over more than 40 years suggests that complex co-occurring disorders including severe and persistent mental illnesses, ongoing substance abuse and physical illnesses, and unstable housing are best handled in the community by the Assertive Community Treatment (ACT) team approach, for which rural remote regional proxies can be developed, which include both telehealth and in-person team enhancements.**[234]

The research completed by the University of Melbourne for the Commission systematically analysed evidence on models of care to best support Victorians needing ongoing intensive treatment, care and support.[235] It outlined the substantial evidence for Assertive Community Treatment.[236] In doing so, it identified that Assertive Community Treatment remains a best practice model of care and strongly supported the expanded availability, or re-establishment where necessary, of Assertive Community Treatment teams statewide.[237]

It indicated that Assertive Community Treatment is effective in improving clinical outcomes, service use, quality of life and rates of employment, and reducing rates of hospital and emergency department admission and lengths of hospital stay.[238] The research indicated that Assertive Community Treatment should also aim to reduce involuntary and compulsory treatment.[239]

The research suggested an evidence-based way to increase engagement with Assertive Community Treatment teams, and to reduce compulsory treatment, is to include a lived experience workforce:

> **ACT teams need to be vigilant in their awareness of the potential harms associated with compulsory treatment and require advanced skills in working with people towards less restrictive care. Peer support workers may assist in shifting the power imbalance in teams and enable improved engagement with people who are reluctant to accept care and treatment.**[240]

For young people requiring services in this stream, mobile assertive outreach teams in the Youth Area Mental Health and Wellbeing Services (a service stream of the Infant, Child and Youth Area Mental Health and Wellbeing Services) will provide outreach-based support when necessary.

While the Commission's vision for the future is that the majority of treatment, care and support will be provided in the community, consumers in this stream may also at times receive support from a bed-based service. Such support includes bed-based extended rehabilitation services based on an intensive rehabilitation model of care in a redeveloped, secure extended-care unit. It may also include support through a community rehabilitation model of care, through a redeveloped community care unit. The Commission's vision for bed-based services, and details on how they will support consumers is contained in Chapter 10: *Adult bed-based services and alternatives*.

Some consumers in this stream will also be supported to obtain access to supported housing, acknowledging the central importance of stable and supported housing options for people with the most complex mental health and wellbeing needs. The Commission's reforms related to housing are set out in Chapter 16: *Supported housing for adults and young people*.

The Commission's reform to establish Regional Multiagency Panels (which are described in detail in Chapter 5: *A responsive and integrated system*), will also be a component of the reformed service response. These panels will support a small number of consumers in this stream, whose coordination needs cannot be met through the care coordination function, to access supports from multiple agencies. Panel members will include representatives from the person's treatment team, senior agency representatives and lived experience consumer and carer representatives. For children and young people, representatives may be from schools, maternal and child health services or child protection. Where appropriate, consumers, families, carers and supporters may also attend panel meetings.

A new model of community-based care for people with ongoing, intensive treatment, care and support needs recognises that high-quality care and therapeutic interventions in the long term are needed to improve outcomes.[241]

The Commission's aspiration for the future mental health and wellbeing system is one anchored in community-based mental health and wellbeing services. It is a system that approaches consumer needs through a biopsychosocial model, including providing the wellbeing supports to enable a contributing life. Through a responsive and integrated system architecture, guided by consumer streams, the future system will appropriately target care proportionate to consumer need, including coordinating that care where needed. This is a substantial shift in the delivery of mental health care in this state. It is one that is necessary to deliver better consumer outcomes and to realise a long-held vision for community-based mental health and wellbeing treatment, care and support in Victoria.

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Chapter 7

Integrated treatment, care and support in the community for adults and older adults

Recommendation 5:

Core functions of community mental health and wellbeing services

The Royal Commission recommends that the Victorian Government:

1. commission and ensure that Adult and Older Adult Local Mental Health and Wellbeing Services and Adult and Older Adult Area Mental Health and Wellbeing Services referred to in recommendation 3(2)(a) and (b) work in collaboration to deliver in each of the 22 service areas short-term, ongoing and intensive services as required and include the following core functions:

   a. Core function 1: integrated treatment, care and support that comprises:

      - a broad range of treatments and therapies;
      - a broad range of wellbeing supports (formerly called psychosocial supports) for those who require them, including those who are unable to access the National Disability Insurance Scheme;
      - education, peer support and self-help; and
      - care planning and coordination.

   b. Core function 2: services to help people find and access treatment, care and support and, in Area Mental Health and Wellbeing Services, respond to crises 24 hours a day, seven days a week.

   c. Core function 3: support for primary and secondary care and related services, through primary consultation with consumers, secondary consultation with providers of those services and a formal model of comprehensive shared care.

2. commission and ensure that Adult and Older Adult Local Mental Health and Wellbeing Services and Adult and Older Adult Area Mental Health and Wellbeing Services referred to in recommendation 3(2)(a) and (b) work in collaboration to deliver multidisciplinary, holistic and integrated treatment, care and support through a range of delivery modes including:

   a. site-based care (such as centres or clinics);

   b. telehealth;

   c. digital technologies; and

   d. visits to people's homes and other places (including targeted assertive outreach).

3. ensure Adult and Older Adult Local Mental Health and Wellbeing Services and Adult and Older Adult Area Mental Health and Wellbeing Services are accessible and responsive to the diversity of local communities.

7.1 Current challenges with community-based treatment, care and support for adults and older adults

This chapter focuses on the core functions of community-based Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services for adults, including older adults.

The chapter should be read in conjunction with the two preceding chapters:

- Chapter 5: *A responsive and integrated system*, which describes the architecture of the whole future mental health and wellbeing system for all ages.
- Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*, which outlines the Commission's rationale for, and intended design of, community-based mental health and wellbeing services. Chapter 6 also explains the Commission's recommendations that Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services are delivered through a range of modes and in ways that are accessible and responsive to the diversity of local communities.

The delivery of the core functions introduced in Chapter 6 will be consistent across all age groups, with some tailoring—for example, to ensure developmentally appropriate services for children and young people. To reduce repetition across the chapters that focus on specific life stages, the core functions are described most fully in this chapter.

This chapter focuses on how the core functions apply to services for people aged 26 years and over. The application of the core functions to community-based services for people aged under 26 years is discussed in Chapter 12: *Supporting perinatal, infant, child and family mental health and wellbeing* and Chapter 13: *Supporting the mental health and wellbeing of young people*. This report also examines the specific needs of older Victorians in Chapter 14: *Supporting the mental health and wellbeing of older people*.

Victoria's current mental health system for adults and older adults consists of a range of different, largely disconnected services.[1]

Most public specialist mental health services—sometimes referred to as 'clinical' or 'tertiary' mental health services—are delivered within area mental health services, which are the responsibility of 17 public health services across the state.[2] There are 21 adult area mental health services,[3] 17 aged persons mental health services,[4] 13 area mental health services for children and young people and a series of statewide services.[5] People request or are referred to these services via triage phone lines in each area service or—as is increasingly the case—via emergency departments and admission to an inpatient unit.

Separate to public health services, several non-government organisations deliver a range of mental health services and supports, including 'psychosocial' support. For reasons explained in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*, the Commission uses the term 'wellbeing supports' instead of 'psychosocial supports'. Wellbeing supports encompass a broad range of supports for community connection and social wellbeing, as well as practical life assistance. Non-government organisations employ a diverse workforce that also provides some mental health nursing services, allied health services, and psychological and other therapies.[6]

The Victorian Government funds some wellbeing supports as 'mental health community support services.' However, as described in section 7.1.5, many supports previously funded under this program have transitioned to the National Disability Insurance Scheme (NDIS).[7]

The wellbeing supports provided by non-government organisations include accommodation, outreach to help people live independently in the community, recreational programs, self-help and peer support groups, other services focused on mental health recovery, and other forms of disability or social care.[8] People can access these services through the NDIS, be referred to these services by area mental health services or enter them directly.

Currently, as evidenced in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services,* Victoria's public specialist mental health services provide treatment, care and support to just over one per cent of the community. The consumers of these services are mainly people experiencing mental illness with intensive support needs. In addition, some public primary and secondary mental health care is delivered in Victoria's 86 community health services. These services offer medical, dental, allied health and social care—including some clinical and psychosocial supports—to communities across Victoria.[9]

Private providers also play a role. As well as inpatient services, private providers offer a range of mental health services on an outpatient basis. For example, the Albert Road Clinic in Melbourne has outpatient clinics offering individual and group therapies (including a dialectical behaviour therapy program, and family and individual psychoeducation) and an outreach program in which clinicians visit patients in their homes to provide tailored short-term or long-term treatment.[10]

Chapter 5: *A responsive and integrated system,* presented the case for reform of Victoria's whole mental health system. Specific issues relating to the need for a new approach to public community-based mental health and wellbeing services for adults, including older adults, are explored further in the following discussion.

7.1.1 Structural problems that undermine integrated treatment, care and support

The different sectors outlined in the previous section are largely governed, accounted for and operated separately, even though they work with many of the same consumers, families, carers and supporters. This siloing of services is both a cause and effect of the great strain the mental health system is under. Challenges described in the Commission's interim report and reiterated to the Commission throughout 2020 include:

- limited connections between the mainly tertiary-level services provided by area mental health services and other levels of the system including primary and secondary services[11]
- lack of integration with alcohol and other drug treatment services (despite many people living with mental illness also experiencing substance use or addiction) and with physical health services (despite large discrepancies in health outcomes and life expectancy between people living with mental illness and others in the community)[12]
- growing disconnection between the clinical services provided by area mental health services and non-government organisations.[13] While there are collaborations at the service and practitioner levels, and some co-commissioned services (for example, Prevention and Recovery Care services, which are delivered by non-government organisations and area mental health services partnerships),[14] the two sectors mainly operate independently.[15] Other than in co-commissioned services, which have common governance at service level, the different services rarely share a governance structure and have limited formal incentives to work together, relying instead on the goodwill of individual staff.[16]

The disconnection between the various services and supports that people may need to recover or live well with mental illness increases the need for care planning and coordination. Many consumers, families, carers and supporters, expressed a need for mental health services to be more proactive in reaching out to them and helping them find other services and supports. For example:

> **[I]t was really useful, because that [program] was providing referrals and chasing up those referrals for me, instead of me having to chase up the referrals which is often what you have to do when you're managing your own care plan.[17]**
>
> **The system currently puts an emphasis on the patient 'controlling their journey' through the health system. Although this might seem ideal, common conditions like depression make it difficult to make lunch or get out of bed let alone try to navigate both the cost and manage the momentum required to arrange appointments, attend appointments, self manage whether those appointments are working etc.[18]**

Carol's personal story in section 7.1.2 illustrates some of the personal impacts of poor care coordination—in this case, between public specialist mental health services, non-government community support organisations and private hospitals. Carol describes how having an NDIS Plan and Support Coordinator has made a difference to her son's experience of care.

7.1.2 Inadequate supply of public specialist mental health services in the community

Chapter 5: *A responsive and integrated system* provides an overview of the unmet demand for specialist mental health services for all age groups. Figure 7.1 presents this information (which is based on the provision of public specialist mental health services rather than wellbeing or other supports), for people aged 26–64 years.

The Commission estimates that in 2019–20, 116,000 Victorians aged 26–64 years had a level of need for specialist mental health services equivalent to the three highest-intensity consumer streams described in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*. They are the short-term treatment, care and support stream, the ongoing treatment, care and support stream and the ongoing intensive treatment, care and support stream.

As shown in Figure 7.1, of those 116,000 people, Victoria's current public specialist mental health services saw only 45,613 (39.3 per cent). A further estimated 22,756 people (19.6 per cent) to 49,318 people (42.5 per cent) accessed specialist mental health services in the private health system in 2019–20. Private specialist mental health services might include mental health services provided in a private hospital or multiple Medicare-subsidised psychiatric services. Such private services are not accessible to all—for example, those with lower incomes or those in areas with limited private sector supply.

Figure 7.1 also shows the service gap for adults—the proportion of those 116,000 people in 2019–20 who were estimated to require services who did not get them in either the public or private systems. This service gap was estimated to be between 21,069 people (18.2 per cent) and 47,631 people (41.1 per cent). This level of estimated unmet need, largely due to underfunding, is consistent with feedback from mental health sector leaders that Victoria's existing public specialist mental health services for adults require significant expansion.[19]

The second part of Figure 7.1 shows that in 2019–20, public specialist mental health services for adults delivered only 735,000 (31.8 per cent) of the estimated 2,310,000 hours of care required by Victorians. This data does not include the gaps in access to wellbeing supports. This suggests that many people who need these services are not getting them—as noted earlier—and also corroborates evidence from Commission witnesses that many consumers do not receive services at the intensity and duration they need. For example, Associate Professor Simon Stafrace, then Program Director of Alfred Mental and Addiction Health, Alfred Health, said that when people do get support from area mental health services, this care is often only for a brief period while they are acutely unwell.[20]

As shown in Figure 7.2, Victoria is well below most other states and territories (and the national average) in terms of the number of community-based clinical service contacts (or the provision of a service) from public specialist mental health services as a proportion of the population aged 25–64 years. This suggests that even when consumers are accepted for service provision, they receive a lower level of service than people in other jurisdictions.

Personal story:

Carol

Carol* lives in regional Victoria with her 32-year-old son, Chris*, who moved home with her eight years ago.

> He completed university and began working, when he suddenly became mentally unwell. He didn't know what was going on, we just knew that there was something very wrong.

Carol said Chris wanted help, but they struggled to find professionals to provide diagnosis, support and treatment.

> He goes to see someone—he's seen many people—and then it'd get too hard for them and they'd just discard him, saying 'I can't help you' and things like that.

Living in regional Victoria, there were limited service options and often long wait times.

Carol said it was a frustrating experience trying to navigate Chris's voluntary admission to the inpatient ward at the local hospital. Despite having it pre-arranged, Carol said none of the paperwork had been passed on.

Carol said Chris stayed at the hospital, despite feeling distressed by the initial interactions and disorganisation. For reasons unknown to Carol, Chris was then put on an order.

> He went there with his own free will to try and get some help and then he had an order put on him. I said, 'but why have you done that?' Anyway, I never really got a proper answer.

After two weeks, the facility called Carol to pick Chris up.

> The psychiatrist said, 'Well, we've organised for him to go to another place'. And I said, 'where is that? It would be nice if we could sit down and talk about this'.

Chris was moved to a Prevention and Recovery Care (PARC) unit for 28 days. After this, he moved back in with Carol, with plans for local community-based supports. However, the service he was referred to was not responsive.

> I said, 'my son hasn't heard anything' and the response was, 'well, he's very low on our list of priorities'.

Supported by Carol and his GP, Chris travelled to Melbourne to access a private inpatient unit for diagnosis and treatment. He also used Skype to connect with his clinicians—this was a good way for Chris to access services outside of the local area without the need for travel.

> My son really liked having the Skype sessions, but unfortunately the psychiatrist retired, and the link with the private inpatient unit ceased because of that, so the contact with the Melbourne specialist came to an end.

Chris was left without a psychiatrist or referral to another clinician. This left Carol and Chris to try to find another psychiatrist on their own, which was compounded by long wait lists, a lack of services in rural and regional areas, and high staff turnovers.

Chris now has an NDIS Plan and Support Coordinator who assists Chris to navigate his support options and arrange the supports he needs.

Carol would like to see a system where carers are recognised and listened to, alongside better provision in rural and regional areas.

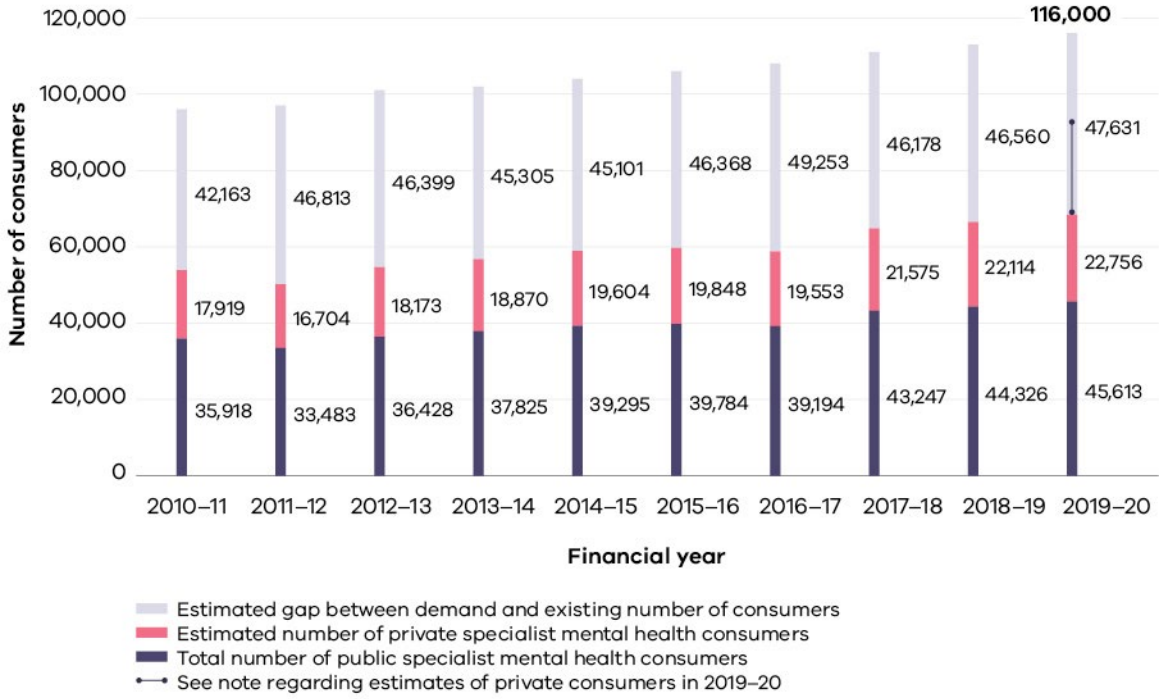
> We need a mental health system where specialist services are available in rural and regional Victoria. Accessing and navigating the current system is a nightmare.

Source: RCVMHS, Interview with 'Carol' (pseudonym), October 2020.

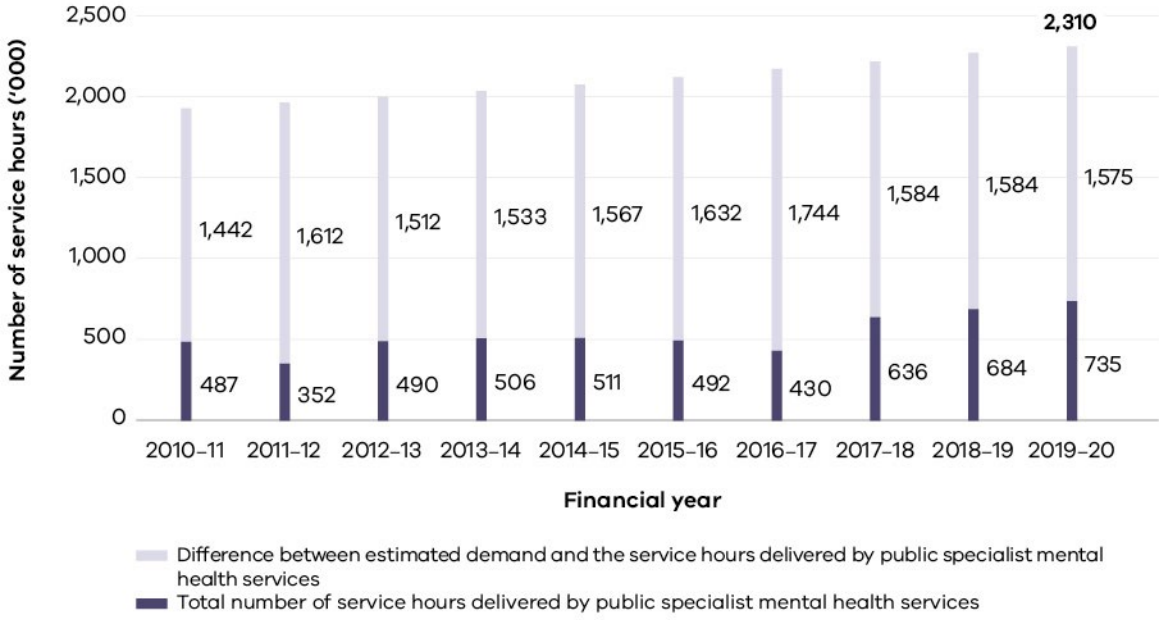
Note: *Names have been changed to protect privacy.

Figure 7.1: The difference between the actual number of people receiving specialist mental health services/actual consumer-related community service hours delivered and estimated demand, 26–64 years, Victoria, 2010–11 to 2019–20

A. Consumers



B. Service hours



Sources: A. Calculation by the Commission based on Department of Health (Commonwealth), *National Mental Health Service Planning Framework*; Australian Bureau of Statistics, Australian Demographic Statistics, June 2020, cat. no. 3101.0, Canberra; Department of Health and Human Services, Client Management Interface/Operational Data Store 2010–11 to 2019–20; Department of Health and Human Services, Victorian Admitted Episodes Dataset, 2010–11 to 2018–19; Australian Government Services Australia, Medicare Benefits Schedule, 2017–18; Australian Institute of Health and Welfare, Mental Health Services in Australia: Medicare Subsidised Mental Health-Related Services 2018–19. Table MBS.2.

B. Calculation by the Commission based on Department of Health (Commonwealth), *National Mental Health Service Planning Framework*; Australian Bureau of Statistics, Australian Demographic Statistics, June 2009 to June 2019, cat. no. 3101.0, Canberra; Department of Health and Human Services, Client Management Interface/Operational Data Store 2010–11 to 2019–20.

Notes: 2011–12, 2012–13, 2015–16 and 2016–17 data collection was affected by protected industrial action. The collection of non-clinical and administrative data (public specialist mental health services) was affected, with impacts on the recording of community mental health service activity and client outcome measures.

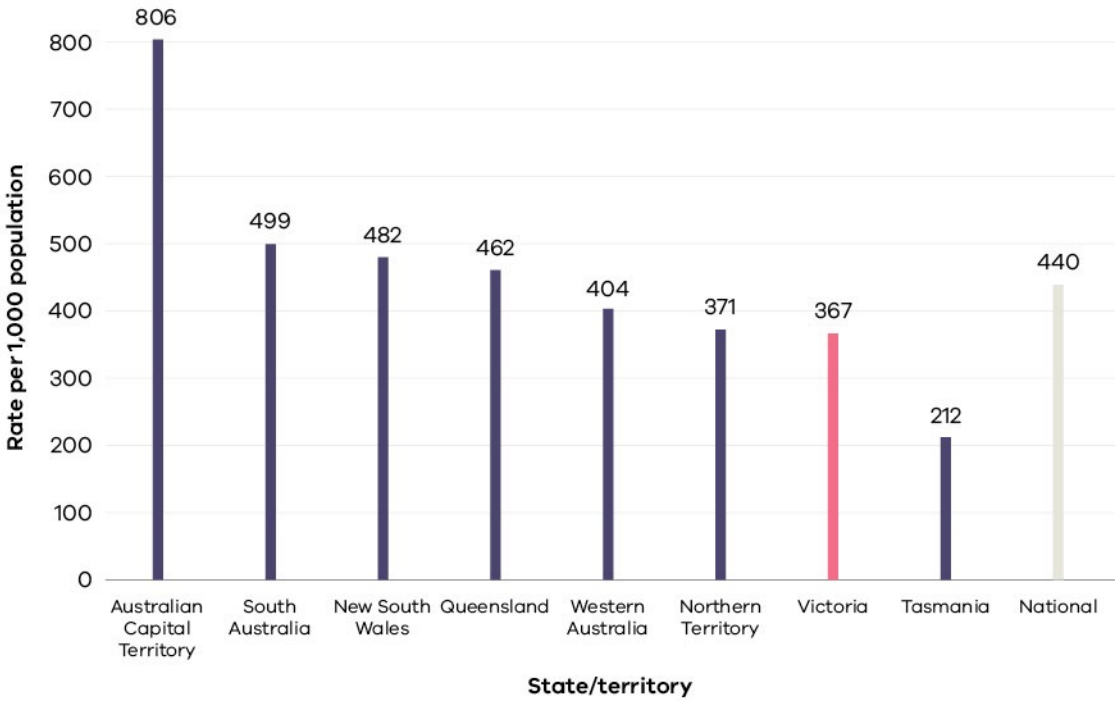
A. Consumers: The estimated number of private clients using the private system is based on the proportion of overall people admitted to a private hospital in Victoria for a mental health reason between 2010–11 and 2018–19. There may be consumers receiving mental health services in both public and private specialist services that are double counted. There may also be people receiving specialist mental health services from other private providers that are not counted with this methodology.

This analysis does not include 'unregistered clients'. Each year there are a number of contacts delivered to consumers that are not registered in the Client Management Interface/Operational Data Store which in 2019–20 was 16 per cent of total contacts.

For 2019–20, there are two alternative estimates of the number of private specialist mental health consumers. First, 22,756 consumers, which would mean there is an estimated gap of 47,631. This estimate is based on the proportion of people that had a mental health admission to a private hospital. Second, 49,318 consumers, which would mean there is an estimated gap of 21,069. This includes all people that received more than one service from a medicare-subsidised psychiatrist or had a mental health-related admission to a private hospital. Anyone who also received public specialist mental health services has been excluded to avoid double counting.

B. Service hours: Some of the gap may be met through services delivered in the private mental health system Consumer-related service hours are defined in the *National Mental Health Service Planning Framework* as time spent working with or for a client. This includes direct activity, for example, assessment, monitoring, and ongoing management, care coordination and liaison, respite services, therapies, peer work, review, intervention, prescriptions, pharmacotherapy reviews, carer peer work and support services, and community treatment teams. It does not include administration, training, travel, clinical supervision and other activities that do not generate reportable activity on a consumer's record.

Figure 7.2: Community mental health care service contacts per 1,000 population aged 25–64, states and territories, 2018–19



Sources: Australian Institute of Health and Welfare, Mental Health Services in Australia: State and Territory Community Mental Health Care Services 2018–19, Table CMHC.3 <www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/community-mental-health-care-services> [accessed 14 October 2020].

Notes: A mental health service contact is defined as the provision of a clinically significant service by a specialised mental health service provider for patients/clients, other than those admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals and those resident in 24-hour staffed specialised residential mental health services, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question. Any one patient can have one or more service contacts over the reporting period (that is, 2018–19). Service contacts are not restricted to face-to-face communication but can include telephone, video link or other forms of direct communication. Service contacts can also be either with the patient or with a third party, such as a carer or family member, or other professional or mental health workers or other service providers.

Contacts include those provided to non-uniquely identifiable consumers/unregistered clients. 'Non-uniquely identifiable consumers' or 'unregistered clients' are defined as those with service contacts for which a unique person identifier was not recorded. Not all jurisdictions report non-uniquely identifiable consumers so comparisons between jurisdictions should be made with caution.

7.1.3 An often narrow and generic model of care in public specialist mental health services

The Commission heard that area mental health services have become overly reliant on a medical model of care and a generic case management approach that does not empower the multidisciplinary workforce to help consumers, families, carers and supporters, using discipline-specific skills and expertise.[21]

Consequently, many evidence-based forms of treatment, care and support are not readily available in the public mental health system. Professor Patrick McGorry AO, Executive Director, Orygen and Professor of Youth Mental Health, University of Melbourne, told the Commission in his personal capacity:

> I could give about ten different examples of treatments that I've seen developed in my time in psychiatry, new treatments, drug therapies and also psycho-social treatments, including many that we've developed here in Victoria, that are simply not available to people; they're not what the system delivers. The system delivers this very basic generic case management and risk management system; it doesn't deliver all the things that we already have at our disposal in an effective way.[22]

These issues are explored in the following sections.

Over-reliance on medical treatment

As discussed in section 7.3.1, many consumers do find traditional biomedical diagnostic and treatment approaches helpful and some people need them to live successfully in the community. However, these approaches, where needed, must be offered alongside other forms of treatment, care and support that have been shown to help people live well. As one area mental health service submitted:

> Frequently employed models with a strong biological treatment focus lack strength in addressing additional determinants of health in the psychosocial sphere. Medications and biological interventions are important to recovery but may be 'prescribed' in isolation from other strategies that could improve psychological and social functioning and wellbeing.[23]

The Commission received substantial evidence about the marked lack of psychological treatments, including 'talking therapies', in Victoria's adult area mental health services.[24] Service providers expressed dismay about their limited capacity to provide evidence-based non-medical interventions.[25] For example, Alfred Health stated that it can provide some psychological therapy through its dialectical behaviour therapy and mentalisation-based therapy programs but that these treat relatively small numbers of consumers and do not meet demand.[26]

When psychological treatment and therapies are available, the range is often narrow, and they are not always offered for long enough to be effective.[27] Another consideration is that therapy is often available only through one-to-one interactions between a clinician and a consumer, meaning opportunities for evidence-based group and family therapy are missed.[28]

Many consumers, families, carers and supporters expressed concern that medication is the main—or sometimes the only—treatment they receive from clinical mental health services.[29] As one carer told the Commission:

> They treat him with medication but do not follow it up with any kind of therapy—my partner is sedated all day. You need a mix of medication and counselling—it is both, not one or the other.[30]

For some people, medical treatment alone is not therapeutic at all. For example, a participant at a community forum in North East Melbourne stated:

> The system is channelling people into a medical way of doing things—great if it works for you but for some people it doesn't work. No alternatives if that doesn't work for you—you're out of luck. I wouldn't survive in the system—I don't feel safe in the system and won't go to them for help.[31]

Consumers told the Commission that the limited availability of psychological therapies in the public system forces people into often unaffordable private services.[32] One consumer said, '[i]t was like getting teeth pulled out to get money out of my super to pay for therapy that isn't accessible in the public system.'[33]

Professor David Copolov AO, Professor of Psychiatry and Pro Vice Chancellor of Major Campuses and Student Engagement at Monash University, told the Commission:

> private hospitals tend to offer a much wider array of therapeutic programs and psychosocial support for patients than public hospitals, including day hospital programs, group therapy, and various forms of psychotherapy, including cognitive behaviour therapy, Acceptance and Commitment Therapy, Dialectical Behaviour Therapy, Mindfulness and Art Therapy. There is generally not enough time in public hospitals to offer much, if any, of this treatment and support. That too should change, so that there is parity of mental health care in the public and private systems.[34]

However, the Commission heard that the private sector can also struggle to provide holistic care. As the Victorian Faculty of Psychotherapy at the Royal Australian and New Zealand College of Psychiatrists stated:

> Psychiatrists in both the public and private [mental health system] are increasingly seeing patients for single or short-term assessments with little or no ongoing support and management. This results in the production of a generation of psychiatrists, in the public and private [mental health system], that have not developed capacity for the provision of continuity of holistic psychiatric care.[35]

Loss of specialisation

The Victorian Government policy framework that guided the establishment of community-based area mental health services following deinstitutionalisation in the 1990s specified that adult area mental health services would establish separate teams for consumers requiring crisis outreach, for those with intensive community treatment needs, and for those with lower intensity ongoing needs.[36]

Due to demand and funding pressures, many area mental health services have moved away from the original service model. Services have evolved differently, but there has been a trend towards a more generic model of care that requires 'everybody to do a bit of everything' rather than working in specialised teams.[37] While area mental health services employ a range of different types of practitioners—such as nurses, social workers, occupational therapists, psychologists and psychiatrists—in community-based teams, many models of care have shifted towards a generic 'case management' approach.[38] Monash Health submitted:

> generic mental health clinicians acting as case managers have lost the therapeutic skills learned in their years of training, and many so-called consultations (welfare checks) are by phone.[39]

As the submission from Monash Health suggests, the generic case management model of care does not allow clinicians from different disciplines (for example, consultant psychiatrists and psychiatry registrars, nurses, psychologists, occupational therapists and social workers) to deliver evidence-based interventions related to their specific disciplines and qualifications.[40] Associate Professor Dean Stevenson, Clinical Services Director at Mercy Mental Health, told the Commission:

> our service went through two phases of what we call integrations of services and in that process you lost the multidisciplinary specificity, I suppose, of clinicians: so, your occupational therapists became generic case managers and your social workers became generic case managers, and so everybody then fulfilled a similar kind of role and you lost the multidisciplinary input into clinical teams which I believe is very, very important in mental health services.[41]

The generic case-management model means that many consumers do not receive specialised therapies suited to their needs. Professor Richard Newton, Clinical Director of Peninsula Mental Health Service, told the Commission:

> The current situation whereby each mental health service has been left to develop its own therapeutic programmes has resulted in an ineffective approach at the State-wide level. Only about one in five of our consumers will receive an effective dose of an evidence based therapy delivered in a rigorous way. This should not be allowed to continue.[42]

As Professor Newton suggests, many non-medication therapies are backed by evidence indicating they can help people recover from mental illness. In contrast, Professor Alan Rosen AO, Professorial Fellow, Illawarra Institute for Mental Health, University of Wollongong and Clinical Associate Professor, Brain and Mind Centre, Sydney Medical School, University of Sydney, told the Commission, 'there is no evidence base for generic mental health teams (that is, mental health teams that try to do a bit of everything)'.[43] The Commission heard that the public sector could increase efficiency by reducing 'its reliance on low-value case management and expand[ing] the delivery of cost-effective psychological treatments'.[44]

While the case management model is undoubtedly in need of reform, the Commission notes that its inclusion in area mental health services' original *Victoria's Mental Health Service: the Framework for Service Delivery* in the 1990s was to ensure that consumers had a consistent point of contact in the service, with a clinician who knew them well and was responsible for coordinating their care.[45] This component remains critical so that workers can still form the 'close and continuing relationships' that case managers typically develop with consumers by 'spend[ing] considerable time with them … and acquir[ing] some in-depth history of their problems and typical presentations in relapse'.[46]

The Commission understands that some adult area mental health services have already begun to transition away from the 'generic' models of care to models that provide more person-centred care, but this is not standard across the system.[47]

Orientation towards certain diagnoses

Clinical leaders told the Commission that the model of care in area mental health services for adults has become oriented towards certain diagnoses, meaning that people who are severely affected by other forms of mental illness or psychological distress are less well served. Dr Neil Coventry, Victoria's Chief Psychiatrist explained that people with 'higher prevalence disorders' (such as depression and anxiety) have been gradually 'forced out of the system'.[48] This is mainly due to demand pressures and the loss of small inpatient and community psychiatry services in general hospitals that, in the 1990s, had particular expertise in treating voluntary patients with high-prevalence disorders.[49]

Associate Professor Stafrace told a similar story. He explained that, while mental health services see a broader group of people in emergency situations, people who receive ongoing care are generally those with psychotic illnesses such as schizophrenia.[50] In relation to people typically seen in emergency situations but not followed up by community mental health services, Associate Professor Stafrace said:

> [T]here's really significant opportunities here for us to be involved in the care of people with a whole variety of needs if in fact that's what they wanted, but [we] don't do so … partly because we're not resourced and partly because the model is designed not necessarily to cater for the needs of clients with those problems.[51]

7.1.4 Reduced access to wellbeing supports

As well as wanting to offer more non-medication clinical therapies, leaders from mental health services and non-government organisations told the Commission that it is time to end the divisions and binary ways of thinking that separate 'clinical' treatment, care and support from 'psychosocial' approaches, and to stop thinking of the organisations delivering them as having essentially different roles.[52] For example, as Dr Shaymaa Elkadi, Executive Director of Strategy, Planning and Performance at Forensicare, summarised:

> '[t]here is a need for continuity of care and a shared care approach between clinical care and psychosocial supports. The two areas currently operate in silos.'[53]

This is the basis for the Commission's recommendation, described in Chapter 5: ***A responsive and integrated system***, that Area Mental Health and Wellbeing Services are delivered through partnerships between public health services or public hospitals and non-government organisations that deliver wellbeing supports.

Currently, however, the siloed approach to delivery of clinical services and wellbeing supports is only one of several issues affecting the delivery of integrated wellbeing supports in the current system. Further considerations are that:

- The range of wellbeing supports available is sometimes narrow.[54]
- When wellbeing supports are available, they are often only offered on a short-term basis, which for some consumers is not effective in supporting their recovery.[55]
- Unstable funding can lead to a proliferation of short-term services that struggle to connect consumers, families and carers to local wellbeing support services.[56]
- Funding that is fragmented across multiple services can make it difficult for providers to collaborate and offer people a range of supports.[57]

In addition, the introduction of the NDIS has disrupted and depleted the non-government workforce that has traditionally provided wellbeing supports.[58] This is discussed below.

7.1.5 The impact of the National Disability Insurance Scheme

The NDIS was designed to provide individualised funding to give people living with disability control and choice over the supports they need to participate in community life.[59] However, many people spoke to the Commission about gaps in the availability of wellbeing supports created by the transition of formerly state-funded support services to the NDIS.[60] Mr Peter Ruzyla, CEO, EACH, told the Commission:

> Before we became part of the NDIS we had a thousand consumers who we were supporting through our community mental health support services, [and] we had approximately 150 trained and skilled community mental health workers. As our community mental health system has been decommissioned, we're currently supporting about 850 people through NDIS packages, and that's across a range of intellectual, physical and psychosocial disability, but we've still managed to maintain support for a predominantly psychosocial disability cohort. But we're down to about 30 or so community mental health workers as the funding levels in the NDIS haven't been able to sustain the levels of salary that a community mental health worker requires as part of the award. What's that meant is that, not only have we been extremely financially impacted by trying to maintain that 150 workers for a long period of time, we maintained that for almost 12 months, but finally we had to begin to replace them with disability support workers.[61]

Mr Ruzyla's comments about the impact of the NDIS on the community mental health workforce were echoed by many organisations.[62] One NDIS participant with primary psychosocial disability told the Commission that, because her NDIS package allocates insufficient funding for experienced and qualified workers, they lack the skills they need to support her.[63] This same witness told the Commission about how this can affect consumers:

> I think that the NDIS could be harmful for many people with psychosocial disabilities because there aren't the resources within its structure to get the level of skill they may need. I am essentially subsidising my NDIS plan by paying $8,000 out of pocket to pay for a highly skilled doctor who is supporting me in my interactions with support workers.[64]

Accessing wellbeing supports under the National Disability Insurance Scheme

The Commission heard from witnesses that many Victorians living with mental illness are ineligible for the NDIS and cannot gain access to the specialised psychosocial supports that were available to them under the former state system.[65]

Data from the National Disability Insurance Agency (NDIA) indicates that, while Victoria has the highest number of participants with primary psychosocial disability in the NDIS of any state or territory, 3,599 Victorians aged 25 years or older have applied and been deemed ineligible for psychosocial supports under the NDIS as at 31 March 2020.[66] As at 31 March 2020, 13,499 Victorians with a primary psychosocial disability were active participants in the NDIS, with the majority aged 25 and over.[67]

The Commission heard that the complex application processes and eligibility criteria can be particularly challenging for people applying for NDIS packages for primary psychosocial disability.[68] For example, the Commission heard:

> We can't receive the care we need for him now. We've had horrible trouble with the NDIS, we've had a psychologist put in a report and the report was rejected. The NDIS gave us no information. We had [a former psychosocial program], a psychologist, a psychiatrist and myself advocating for my husband and the NDIS sent us a letter saying "due to an overwhelming number you are in the queue". No one listens.[69]
>
> The NDIS said he didn't qualify for NDIS-services and was told "it was none of my business" when I asked why he was not eligible.[70]
>
> It was heartbreaking to help someone prepare for a NDIS meeting and come back with a brick wall.[71]

Further, the Commission has heard that the current challenges surrounding access to the NDIS may risk exacerbating health inequalities and disadvantage.[72] Separate reports from Mental Health Australia and the Joint Standing Committee on the National Disability Insurance Scheme made similar findings, respectively stating that:

> Regardless of documentation supplied, clients with mental illnesses applying for NDIS are taking part in a lottery. Some have been rejected and told that Post Traumatic Stress disorder is not permanent, that depression is not permanent, that anxiety is not permanent, whilst other persons with lesser disability are accepted.[73]
>
> [T]his scheme is turning into a dual-track system, where people who have advocates or families in their corner, or who are more well-resourced and more well educated, can get one set of outcomes—it's still tough but they're more likely to get a good set of outcomes—while those people who don't have those things, who perhaps come from a culturally or linguistically diverse background, who have more complex needs, who maybe come from an Aboriginal or Torres Strait Islander background, who don't have families in their corner to go in to bat for them, are getting a different set of outcomes and a poorer set of outcomes.[74]

Service providers also told the Commission that people who previously had wellbeing supports are struggling to gain access to the NDIS.[75] The reasons why some people who were receiving wellbeing supports are no longer receiving them under the NDIS are varied. The Commission is aware of the following:

- NDIS eligibility criteria require people to prove they have a permanent disability. This disadvantages people living with episodic mental illness and younger people who have been unwell for a relatively short time.[76]
- There are complex application processes, which can be overwhelming for some consumers, families, carers and supporters, and can deter people from applying.[77]
- Expectations are placed on consumers to seek out and navigate their own support.[78]
- Many support providers told the Commission that services are low-priced, which may lead to a 'thin market' of appropriate providers of supports to mental health consumers.[79] That is, there may be a disincentive for providers to deliver treatment, care and support to this cohort, so fewer of them offer the services needed.[80]

In response to these challenges, the NDIA is introducing a range of reforms including pricing changes and pathways intended to provide more tailored assistance for people to access supports for primary psychosocial disability.[81] The NDIA acknowledges that more work is required, stating:

> Although pathways have assisted participants' route into the NDIS, more concerted efforts are needed to engage with people with disability who may be eligible for the NDIS but have not yet connected.[82]

Challenges using the National Disability Insurance Scheme

The introduction of the NDIS saw a 60 per cent increase in the Victorian Government's committed annual investment in disability services (for all disability types).[83] This investment means that NDIS packages can offer significant funding—the average annualised plan budget for active participants with a primary psychosocial disability in Victoria as at 31 March 2020 is $48,581, with most people receiving between $20,000 and $100,000 in their annualised committed supports, noting these figures include funding for people in supported independent living.[84]

The NDIA told the Commission that, while direct comparison is not possible due to different funding models, average investment was around $11,000 per person before the scheme, indicating a substantial increase under the NDIS.[85]

Despite the increase in investment, Victorians have had variable experiences in securing funding that meets their needs through the NDIS.[86] The Commission heard that, even when funding is available, consumers may be unable to purchase the supports that meet their mental health and wellbeing needs because these are not listed on the NDIS price guide or there is a lack of suitable supply in their area.[87] As one person told the Commission:

> He has managed to get funding through the NDIS. However, the access form is focused on [physical] disability not mental illness. I was told that funding is provided based on the impact of the disability. If he needs someone to help him upskill to get him back in the workforce, they won't fund it.[88]

In some cases, the supports a consumer needs are not included in their plan, despite the item being included in the price guide.[89] For example, the Office of the Public Advocate told the Commission about the following experiences of two Victorians:

> Unlike under his [previous supports], there was no funding in Brian's NDIS plan for his psychologist to attend care team meetings or provide updated risk assessments. Similarly, unlike under her [previous supports], the following were not funded under Yasmin's plan: any of the team of allied health professionals who had provided clinical leadership, regular meetings between her support providers, [nor] training and behaviour management support for her secondary support provider.[90]

In a report prepared for the Commission by researchers from the University of Melbourne regarding the needs of consumers requiring ongoing intensive treatment, care and support, a consumer described the impact of the NDIS on the supports they had received under the previous 'psychiatric disability rehabilitation and support services' system:

> The introduction of the NDIS was experienced as devastating by many consumers. Unlike the [psychiatric disability rehabilitation and support services] system, individuals working for the NDIS are not required to be trained in mental health. As a result, a significant number of consumers have experienced a critical decrease in funding or received no funding despite receiving services; these consumers may have little to no support outside of their current services to help them identify and connect with new supports.[91]

The Commission also heard that the transition to the NDIS has sometimes resulted in the loss of long-term trusting relationships forged between consumers and workers:

> Historically services were there for the long-haul and could support episodic illness. The team of workers knew the people and could identify pretty early on if there were signs they were getting worse. Those staff had the relationship and were skilled at meeting people's needs. We're losing that with the NDIS.[92]

Policy context of the National Disability Insurance Scheme in Victoria

Victoria was once a national leader in providing wellbeing supports.[93] In 2004, the state invested the highest proportion of government expenditure of all states and territories in non-government organisations that deliver wellbeing supports and had the best developed psychiatric rehabilitation services in the country.[94]

The Victorian Government transitioned most of the funding for the state's previous wellbeing supports (that is, psychosocial supports) to the NDIS through the Bilateral Agreement signed with the Commonwealth Government in 2015.[95] Historical Victorian Government funding (about $77 million annually) for wellbeing supports now largely forms part of Victoria's contribution to the NDIS.[96] As described in the Commission's interim report, the transition to the NDIS has left the Victorian Government with responsibility for a relatively small range of psychosocial support services.[97]

In contrast, other Australian jurisdictions did not choose to shift all of their funding for community mental health services to the NDIS,[98] but instead retained a higher level of responsibility for funding state-based psychosocial supports.[99] For example, the New South Wales Government retained ongoing responsibilities for funding community-based psychosocial services outside of the NDIS.[100] A 2018 report from the New South Wales Parliament highlighted feedback from non-government sector leaders on the positive impacts of the state government retaining responsibility and funding for psychosocial supports.[101]

The Commission considers that the almost wholesale transition of psychosocial support funding to the NDIS has contributed to the shortfall in appropriate wellbeing supports for Victorians with short-term, ongoing and intensive treatment, care and support needs.

In recognition of the challenges arising from the transfer of funding to the NDIS, in 2019 the then Victorian Department of Health and Human Services provided temporary funding through a new Early Intervention Psychosocial Support Response program, designed to support those people who have been deemed ineligible for the NDIS or who experience a delay in their application.[102] While welcome, temporary funding for programs like this puts extra administrative burden on the commissioning health services and non-government organisations that provide supports under the program, and they have to adapt their operations to deliver what may only be a short-term service.[103]

Wellbeing supports and the National Disability Insurance Scheme in the future system

The Productivity Commission has estimated that even when the transition to the NDIS is fully complete, up to 154,000 people across Australia will not be able to get the psychosocial services they require, based on current policy settings.[104]

On a population basis, this would mean that approximately 40,000 Victorians who need wellbeing supports are outside of the NDIS and are unable to receive those supports. This aligns with evidence presented to the Commission, which puts this estimate at approximately 45,000 people.[105]

The Commission considers that substantial operational and policy work by the Victorian Government, the Commonwealth Government and the NDIA will be required to ensure that the people who access wellbeing supports through the NDIS have those supports integrated into the broader mental health and wellbeing treatment, care and support that they need.[106]

In particular, supports provided through the NDIS are expected to form one important part of treatment, care and support for consumers who require intensive and extended rehabilitation services. As described in Chapter 10: *Adult bed-based services and alternatives*, Chapter 5: *A responsive and integrated system* and Chapter 16: *Supported housing for adults and young people,* the Commission recommends establishing a new rehabilitation pathway for people living with mental illness who require ongoing intensive treatment, care and support. The new rehabilitation pathway includes care in the community, based on the Assertive Community Treatment model, two new bed-based rehabilitation models of care, supported housing and Regional Multiagency Panels.

Substantial operational and policy design work will be required to ensure that supports provided through the NDIS are seamlessly integrated at each part of this pathway. For example, Regional Multiagency Panels will monitor outcomes and service and agency accountability for the proportion of people, or 'shared clients', in a region using services provided by multiple agencies—including supports provided through the NDIS.

Close collaboration will be required between the Victorian Government, the Commonwealth Government and the NDIA to ensure that supports provided through the NDIS form a cohesive part of the services delivered under an Assertive Community Treatment model.[107]

The NDIA acknowledges that this further work is required to integrate supports provided through the NDIS with mental health and wellbeing services. It stated:

> **Even with the Agency's significant investment in the funding of support co-ordination, the Agency's experience is that the current planning and collaboration arrangements need further improvement at the NDIA, jurisdictional and clinical mental health service levels.**[108]

The Commission recognises the complex relationship between the Victorian Government, the NDIA and the Commonwealth Government in relation to funding for wellbeing supports. To improve access to and the experience of integrated wellbeing supports both within and outside of the NDIS, funding will need to be shared across both the Victorian and Commonwealth governments.

A new National Mental Health and Suicide Prevention Agreement is to be negotiated by the end of November 2021.[109] A new Select Committee on Mental Health and Suicide Prevention is to be established to inquire into the findings of the Productivity Commission *Mental Health Inquiry Report* and other strategic reviews including the Royal Commission.[110]

Negotiations to establish the new National Mental Health and Suicide Prevention Agreement may be informed by key inputs such as the Royal Commission's report and other reports from the Select Committee on Mental Health and Suicide Prevention, the Productivity Commission, the National Suicide Prevention Advisor, and the National Mental Health Commission's Vision 2030. The upcoming negotiations of this agreement provide an opportunity to reach national consensus on roles and responsibilities for wellbeing supports for different consumer streams, not just those who are eligible for the NDIS. The Commission encourages the Victorian Government to work collaboratively with the Commonwealth Government and NDIA towards this end.

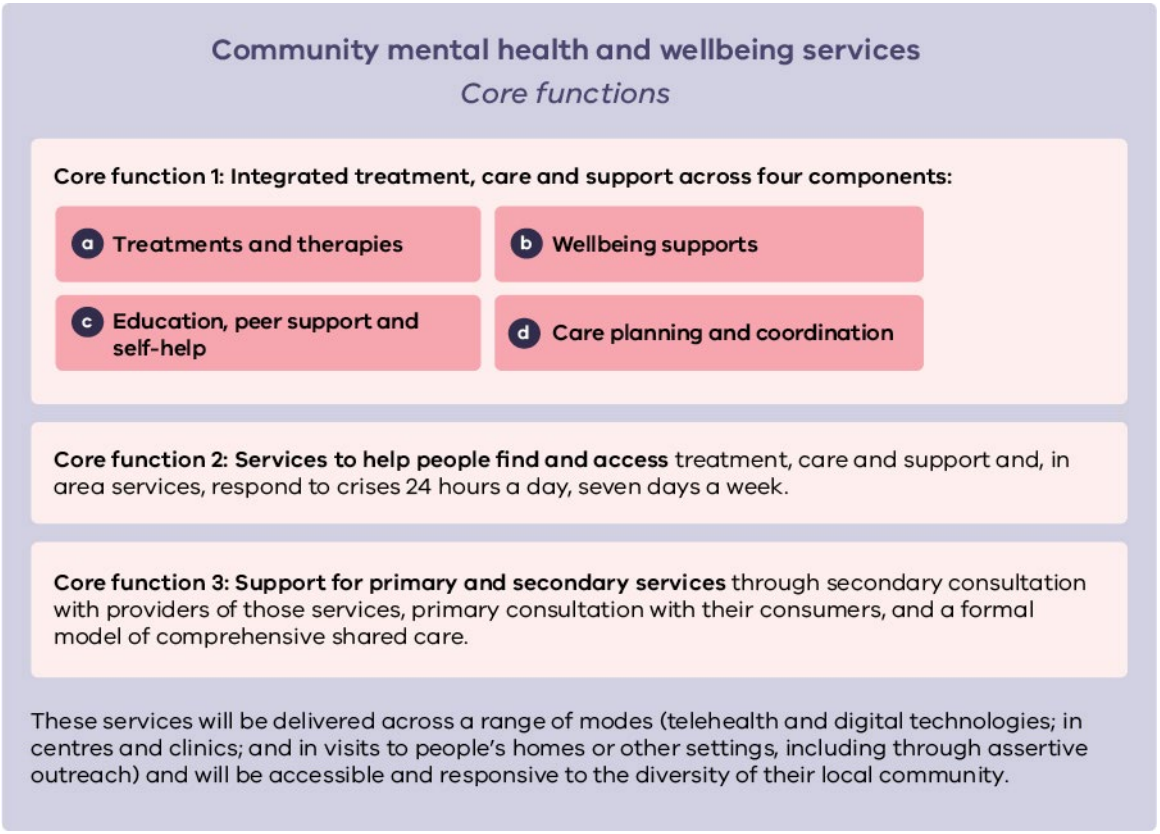
The Commission has designed a future mental health and wellbeing system that responds to the challenges outlined in section 7.1. As described in the remainder of this chapter, mental health and wellbeing services will provide comprehensive, integrated treatment, care and support across three core functions. The core functions are designed to ensure that people receive comprehensive care that responds to their holistic needs, and that consistent types of services are available regardless of where they live. The intensity of treatment, care and support will be proportionate to people's needs and will adapt as people's strengths and needs change over time. The Commission expects that the new mental health and wellbeing system will ensure continuity of care though seamless integration and coordination across multiple services, sectors and systems. This includes drawing together NDIS-funded supports for those who are eligible and helping people to gain entry to the NDIS where appropriate.

7.2 Overview of mental health and wellbeing services' core functions

As the above analysis makes clear, Victorians experiencing mental illness or psychological distress require more comprehensive, integrated and responsive services than the current system is able to provide. The Commission's recommendation to build a network of Local Mental Health and Wellbeing Services that are strongly linked to primary care providers (such as GPs), secondary care providers (such as independent psychologists) and to higher-intensity treatment, care and support in Area Mental Health and Wellbeing Services is fundamental to achieving this.

As discussed in Chapter 5: *A responsive and integrated system*, future mental health and wellbeing services will be provided through partnerships between public health services or public hospitals and non-government organisations that provide wellbeing supports. In each area of the future system, these services will collaboratively deliver a broad range of treatment, care and support services to respond to people's individual needs. Each partner will contribute to the delivery of all core functions. It is not intended, for example, that one of the partners only provides medical treatments, nor that one of the partners only provides wellbeing supports. The core functions of the services are summarised in Figure 7.3.

Figure 7.3: Community mental health and wellbeing services: core functions



To fulfil the first core function (integrated treatment, care and support), Adult and Older Adult Local Mental Health and Wellbeing Services and Adult and Older Adult Area Mental Health and Wellbeing Services will provide treatment and therapies; wellbeing supports; education, peer support and self-help; and care planning and coordination. This function is explained in section 7.3.

As part of the second core function (to help people find and access treatment, care and support), Adult and Older Adult Local Mental Health and Wellbeing Services and Adult and Older Adult Area Mental Health and Wellbeing Services will help people—whether they are current consumers or not—to find and access treatment, care and support. In addition, Area Mental Health and Wellbeing Services will respond to crises 24 hours a day, seven days a week. This function is briefly described in section 7.4 and detailed in two separate chapters—Chapter 8: *Finding and accessing treatment, care and support* and Chapter 9: *Crisis and emergency responses*.

Adult and Older Adult Local Mental Health and Wellbeing Services and Adult and Older Adult Area Mental Health and Wellbeing Services will deliver the third core function (support for primary and secondary services) through secondary consultation with providers of those services, primary consultation with their consumers and a formal model of comprehensive shared care. Section 7.5 describes this function.

Each of the 22 Adult and Older Adult Area Mental Health and Wellbeing Services will carry out all the core functions outlined earlier. Local Mental Health and Wellbeing Services will not deliver crisis responses and, depending on their size and capability, will not necessarily support primary and secondary services or provide home and community visiting services. They may partner with Area Mental Health and Wellbeing Services to deliver some aspects of the integrated treatment, care and support function.

A range of professionals from different disciplines will be employed in Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services. For example, as described in Chapter 15: *Responding to trauma*, each Adult and Older Adult Area Mental Health and Wellbeing Service will employ up to three specialist trauma practitioners to work with peer support workers in Local Mental Health and Wellbeing Services to provide and facilitate access to a broad range of trauma supports for consumers.

While retaining a consistent set of offerings across mental health and wellbeing services in all parts of Victoria, some flexibility will be allowed to avoid stifling innovation.[111] Therefore, implementation of the core functions will be adapted to meet local community needs and preferences.

In implementing all core functions, services will be expected to work in a much more multidisciplinary and integrated way than is currently the norm, both within and between mental health and wellbeing services. The Commission anticipates that Adult and Older Adult Local Mental Health and Wellbeing Services and Adult and Older Adult Area Mental Health and Wellbeing Services will also work more closely with the wider service system, such as medical and allied health services, alcohol and other drug services, housing, family violence and employment services.

Finally, as discussed in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*, mental health and wellbeing services will be expected to:

- deliver services in a range of modes—for example, by increasing the availability of telehealth in regional and rural areas where site-based services may be too far for people to travel
- ensure that treatment, care and support is accessible and responsive to the diversity of local communities and provide person-centred care that responds to and respects people's unique needs relating to language, culture, sexuality, socioeconomic status and other factors that may affect their experience of services.

7.3 Core function 1: Integrated treatment, care and support

Working in collaboration with each other in each area, Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services for adults and older people will provide comprehensive, integrated treatment, care and support in proportion with the person's needs, across four components. As mentioned in the previous section, these are:

- treatment and therapies, including a broad range of psychological therapies, medical treatments, other therapeutic interventions and integrated support for physical health and substance use or addiction
- wellbeing supports, including supports for community connection and social wellbeing, supports for building life skills, supports for securing and maintaining housing, and education, training and employment supports
- education, peer support and self-help, including through recovery colleges, peer support and guided self-help
- care planning and coordination, to ensure treatment, care and support is proportionate to need and to ensure continuity of care.

Together these represent a reformed, more balanced approach to treatment, care and support in the mental health and wellbeing system. One witness, Ms Eva Sifis, told the Commission of the need for a holistic approach to recovery from her brain injury:

> Part of recovery involves embracing the totality of your experience. It's not just physical rehabilitation, it's psychological rehabilitation, social rehabilitation, spiritual rehabilitation; it is the totality of life ...[112]

These four components of integrated treatment, care and support, and the reasons the Commission recommended them, are described in the following sections.

7.3.1 Treatments and therapies

The Commission expects that mental health and wellbeing services will provide a far broader range of evidence-based treatments and therapies than are offered in Victoria's current, resource-constrained public specialist mental health system and in its equally constrained non-government sector.

In the reformed service system, treatment and therapies will encompass:

- psychological therapies (also called 'talking therapies')
- medical treatments, including prescribed medications and non-medication treatments (for example, potentially transcranial magnetic stimulation, a non-invasive form of brain stimulation that uses magnets applied to the skull)[113]
- allied health and creative therapies, such as occupational therapy, speech therapy and arts and creative therapies
- integrated treatment, care and support for co-occurring physical health problems
- integrated treatment, care and support for co-occurring mental health and substance use or addiction
- Assertive Community Treatment for a small group of consumers who have complex needs.

Psychological therapies

Research suggests there are more than 400 evidence-based psychological therapies in existence.[114] While the Commission does not prescribe the therapies that mental health and wellbeing services should offer, it does expect that a broad range of therapies will be available and delivered by appropriately qualified staff such as psychiatrists, clinical psychologists and other professionals.

The length of time people receive therapies will be based on their individual needs and available evidence about the optimal 'dose' of a specific therapy. People will be able to make use of multiple forms of treatment and therapy during the same period if needed.[115]

Table 7.1 gives examples of some evidence-based psychological therapies. Some of these therapies can be conducted with groups of consumers, or with consumers, families, carers and supporters. For example, dialectical behaviour therapy, which may be effective in treating borderline personality disorder, often has a group component.[116] Mindfulness training programs can also be conducted in group settings by a skilled trainer over several short sessions.[117] Currently, little group work or family therapy is done in mainstream adult public mental health services and many psychologists have left for the private sector.[118]

The Commission is aware that some of these therapies are currently offered by non-government organisations, which may employ allied health practitioners and mental health nurses, as well as community mental health practitioners.[119]

Table 7.1: Examples of psychological therapies

Type of therapy	Description, examples and indications
Psychotherapy	Examples include cognitive behaviour therapy, dialectical behaviour therapy, interpersonal psychotherapy and psychodynamic psychotherapy.[120] These can be effective for people with a range of mental health needs, including those requiring higher intensity services.[121] A range of other examples have been suggested to the Commission, including narrative therapy, which can help people recognise stigma and can be culturally appropriate for Aboriginal people.[122]
Mindfulness	Mindfulness therapies apply meta-cognitive exercises and 'detached observation of one's thoughts and feelings'.[123] Evidence indicates that these therapies can have positive effects on overall symptoms, including for people experiencing psychosis.[124]
Cognitive remediation therapy	Cognitive remediation therapy is a learning-based behaviour therapy that provides training in a set of tasks aimed at improving cognitive skills.[125] This therapy shows promising results for reducing negative symptoms and may be particularly beneficial for people with longer term and complex support needs.[126]
Family therapies	There are a range of different family therapies designed or suitable for working with families, carers and supporters, with or without the consumer present. For example, behavioural family therapy aims to equip families with the skills they need for daily living.[127] There is strong evidence that some family therapies can improve outcomes for consumers and their family members.[128] Research relating to therapies that include family members to improve their understanding of experiences of psychosis indicates that family therapies can be effective in decreasing consumers' relapse rates, decreasing the need for acute inpatient admissions, supporting consumers to manage medication and reducing psychotic symptoms.[129]
Single-session therapy	Single-session therapy is a specific approach to supporting people and discussing their needs in their initial meeting with mental health services.[130] Despite its name, single-session therapy does not necessarily mean the consumer will receive no further mental health support.[131] However, it aims to make the best use of the first encounter, on the basis that this might be the only contact the person wants or needs at that stage, because even a brief encounter—delivered when people are most ready to accept help—can be therapeutic.[132] The approach is highly collaborative, based on strengths and focused on solutions. Clinicians aim to identify the strengths of the consumer, and their family and supporters, not just their challenges, and work on what they need and want.[133] Single-session therapy is used by some area mental health services in Victoria, most commonly in services for children and young people but also in some triage services for adults.[134] For example, Ms Karyn Cook, Executive Director of Mental Health Services at South West Healthcare, Warrnambool Community Health, spoke about a single-session model that the service developed during the COVID-19 pandemic. The therapy was a basis for supporting people who were not eligible for services provided by the area mental health service.[135] Evidence indicates that single-session approaches can lead to short-term reductions in people's distress and improve their ability to manage daily tasks.[136] Single-session family therapies may also support improvements in other areas such as increasing people's confidence in their parenting skills.[137]

Medical treatments

Most medical treatments used in mental health services are 'psychotropic' medications to ease the symptoms of mental illness or psychological distress (for example, antipsychotic medication and anti-anxiolytics to help people experiencing high levels of anxiety).[138] Psychiatrists and other doctors may also prescribe medications for substance use or addiction, including agents that help consumers withdraw from alcohol or other drugs, and to manage the symptoms of withdrawal.[139]

When used appropriately, medication can be an important element of treatment for people experiencing mental illness. A group of Victorian psychiatrists explained the critical role that medication can play in combination with other approaches—such as psychosocial supports, inpatient and outpatient care—in preventing suicide among people with 'serious mental illness (schizophrenia, bipolar disorder, psychotic depression)'.[140] The efficacy of many medications in controlling the symptoms of mental illness is well evidenced in the medical research literature.[141] Further, a range of medications can be effective at reducing people's experiences of symptoms of different types of mental illness.[142]

Despite frequent misgivings about medication side effects, some consumers emphasised that they need medication to cope with the symptoms of their mental illness or psychological distress. The following quotes provide two examples of this feedback:

> I know I need it, but I hate it so much … I hate the drooling and the weight gain … [but I need it because] it's been the best for my psychosis … It has kept me out of hospital.[143]

> I have had several psychologists and other health professionals tell me to reduce my medication. I've tried it–it doesn't go well.[144]

However, considerable evidence before the Commission indicates a need for better prescribing and medication management and monitoring practices in Victoria's mental health and wellbeing system. This is consistent with the high number of complaints about medication prescribing—in 2017–18, complaints about medication constituted 19 per cent of new submissions to the Mental Health Complaints Commissioner.[145]

According to the Mental Health Complaints Commissioner, a common concern is that mental health services do not adequately consider or respond to consumers' concerns about medication side effects.[146] This was also a strong theme in evidence received by the Commission. The following quote is illustrative:

> There needs to be more [doctor] awareness of bad side effects and the [doctors] need to listen if a person has a complaint about the medication, rather than the [doctors] making out as though the 'bad side effects' are part of the person's mental condition. There needs to be more awareness of the rights of people. More advertising on wards regarding how someone has rights and how to get support and [a] second opinion if desired.[147]

Many consumers spoke to the Commission about these 'bad side effects.' For example, witness Mr Dave Peters said:

> [The] physical health of people with mental illness can be affected by the medications they take for their mental illness. In addition to the significant impacts on physical health and life expectancy … certain medications can have a terrible impact on oral health. In addition, the sedation effects of some medications can cause the people taking them to suffer from apathy and disengagement from life. That is something that I still struggle with.[148]

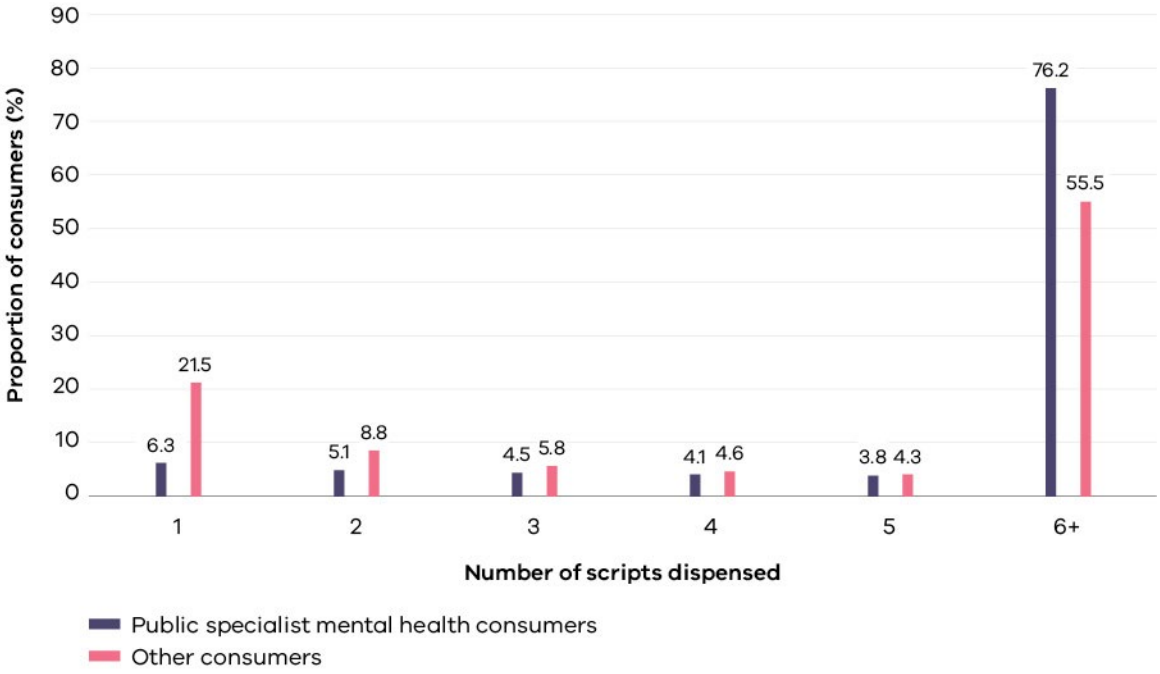
Apart from the medication side effects noted by Mr Peters, many psychotropic medications are known to dramatically increase appetite.[149] This can result in physical health challenges such as excessive weight gain and related health problems.[150]

Given the potentially serious nature of these side effects, the Commission is concerned by evidence of poor prescribing practices, including a lack information about the medications given by clinicians administering the products.[151] The following quotes exemplify this evidence:

> One glaring flaw is a prevalent lack of respect and recognition of humanity for people with mental illness. Too many are treated as objects rather than human beings, reckless prescribing of medication which is a result of not conducting proper consultation. It's somehow OK because these people are not very good at standing up for themselves, especially when their mind is sent into a state of confusion by the medication.[152]
>
> The propensity to immediately medicate and not ask questions after unless it was to increase the dosage left me with serious doubts in the nature of mental health care.[153]
>
> My family member was moved to a new anti-psychotic, starting on a high dose, the resulting side effects included a heart rate of 180–200 which required beta-blockers, weight gain has now reached 50kg and smoking cigarettes was ignored/not managed which has now resulted in ulcers in her oesophagus. The side-effects are not managed, the medication is not reduced without family pushing to have it reviewed. My family member is no longer experiencing psychosis and this is considered a win and now she is left to the community on a [Disability Support Pension] with a very low ability to be a part of the community due to the side effects of the medication.[154]

The need for expert pharmacological management and support for consumers, families, carers and supporters, to participate in decision-making around medications, is heightened by the fact that many consumers are on several different medications. As shown in Figure 7.4, consumers of public specialist mental health services were much more likely to be dispensed six or more scripts than other Victorians who were dispensed mental health-related scripts under the Pharmaceutical Benefits Scheme in 2017–18.[155] High levels of medication, and the use of multiple medications, increases the chance of medication errors and adverse reactions.[156]

Figure 7.4: Number of mental health-related prescriptions dispensed per person in one year, by number of scripts, Victoria, 2017–18



Source: Department of Health and Human Services, Integrated Data Resource, Client Management Interface/ Operational Data Store 2017–18; Australian Government Services Australia, Pharmaceutical Benefits Scheme 2017–18.

Note: Other consumers excludes consumers admitted to private mental health facilities and clients that presented to emergency departments. Data includes people with Victorian postcodes and if the patient's address is unknown, supplying pharmacies with a Victorian postcode are included. Data where the prescriber postcodes are null are also excluded.

To ensure that health professionals work closely with consumers to understand the effects of medications, it may be necessary to mandate that health workers engage regularly with consumers to monitor and discuss with them the impacts of these medications. This happens, for example, in the use of the drug clozapine. A group of psychiatrists informed the Commission that clozapine is the 'gold standard' for treatment of schizophrenia when other medications have been unsuccessful.[157] Their submission suggested that the drug improves outcomes and can prevent suicides in people who are described as having 'treatment resistant schizophrenia'.[158] They considered that, as well as the properties of the medication itself, the superior outcomes associated with clozapine can be attributed to the fact that the impact of this medication must be closely monitored by health professionals:

> Clozapine treatment requires monthly blood tests to monitor for neutropaenia and this requires care coordination on an ongoing basis. Indeed patients receiving clozapine have reduced mortality and this is partially attributed to the benefits of the ongoing care coordination role … The lifelong clozapine care coordination and monthly appointments likely help in a number of ways, including general support, addressing psychosocial issues, observing for early warning signs and relapse prevention, lifestyle checks, metabolic monitoring, coordination of appropriate medical interventions, liaison with primary care and family, management of side-effects, and monitoring overall adherence.[159]

The psychiatrists quoted above suggested that the level of ongoing monitoring and care coordination received by consumers taking clozapine should be offered to all consumers with 'enduring, and relapsing symptoms' regardless of the medication they are taking.[160] They noted that medication should be one part of comprehensive programs that 'can support recovery, and promote employment, education, housing, relationships, and health'.[161]

In its recent mental health inquiry, the Productivity Commission examined medication prescribing in some detail. The Royal Commission supports its findings and recommendations in this area, as reproduced below:

> As a priority reform, clinicians offering mental health medication as treatment should be required to inform the consumer of the side effects prior to prescribing and offer alternative non-pharmaceutical treatment options. The clinical benefits of many mental health medications (particularly for conditions that are not severe) and the long-term physical and mental health outcomes for people who use them, are disputed, with severe side effects in some population subgroups and substantial overprescribing for others. More research focused in these areas, and uptake of its resulting lessons among treating clinicians, could generate significant improvements in mental healthcare treatment outcomes.[162]
>
> The Australian Government should act to improve practitioners' training on medications and non-pharmacological interventions.[163]

In Chapter 36: *Research, innovation and system learning*, the Commission presents its findings on the urgent need for new and better medications for mental illness but—equally critically—for research to identify interventions that reduce or eliminate the need for medication. In addition, the Commission considers that researchers should help identify the barriers to uptake of existing approaches that reduce medication needs. For example, transcranial magnetic stimulation appears to be effective in treating depression for some people but is rarely offered in public mental health services.[164]

Allied health and creative therapies

Many people spoke to the Commission about the importance of allied health therapies and therapeutic creative activities. In 2017, the *WPA-Lancet Commission on the Future of Psychiatry* highlighted the importance of an extended range of therapies, including art therapy.[165] Table 7.2 lists examples of some of the allied health and creative therapies that could be offered in Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services.

Table 7.2: Examples of allied health and creative therapies and approaches

Type of therapy	Description, examples and indications
Occupational therapy	There is a growing evidence base for a range of occupational therapy interventions.[166] Evidence indicates that occupational therapy interventions can be successful in helping people to develop habits and routines for daily living.[167] Other effective interventions include setting individualised, person-centred goals and delivering cognitive training.[168] Occupational therapy can assist people to: > engage in activities that are personally relevant, such as specific vocational and leisure interests; … develop ways to enhance their social connectedness and community engagement; develop skills and qualities such as assertiveness and self-awareness …[169]
Social work	Social workers can provide a range of supports including assessment, therapeutic supports, advocacy, community development and care coordination of services outside of the mental health sector such as family supports, family violence prevention, child protection, housing, alcohol and other drug treatment and aged care.[170]
Speech pathology	Sometimes people experiencing mental illness or psychological distress can find it difficult to communicate and may also experience difficulty swallowing, which is sometimes related to medication.[171] Speech pathologists help to identify these challenges and improve a person's communication and swallowing skills so they can function in everyday life.[172]
Creative therapies	These include evidence-based and evidence-informed therapies such as arts therapy in a range of forms, including music, drama, dance and visual arts. As summarised by one evidence review from the World Health Organization, for those with 'severe mental illness … art and music therapy has been shown to improve global state, general symptoms, negative symptoms, depression, anxiety and functioning in those in the community and within inpatient settings'.[173]

Witness Ms Rachel Bateman's personal story is consistent with feedback from many consumers and service providers about the importance of creative therapies such as art therapy and music therapy.[174] Another witness, Ms Julie Dempsey, said:

> One of the methods I use for coping when I am seriously unwell is my art … [An art excursion] was a revelation for me, a different way of seeing the world and this sparked some hope in me that had long since been trampled on by illness and the system that was supposed to treat it.[175]

Personal story:

Rachel Bateman

Rachel* has been involved with the mental health system since she was 14 years old, with several admissions to inpatient units. Rachel felt that her local area mental health service was not offering her anything more than medication, with little access to different therapeutic approaches.

> In my experience, clinicians within [area mental health services] do not view their role as providing therapy … They just keep saying, 'That's not what we're here for. Go and get therapy elsewhere'.

Rachel feels that while 'the phrase "person-centred care" is thrown around a lot' it is not embedded in mental health services.

> If organisations were truly person-centred, they'd be set up in a way that delivers the support that people need at various parts of their recovery journey.

Rachel advocates for a broader range of supports.

> There needs to be a variety of support options available to people, whether it be: phone support; drop-in clinics; care or food packages; follow-up appointments at home (where people feel comfortable); and access to groups, including groups in the community ([for example] art classes, visits to the zoo, cafes).

Rachel noted there are a number of people who have helped with her healing including her GP, a private social worker and a peer support worker.

> For me, seeing a peer-support worker doesn't take the place of support from the social worker I see but it has been such an integral part of me starting to view myself as someone who isn't 'sick' or 'broken'.

Rachel said she has made her own connections to these supports, and while her GP is willing to bulk bill, Rachel said she has not always had the financial means to see the private social worker.

> I've recently been able to access weekly support from her. If I'm able to access this support on an ongoing basis, I feel this will be one of the most significant opportunities I have to heal and hopefully not struggle with significant mental health issues over the long term.
>
> [M]y relationship with my private social worker is one where I can receive therapy. I get to have genuine conversations about how I'm feeling, about current day stressors and about past trauma.

Having agency in her own care planning and coordination is very important to Rachel.

> I believe that all consumers should have access to sitting in on clinical reviews and handovers, if this is what they choose. I additionally believe that all mental health staff should co-write notes with consumers wherever possible.
>
> At the moment, the perspectives of clinicians are privileged … There needs to be a shift in ensuring that consumer perspectives are held central in the individual care that they receive.

Rachel's mental health also improved with studying, where she found a new sense of purpose and created new friendships. She said she is currently feeling positive and has been self-harming less frequently. She puts this down to having a job that she enjoys and a range of supports around her.

> Some of the biggest things that are actually helping me as an individual are not actually any of the public mental health supports I've been getting—it's the fact that I have, over the past year, been in a job that I love and that I feel secure in, and I am also receiving very beneficial support from my GP and the private sector.

Rachel currently works as part of the lived experience workforce and provides a consumer perspective at the executive level of an area mental health service.

Source: *Witness Statement of Rachel Bateman (pseudonym)*, 16 June 2020.
Note: *Names have been changed in accordance with an order made by the Commission.

Integrated treatment, care and support for physical health and wellbeing

As noted by witness Mr Peters, '[b]eing mentally unwell can impact a person's physical health, just as being physically unwell can impact a person's mental health.'[176] Unfortunately, four out of every five people who have a mental illness also live with a physical illness,[177] and people with a mental illness have significantly poorer health outcomes than those without a mental illness.[178]

Co-occurring physical and mental illness is associated with a life expectancy of between 10 and 23 years less than that of the general population.[179] Clinicians working in area mental health services shared first-hand experiences of consumers with co-occurring physical and mental illness dying prematurely. For example, Mr Peter Kelly, Director Operations, NorthWestern Mental Health, Melbourne Health, The Royal Melbourne Hospital, indicated that:

> Over the past 12 years, 165 [NorthWestern Mental Health] consumers have died of natural causes. The average age at death of those consumers is 50.8 years. Mostly, the consumers died of preventable and treatable physical causes, such as cardio-vascular disease, respiratory disease and (treatable) cancers.[180]

This situation is unacceptable and preventable. Victorians with mental illness or psychological distress have the right to the highest attainable standard of health without discrimination under both the *International Covenant on Economic, Social and Cultural Rights*[181] and the *Convention on the Rights of Persons with Disabilities*.[182] If the future mental health and wellbeing system is to be contemporary and evidence-based, mental health and physical health will need to be integrated.[183] Dr Coventry spoke about this imperative:

> it is imperative that mental health clinicians are mindful of consumers' physical well-being and take action to encourage screening, testing and treatment of physical health conditions where indicated. It is no longer acceptable to expect physical and mental health to be addressed by different health providers in different places at different times. Where consumers have limited access to health care, mental health clinicians must take an assertive role to help consumers overcome barriers to good health.[184]

In 2019, the then Department of Health and Human Services released *Equally Well in Victoria: Physical Health Framework for Specialist Mental Health Services*.[185] This framework describes a range of ways in which mental health services and clinicians can 'work in partnership with consumers and carers to discuss physical health in the context of a recovery plan'.[186] It was developed in collaboration with specialist mental health services, non-government organisations, university and professional groups, and consumer and carer peak bodies.[187]

The *Equally Well* framework applies to all Victorian specialist mental health services and to all age groups.[188] However, the Commission has heard that the success of the framework has been limited because some services have not received funding for project resources or administration to progress implementation.[189] For example, Ms Cook said that:

> Whilst some training and resources have been provided by [the then Department of Health and Human Services] to support the implementation of the framework, [South West Health Mental Health Service] has not received funding for the project resources or administration, and therefore the implementation lacks structure and ongoing evaluation. It is difficult for rural [area mental health services] to roll out programs with existing resources.[190]

Some non-government organisations that support people experiencing mental illness have an explicit aim to improve consumers' physical health.[191] Several area mental health services have also integrated physical health into their clinical services. For example, at St Vincent's Hospital, physical health interventions are offered by a dietitian and community health nurse to help consumers 'to address areas such as poor diet, sleep problems, smoking and health lifestyles'.[192] Another example is NorthWestern Mental Health, which has a physical health nurse working in its mental health clinics and processes in place so all consumers have their physical health (height, weight, body mass index, blood pressure, blood glucose and blood lipids) checked and are referred for physical health treatment if needed.[193]

To respond to this evidence of poorer physical health outcomes for people living with mental illness, across all age groups, Area Mental Health and Wellbeing Services and Local Mental Health and Wellbeing Services will ensure they discuss and understand a person's physical health needs as part of the service entry processes. These service entry processes are described in Chapter 8: *Finding and accessing treatment, care and support* and the care planning and coordination processes described in section 7.3.4. These processes should include, where necessary, proactive referral and connection of consumers to general practice, including GPs and practice nurses available in community health centres.

As well as employing physical health staff within multidisciplinary teams where possible, there are a range of measures that can help to better integrate physical and mental health care. Evidence is still emerging, but promising interventions are detailed in Table 7.3.

Table 7.3: Examples of physical health initiatives

Type of therapy	Description, examples and indications
Health literacy	Helping people to manage their physical health by building their health literacy and supporting them to adopt healthy ways of living while respecting their decision-making autonomy and preferences in relation to their physical health.[194]
Healthy lifestyle programs	Offering a combined healthy eating and physical activity program, designed and delivered by professionals such as dietitians, physiotherapists and exercise physiologists.[195]
Help to quit smoking	Offering a combination of medications and therapies that can help people to stop smoking—for example, nicotine replacement therapy.[196]
Assessment and monitoring	Assessing and monitoring people's physical health, including their sexual health, vision, hearing, substance use or addiction, and thyroid function.[197]
Collaboration and shared care	Collaborating and/or sharing care with other health practitioners who are caring for the person.[198]
Dental care	Offering accessible dental care from professionals who are skilled at working with people experiencing mental illness or psychological distress.[199]

Case study:

First Step

First Step is a mental health, addiction and legal services hub in St Kilda, Melbourne. It provides clients with support from a team that includes doctors, psychologists, drug and alcohol workers, lawyers, mental health nurses, care coordinators and educators as well as from outpatient psychiatric services.

First Step uses a single team approach to care that supports the broad needs of consumers. First Step's CEO, Patrick Lawrence, said that having such a range of relevant disciplines in the one building means First Step 'can build a team around a client simply by walking across the corridor'.

Mr Lawrence said that First Step focuses on 'incremental whole-of-life improvements' to support people facing multiple challenges such as mental illness, addiction, homelessness, social isolation and a history of trauma. Having an interdisciplinary staff team on site means that a consumer's support team can include, for example, alcohol and other drug education, counselling and medication support, general medicine, mental health therapy and legal representation. The support team can quickly expand or change around a consumer at any time to reflect the type of support they need. Mr Lawrence believes that services should aim to provide all the help people want and need from one team in one place.

> If … an individual has multiple areas of their life … that are adverse enough to be debilitating, then each area of deficit is likely to hinder improvements in each other area.

According to Mr Lawrence, communication is vital to providing interdisciplinary care.

> Planning and implementing care as a team is not possible unless the staff can communicate in a variety of forums, with or without the client present: clinical meetings, case conferencing, ad hoc conversations etc.

Megan* is currently participating in a program run by First Step. She notes that one of the main benefits of First Step is that 'all the right people to refer me to are in the same hub'. Previously Megan had felt that her health services were disconnected from each other, but First Step was able to provide her with a range of health services and legal services in a supportive environment.

> With all of my connections at First Step, I couldn't believe that all these people took an interest in me and my wellbeing. I felt safe and was able to disclose things, including a legal matter … I was able to avoid a conviction because I was represented by people who knew me.

Photo credit: Patrick Lawrence

Mr Lawrence reiterated the importance of providing all of the services under one roof and the effect this has on building trust with clients.

> In addition to this life-saving convenience around service delivery, our approach is also based on the building of trust that comes from team building rather than referring or directing clients to other service providers.

First Step also provides support to carers. While Natalie's* son was provided with therapeutic and legal support services, Natalie was also able to access support herself.

> It didn't occur to me [that I too could access support] before someone from First Step reached out to me and asked if I needed help … First Step had a mental health nurse look after me and my hyper anxiety, my confusion about what addiction was, the pharmacological changes that were going on in my son's brain and my own reaction and behaviour.

Source: First Step, <www.firststep.org.au/>, [accessed 16 July 2020]; First Step meeting with Commissioner Armytage, 7 April 2020; *Witness Statement of Patrick Lawrence*, 28 May 2020; RCVMHS, *Carer Human Centred Design Focus Group—Alcohol and Other Drugs: Record of Proceedings*, 2020.

Note: *Names have been changed to protect privacy.

Integrated treatment, care and support for substance use or addiction

Chapter 22: *Integrated approach to treatment, care and support for people living with mental illness and substance use or addiction* presents the Commission's evidence and recommendations on the need for better integration of mental health care with treatment for substance use or addiction. The First Step case study describes an example of an existing approach to integration.

Mental illness and substance use or addiction often co-occur. Data analysed by the Commission show that an estimated 43.8 per cent of consumers aged 26–64 years and an estimated 13.2 per cent of consumers aged 65 years or older who used public specialist mental health services in 2019–20 were also living with substance use or addiction.[200]

Consumers with both mental illness and substance use or addiction need integrated care from the time that they seek help or are referred to mental health and wellbeing services. The academic literature supports a broad range of psychological therapies to treat substance use disorders and addictions.[201] However, most mental health services do not currently provide these therapies.[202] As one consumer stated:

> There are definite problems in the current system in dual diagnosis. So many people living with mental illness use alcohol and drugs to cope with the symptoms. They are not separate issues.[203]

The inability to get integrated care can result in substantially poorer outcomes across mental health, addiction and wellbeing domains, especially for consumers with more complex treatment, care and support needs.[204] The research literature suggests that integrated care for mental health and substance use or addiction is associated with a range of better outcomes for consumers, including:

- increased participation in care and treatment programs and involvement with services[205]
- reductions in substance use and improvements in mental illness symptoms[206]
- improvements in other indicators of wellbeing, such as quality of life, and decreased risk of homelessness or interaction with the justice system.[207]

Assertive outreach

In addition to general home and community visiting services (as discussed in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*), Area Mental Health and Wellbeing Services will offer a specific model of outreach, called assertive outreach, to consumers requiring the highest level of service intensity (that is, the ongoing intensive treatment, care and support steam defined in Chapter 6). Box 7.1 outlines the essential features of this model.

Box 7.1: Model of assertive outreach recommended by the Commission

Treatment, care and support provided through assertive outreach will include the following features:

- Consumers will receive comprehensive treatment, care and support across multiple domains, including all necessary treatment and therapies; wellbeing supports; education, peer support and self-help; and care planning and coordination.
- Consumers will have face-to-face contact with multiple team members at least every month and more frequently as needed.
- Treatment, care and support will be delivered to the consumer where they live, rather than in a clinic or health centre, unless that is their preference.
- The kind and intensity of care will be matched to the needs of the consumer, with a focus on recovery to enable consumers to transition to less intensive supports.[208]
- Support will be provided proactively, with a focus on engaging the consumer on their terms.
- Service delivery will be based on the principle of supported decision making. Where a consumer has a compulsory treatment order, the support provided through the assertive outreach program will aim to have the consumer resume decision-making autonomy about their treatment, care and support.

The model of assertive outreach recommended by the Commission is based on 'Assertive Community Treatment'.[209] This is a comprehensive, structured outreach program that offers treatment, care and support to consumers with high-intensity mental health and wellbeing needs.[210] Assertive Community Treatment is delivered by multidisciplinary teams that have low caseloads. Importantly, the model involves both clinical care, such as medical treatment, and wellbeing supports to build life skills and social connections.[211]

Victoria's mental health services have a history of delivering treatment, care and support using the Assertive Community Treatment model.[212] Mobile support and treatment teams were a part of the mental health service system established in the 1990s and were an example of what Professor Rosen describes as 'distinct, evidence-based mental health teams'.[213] However, over time, the capacity of community mental health services to deliver this has diminished due to funding cuts.[214] The reduction of these functions in most areas of the state largely reflected funding pressures rather than lack of value.[215]

In Victoria's reformed mental health and wellbeing system, priority populations for assertive outreach may include people living with mental illness who are experiencing homelessness and others who face significant barriers to engaging with mental health services on site.[216]

As discussed in section 7.1.5, the Commission heard that Assertive Community Treatment should be coordinated with supports provided through the NDIS, where consumers have an NDIS plan.[217] Professor Rosen said that:

> In my view, and that of my co-authors … the NDIS should provide the support component for ACT teams (because they are only mandated to provide support), while the states should provide the clinical components, of combined and co-located ACT and support teams for the most long-term, recurrent or persistent and enduring mentally illnesses.[218]

Professor Rosen further explained that coordination of clinical care and NDIS supports could involve co-location of NDIS-funded services with the practitioners delivering the clinical components of Assertive Community Treatment.[219]

The Commission expects that a contemporary Victorian adaptation of Assertive Community Treatment will draw together NDIS-funded supports to ensure seamless and comprehensive care. This will involve close collaboration between mental health and wellbeing services and the NDIA. It will require substantial policy and operational design work across the Victorian Government, the Commonwealth Government and the NDIA.

Implementation considerations for integrated treatment, care and support

Multidisciplinary approaches—that is, when professionals from different disciplines work together to deliver comprehensive care[220]—will underpin the integrated delivery of treatments and therapies.

Co-location of Area Mental Health and Wellbeing Services with community health centres and non-government organisations would encourage integration between wellbeing supports and treatments and therapies. As noted by the World Health Organization, however, 'truly integrated care involves more than co-locating health workers with diverse specialties into the same building'.[221] The level of holistic treatment, care and support that the Commission expects to become standard practice in the future mental health and wellbeing system will require significant change—at the system, governance, service, team and people levels. Clinicians and practitioners from disciplines not traditionally used in mental health must be embedded in services and recognised for the value they add to peoples' treatment, care and support.

To ensure equity of access to psychological therapies, interpreters will be used when required. The Australian Psychological Society states that 'there is strong evidence for the effectiveness of interpreters when delivering psychological therapy, including the benefit of professional interpreters in bridging cultural barriers to service access'.[222] Chapter 21: *Responding to the mental health and wellbeing needs of a diverse population*, describes the Commission's recommendation for improving the availability of interpreting and translator services.

7.3.2 Wellbeing supports

As discussed in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*, the reforms recommended by the Commission aim to achieve a better balance of clinical treatment and care and wellbeing supports.

Wellbeing supports provide forms of assistance that people living with mental illness may need to live well in the community.[223] Mind Australia describes wellbeing supports as those 'that aim to assist people with the practical and emotional support they need to gain/regain a productive and meaningful life'.[224]

At the heart of wellbeing support is recovery-oriented practice that tries to understand how the person's experience of mental illness or distress has affected their sense of self and their ability to navigate the world.[225]

Examples of wellbeing supports include help with managing a residential tenancy or finding a more secure place to live; help to go back to tertiary education, finish a qualification or work towards getting a paid job; and help with learning to use public transport.[226]

Ms Julie Anderson, Senior Consumer Advisor in the Office of the Chief Mental Health Nurse and the Office of the Chief Psychiatrist, giving evidence in a personal capacity, told the Commission about the importance of the wellbeing supports she received:

> **An example of support I had that was empowering and educational was … around budgeting and housing. … I also needed to be taught how to streamline or how to make a weekly menu because I couldn't think of what I would cook. Therefore, what is needed is psychosocial supports or psychosocial rehabilitation support, which is supporting people to do things for themselves.**[227]

Wellbeing supports do more than just help people to achieve practical tasks; they also help people feel hopeful, valued and safe so they can gain or regain a sense of purpose and the enthusiasm to pursue things they care about.[228] A focus on wellbeing supports also recognises that it is difficult for people to focus on their recovery if fundamental aspects of their life, such as where they live, key relationships or their financial security, are uncertain.

While not everyone experiencing mental illness will need wellbeing supports, some people do need extra help to live well in the community, either for a short period while things might be unstable and tough or over longer periods.

There is evidence suggesting that wellbeing supports can help people substantially improve their quality of life.[229] A 2020 review conducted for the Commission by academics at the University of Melbourne found strong evidence that supported employment and supported housing are both likely to promote recovery.[230] Programs that support people to choose and gain access to properties through the open rental market have had success in securing housing, improving people's general wellbeing and reducing use of health services.[231] As these studies suggest, some people may require intensive wellbeing supports, such as safe housing and accommodation, before they are able to engage with other therapeutic interventions.[232]

Evidence also suggests that people experiencing psychosis might have better clinical outcomes when they receive a combination of wellbeing supports and medication, compared with people who only receive medication.[233] The Commission also heard that, for some people, wellbeing supports can be effective in the absence of medication:

> The critical misunderstanding here can be that treatment implies medication. Not all people with psychotic experiences need, or require, medication but respond well to psychosocial interventions.[234]

Wellbeing supports can be cost-effective. Studies have found that, when combined with GP contact, increased support from community mental health teams and care coordination, continuing wellbeing supports can yield savings for government over many years.[235] The Productivity Commission also found that psychosocial support programs can be cost-effective, because they prevent mental illness getting worse and therefore reduce demand for more resource-intensive services.[236]

The wellbeing supports that the Commission considers should be available for adults and older adults can be categorised into five domains:[237]

- **supports for community connection and social wellbeing**—for example, helping people connect to local community activities and with groups focused on mental health and wellbeing, such as peer support, group programs, and social skills development and training
- **supports for building life skills**—for example, helping people develop the skills to manage daily household tasks, plan meals and do the shopping, navigate public transport and get involved in community life
- **supports for housing**, such as helping people to secure and maintain housing, including supported housing, and to live independently in the community
- **education, training and employment supports** to help people achieve their goals and aspirations
- **connections to other supports**, such as legal, disability, financial and income supports; family violence, housing, migration and refugee services; culturally specific services; employment, education and training; and gambling support.

Each of these domains is described in more detail below.

Supports for community connection and social wellbeing

Social connection is essential for mental wellbeing.[238] The Victorian Mental Illness Awareness Council heard much about the importance of supports for social and community connection in its consultations with the community.[239] As Dr Tricia Szirom, former CEO, Victorian Mental Illness Awareness Council, told the Commission:

> Respondents wished for support and therapy groups, creating groups, peer support groups, nature activity groups … Some explicitly requested individual supports … Others stated that they wanted music, art, political action, consumer activism, and for social issues to be addressed. Conversations and listening were also strong themes, including the deep need to be heard by another person.[240]

The Commission also heard of the benefits of engaging in meaningful activities and doing things with like-minded people. As one consumer stated:

> **[People may] need help to find a hobby, to join a group somewhere, or to volunteer for something. Community supports need to look more carefully at the bigger picture of people's lives.**[241]

Unfortunately, often because of experiences of stigma and other life circumstances, some people with lived experience may need help to develop or regain the confidence and social skills needed to form and establish strong connections with others.[242]

Consumers said that wellbeing supports should encompass social activities outside of formal mental health settings. One consumer said that:

> **It is important that you have access to social groups that do not take place within a therapeutic environment. Sometimes you just want a book club that is a book club.**[243]

Supports for social connectedness are particularly important for older Victorians, given that the prevalence of loneliness and isolation increases as people get older. As Professor Sir Michael Marmot, Director of the Institute of Health Equity at University College London, told the Commission in a personal capacity, '[p]art of the curative function of adult social care comes from sitting with the older person, having a cup of tea and chatting with them.'[244]

There are many examples of programs to support community connection and social wellbeing. The Commission heard strong support for peer programs where people with experiences of mental illness and recovery come together to share their unique experiences of knowing about distress and healing in a welcoming and safe environment. Alcoholics Anonymous and Narcotics Anonymous are two well-known programs that combine peer-to-peer delivery with a structured program of steps to social wellbeing following disruption caused by addiction. Similarly, the international 'hearing voices' movement gives people with experiences of trauma and psychosis the opportunity to belong to a global community that feels safe and welcoming, and allows people, both individually and in groups, to explore their experiences.[245]

The Commission also heard about the emerging environmental care movement, including 'green care' and 'care farming', which offer nature-based activities that support recovery and healing.[246] Features of green care include 'contact with animals and nature, supportive natural environments, social acceptance and fellowship with other participants and meaningful activities' that are individually adapted and offer people experiences of 'mastery' by learning new skills.[247]

Programs to support social connection should offer consumers choice and control over what they participate in. For example, some people with high-intensity and complex needs may prefer to take part in group activities where they can receive support to develop social skills, rather than participating in explicit social skills training.[248]

Supports for building life skills

Some people experiencing mental illness find it difficult to manage 'activities of daily living' such as household tasks, cooking and healthy eating, shopping, using public transport, or making and keeping appointments with care providers.[249] Where needed, it is imperative that people are supported in undertaking these activities so they can build independence.[250] Ms Anderson told the Commission about her experience of receiving living skills support:

> It wasn't just about providing services, like house cleaning or shopping, but actually working to my strengths and empowering me to take charge of my life. I had problems with budgeting and the community support worker suggested how I could do my budget. We sat down and did our budgets together. She did her budget while I did mine and we had a discussion about it. I think being personal when supporting people on their recovery journey makes a lot of difference.[251]

Supports for housing

As mentioned earlier, stable, secure and appropriate housing is paramount to recovery and living well. It is not possible to flourish without a place to live and the support to stay there. While most people living with mental illness will not need support to get or maintain their housing, for a small number of people this will be a vital part of living well.

Victoria's future mental health system will include initiatives like tenancy supports, to support people who already have accommodation but need help to maintain it. The level of support provided will vary depending on the consumer's needs, which can change over time.[252] There will also be an additional 2,000 dwellings assigned to Victorians living with mental illness in the Big Housing Build, with Area Mental Health and Wellbeing Services assisting with the selection process. This is described in Chapter 16: *Supported housing for adults and young people*.

Education, training and employment supports

Work, whether paid or voluntary, remains a valued activity and aspiration for many consumers. Education and training are important pathways to employment, as well as being valued in their own right.

An employment program called Individual Placement and Support stands out due to its robust evidence base.[253] High-quality evidence indicates that Individual Placement and Support can be more effective than other programs in increasing rates of employment, improving job duration, hours worked per week and wages, and decreasing healthcare costs for some people living with mental illness.[254] Experts, professional bodies and service providers told the Commission about the need to expand Individual Placement and Support.[255] Individual Placement and Support uses a 'place–train' model that rapidly places people into competitive jobs while simultaneously providing on-the-job training.[256] The model integrates employment and vocational services by embedding employment specialists within multidisciplinary community mental health teams.[257]

The Commission supports the Productivity Commission's proposal that 'a cooperative funding model for [Individual Placement and Support] services could be established—potentially through a national partnership'.[258] Because employment support is the responsibility of the Commonwealth Government, Commonwealth co-funding should be secured to enable Adult and Older Adult Area Mental Health and Wellbeing Services to incorporate Individual Placement and Support into their model of care.

The Commission also supports the Productivity Commission's proposed progressive rollout of Individual Placement and Support, with a focus on testing and refining the model in local communities.[259] Efforts to scale up the model should follow a realistic timetable with ongoing monitoring and evaluation.[260]

Beyond Individual Placement and Support, Victoria's future mental health and wellbeing services will also support consumers who want to engage in education and training to realise their aspirations. For example, this could involve partnering with local employment services and vocational services, including social firms (also known as social businesses or social enterprises).[261] It will also mean working closely with employment services such as Disability Employment Services to tackle non-vocational factors that are barriers to finding and maintaining employment.[262] Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect*, discusses education, training and employment in more detail.

Connections to other supports

In line with the *National Framework for Recovery-Oriented Mental Health Services*, mental health and wellbeing services will connect people to supports in other services and systems. This includes, as required, legal, disability, financial and income supports; family violence, housing, migration and refugee services; culturally specific services; employment, education and training; and gambling support.[263]

Evidence indicates that wellbeing support programs can form successful partnerships with non-mental health services—such as homelessness and housing services, Aboriginal services and correctional services—to provide more holistic support for people.[264] In the alcohol and drug sector, Odyssey House has formed partnerships to offer clients integrated care that includes financial counselling and gambling support.[265]

Implementation considerations for wellbeing supports

The intensity of the wellbeing supports that each consumer needs will be discussed and jointly agreed as part of the standardised processes they are taken through when they first ask for help, review their needs or re-enter the system after previously being discharged. Outlined in detail in Chapter 8: *Finding and accessing treatment, care and support*, these processes include an 'initial support discussion' for people referred to or wishing to use mental health and wellbeing services. Some people will also participate in a 'comprehensive needs assessment and planning discussion'.

The intensity and type of wellbeing supports that people receive will vary across the five consumer streams outlined in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*. The Commission considers that the following examples are indicative of how wellbeing supports could differ between streams, depending on individual need:

- People in the communities and primary care, and primary care with extra supports streams are unlikely to need dedicated wellbeing supports. People in these streams will generally derive supports from their own resources and networks, including family and friends and wider resources in the community.
- People in the short-term treatment, care and support stream will generally receive limited duration supports focusing on the immediate matters that consumers want to work on to live well. A priority will be to connect people to resources and activities in their local community.
- People who require ongoing treatment, care and support will have access to a broad range of wellbeing supports, targeted to their individual needs and delivered for required lengths of time, including supports to connect people to resources and activities in their local community.
- People who require ongoing intensive treatment, care and support will receive intensive wellbeing supports across a range of programs including through assertive outreach as described in section 7.3.1.

Wellbeing supports will complement rather than duplicate any supports that a consumer already receives through other sectors, such as education, training, homelessness and disability services.

For people who have an existing NDIS package based on 'psychosocial disability', NDIS-provided supports are expected to comprise the wellbeing supports that an individual can use. The creation of state-funded wellbeing supports, as recommended by the Commission, will not duplicate the funding responsibilities of the NDIS. Consumers with NDIS plans will have the wellbeing supports they need provided through their NDIS plan, and these will be integrated with the other treatment, care and support they receive from mental health and wellbeing services.

For consumers who do not have an existing NDIS package, but where the comprehensive needs assessment and planning discussion indicates that they could be eligible, the priority will be to help them gain entry to the NDIS and in the meantime they should be provided with wellbeing supports. Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services will help people collect evidence for the NDIS assessment.

7.3.3 Education, peer support and self-help

In a significant reform, the Adult and Older Adult Mental Health and Wellbeing Services of the future will provide:

- mental health and wellbeing education, including through recovery colleges that will be established by all Adult and Older Adult Area Mental Health and Wellbeing Services
- peer support
- guided self-help.

Importantly, all of the above activities will have elements of peer support, not just the peer support programs.

The inclusion of these activities in the core functions of mental health and wellbeing services reflects the Commission's view that the future system should help people to actively self-manage their own mental health and wellbeing challenges. This approach is aligned to the principles of recovery, self-determination and personal growth and aims to give consumers more choice and control over their own treatment, care and support. It also further reinforces the Commission's respect for the significant value that people who have experienced, or are experiencing, mental illness or psychological distress can offer each other.

Overall, these supports have not been researched to the same extent as clinical treatments and as a consequence the evidence base is still emerging. However, some forms, such as peer support groups and psychoeducation, are backed by an established body of research evidence.[266] Research for the Commission by the University of Melbourne suggests:

> **[S]elf-management interventions [a form of mental health awareness and understanding supports] are evidence-based, support recovery, promote choice and control, and have the potential to improve the lives of people with severe mental illness.[267]**

Other forms of support are newer and emerging, such as digital self-help tools.[268]

On the basis that these supports may be valuable to people regardless of the intensity and complexity of their mental health needs, the Commission expects that some—such as the recovery colleges described in the following section—will be made available to all members of the community. This is intended to reduce the stigma and discrimination associated with mental illness and improve the community's understanding of mental health and wellbeing.

Mental health and wellbeing education

Group learning environments are important not only for building an individual's knowledge and skills but also for forming relationships and social connections through the activities of learning and teaching. Research in Victoria has highlighted the therapeutic benefits of engaging in education and self-help activities with peers and like-minded people.[269] The benefits include increased confidence, a sense of connection and belonging to a community, and increased social interaction.[270] This is consistent with evidence from the academic literature that learning is good for people's mental health.[271]

Case Study:

Recovery colleges

Recovery colleges are an education-based approach to supporting mental health recovery through a framework of shared learning and co-production. Originally developed in the United States in the 1990s, the recovery college model emerging in Australia is based on the United Kingdom model, which launched in 2009 and has grown to more than 80 colleges.

Recovery colleges in the United Kingdom are based on foundational principles and values, including:

- *Co-production and co-design*

  Recovery colleges aim to break down the clinician–patient power dynamic often found in traditional models of care.

  Course offerings at recovery colleges are varied and developed locally as part of the co-design process. They can include areas such as dealing with difficult emotions, mindfulness, goal setting, tackling stigma, interview skills and healthy living.

  Courses are delivered by people with lived experience alongside those with professional expertise on the relevant topic.

- *Bringing everyone together*

  Recovery colleges bring together consumers, family members, interested members of the community and mental health clinicians to share knowledge, experience and skills to support recovery.

  Recovery colleges are open to everyone; there is no diagnosis required to attend. This approach means no individual is seen as a consumer requiring treatment but as a student who works with facilitators in a classroom to learn about themselves, others, mental illness and approaches to recovery.

- *Education focus*

  Recovery is supported when people learn new skills and gain new knowledge. The recovery college model engages students in the familiar educational process of growth and development, rather than a pathology-based process of 'getting better'.

While recovery colleges are not a substitute for specialist clinical and therapeutic assessment and treatment, they have shown success in improving outcomes for consumers. Studies from the United Kingdom show the colleges contribute to consumers achieving their recovery goals and improving their quality of life and wellbeing. They are also cost-effective.

Recovery colleges now operate in other states and territories in Australia, including two in New South Wales, a statewide college in Western Australia and one in the Australian Capital Territory. Victoria has two recovery colleges—the Recovery College (operated by Mind Australia) and the Discovery College (operated as a partnership between Alfred Health and headspace National). These colleges connect and share ideas regularly through a community of practice.

The Discovery College

The Discovery College is a youth-focused recovery college. Dr Paul Denborough, the Clinical Director of Child and Youth Mental Health Services and headspace, Alfred Health, experienced a recovery college overseas and saw an opportunity to bring the model to Melbourne.

> I was a student at a recovery college in England and the training was the best I have received in my professional career. You can't really understand the power of the model until you have been a student. I was inspired to replicate the model as a way of implementing recovery-oriented practice in our youth services.

There are four phases of co-production at the Discovery College (co-plan, co-design, co-deliver and co-evaluate), ensuring the entire service is built with equal partnership between everyone involved, including people with lived experience. Dr Denborough said that this is an important cultural aspect of the Discovery College.

> There is meaningful participation for people with lived experience in the actual work of the Discovery College. People with lived experience are valued professionals, as well as those with other expertise relevant to the operation of the service.

Dr Campbell Thorpe, a psychiatrist and Discovery College facilitator, said co-production opens up the discussion and thinking around mental health.

> Co-production moves us out of traditional roles, relationships and power imbalances to talk about mental health in new ways. Each experience can influence the other's thinking and together new understanding and meaning can be formed between us.

Jack, a peer support worker, described the Discovery College as an 'open classroom':

> Everyone's a teacher and everyone's a student.

Dr Denborough said the model, with no referral, prescription of courses or requirement of diagnosis, provides consumers with agency in their engagement with the college.

> A critical aspect is that rather than a doctor telling you what you need to get well, you choose what is right for you to help you get better.

Following its launch in May 2016, more than 750 students have participated in some 120 separate courses, workshops and panels at the Discovery College, covering topics such as medication, mindfulness, creativity and supporting others.

The Discovery College operates alongside the headspace Recovery Program, which offers a range of courses including life skills where young people learn how to pay bills, use public transport and cook. Courses at the Discovery College complement the Recovery Program's life skills courses by supporting young people to negotiate their environment and to understand and manage their sensory triggers with courses such as 'Making sense of your senses' and mindfulness.

The Discovery College is closely connected to four headspace locations at Bentleigh, Frankston, Dandenong and Narre Warren, with courses mostly offered at community-based venues across south-east Melbourne. In response to the COVID-19 pandemic, courses are now offered online and weekly 'Discovery Convos' are hosted on Instagram, focusing on self-care, isolation and connection and resilience.

Source: RCVMHS, *Interview with Dr Paul Denborough*, September 2020; Rachel Perkins and others, *Recovery Colleges 10 Years On, ImROC Briefing Paper, Nottinghamshire Healthcare Centre for Mental Health*, 2018; Discovery College, 'How we work' <www.discovery.college/how-we-work> [accessed 6 August 2020].

Consumers told the Commission about the importance of mental health education:

> As someone diagnosed with bipolar disorder at the age of 43, and with no information from mental health services, I've had to learn myself what the diagnosis means, how to manage my condition and how to achieve a sense of healing and recovery. This has taken me six years to achieve. It has been exhausting. I've achieved an understanding of bipolar disorder through reading people's memoirs, reading information online and through being member of a meetup group for people diagnosed bipolar/ mood disorder. [272]

Mental health education initiatives such as recovery colleges (also sometimes referred to as 'discovery colleges') provide important opportunities for people with lived experience to work alongside those with learnt expertise to develop and deliver interventions for people experiencing mental illness. This occurs, for example, at the United Kingdom's Recovery College East, where people with lived experience provide training to the mental health workforce for the local Mental Health Trust, with the aim of strengthening the recovery focus of the Trust and breaking down barriers between people using and working in the Trust's services.[273]

In Victoria's future mental health and wellbeing system, each Adult and Older Adult Area Mental Health and Wellbeing Service will establish and run a recovery college. Learning modules offered by the recovery colleges will be delivered in a range of locations and venues in communities across Victoria, including in Adult and Older Adult Local Mental Health and Wellbeing Services and online.

The Victorian Collaborative Centre for Mental Health and Wellbeing (recommended in the Commission's interim report) will help implement the recovery colleges by working with local communities to develop policies and procedures for the structure of each recovery college, as well as statewide curricula and learning modules.

In taking this leading role, the Collaborative Centre for Mental Health and Wellbeing will ensure there is a good balance between consistency and quality across the system and local customisation and responsiveness. It will also ensure that people with lived experience of mental illness or psychological distress and their families are central to the establishment of the recovery colleges and that the learning modules are co-designed and co-delivered as appropriate.

In taking this leading role, the Collaborative Centre for Mental Health and Wellbeing will be able to harness the international evidence and lessons from recovery colleges around the world, including on resourcing profiles, governance and effective scaling. The following quote is a reflection on the growth of recovery colleges in the United Kingdom:

> All Recovery Colleges started small [offering a handful of courses] but most have grown rapidly to offer dozens of different courses in multiple locations and serve thousands of students each year. Typically, a College will have a small team of peer and mental health practitioners employed directly by the College, supplemented by a larger group of sessional peer trainers and sessional mental health practitioner trainers drawn from among staff within mental health services and from community agencies.[274]

There is a growing evidence base that demonstrates the effectiveness of recovery colleges.[275] While evidence to date has yet to include a randomised control trial, an increasing number of studies highlight a positive impact of recovery colleges in areas such as consumer satisfaction and supporting people to work towards their recovery goals.[276] For example, one study said that:

> Recovery Colleges form a core part of the development of more recovery-focused mental health services that enable people to grow within and beyond what has happened to them; discover a new sense of self, meaning and purpose in life; explore their possibilities and rebuild a satisfying and contributing life.[277]

Evidence also indicates that students of recovery colleges may require fewer inpatient and community mental health services, compared to their need for these services prior to attending recovery colleges.[278]

According to a 2016 evaluation of the recovery college run by the non-government organisation Mind Australia, students reported benefits such as gaining new knowledge and ways of thinking, increased confidence to pursue other education and recovery opportunities, and learning how to develop and maintain a healthy lifestyle (for example, through reduced smoking or increased physical exercise).[279] The study also found that the Mind Recovery College acted not only as an education service but also as a 'different service model' and a 'complementary mental health service' in the way that it fostered a strong sense of community and connection between students and staff, and empowered students to build their skills and achieve personal growth.[280]

Recovery colleges and similar group learning environments, when paired with other forms of mental health services, can 'contribute powerfully and efficiently' to an individual's recovery and wellbeing.[281] As one carer told the Commission:

> [Mind Recovery College] … facilitated open dialogue, helped us to make contacts with other carers and made the situation we were in with our son feel more normal. We met other people coping with many of the same problems we were facing. [It] also helped with education and expanded our insight into the whole issue of mental illness. The program was staffed with warm, encouraging professionals who made us and our son feel at home. But these kinds of programs need to be accessible and affordable. There should be a lot more of them.[282]

Peer support

Workers with a lived experience of mental illness or psychological distress (referred to as peer workers), play an important role in building recovery-oriented approaches to treatment, care and support, providing meaningful support to people experiencing mental health and wellbeing challenges and modelling positive outcomes of experiences and recovery.[283] Peer workers draw on their own personal experiences, and their experiences of supporting others experiencing mental illness or psychological distress, to offer support and guidance to others that are in similar situations.[284] They perform a variety of roles, including providing individual support, delivering education programs and coaching, and running groups and activities. Evidence suggests that peer workers can support people to make healthy lifestyle changes, help people to respond to stigma and discrimination, and encourage recovery-oriented practice.[285]

At times, peer support can be a simple offer of friendship. As Teresa, a witness before the Commission, described:

> [The program] provided me with a pseudo friend to help me get back into my life and made me able to work again. They were there for me whenever I did not feel worthwhile. Instead of having appointments at a clinic they would meet me at home or at a coffee shop. This helped me feel normal and part of society … I feel better supported now then I have in the last twenty years of pits and falls of my mental health journey. The three months of somebody taking me out to coffee and assisting me was incredibly good value.[286]

The Commission heard from consumers of their strong preference for more access to peer support. In a significant reform, the provision of peer support programs through the employment of peer workers in adequate numbers will become standard practice in the Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services. The Commission already signalled a more significant role for peer workers, with recommendation 6 of the interim report calling for a major expansion of the lived experience workforces.[287]

There are many examples of programs run by peer workers in Victoria. For example, the Victorian Mental Illness Awareness Council delivers a 'check-in' peer support service. This has provided innovative ways for consumers experiencing distress to get support during the COVID-19 pandemic, including telephone or video-conference peer support sessions, group wellbeing, yoga and meditation sessions.[288] Another example is Voices Vic, an initiative of Uniting Prahran that delivers a specialist program led by people with a lived experience to help people who hear voices.[289]

There is evidence for the effectiveness of specific peer-led programs. For example, SANE Australia and Neami National piloted a peer health coaching program delivered by peer support workers that focused on the physical health needs of people living with a mental illness.[290] While the evaluation had a small sample size, it found that people who participated reported increased confidence and health literacy regarding their physical health.[291]

A 2017 evaluation of an Australian peer-delivered post-discharge support program following an acute inpatient admission in a mental health unit found that the program 'supported positive outcomes for participants in terms of recovery, wellbeing and hospital avoidance [and] [p]articipant feedback suggested that the use of support workers with their own lived experience of mental illness was a particularly powerful aspect of the program'.[292]

Peer support programs typically emphasise personal recovery outcomes, choice and control, and the value of self-directed care. The availability of these programs within mental health and wellbeing services will enhance consumers' choices and satisfaction with services and help them to identify and work towards their recovery goals.

Guided self-help

Guided self-help encompasses a wide variety of tools, resources and programs that offer self-assessment, monitoring, symptom management, treatment and information about mental health and recovery, often used in combination with care from a mental health practitioner or as part of a structured program.[293] Most self-help supports are now delivered through digital technologies such as apps and websites.[294]

Various forms of self-help can also help people connect to community resources.[295] These include supports to help consumers build connections and use resources in their community—for example, support to enjoy social and physical activities, such as walking groups.[296] This is similar to the concept of 'social prescribing', an emerging approach in which primary care providers link people to groups and resources that respond to social factors in chronic health conditions.[297] Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect*, describes the Commission's recommendation for establishing social prescribing trials across Victoria.

7.3.4 Care planning and coordination

Care planning and coordination that is consumer-centred is the 'glue' that ensures all of a consumer's needs are being met in a coordinated, helpful way.[298] In the reformed system, care planning and coordination will organise and connect the treatment, care and support that consumers receive from Adult and Older Adult Local Mental Health and Wellbeing Services and Adult and Older Adult Area Mental Health and Wellbeing Services, as well as from organisations and agencies in other systems. While not all consumers will need formal care coordination services, for those who do, care planning and coordination will be a separate service component, with dedicated resources.

The importance of care planning and coordination to consumers' outcomes and experiences was described by Professor Suresh Sundram, Head of the Department of Psychiatry, School of Clinical Sciences at Monash University and Director of Research in the Monash Health Mental Health Program, who gave evidence in a personal capacity:

> **It is vital that the service components or providers are linked … through a supported care coordination mechanism, to ensure that when people require support and services, they know how and where to access those services. This could be done by the mental health community support sector taking on a central care coordination role, to work with individual clients to develop a care plan, identify their specific service needs and to enable those individuals to access resources across the spectrum of service providers in a centralised way. Mental health community support coordinators would then accompany an individual on their journey to ensure they are able to actualise all of the components of their needs or projected needs.**[299]

Evidence suggests that good care planning and coordination can improve recovery outcomes for consumers by enhancing continuity of care.[300] It is also associated with improved cost-effectiveness for the service system.[301]

In the future Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services:

- Staff undertaking care planning will work collaboratively with consumers, families, carers and supporters to design and agree on the treatment, care and support the consumer needs and wants.

- Staff undertaking care coordination will work with consumers to draw together what they need from a range of services so their experience of care is integrated and continuous, and responds to both their continuing and episodic needs.[302] Clinicians and support staff will make sure the services and supports needed across the core functions of mental health and wellbeing services, and from other services (for example, income supports, housing and legal assistance), are planned and coordinated to deliver the best outcomes for the individual.

As well as drawing together treatment, care and support, care planning and coordination also ensures there are smooth transitions between settings, services, and streams. Ms Lynda Watts, a carer and witness, told the Commission how important this is:

> Effective care coordination can alleviate the immense frustrations, experienced by carers, of unresponsive services: phone calls never returned or returned weeks later after a crisis, emails never responded to, timeframe commitments never honoured, etc. … Care coordination also addresses the problem of 'one hand doesn't know what the other hand is doing', by ensuring that communication is happening between services and there are appropriate follow-ups. It breaks down the proverbial silos, it helps staff to connect with other services, and form solid working relationships and friendships.[303]

Different levels of intensity of care planning and coordination

Consumers will need different levels and types of planning and coordination of their treatment, care and support. Their needs will depend on the type and severity of their mental illness or psychological distress, and the level of support they have from other sources such as families, carers and supporters and, where applicable, the NDIS.

Consumers will also need care planning and coordination for different lengths of time—some consumers might require high-intensity planning and coordination only at the start of their involvement with mental health and wellbeing services and some consumers might need it throughout the entire journey. Ms Nicole Bartholomeusz, Chief Executive, cohealth, touched on this when she described the needs for formal care coordination roles for people living with mental illness:

> for people with serious mental illness, our experience has indicated a need for a service navigator/advocate/care coordination function that assists people to identify what their needs are and to navigate the broader system.[304]

The Commission considers that indicative levels of need for care planning and coordination could be described as follows:

- People in the short-term treatment, care and support stream may need help to obtain and coordinate their own care for short periods of time when they are in crisis or acutely unwell. For example, low-intensity care planning and coordination could be provided through the front-end functions discussed in Chapter 8: *Finding and accessing treatment, care and support*—the 'initial support discussion' and the 'comprehensive needs assessment and planning discussion'—or through a discussion with an access and navigation support worker (also defined in Chapter 8). Short-term high-intensity care coordination will also be available for people requiring brief interventions to support recovery.[305] Care coordination support will taper off as people recover and can return to their usual lower-intensity care arrangements.

- For people in the ongoing treatment, care and support stream, a multidisciplinary team may draw together a comprehensive range of treatment, care and support across multiple services that respond to the individual's holistic strengths and needs. The team will then assume accountability for continuity of care as the consumer transitions between settings and will assist them to get and coordinate care from other systems, such as the NDIS. For most people, this care planning and coordination will be obtained through Local Mental Health and Wellbeing Services. However, at times people may need to get care planning and coordination from Area Mental Health and Wellbeing Services—for example, when diagnosis-specific outpatient care is needed.
- In the ongoing intensive treatment, care and support stream, services may provide consumers with high-intensity support across a range of aspects of their life. This will include care planning and coordination through the Assertive Community Treatment model described in section 7.3.1. As Professor Rosen told the Commission, Assertive Community Treatment teams are 'the gold-standard of active-response (rather than passive-response) case-management or care coordination'.[306]

Care planning and coordination at service entry and transitions

Care planning and coordination should ensure smooth transitions at important points. These include:

- when someone reaches out for help for the first time
- when someone has been travelling well with minimal or no formal support, but then needs some extra help from Local Mental Health and Wellbeing Services or Area Mental Health and Wellbeing Services
- when things have changed in a consumer's life, such as a situational crisis, and they need extra support
- when someone is moving from one provider or setting to another—for example, entering or leaving bed-based care or moving from one age-based system or consumer stream to another.

Table 7.4 provides examples of how mental health and wellbeing services will ensure continuity of care at important transition points.

Table 7.4: Examples of how care planning and coordination will be enabled at service transition points

Entry	Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services will share common tools for undertaking and recording the outcome of 'initial support discussions' (which, as explained in Chapter 8: *Finding and accessing treatment, care and support,* are provided for people seeking or referred to Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services), and for the 'comprehensive needs assessment and planning discussion' (which is provided for people who need a more comprehensive assessment of their needs). Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services will have agreements in place to automatically accept referrals from each other without the need for triaging consumers again. This will ensure consistent care planning processes and smooth entry pathways and, importantly, the consumer will not have to retell their story.
Re-entry	Mental health and wellbeing services will ensure consumers can easily reconnect with services if their needs escalate, even after long periods when they have not required support.
Review	Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services will share common approaches for regularly reviewing consumer treatment, care and support needs as people's strengths and needs evolve. Where reviews result in transitions between services, these services will have agreements in place to accept referrals from each other without the need for triaging consumers again.
Transitions	Between consumer streams: When consumers transition from lower to higher intensity services, they may need to work with new practitioners. Care coordination, supported by suitable processes and information-sharing tools, will minimise the need for consumers to retell their story and to be reassessed and re-registered in another system. Transitions to lower intensity services—for example, from the ongoing treatment, care and support stream to the primary care with extra supports stream—will be gradual, with assured continuity of care. In this case, the Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services would monitor the consumer following their transition to the lower stream, working closely with the primary care provider. Between Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services: Services will work together to ensure smooth transitions between settings. For example, the Local Mental Health and Wellbeing Service will maintain contact with a consumer during their treatment at the Area Mental Health and Wellbeing Service, collaborate with staff throughout the course of the treatment, and coordinate discharge medications and supports to transition back to local care. Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services will have agreements to accept referrals from each other without the need for triaging consumers again.

Care planning and coordination for consumers on compulsory treatment orders

Care planning should promote autonomy and supported decision making, including when consumers are subject to compulsory treatment orders.[307] While this is already a legal requirement in Victoria, aspirations to embed supported decision making into treatment, care and support have not been realised.[308] There are many ways of involving people in decision making, even in situations where there are communication difficulties or in the context of compulsory treatment.[309] This is discussed in Chapter 32: *Reducing compulsory treatment*.

Care planning and coordination is expected for every person subject to a community treatment order. To ensure families, carers and supporters are engaged where appropriate, a family meeting should occur before a person is placed on a compulsory order and in the event that an extension to the order is being sought.

The Commission recognises that there is a tension between compulsory treatment and the strengths-based, collaborative care coordination approaches it has recommended. For example, some consumers who receive care coordination through the Assertive Community Treatment model recommended by the Commission will, at least initially, be under a compulsory treatment order.[310] Given this tension, it is important that services develop advanced skills in supported decision making to minimise rights limitations, as well as skills to help people transition away from compulsory treatment.[311]

Some evidence indicates that Assertive Community Treatment can lead to a substantial reduction in compulsory admissions and—through its sustained contact and development of close relationships with consumers—to reduced coercion.[312]

Implementation considerations for care planning and coordination

The intensity of care planning and coordination that consumers receive should adapt to their changing strengths and needs. As well as being matched to a consumer's stage of recovery, care planning and coordination needs to respond to events in a consumer's life that may mean they need more support, such as loss of employment or housing.

Another important implementation principle is to ensure consumers—and families, carers and supporters where applicable—are actively involved in their own care planning processes. These are existing obligations under the Office of the Chief Psychiatrist treatment planning guidelines,[313] which give effect to the principles and provisions of the *Mental Health Act 2014* (Vic). The Commission notes evidence that these obligations are currently not always upheld. For example, one consumer told the Commission that '[o]ver 27 years I have never been involved in the design of a case management plan'.[314]

Wherever possible, the same care planners and coordinators should work with the consumer over the period they need this support. This will enable the consumer to form a relationship with a clinician or support worker who deeply understands their strengths, needs and aspirations. As Professor Rosen told the Commission:

> Care co-ordination is best done by somebody who will see a person through their entire episodes … or throughout their long-term care … and who knows their early warning signs. A care co-ordinator provides the person not only with navigation, but also with coaching, shoulder-to-shoulder advice and a number of different interventions that may help over time.[315]

Care coordination should be informed by evidence-based models including clinical 'case conferencing' and 'multidisciplinary team reviews', and less clinically oriented models such as Partners in Recovery, which coordinates and drives collaboration between relevant sectors and services to meet people's needs.

As described in Chapter 35: *New approaches to information management*, the Commission is recommending a range of reforms to facilitate the effective, safe and efficient collection and sharing of mental health and wellbeing information. This chapter discusses the importance of services sharing information appropriately to improve care coordination and continuity and reduce the need for people to repeat their stories. As one consumer told the Commission:

> Each time I go to an appointment, I have to tell my story and it triggers the trauma to come back … sometimes I get upset because I want to move on from what I've gone through.[316]

The Commission has also recommended establishing Regional Multiagency Panels. While the panels will not usually oversee the care of individual consumers, they may be used on occasions when additional input from multiple agencies is required to support consumers receiving ongoing intensive mental health treatment, care and support from mental health and wellbeing services. The Regional Multiagency Panels, described in detail in Chapter 5: *A responsive and integrated system*, will increase the level of accountability across providers to ensure all the consumer's needs are met.

7.4 Core function 2: Helping people find and access services and responding to mental health crises

In addition to mental health and wellbeing services, a range of services are involved in helping people find and access mental health support, including in crisis situations. These include non-government helplines (such as Lifeline and Beyond Blue), emergency departments and emergency services (police and ambulance). Due to their broad-ranging nature, the Commission has devoted separate chapters of this report to how people find and access services and supports (Chapter 8: *Finding and accessing treatment, care and support)*, and to services for people experiencing mental health crises (Chapter 9: *Crisis and emergency responses*).

The major implications of the reforms outlined in Chapters 8 and 9 for mental health and wellbeing services are that:

- Local Mental Health and Wellbeing Services will be accessible to the community. While a referral from a GP or any other service provider will be encouraged, access and navigation support workers employed by the local services will be able to facilitate access to clinical assessment and initial support.
- Except in crisis situations, Area Mental Health and Wellbeing Services will be accessible only through a referral from a Local Mental Health and Wellbeing Service or through direct referral from a medical practitioner.
- Area Mental Health and Wellbeing Services will provide crisis responses to anyone in the community. Crisis responses, including reformed crisis outreach teams, will be available 24 hours a day, seven days a week.
- Statewide services will be accessible through a referral from an Area Mental Health and Wellbeing Service.

These reforms seek to provide better and more timely access to treatment, care and support in the recommended network of 50–60 Adult and Older Adult Local Mental Health and Wellbeing Services. Higher intensity services in Area Mental Health and Wellbeing Services will be dedicated to those most in need but will still be accessible via clear referral pathways from primary and secondary care services and Local Mental Health and Wellbeing Services.

Expanded crisis response capacity in Area Mental Health and Wellbeing Services will support the Commission's recommendation that people experiencing mental health crises and emergencies should receive a health-led response wherever possible and safe, rather than a police-led one.

7.5 Core function 3: Supports for primary and secondary care

The Commission heard that the lack of connection between (mainly Commonwealth Government-funded) primary and secondary care services and state-funded area mental health services (which provide specialised and tertiary services) has contributed to unsustainable pressure on the latter. For example, a participant in one of the Commission's roundtable meetings said:

> at the moment, we have been a system where you've had a primary care platform funded by the Commonwealth with no secondary care, no stepped care genuinely, and a tertiary system trying to fend off all of this work that is overwhelming it because there is no earlier intervention and support for people and so they are presenting acutely unwell more often, deeply distressed.[317]

Strengthening the connections between mental health and wellbeing services and primary and secondary care providers is an essential part of the Commission's overall reform agenda. As part of achieving this, the Commission expects that Adult and Older Adult Area Mental Health and Wellbeing Services will support GPs and other primary and secondary care providers, such as psychologists working privately or for non-government organisations.

Primary and secondary care providers will be supported by Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services, through:

- secondary consultation with service providers
- primary consultations between consumers and mental health specialists
- comprehensive shared care, in which Adult and Older Adult Area Mental Health and Wellbeing Services form partnerships with GPs and other primary care providers to collaboratively provide treatment, care and support for consumers with complex support needs.

Mental health and wellbeing services will have flexibility in how they design and deliver these functions. Advantage should be taken of any existing regional primary care support programs (for example, those currently being implemented by Primary Health Networks).[318]

The specific needs of primary and secondary care practitioners in rural and regional areas will need to be considered in implementing the programs. Videoconferencing, which is used in the Project ECHO program described in this chapter, demonstrates how this technology can assist in connecting practitioners and clinicians across distances. The increased use of telehealth in Victoria in 2020 suggests that this mode of communication may also be appropriate in certain circumstances to connect consumers and practitioners.

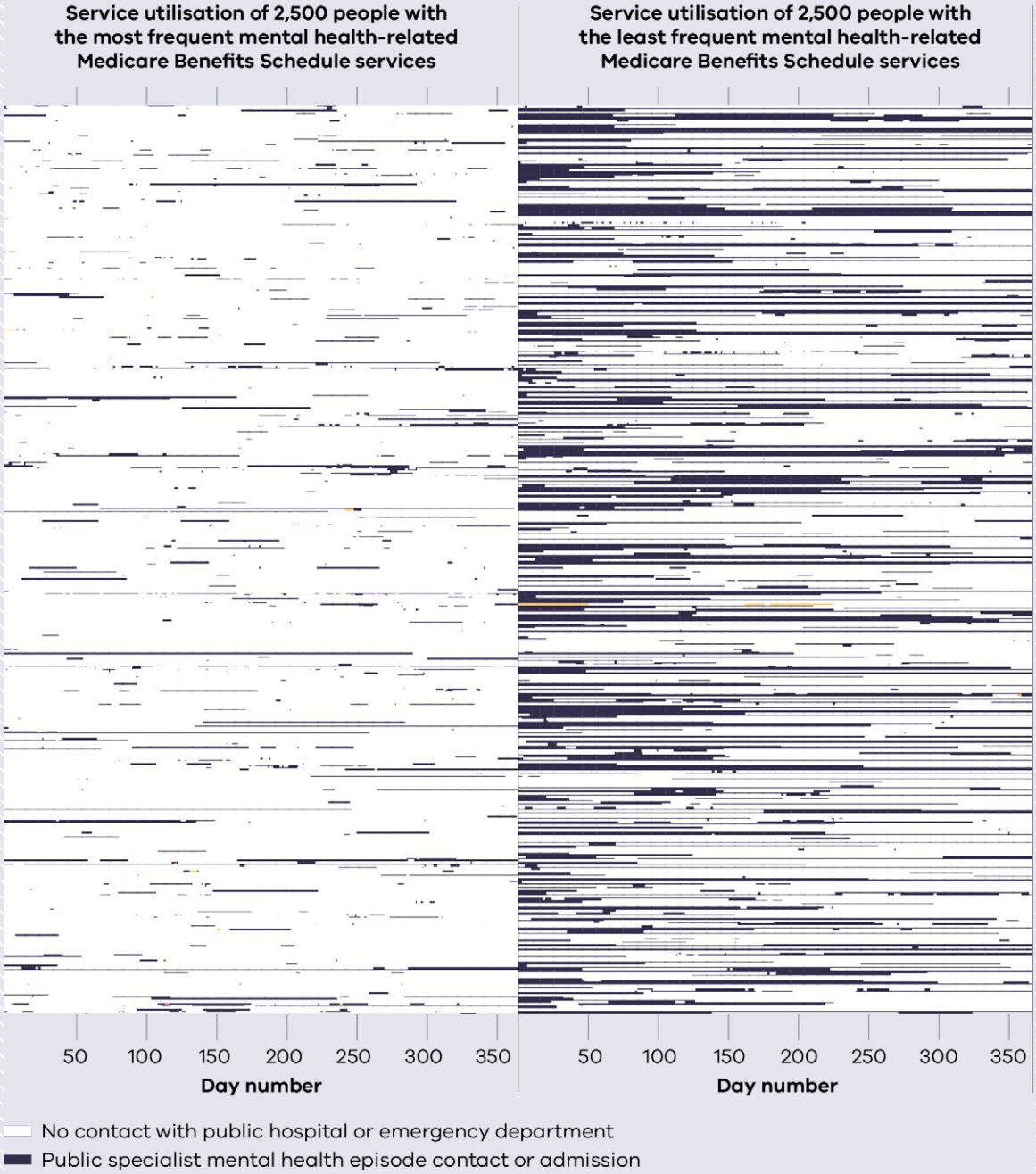
The Commission also notes the Productivity Commission's recommendation that a Medicare Benefits Schedule item be created for GPs and paediatricians to seek advice from a psychiatrist about a consumer under their care.[319] This recommendation is welcome and aligns with the Commission's reforms.

These reforms are intended to support people to maintain their treatment, care and support in primary and secondary care services. This may result in relatively lower levels of demand on Adult and Older Adult Area Mental Health and Wellbeing Services, as discussed below in relation to Figure 7.5.

Figure 7.5 depicts analysis undertaken by the Commission of the levels of service utilisation of people aged 26–64 years during episodes of treatment, care and support in public specialist mental health services (both bed-based and community services) in 2017–18. On the left-hand side is the 2,500 adult consumers in 2017–18 who accessed Medicare subsidised mental health services in the community the *most*, while also accessing public specialist mental health services. On the right-hand side is the 2,500 adult consumers in 2017–18 who accessed Medicare subsidised mental health services in the community the *least*, while also accessing public specialist mental health services.

The group shown on the right, who accessed Medicare subsidised mental health services in the community the least, used public specialist mental health services far more often that year. While this data should be interpreted with caution, it may indicate, for adults who have successfully accessed public specialist mental health services, the use of Medicare subsidised mental health services in the community reduces the level of need for those public specialist mental health services.

Figure 7.5: Service utilisation of public hospital and emergency departments by public specialist mental health system active consumers aged 26–64 years, that used Medicare subsidised mental health services by frequency



Source: Department of Health and Human Services, Integrated Data Resource, Client Management Information System/Operational Data Store, Victorian Admitted Episodes Dataset, Victorian Emergency Minimum Dataset 2013–14 to 2017–18.; Government Services Australia, Medicare Benefits Schedule 2013–14 to 2017–18.

Note: Each line is an aggregate of five people and their service utilisation in 2017–18 by day. In order to preserve the patient level trends whilst protecting privacy regulations, the aggregated records reflect the most frequent service setting on each day for the five individuals within each sample. When there is an equal number of most frequent settings, then preference is given to the public specialist mental health system (inpatient or community), followed by non-mental health public admissions and then mental health related emergency presentations. The data excludes people that used private hospitals and people where there was no mental health diagnosis recorded. Different colours represent different settings. Purple bars represent public specialist mental health episode contacts or admissions. Yellow bars, where they appear, represent non-mental health public hospital admissions. Pink bars, where they appear, represent mental health related emergency department presentations.

7.5.1 Secondary consultation

In the mental health context, secondary consultation involves mental health practitioners or multidisciplinary teams providing information, advice and expertise to another service provider, usually without a consumer present. This enables different care providers to work together to respond to any matters relating to an individual's care.

Mental health specialists can also use secondary consultation models, without focusing on individual consumers, to build primary and secondary care providers' capability or knowledge in a particular approach to care.

Evidence suggests that secondary consultation is an effective model of care.[320] Many GPs told the Commission they want better access to secondary consultation. Dr Caroline Johnson, General Practitioner, stated:

> I think that case conferencing between GPs and other mental health professionals might help. For example, a psychiatrist could provide detailed advice to the GP, preferably with input from a multidisciplinary team, as to what strategies to use with a patient with a complex psychiatric problem.[321]

Although secondary consultation usually occurs between healthcare practitioners only, without a consumer present, there are occasions where it is appropriate to include the consumer in this discussion. For example, consumers should be invited to take part in the discussion when major decisions about their care are being made.

Primary Health Networks are stepping into this space. For example, Eastern Melbourne Primary Health Network has implemented a program to provide general practices with access to secondary consultation and advice from private psychiatrists and mental health nurse practitioners.[322]

Project ECHO is an innovative model of secondary consultation developed at the University of New Mexico.[323] It aims to extend capacity in rural and regional areas to manage chronic disease in primary care settings. [324] A case study on a Project ECHO program in Victoria is presented below.

Secondary consultation models such as Project ECHO can improve quality of care and the number of consumers being seen in primary settings. This reduces the need for them to increase use of resource-intensive tertiary services.

7.5.2 Primary consultation

Primary consultation, sometimes referred to as a 'second opinion', occurs when a mental health clinician meets directly with a consumer. Currently, GPs refer most patients needing specialised mental health care to private psychologists and psychiatrists. However, the Commission heard that a model of primary consultation delivered through public mental health clinicians 'in-reaching' to primary care settings would have benefits for consumers who are unable to afford private services. Dr Johnson told the Commission that:

> Collaborative care isn't necessarily the total answer, but getting specialists to come into a GP practice to do care and follow-up does have wins—it allows the patient to be supported in their own environment, plus the GPs upskill over time as they see what specialists recommend.[325]

The Commission expects that, in the future, clinicians from Area Mental Health and Wellbeing Services will offer primary consultations to consumers through a combination of spending time in primary or secondary care settings, such as general practice clinics and community health services, or through outpatient clinics within Area Mental Health and Wellbeing Services. Greater adoption of video telehealth technology will make this much easier than it has been in the past.

7.5.3 Comprehensive shared care

While 'shared care' is a widely used term, the Commission has adopted the definition developed by academic Professor Brian Kelly and his colleagues:

> A structured system for achieving integration of care across multiple autonomous providers and services with primary and secondary care practitioners contributing to elements of a patient's overall package of care. Shared care involves some agreement about the shared activities and levels of responsibility for each provider and appropriate communication processes to support this integration.[326]

Shared care offers an extra layer of support for clients of primary and secondary care providers who may otherwise need more intensive involvement with public specialist mental health services.[327] There is evidence that shared mental health care is effective for consumers with more complex support needs because it can encourage recovery,[328] prevent relapse and reduce admissions to tertiary mental health services.[329] Shared care can also increase collaboration between primary and tertiary mental health services and reduce overall healthcare costs.[330]

Successful implementation of shared care programs in mental health and wellbeing services will require effective information management strategies—including shared care plans and health records—with consumer consent and participation.

Under the shared care model anticipated by the Commission, a GP will be the consumer's main care provider, supported by professionals from the Area Mental Health and Wellbeing Service, who will deliver certain aspects of the consumer's treatment, care and support. This support might include primary or secondary consultation, consultation-liaison and education and capability building.

Case Study:

Project ECHO

Project ECHO (Extension for Community Healthcare Outcomes) is a guided practice model that was developed in 2003 at the University of New Mexico in the United States. It aims to extend capacity in rural and regional areas to manage chronic disease in primary care settings.

Project ECHO increases access to best-practice care and reduces geographical health disparities through hub and spoke networks that facilitate the sharing of knowledge, experience and expertise. Project ECHO connects community providers ('spokes') with teams of specialists at centres of excellence ('hubs') in regular real-time collaborative sessions. A brief lecture, followed by online case-based discussion, provides a platform to come together as a learning community.

The model enables clinicians and other providers in primary care to develop skills and knowledge in best practice in the care of people with complex needs. The primary care clinician retains responsibility for managing the patient with input from other participants.

Project ECHO now operates in 400 locations across the world in numerous medical fields. A 2016 review found that 'Project ECHO is an effective and potentially cost-saving model that increases participant knowledge and patient access to healthcare in remote locations'.

The researchers suggested that a number of factors explain its success, including the development of a 'community of practice' resulting in change in participants' behaviour; its cost-effectiveness; and improvement in patient care. This is achieved through its ability to use technology to leverage scarce specialist and academic resources, to share knowledge with primary care clinicians to help master complexity and reduce disparity. Each Project ECHO hub in turn is supported by a dedicated account representative from the ECHO Institute at the University of New Mexico.

Project ECHO can increase the quality of care and number of patients being seen in primary settings, reducing the need for patients to access resource-intensive tertiary services. The model promotes a system of care across primary, secondary and tertiary settings. In addition to capacity building, it builds relationships at local levels between clinicians, which assists with warm referrals (referrals where services support the person to connect to another service), and reduces the need for patients having to retell their story.

Goulburn Valley Health Joint Addiction and Mental Health ECHO
The Joint Addiction and Mental Health (JAMH) ECHO is an initiative led by Goulburn Valley Health's two divisions, Goulburn Valley Alcohol and Drug Service and Goulburn Valley area mental health service, supported by the ECHO Institute at the University of New Mexico.

Primary and secondary care services in the Goulburn Valley area, including community health service providers, GPs, medical specialists, alcohol and other drug clinicians, and maternal and child health practitioners, access an interdisciplinary panel of experts from across the state. This program supports workforce development and the learning needs of trainee doctors, nurses and allied health students in the local tertiary mental health, and drug and alcohol services.

JAMH ECHO sessions are held weekly. While these sessions are not formal secondary consultations, they provide an opportunity for participants to discuss cases with peers and experts in a tertiary specialist centre, much like 'hallway discussions', but over videoconference.

Lisa Pearson, coordinator of the JAMH ECHO, noted the benefits of Project ECHO in sharing scarce specialist resources in a collegial manner.

> It comes from a position of de-monopolising healthcare, about trying to access the scarce specialist resources and amplify them using a philosophy of 'all teach, all learn'.

Ms Pearson described how Project ECHO can improve care and treatment provided to the consumer.

> You have a network of health professionals from different disciplines meeting together to provide the best care around a particular client. The approach opens up new referral pathways and builds health professionals' confidence and competencies in mental health, and alcohol and drugs. People shouldn't have to wait for two years to get specialist input into their care. If they have a primary carer who is affiliated with JAMH ECHO, they can bring that case and have an entire community to assist with that case within a matter of weeks.

Ms Pearson said that since beginning in July 2020, they have grown to more than 100 members, with around 30 participants attending each week.

> We are doing a lot of work in the background to increase the representation and discipline diversity of service providers. We would also like to see Goulburn Valley Health's Project ECHO platform support more clinics using this model of care, whether that is in mental health and addiction, or mental health and other areas, for example, women and babies, or we could go in multiple directions. We will also be evaluating the efficacy of the JAMH ECHO in changing participants' behaviours and patient outcomes.

Source: RCVMHS, *Interview with Lisa Pearson*, September 2020; RCVMHS, *Inpatient Consultation Liaison Services Expert Roundtable: Record of Proceedings*, 2020.; Carrol Zhou and others, 'The Impact of Project ECHO on Participant and Patient Outcomes: A Systematic Review', *Academic Medicine*, 91.10 (2016), 1439–1461; Goulburn Valley Health, 'Joint Addiction and Mental Health' <www.gvhealth.org.au/jamhecho/> [accessed 25 September 2020].

General practices will be eligible to take part in a shared care partnership with a mental health and wellbeing service only if they have:

- practitioners with the skills and commitment needed to provide high-quality mental health care (for example, GPs who have completed training to deliver focused psychological therapies)
- capacity to coordinate consumer care across multiple health and other services
- resources and technology to collect data and to maintain clear communication with the Local Mental Health and Wellbeing Service or Area Mental Health and Wellbeing Service.

In addition to fulfilling these basic requirements, other features of strong shared care arrangements include:

- a structured and systematic approach to collaborative care, where primary and tertiary mental health providers share 'a common goal of improved mental health care'
- an evidence-based care model that is appropriate for the consumers who participate in the shared care program
- agreed care pathways and systems to monitor consumer outcomes, enabling the mental health expert to intervene early
- sufficient staffing to enable care coordination and linkage
- a well-established clinical governance framework.[331]

While the Commission is not prescribing a shared care model for Victoria's mental health and wellbeing services, Consultation-Liaison in Primary Care Psychiatry (CLIPP) is an evidence-based approach that services may choose to adopt. The CLIPP model was developed in Australia in the 1990s to link GPs with mental health specialists and provide shared care to consumers with complex mental health support needs. CLIPP comprised four main components:

- 'a consultation, liaison and education service provided by psychiatric consultants at participating general practices'
- 'the transfer of selected patients from community mental health services into general practitioner-based collaborative care'
- 'a clinical case register and reminder system managed by the specialist services used to actively promote follow up for transferred clients'[332]
- the use of 'relapse signatures' to promote early intervention for consumers with schizophrenia.[333]

In area mental health services where the CLIPP model was well established, up to 20 per cent of consumers were identified as eligible for a shared care program in general practice.[334] Evaluations of the model suggested positive health and wellbeing outcomes for consumers who participated in the program.[335] Notwithstanding this evidence, the Commission notes that updates to the model are likely to be required—for example, to reflect a greater focus on supported decision making in current legislation and contemporary practice.

Another established shared care model currently operating in Victoria is where a psychiatrist supervises a GP who is providing care to a consumer using clozapine, an antipsychotic medication. As mentioned in section 7.3.1, because of the drug's potentially serious side effects, the care of consumers is monitored by a psychiatrist.[336] Professor Copolov draws on the Adult Psychiatry Imperative consortium of psychiatrists to assert that clozapine coordination models may be associated with a significant lowering of mortality, not only because of the pharmacological properties of the medication but also because of the intensive and regular monitoring of blood tests, continuity of care and care coordination, which means that people have regular contact with clinicians.[337]

Shared care between primary care practitioners and Local Mental Health and Wellbeing Services or Area Mental Health and Wellbeing Services requires a high degree of care coordination and planning. The Commonwealth Government does already support certain models of shared care. A notable example is the Health Care Home model, which is funded by the Commonwealth Government. This model enables general practice, including Aboriginal community-controlled health organisations, to coordinate the care of consumers with chronic and complex conditions. By providing eligible practices with a bundled payment model, Health Care Home general practices are able to 'provide general practitioners, nurses and other health care professionals, greater flexibility to share care around an individual patient's needs and goals, and encourages patients to participate in and direct their own care'.[338]

The strong collaborative partnerships established through the provision of the supports described earlier will enable consumers to move more easily between primary and secondary and mental health and wellbeing services as their needs change. It will allow many other people to keep receiving their treatment, care and support in primary and secondary settings and avoid escalations of mental illness or psychological distress that may require higher-intensity or crisis responses by mental health and wellbeing services.

The Commission acknowledges these reforms, and those described earlier in this chapter, are ambitious and will take time to roll out and scale up across Victoria. Once implemented, these reforms will mean that people will be offered the right services and supports for their mental illness and psychological distress, at the right time.

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Chapter 8

Finding and accessing treatment, care and support

Recommendation 6:

Helping people find and access treatment, care and support

The Royal Commission recommends that the Victorian Government:

1. ensure people can access Local Mental Health and Wellbeing Services through a referral from a general practitioner or any other service provider, or through a discussion with the relevant service's access and navigation support worker.
2. ensure people can access Area Mental Health and Wellbeing Services through a referral from a Local Mental Health and Wellbeing Service or through direct referral from a medical practitioner.
3. ensure people can access Statewide Mental Health and Wellbeing Services through a referral from an Area Mental Health and Wellbeing Service.
4. promote, and co-produce with people with lived experience, a website that provides clear, up-to-date information about Victoria's mental health and wellbeing system that helps users to:
    a. understand their mental health needs;
    b. identify services and supports across all relevant provider types; and
    c. access online self-help resources.
5. collaborate with its funded non-government helpline services to improve helplines' connections with mental health and wellbeing services and to assist people to find and access treatment, care and support.

Recommendation 7:

Identifying needs and providing initial support in mental health and wellbeing services

The Royal Commission recommends that the Victorian Government:

1. ensure mental health and wellbeing services provide three 'needs identification and initial support' functions:

   a. access and navigation support;

   b. initial support discussions; and

   c. comprehensive needs assessment and planning discussions.

2. ensure these functions are delivered based on a philosophy of 'how can we help?' to enable people to be supported from their first to their last contact with mental health and wellbeing services.

8.1 Challenges in finding and accessing treatment, care and support

Chapter 5: *A responsive and integrated system* and Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services* discuss the Commission's approach to creating a more comprehensive, integrated and responsive mental health and wellbeing system.

Some of the main issues compelling the reforms described in these earlier chapters are the complexity and fragmentation of the current mental health system and the high threshold for access to Victoria's current public specialist mental health services. Many consumers, families, carers and supporters, service providers and academics urged the Commission to improve the ease of navigation for people who need help with mental health and wellbeing challenges.[1]

This chapter begins by examining in more detail how these issues affect people's experiences of trying to find and access mental health services—in particular, public specialist mental health services. It then presents evidence underpinning the Commission's recommendations for improving service navigation and access in Victoria's future mental health and wellbeing system.

These recommendations, which apply across all age groups, focus on:

- clearer, easier to find pathways into the new system of Local Mental Health and Wellbeing Services, Area Mental Health and Wellbeing Services and statewide services
- how people will have their needs assessed and responded to when they seek or are referred to mental health and wellbeing services
- how the Victorian Government will build the range of supports that everyone in the community can use to improve their mental health and wellbeing and to find services across the full spectrum of public, private, non-government organisations and other sectors. This includes a new mental health and wellbeing website and actions to strengthen current non-government organisations' helplines and their connections to mental health and wellbeing services.

In essence, the Commission's strategy seeks to make it much easier to find and access the right supports in a timely manner. Better system navigation will also contribute to more effective use of localised and lower intensity services and enable acute and tertiary-level services to be better targeted to those most in need.

In addition to the recommendations explained in this chapter, many of the Commission's other recommendations will improve system-wide service accessibility and navigability. Box 8.1 notes some of the main interdependencies between the recommendations explained in this chapter and the broader system design recommendations discussed in other chapters.

Box 8.1: Broad system design features that will improve service accessibility and navigability

The reforms discussed in this chapter build on earlier chapters that articulated the need for a new mental health and wellbeing system.

As described in Chapter 5: *A responsive and integrated system*, the reformed system will include public mental health and wellbeing services at the local, area and statewide levels. This includes 50–60 new Adult and Older Adult Local Mental Health and Wellbeing Services, 13 Infant, Child and Youth Area Mental Health and Wellbeing Services and 22 Adult and Older Adult Area Mental Health and Wellbeing Services. These services will provide a range of medical, psychological and other treatments and therapies, together with integrated wellbeing supports; education, peer support and self-help; and care planning and coordination. Face-to-face services will be complemented by services delivered via telehealth and digital technologies.

The new Local Mental Health and Wellbeing Services will mean more services are available closer to people's homes and that services are more strongly connected with, and responsive to, the needs of local communities.

The Area Mental Health and Wellbeing Services will build on, reform and expand Victoria's current public specialist mental health services, which include child and adolescent mental health services, child and youth mental health services, adult mental health services and aged persons mental health services. In a major reform, Area Mental Health and Wellbeing Services will be delivered through partnerships between public health services or public hospitals and non-government organisations that currently provide wellbeing supports. The delivery of the front-end functions outlined in this chapter, and the treatment, care and support people will access, will be shaped by these new partnerships.

Within the new mental health and wellbeing system, several recommended reforms will make it easier for people to find and access the services they need:

- Chapter 5: *A responsive and integrated system* outlines an approach to better system planning through a service capability framework, streamlining of area-based catchments, and the abolition of fixed catchments.
- Chapter 7: *Integrated treatment, care and support in the community for adults and older adults* describes how primary and secondary care providers will be supported to help people with mental illness or psychological distress and connect them with other services they need.
- Chapter 21: *Responding to the mental health and wellbeing needs of a diverse population* describes initiatives to improve service access and navigability for diverse and marginalised communities.
- Chapter 35: *New approaches to information management* describes efforts to join up services through better communication and information sharing. This is complemented by Chapter 29: *Encouraging partnerships*, which discusses opportunities for Commonwealth–state co-commissioning of services.

People who use Victoria's current mental health services enter the system in many ways depending on the services available in their local area and their knowledge, preferences and needs. Currently, the places people—including families, carers and supporters—go to find and access treatment, care and support include:

- private services, such as private GPs, specialists and mental health practitioners (for example, private psychologists and other allied health clinicians)
- government health and community services (for example, primary care and secondary care providers in community health services, schools and maternal and child health services)
- non-government organisations, including those that provide wellbeing supports and alcohol and other drug services
- access and referral services provided by Primary Health Networks
- helplines such as Lifeline and the Beyond Blue Support Service
- peer support and advocacy services
- triage phone lines in Victoria's area mental health services—where triage is a process of initial clinical assessment to determine the person's need for mental health or other services and the nature and urgency of the care required[2]
- crisis and emergency services such as area mental health services' crisis assessment and treatment teams, emergency departments, police and ambulance.

The services listed above may provide mental health treatment, care and support directly or, if they are unable to do so, refer people to alternative services for support.

However, the Commission heard repeatedly that finding the right treatment, care and support through this patchwork of services is challenging. For example, a mother of a teenager experiencing co-occurring mental illness and addiction described her experience of trying to navigate different services when her son was very unwell:

> **It seemed like there were disparate units all over the place doing different things and employing different techniques … my son, you know, tried to kill himself as well. So we had that on top of it … as the person in crisis, or the carer trying to navigate the system … when I was going through it, it … was a maze … And it didn't quite make sense to me what I was looking for, what I needed or how do I get in the door and then feel safe with it?**[3]

This quote reflects the experiences of many people. Some challenges that lead to this type of experience are discussed further in this chapter.

8.1.1 Complicated and fragmented pathways into services

Victoria's current mental health system consists of a range of Victorian Government, Commonwealth Government, private and non–government funded services that are not well connected with each other.[4] This is compounded by a lack of connection between the mental health system and other systems that people might need to recover from mental illness or psychological distress, such as the broader health system, community-based organisations, legal and non-legal advocacy services, and housing and social services.[5] The current system is so complex that many service providers are unaware of the full range of services available and how to connect people to them.[6]

Many people with lived experience of mental illness or psychological distress told the Commission about how the complexity and fragmentation of the system makes it difficult to find and access timely and appropriate mental health services. This results in people being unable to get the right support when they need it—with sometimes tragic consequences for individuals and families, carers and supporters, as well as increased demand for crisis, justice and emergency services.

These issues are widely understood by policymakers and others familiar with the mental health system. In releasing the Productivity Commission's *Mental Health Inquiry Report* in November 2020, the Prime Minister noted that the system 'fails too often because it is too complicated to navigate' and is 'plagued by a bewildering array of unpredictable gateways to care'.[7] The Prime Minister also said that states and the Commonwealth Government must work with each other, and with non-government and private organisations, to overcome these challenges and the resulting barriers and service gaps experienced by people needing help with their mental health.[8]

These challenges are present across age groups. For example, the Victorian Auditor-General's Office presented a report in 2019 that found '[s]pecialist child, adolescent and youth mental health services do improve many of their clients' outcomes, but they do not meet service demand or operate as a coordinated system.'[9]

As discussed further in Chapter 29: *Encouraging partnerships*, many submissions and witness statements highlighted the need for the Commonwealth and Victorian governments to work together to clarify referral pathways. In its submission to the Commission, St Vincent's Hospital Melbourne stated:

> **Clarity is needed regarding what services can be delivered in Area Mental Health Services and primary health care settings. Where they intersect, how they support each other and clearer referral pathways are needed. Services should be able to assist people to get the help they need at the time they need it.**[10]

As this quote suggests, because the system is so complicated, the role and focus of different types of mental health services is not well understood by the community.[11] Consumers, families, carers and supporters said they need better communication about mental health services' offerings, models of care and the roles and responsibilities of workers.[12] This information is needed at all parts of their journey but particularly at the start. Many consumers who had been using services for some time commented on the difference it would have made if the knowledge they had now was available when they first entered the system. For example, one consumer, who is now employed as a peer worker, said, '[t]here are a lot of things you learn after seven years … that would have been helpful to know in the first six months.'[13]

Many people told the Commission that pathways into the mental health system need to be streamlined, better integrated and better understood by service providers.[14] One community witness reflected on the challenges accessing support in the current system:

> I found accessing mental health services to be quite difficult. First, because I was living alone, I hadn't told my family, so finding the money to see a psychologist was difficult. Secondly, no one was willing to see me because, as one psychiatrist put it, I had too many complex psychiatric issues for them to deal with. It took so much persistence to access any services and by the time I finally found a service, things had gotten much more severe.[15]

Further, the way mental health services communicate and collaborate with primary care services and other referrers is critical to consumers' experiences of care continuity and coordination.[16] This communication is currently challenging and means consumers may need to tell their story multiple times, which goes against a patient-centric, trauma-informed approach to treatment, care and support.[17]

The personal story from Dr Cameron Martin, a Melbourne GP, highlights opportunities to improve referrers' experiences when trying to connect people with mental health services.

8.1.2 Problems in accessing existing public specialist mental health services

The Commission's interim report showed that the community's need for mental health services exceeds the system's capacity to respond.[18] While public specialist mental health services are only one of several service types that currently help people living with mental illness or psychological distress, the Commission's analysis of data on the estimated need for these services compared with the number of current consumers shows a substantial gap in service supply. This analysis is provided in Chapter 5: *A responsive and integrated system*.

To manage demand, area mental health services have raised their thresholds for entry to community-based services.[19] Eligibility and priority for these services is generally based on acuity of need and an assessment of the immediate risks to self or others.[20] Resource-limited area mental health services currently see only the most unwell, such as people experiencing severe psychosis and those considered at high risk of harming themselves or others.[21] As Dr Neil Coventry, Victoria's Chief Psychiatrist, explained to the Commission:

> While the specialist mental health system has evolved incrementally since the 1990s, growth in demand has increased at an unexpected rate … Increased demand has led to a higher threshold for consumers to access specialist services, raising the level of acuity expected to be treated in the community.[22]
>
> In response to high demand, mental health service providers focus on the most acute and severely unwell consumers. Consumers may receive less treatment and treatment later in an episode of illness resulting in increased severity of symptoms.[23]

Personal story:

Dr Cameron Martin

Cameron is a GP in Melbourne, with extensive experience in treating people with mental health challenges.

> Treating mental health comprises about one third of my work. I have worked with patients for over 15 years in the community and have first-hand insight into the practical problems that patients face seeking appropriate treatment.

Cameron said that in his experience, accessing support for people with severe mental illness can be challenging, especially when he compares it with referring people to other specialist services.

> It is important to appreciate the contrast between the way mental health (psychiatric) services are now provided, compared to the rest of healthcare. In every other part of medicine, the approach to services is straightforward … The problem is diagnosed, treated at that contact and, if necessary, referrals are made to appropriate specialist medical or allied health providers.

Cameron says he has required expert assistance to support his patients, which he has not been able to access in the public mental health system.

> There are times when I specifically want an expert opinion from a specialist psychiatrist that would make a significant difference to treating the patient. A common example would be establishing a diagnosis of bipolar affective [disorder], which is often subtle. I cannot get that in the public health system in Victoria.

He has also often not been able to refer people to the public mental health system for treatment, care and support.

> Referrals are often rejected out of hand, and never redirected to an alternate service if the first service does not want to take them on.

Cameron suggests there should be a simple central intake process, because it is currently too complicated.

> I may try to refer to the local area mental health service, but there is no central referral system. Each part of the service has its own separate referral requirements, which change frequently.
>
> To illustrate, in my local area, the local crisis assessment service, aged persons psychiatry service, child and adolescent mental health service and primary mental health service are all run by the same area mental health service, but have their

> own unique referral processes. This often involves complicated proformas and specific phone calls, just to make a referral.

Cameron also suggests that the different treatment, care and support options should be clearer, with pathways such as outpatient psychiatry easily available for referral and assessment, as well as the various other services that are required.

> For mental health (psychiatric) care, beyond the general practitioner, the services are a mess. If I would like a patient to see a public psychiatrist, or wholly publicly funded psychologist, there is no straightforward process for this. If I want to organise a case manager, or some assistance with peer support, or to find some social activities for a patient to engage with, or special assistance finding suitable accommodation, there are no defined pathways for this.

Cameron says there should be clear and uniform naming conventions of services and roles across the state, with a reduction in the types of services, to make the system easier to understand and more accessible.

Cameron also advocates for better access to suitable accommodation, among other supports for people with severe mental illness in the future mental health system.

> There would be access to stable, appropriate accommodation and there would be access to financial support. There would also be support services for the family and friends of the patients.

Source: Dr Cameron Martin, *Submission to the RCVMHS: SUB.0002.0028.0508*, 2019.

Reflecting the mismatch between service supply and demand, area mental health services' telephone triage services are now overwhelmed.[24] Figure 8.1 shows there has been steady growth in triage contacts in recent years. The 2019–20 numbers have been affected by additional services contributing to the triage minimum dataset, as noted underneath the figure. The COVID-19 pandemic may also have had an impact. While data on the impacts of COVID-19 are still emerging, Department of Health and Human Services data suggest there was a slight increase in triage episodes after February 2020, especially in those requiring an emergency or crisis response.[25]

The data represent only those people whose calls to triage lines were answered. The department does not collect data on waiting times or non-answered calls to triage, which makes it impossible to know the true extent of demand for area mental health services. Nor is it possible to say whether the people whom triage clinicians refer or direct to other services actually connect with those services.

Many health services informed the Commission that long wait times and failure to answer or follow up on calls are major issues.[26] For example, the Commission obtained data from one metropolitan health service showing that 43 per cent of triage calls were abandoned by the caller in July 2019. Although this service's call-answer rate improved over the next 12 months (and the abandonment rate was 12 per cent in June 2020), the Commission's evidence suggests there are systemic problems with the responsiveness of triage services.

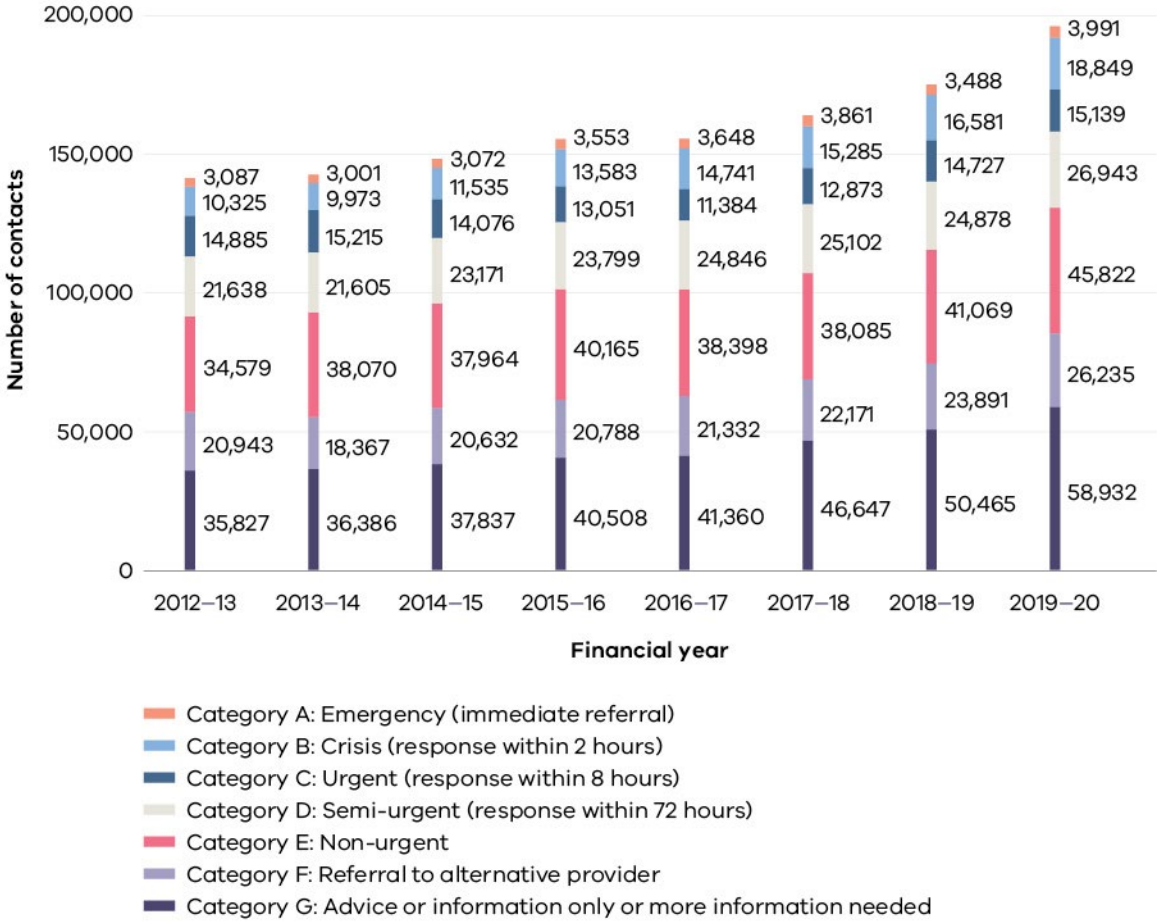
The following quote illustrates feedback to the Commission from many health professionals, such as GPs, who said they do not have the time to wait on hold for triage lines to be answered during busy clinics, and that mental health services provide no other way for them to refer people.

> **It's not the fault of the clinicians but calls go to message bank because the service is … understaffed. I can account for at least one time I left five messages regarding a client with a 20 year history of mental illness and I didn't have one call back. Health professionals can't get a response from triage when they have a patient in the community. That isn't an ok system especially when callers are people with a mental illness or their carers and their families.**[27]

As shown in Figure 8.1, many of the calls that are answered do not result in action by Victoria's area mental health services. This figure shows that 43.5 per cent of the 195,911 triage contacts in 2019–20 resulted in the person receiving advice or information only or referred to an alternative provider.[28] This 'turn away' rate was 48.1 per cent for self-referrals and contacts made by people's family, carers and supporters, compared with 38.8 per cent for referrals made by service providers, such as GPs, emergency departments and drug and alcohol services.[29]

Further, it appears that even when referrals directly from consumers, families, carers and supporters receive some initial action by the mental health service—such as a clinic-based appointment—people referred from these sources are relatively unlikely to receive ongoing services. In 2019–20, only 11.4 per cent of Victoria's new registered public mental health consumers had their source of referral listed as 'self' or 'family'.[30]

Figure 8.1: Number of triage contacts, by triage category, all ages, Victoria, 2012–13 to 2019–20



Source: Department of Health and Human Services, Triage Minimum Dataset 2012–13 to 2019–20.

Notes: Not all campuses reported to the Triage Minimum Dataset in previous years. Prior to 2019–20, some services only reported data from the centralised triage telephony service. Reporting to the Triage Minimum Dataset began for a number of additional campuses in 2019–20. Data excludes the Albury campus of Albury Wodonga Health.

The Commission also received extensive feedback about inconsistent and unclear service entry processes across different public specialist mental health services, and differences in the types of assessment and service responses provided to people with similar levels of need.[31] This creates difficulties for consumers, families, carers and supporters, as well as for professionals who need to refer people to public specialist mental health services. The Centre for Psychiatric Nursing captured the current challenges and necessary reforms:

> A quality first contact is essential for people who are newly accessing [mental health] services and for people seeking help in crisis. There also needs to be an effective, accessible resource in response to enquiries and referrals from primary care settings, such as GPs and community health. At present people, families and primary care colleagues report a 'hit and miss' experience, differing over sites and even within services.[32]

8.1.3 Being 'screened out' of services without receiving help

The pressures on triage services mean that clinicians may not have time to properly understand the needs of consumers who do not meet their high entry thresholds.[33] Their responses to requests for assistance often focus on risk management and protecting their services from excess demand, rather than trying to relieve people's distress and, if necessary, helping them gain access to mental health services or other forms of support.[34] According to a contributor to Victoria Legal Aid's *Your Story, Your Say* submission:

> over my journey I have learnt that the only way to get help is to risk your life. The system only responds to risk and isn't trained to deal with distress. A lot of people die trying to get the help they need.[35]

Associate Professor Ruth Vine, the then Executive Director of NorthWestern Mental Health, Melbourne Health, explained that people's experiences were related to a lack of funding for services and staff:

> When a system is under pressure, staff tend to put up barriers and give reasons for not accepting a person for care, rather than keeping an open-door policy.[36]

These barriers are not confined to public specialist mental health services. The Commission received evidence about people being 'screened out' of multiple services.[37] Some people 'bounce around' the system, entering many wrong doors and having many assessments with little therapeutic support.[38] A consumer who participated in the Commission's focus group on entry pathways said:

> I've had mental health problems since I was a teenager. And so, I've been trying to access the system since then, I guess. I've got really good support now, but it took a long time to find good support, so lots of referrals to services and services would say, oh no our service isn't appropriate, try this one and then I would try it. And then they would say the same thing. And so … there was a year or two years before I could even get any help. And then that kind of wasn't the right help. And then a few years until I could receive proper help. So that's kind of my experience as a consumer.[39]

While it is clear that mental health services are under pressure, a culture that is overly focused on managing demand and gatekeeping can lead to negative experiences for help-seekers and referring service providers. Dr Paul Denborough, Clinical Director of Alfred Health's Child and Youth Mental Health Service and headspace, told the Commission in a personal capacity:

> I believe that people are still wary of contacting mental health services, and if they are turned away … during that initial contact it can be particularly discouraging.[40]

The discouragement noted by Dr Denborough can result in lost opportunities to prevent the escalation of mental illness or psychological distress by offering immediate support when people, or their families, carers and supporters, first ask for help.[41] The Victorian Mental Health Complaints Commissioner highlighted that negative experiences of asking for care can cause considerable trauma and distress.[42] Research suggests that having positive experiences with health professionals is important in promoting future help seeking among young people experiencing mental illness or psychological distress.[43]

8.1.4 Lack of proactive connection to other services and supports

Currently, the Victorian Government's triage guidelines require that area mental health services proactively refer people to other services in cases where they are assessed as not needing public specialist mental health services:

> Where it is determined that the mental health service is not the most appropriate service, every effort should be made to proactively link the consumer (or carer/referrer) with a more suitable service. Where appropriate, the clinician should make contact with this service on behalf of the person requesting assistance.[44]

This guidance is similar to the concept of a 'warm transfer' or 'warm referral', which is defined in the Commonwealth Government's consultation paper on the potential service model for its adult mental health centres as:

> the [Adult Mental Health] Centre actively communicates with the service to which the individual is connected to provide essential information about their needs before transferring them. Support is maintained for the individual by the Centre until they are received by the service.[45]

Influential research in the 1980s demonstrated that a warm referral (rather than a passive recommendation for people to themselves contact another service) was more effective in getting people with alcohol use problems to connect with treatment services.[46] Further, a report commissioned by the Queensland Mental Health Commission, *One Person, Many Stories: Consumer Experiences of Service Integration and Referrals in Far Western Queensland*, indicated that warm referrals were essential for improving uptake of referrals across mental health services.[47]

Currently, despite the government's policy direction, people contacting area mental health service triage lines are often not connected with or even directed to appropriate supports within or outside the mental health system.[48] The Commission notes that some other services in the mental health system have prescribed warm referrals as standard practice. For example, if a headspace centre itself is not able to address any presenting issue, then a warm referral that ensures the young person gets to an appropriate service is required.[49] The Victorian Government's Orange Door family violence services also makes warm referrals, including phoning the service for the person, passing on information to the service with the person's consent and, in some cases, directly helping them to navigate the service system.[50]

While recognising the pressures on triage clinicians in Victoria's current mental health system, the Commission considers that the mental health and wellbeing services of the future must do more to help consumers, families, carers and supporters to connect with other services, subject to appropriate consent and the person's choices and preferences. This is particularly important because, as discussed in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*, not all people experiencing mental illness or psychological distress want or need high-intensity support services. Several Commission witnesses said that existing service entry points are heavily concentrated in the public specialist mental health system, and governments need to promote other forms of support, including self-help.[51]

Similarly, the Productivity Commission's *Mental Health Inquiry Report* focused on the opportunity to more widely use 'low cost, low risk and easy to access services', including digital mental health services. The Productivity Commission suggested that such services were under-used on account of 'a lack of information—for referring [service providers] and for consumers—about the existence of such services and their clinical and cost effectiveness'.[52]

Mr Bill Buckingham, Director of Buckingham Consulting, speaking in a personal capacity, explained how lower intensity services must be accessible so the highest-level services remain available for people with the greatest needs. Mr Buckingham, who has long history and expertise in mental health system design, presented a schema in which the 156 packages of care defined in the *National Mental Health Service Planning Framework* are classified into five levels.[53] Mr Buckingham said:

> If we do not have the right supports at level 1 and a fully functioning primary care system at levels 2–4, then the level 5 services will be flooded with demand … Successful implementation of a stepped care model requires: (a) an organised system that allocates people to the right level of care; (b) informed referrers (mainly GPs) who understand how to use self-management and low intensity options, and who trust that those options can meet an individual patient's needs; (c) an effective system of self-management and low intensity assistance options; and (d) community acceptance and trust.[54]

8.1.5 Lack of support for navigation

The Commission heard on many occasions about the frustration that people experience when trying to find mental health services for themselves or someone they care for. For example, in research undertaken by ReachOut, parents indicated that 'not knowing where to get help' was a major barrier to accessing help for their child's mental health challenges.[55] These barriers are even stronger for people whose first or preferred language is not English, or for people who are unfamiliar with Victoria's mental health system.[56]

People's attempts to find mental health services or supports often start with an online search.[57] However, Victoria does not have a website with comprehensive, up-to-date and easy-to-navigate information about services and how to access them. The Victorian Department of Health has several webpages about mental health, but these are spread over numerous websites and are difficult to find. Mr Angus Clelland, CEO of Mental Health Victoria, explained the consequences for people trying to find online information about mental health services and supports:

> At the moment, because the mental health system is so fragmented, the consumer loses out. If, for example, you did an internet search for "mental health services" or "help near me", you would be overwhelmed with websites about individual providers and government agencies that you probably have not heard of before. It is really difficult to know where to start.[58]

A range of non-government organisations run helpline services that provide advice and referral for people experiencing mental illness or psychological distress. As discussed in section 8.4, these helplines are not well connected with each other or with on-the-ground mental health services. Unlike most other states and territories, Victoria has no statewide phone number for its public specialist mental health services.

Some people with complex support needs require assistance to connect with and navigate between services. In the past, many psychosocial support services had staffing positions that helped people access the range of services they need. These positions have diminished as demand and cost pressures on services have increased, and people who are not eligible for the National Disability Insurance Scheme can no longer access many of these services.[59] This leaves people without support when they are trying to find the right services.[60]

Ms Alexandra Sutherland, whose personal story is presented in this chapter, told the Commission that many services that previously helped people living with mental illness or psychological distress to navigate the system are now no longer available.[61]

8.1.6 Barriers that some people face

The Commission's interim report identified inequalities in services available to different groups in the community. Whether mental health services are accessible depends on the person's income, private insurance status, location, language, culture and other factors.[62]

Among the main access barriers that the Commission noted in its interim report were challenges faced by people who do not speak or read English well, especially in getting timely interpreting and translation services. Government-funded language services do exist, but they are often difficult to get at short notice or in less common languages.[63]

The Commission also received evidence of the difficulty finding services to meet the needs of specific communities—for example, services for LGBTIQ+ people.[64] As discussed in Chapter 21: *Responding to the mental health and wellbeing needs of a diverse population*, services such as Switchboard (a 'peer based, volunteer run support service')[65] play an important role in connecting consumers to mainstream services and can advocate on their behalf if they are experiencing access barriers or poor care related to their sexuality.[66]

Many Aboriginal people obtain mental health treatment from 'mainstream' mental health services and, reflecting their higher level of need for mental health care, access these services at a higher rate than other Victorian people.[67] Although some services—such as those at Mildura Base Hospital and Goulburn Valley Health—build cultural competency through partnerships with Aboriginal community-controlled health organisations (ACCHOs), a 2014 Victorian Auditor-General's report indicated that such collaboration is not the norm.[68]

In response to its finding that mental health services often do not respond in culturally appropriate and safe ways to the needs of Aboriginal communities, the Commission's interim report recommended establishing or expanding multidisciplinary social and emotional wellbeing teams in every ACCHO in Victoria.[69] To support this work, Area Mental Health and Wellbeing Services will develop partnerships and collaborative working arrangements with ACCHOs to ensure continuity of care for consumers. Mental health and wellbeing services will also provide practical assistance to help ACCHOs—for example, through clinical expertise and effective service partnerships—where necessary.[70] Chapter 20: *Supporting Aboriginal social and emotional wellbeing* discusses these reforms in more detail.

People in rural areas, and those experiencing socioeconomic disadvantages, also face barriers to accessing mental health services. The Commission's interim report highlighted that access to mental health services varies across areas of the state.[71] As expressed by a group of leading mental health clinicians and academics:

> rural areas have high transport disadvantage, and there is insufficient investment in telehealth … Distances are huge, and populations are more dispersed. It takes longer for travelling clinicians to get to a person and then more time to get to the next person. Such travel times are not counted for as 'activity' in any sort of planning, or financial or case-load management.[72]

Across Victoria, the distribution of mental health services is not well aligned with need. Australian mental health surveys—the *Second Australian Child and Adolescent Survey of Mental Health and Wellbeing* and the *National Survey of Mental Health and Wellbeing*—suggest there is a higher prevalence of mental illness in areas with high levels of socioeconomic disadvantage.[73] Unfortunately, despite there being higher need, there are fewer mental health services in these areas. This is mainly due to the marked under-representation of GPs and private mental health practitioners in these areas.

The misalignment of service need and availability is especially evident in services subsidised through the Medicare Benefits Schedule (for example, under Better Access).[74] In comparison, while there are still inequities in the distribution of state-funded community mental health services, they generally have greater reach to the most disadvantaged communities and rural and regional areas.[75]

Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services* analyses a wide range of barriers to accessing primary and secondary mental health care, including gap fees (out-of-pocket costs) to access private practitioners and services. The Commission was told that for people on low incomes, the out-of-pocket costs associated with private psychologists or psychiatrists could be a fundamental barrier to access.[76] Gap fees can also be a substantial challenge when a consumer has support needs that mean they need more visits or sessions.[77]

The Commission's recommended actions to improve service access and navigability for diverse communities are discussed in various chapters of this report, as outlined in Box 8.2.

Box 8.2: The Commission's recommendations to improve service access and navigability for diverse communities

A range of recommendations made by the Commission will help reduce the service access and navigation challenges experienced by some people in the community.

Other chapters of this report highlight that, in the reformed mental health system, services will be planned and commissioned to recognise and respond to the diversity of the communities they serve. Responsiveness to the diversity of communities has been identified as a critical element of the community-based mental health and wellbeing service model described in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*.

The recommendations in Chapter 20: *Supporting Aboriginal social and emotional wellbeing* build on the recommendations for Aboriginal communities contained in the Commission's interim report.

Chapter 21: *Responding to the mental health and wellbeing needs of a diverse population* discusses the needs of diverse communities in detail. The recommendations made in that chapter aim to increase access to professional translation and interpreting services, including for the Deaf community, and to strengthen specialist support for the LGBTIQ+ community.

As described in Chapter 33: *A sustainable workforce for the future*, expanding the presence of Koori mental health liaison officers and liaison or peer support roles to support LGBTIQ+ and culturally diverse communities will strengthen the diversity and responsiveness of services.

In Chapter 34: *Integrating digital technology*, the Commission recommends that the Victorian Government draw on examples such as the program it began during the COVID-19 pandemic to supply phones and extra mobile data to consumers of public mental health and wellbeing services who wish to use digital mental health services but are otherwise unable to do so.

Implementation of the Commission's recommendations in the current chapter will include:

- co-design of the proposed Victorian mental health website with people from diverse communities, as well as including links to supported online treatment and services that meet the needs of people from culturally diverse backgrounds
- expanded use of telehealth services for assessing people's needs and providing initial support, which will assist people in rural and remote areas. The increased delivery of services via telehealth and digital technologies will also open up opportunities to make culturally and linguistically appropriate services more available across the state.

Personal story:

Alexandra Sutherland

Alexandra works for a community health service and her first full-time job was as a peer worker. She reflected on the irony that the condition she once thought would end her life became the reason she was employed in her role.

Alexandra recalls that when she was about 23 years of age, she sought help for her mental health through her GP and a psychologist, but recalls feeling they did not seem to consider the social factors that may have been contributing to her sudden decline in mental health.

Alexandra said that not long after that she ended up in hospital when she became suicidal. She wishes she could have known about and had access to more options when she was unwell, such as a community mental health service.

> Even though I'd studied psychology and counselling, I didn't even know about support groups or community services.
>
> There weren't any options like a community mental health service. While the clinical workers offer you a lot of empathy most of the time, it's not the same as making you feel human. Because you're not feeling human, you're not feeling in your body. So having someone remind you would be nice.

Alexandra has since been able to reflect on and consider how her mental health issues were related to family violence and trauma. At the time, she did not discuss these issues with her psychologist and thinks she may have opened up more in a non-clinical relationship.

> I think that maybe if I had a support worker or someone to just check in with on a casual basis, I'd have been able to form the type of rapport that I needed, rather than a clinical rapport with someone.

Alexandra has also felt more comfortable talking with people on telephone helplines, compared with contacting clinical triage services.

> With the community model, it feels more comfortable, it feels like there's a better understanding of the spectrum of mental health and that you can have a more honest relationship.

Alexandra hopes that the future mental health system will include more access and options for people to use community services.

> I think one of the big benefits to community mental health services as compared to clinical care services is the fact that most people in any challenging situation need a wraparound service, not just to cover one sole thing.

Alexandra says being able to refer people to other social and community options is an important feature of community services, and they apply the 'no wrong door policy'.

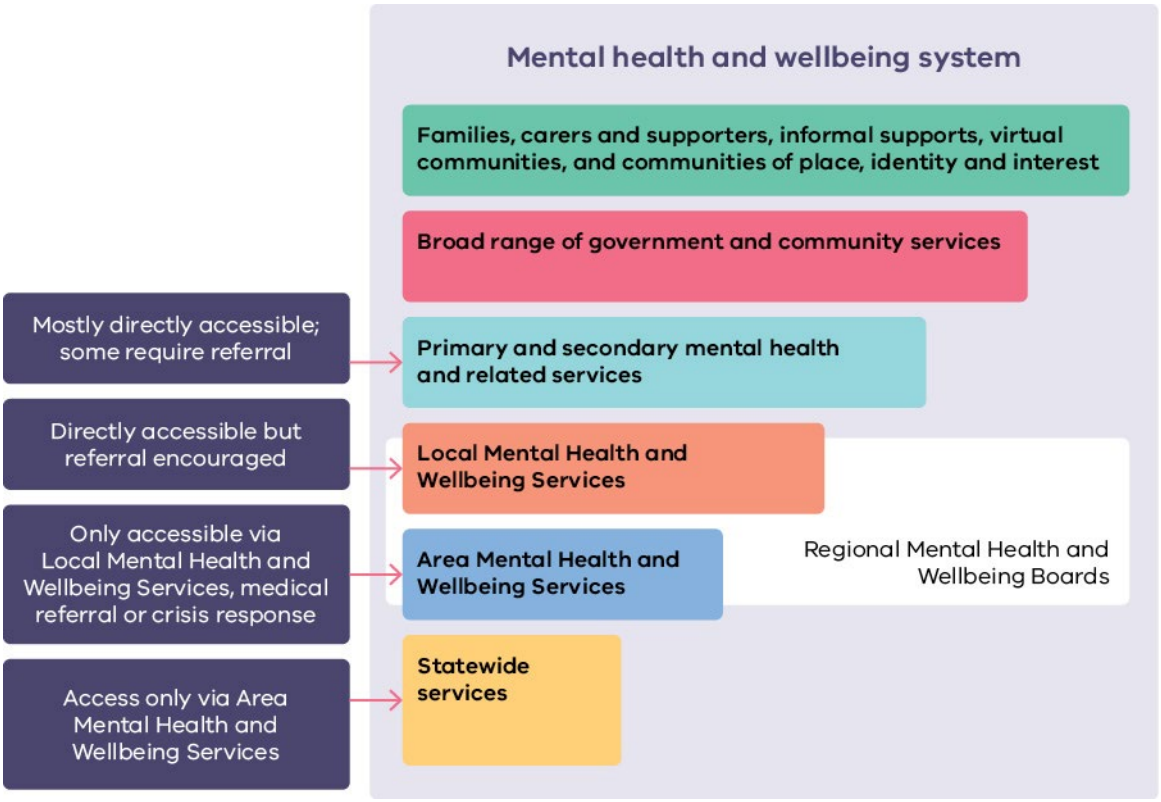
> One of the things that frustrates me so much about some services out there is that you might not be eligible, because you tick too many boxes. People try and handball situations when really you just need an all-round approach. I just don't think you can have that without having community mental health services. I've never seen any other services be able to do it.

Source: RCVMHS, *Interview with Alexandra Sutherland*, November 2020.

8.2 Pathways into new mental health and wellbeing services

Figure 8.2 is a high-level overview of how people will access services in the reformed mental health and wellbeing system.

Figure 8.2: Access to a responsive and integrated system of treatment, care and support



As shown in Figure 8.2, most independently governed primary and secondary care providers are directly accessible to the community, although some may require a referral. While Local Mental Health and Wellbeing Services will also be accessible to anyone in the community, graduation to the more intensive and specialised services delivered by Area Mental Health and Wellbeing Services and statewide services will be carefully managed via a new referral system. This reform acknowledges the important role GPs and other primary care providers can play in providing mental health treatment, care and support, and the value of well-connected services working together to support people experiencing mental illness or psychological distress. Like referral pathways in other areas of health, this reform will balance the system so that higher intensity supports are focused on and available to those most in need but are still accessible via clear referral pathways from primary and secondary care services.

Figure 8.3 gives an overview of how Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services will work with each other to ensure people access the right level of treatment, care and support at the right time. The 'initial support discussion' and the 'comprehensive needs' assessment and planning discussion' shown in Figure 8.3 are the mechanisms through which people will be matched to services, including short-term or ongoing care planning and coordination. These components of the new service model are discussed in section 8.3.

The new pathways to access mental health and wellbeing services in the future system are further explained throughout this section.

8.2.1 Widely accessible Local Mental Health and Wellbeing Services

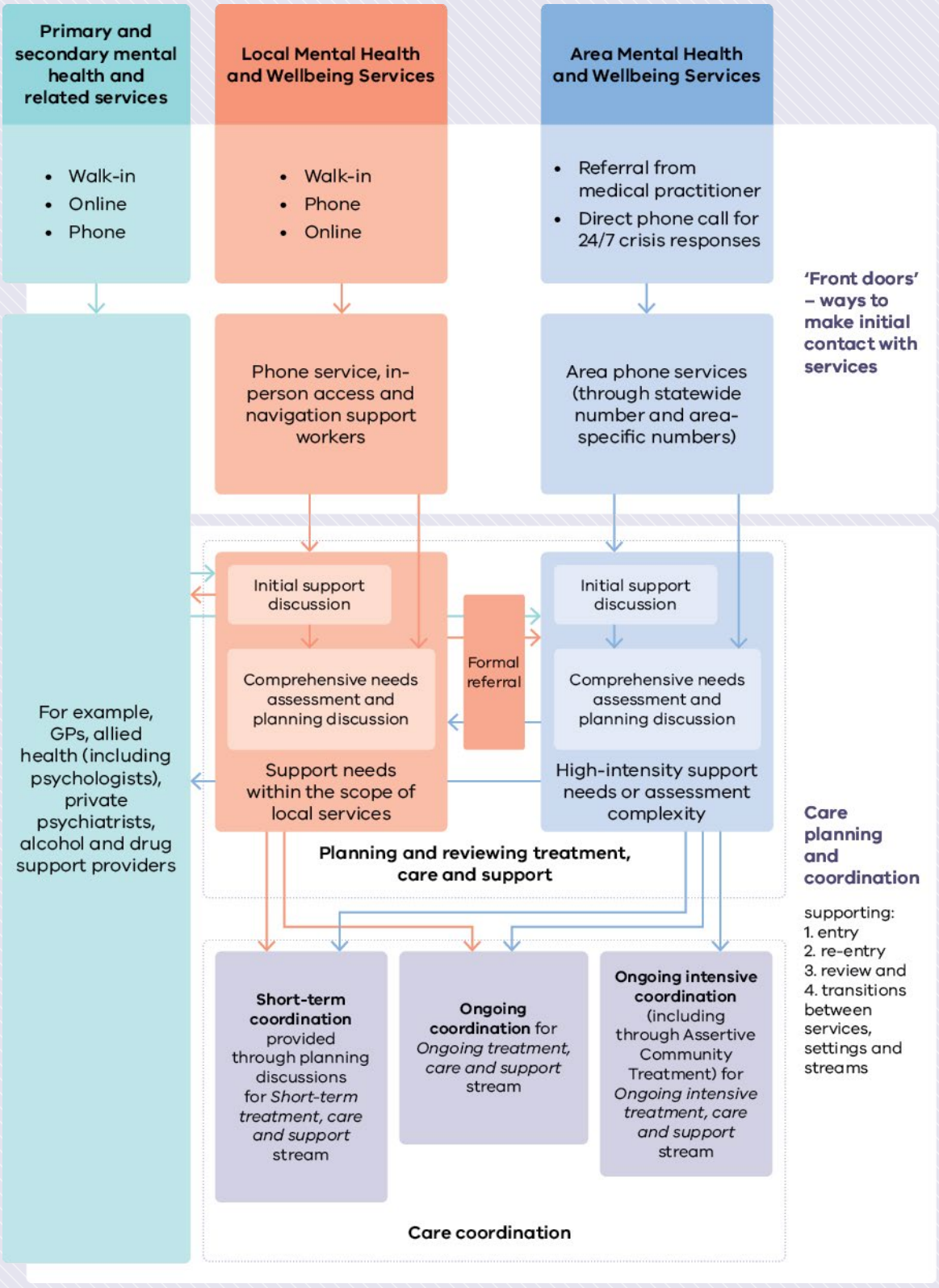
In the reformed mental health and wellbeing system of the future, most people who need treatment, care and support from public specialist mental health services will access the system primarily through Local Mental Health and Wellbeing Services across Victoria. The numbers and providers of Local Mental Health and Wellbeing Services will vary across the age groups. For example, once established, there will be 50–60 of these services in the adult and older adult system. For young people, Local Mental Health and Wellbeing Services will initially be the network of headspace centres.

The system of locally accessible services will build a wider front door to a fuller and more integrated range of public mental health and wellbeing services. Compared with the current system, a broader group of people will be able to access these services. Where necessary, they will be helped to connect with additional or alternative supports outside the mental health and wellbeing system or with Area Mental Health and Wellbeing Services if they need more intensive treatment, care and support (including bed-based services) that the Local Mental Health and Wellbeing Service cannot provide.

This fundamental part of the Commission's reform agenda will make it easier for people of all ages to get help earlier—in culturally inclusive services close to where they live. Local Mental Health and Wellbeing Services will provide a welcoming and comfortable drop-in space during extended business hours (for example, 8.00 am to 8.00 pm). This will be led by the access and navigation support workers described in section 8.3, who will offer an alternative 'soft entry' to the system for those who prefer that entry point. Access and navigation support workers will greet and support people who seek help, with specialist backup available as required.

Each Local Mental Health and Wellbeing Service will have a phone contact for enquiries from referrers and the general community. Contact details and information about the service will be promoted to the community and clearly explained on the service's website.

Figure 8.3: Entry pathways to Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services



Local Mental Health and Wellbeing Services will receive support (such as primary and secondary consultation) from Area Mental Health and Wellbeing Services to help them assess and care for people with more complex support needs. Associate Professor Steven Moylan, Clinical Director for Mental Health, Drug and Alcohol Services at Barwon Health, gave an example of how some area mental health services are already playing this role in the system—in this case using opportunities presented by digital technology:

> **A simple example that may highlight this opportunity is the possibility for Area Mental Health Services to partner with community mental health organisations via telehealth platforms. In our region, we are exploring a partnership with Bellarine Community Health where consumers could utilise their infrastructure to access a safe space, close to home, with reliable infrastructure, to receive specialist services via telehealth.**[78]

8.2.2 Accessing higher intensity supports in Area Mental Health and Wellbeing Services

Once the reformed system is established, consumers will access higher intensity supports in Area Mental Health and Wellbeing Services only when they need treatment, care and support that cannot be provided by a Local Mental Health and Wellbeing Service.

While some consumers will require longer term or even lifelong care from Area Mental Health and Wellbeing Services, in most cases these services will aim to assess, stabilise and plan for the consumer to return to their Local Mental Health and Wellbeing Service or GP for ongoing treatment, care and support. For example, an Area Mental Health and Wellbeing Service might see a person for a short time during a period of crisis before working collaboratively with their Local Mental Health and Wellbeing Service to provide continuing care, with a scheduled review from the area service.

As discussed in Chapter 9: *Crisis and emergency responses*, Area Mental Health and Wellbeing Services will provide crisis responses, via 24/7 telephone lines, directly to anyone in the community.

In other circumstances, access to Area Mental Health and Wellbeing Services will be through:

- referral from a Local Mental Health and Wellbeing Service
- referral from a GP or other medical practitioner.

The introduction of the requirement for a referral to access Area Mental Health and Wellbeing Services will align the public mental health and wellbeing system with the Commonwealth Government's requirements for Medicare-subsidised access to private psychiatrists. The introduction of this referral requirement will be staged in each area to ensure Local Mental Health and Wellbeing Services are established before referral requirements are introduced. During the transition period, when Local Mental Health and Wellbeing Services and referral pathways and processes are being developed, existing triage lines will continue to accept calls from anyone in the community.

It is likely that agencies that see many people who require referral to Area Mental and Wellbeing Services will choose to develop partnerships with community health services or other providers that can provide medical referrals as needed. This would be a positive development because more consumers—especially those who cannot afford or do not wish to see a private medical practitioner—would be connected with services that provide general health care.

Over time, some Area Mental Health and Wellbeing Services may develop ad hoc arrangements for giving specific agencies—for example, agencies with which they have formal partnerships or shared care arrangements—the right to refer directly to them without a medical referral. However, the Commission's strong expectation is that medical referral will be the main way of accessing Area Mental Health and Wellbeing Services.

The websites of Area Mental Health and Wellbeing Services will provide user-friendly and up-to-date information about their services, processes for making referrals and the types of services that may be requested—for example, secondary consultation, shared care or participation in a specific program. These resources will be designed to reduce inappropriate referrals and build the capacity of other services and systems to support people experiencing mental illness or psychological distress.

Electronic referrals will be the preferred form of non-crisis referrals to Area Mental Health and Wellbeing Services and statewide services. This will allow information about the consumer to be received by the area service, with consent, in a standard form and will facilitate orderly management of referrals and communication with referrers. Qualified and experienced mental health professionals will assess written referrals and will also assist referring service providers over the telephone or via video telehealth.

Each Area Mental Health and Wellbeing Service will have a clear point of contact—for example, an 'access and intake service'—for enquiries about services and referrals. As part of their broader function of supporting primary and secondary care providers (as discussed in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*), Area Mental Health and Wellbeing Services will assist GPs and other service providers with decisions about the most appropriate referral options and will help them with the referral process.

While there is a minimum expectation that each Area Mental Health and Wellbeing Service will have a centrally coordinated access and service entry process (including for crisis responses), the Department of Health's implementation of the reforms should allow flexibility for these access points to be grouped across several Area Mental Health and Wellbeing Services or even a whole region. This is consistent with evidence before the Commission that greater centralisation of triage services over larger geographical areas can promote consistency of practice, strong clinical governance and accountability, and develop a workforce that is highly skilled in assessing and responding to requests for assistance.[79]

For example, Mr Peter Kelly, Director of Operations at NorthWestern Mental Health, Melbourne Health, The Royal Melbourne Hospital, told the Commission:

> the larger the service, the greater the economies of scale and the greater the efficiency in terms of roster numbers, roster patterns etc.
>
> [another] strength of centralised screening and triage services is that it is easier to establish and maintain the skill level of those performing the screening, maintain adequate training and ensure fidelity to the Statewide screening tool across the system. Triage is highly skilled work and suitably skilled and experienced clinicians are required to conduct a thorough assessment ...[80]

Chapter 7: *Integrated treatment, care and support in the community for adults and older adults* outlines the core functions of mental health and wellbeing services. One of those core functions is care planning and coordination. Activities to deliver this core function will facilitate the timely discharge of consumers from Area Mental Health and Wellbeing Services to Local Mental Health and Wellbeing Services, or alternative services in the community, and increase the capacity of Area Mental Health and Wellbeing Services to provide treatment, care and support to more people.

8.2.3 Accessing statewide services through Area Mental Health and Wellbeing Services

Chapter 5: *A responsive and integrated system* describes the future role of statewide services and how they will be accessed. Statewide services are highly specialised services. In the future, there will be clear pathways for providers to access statewide services and their expertise.

Access to statewide services will require a referral from an Area Mental Health and Wellbeing Service. This will often be undertaken after assessment processes are complete. The Department of Health, in conjunction with statewide services, will need to establish clear access policies that provide clarity for Area Mental Health and Wellbeing Services about how referrals to statewide services will be managed. These policies will be monitored and periodically updated to reflect changes in need, demand and expectations among consumers, families, carers and supporters.

Wherever feasible and safe, statewide services will be delivered through Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services, rather than through a model of service provision that requires consumers, families, carers and supporters to travel away from their home and support networks. This will include both virtual and onsite consultations.

8.2.4 Rationale for a new approach to accessing mental health and wellbeing services

The reforms outlined in this chapter represent a big change, particularly for consumers, families, carers, supporters and referrers who are used to using area mental health services' triage lines. While the need for people to get a referral to access an Area Mental Health and Wellbeing Service represents a departure from the current system—in which anyone can request access via each area mental health service's telephone triage line—the Commission is of the view that, combined with an investment in Local Mental Health and Wellbeing Services, such a policy is required.

As discussed in section 8.1, the current situation—in which there is no integration (for most of the system) between primary and secondary mental health and related services and area mental health services—has resulted in unmanageable demand on public specialist mental health services and their triage lines. This is the case despite triage line numbers being reasonably difficult to find and not widely advertised. It means that everyone who currently tries to access public specialist mental health services—including those experiencing or referring someone in crisis—potentially faces long waits to connect with a clinician and, as discussed earlier, has encounters that are not as helpful as they could be.

In the current system, as shown in Figure 8.1, more than 40 per cent of people who receive triage assessments in area mental health services are turned away from the service—that is, they receive advice and information only or are referred to another service.

Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services* examined epidemiological data on demand for mental health treatment, care and support. Based on this data and analysis of the current system, it is the Commission's view that there is a large number of people whose mental health needs, while too complex to be met by primary care providers alone, could be met by the Local Mental Health and Wellbeing Services—especially if they are helped early. As outlined in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*, these services will provide wellbeing supports, proportionate to need and outside the National Disability Insurance Scheme, alongside clinical supports.

In the future mental health and wellbeing system, such individuals will not need to go straight to Area Mental Health and Wellbeing Services or statewide services, and the expertise of those services would only be called upon when necessary. They will access the system through the new, widely distributed Local Mental Health and Wellbeing Services. These services will be nearby to people's homes and will not require a referral, although referrals will be encouraged. Access and navigation support workers—a new role in the system, explained in section 8.3—will be able to arrange for a person to see a clinician in the Local Mental Health and Wellbeing Service with or without a referral. These services will be responsive to the diversity of their local communities and will be networked with and supported by their proximate Area Mental Health and Wellbeing Service.

These reforms will allow Area Mental Health and Wellbeing Services to focus their resources on offering higher levels of responsiveness to people assessed by Local Mental Health and Wellbeing Services or medical practitioners in the community as requiring more intensive or very specialised services, and to people in crisis.

The need for a medical practitioner referral to access Area Mental Health and Wellbeing Services aligns the mental health and wellbeing system with the arrangements to access specialist services in other parts of the health system—that is, the need for a medical referral to access medical and surgical services in public specialist outpatient clinics[81] and Medicare-subsidised services from private psychiatrists.[82]

8.2.5 An integrated system

The system design described above is underpinned by an expectation that the future system will be integrated and interconnected. This will allow for high levels of communication, productive relationships and feedback between services.

This is important because it is common for people experiencing mental illness to have an immediate high-intensity (acute) phase followed by a lower intensity phase. Therefore, clear and effective pathways from high-intensity treatment in Area Mental Health and Wellbeing Services to Local Mental Health and Wellbeing Services and independently governed primary and secondary care providers are critical. Ms Kym Peake, then Secretary of the former Department of Health and Human Services, recognises this:

> **We also know that for some people—particularly those with enduring or episodic mental health needs—their treatment journey will see them move between primary care and the specialist mental health system as their needs change and evolve. This characteristic of mental illness is why the stepped care model is the nationally agreed approach—it supports people throughout their illness as their needs change over time.**
>
> **For these consumers, clear entry points and strong pathways between primary and specialist services would help to prevent the need to re-tell their story or navigate themselves towards the service that meets their needs.**[83]

The Commission has recommended in Chapter 5: *A responsive and integrated system* that the Department of Health develops a capability framework outlining, according to each level of service, responsibility to support lower level services and referral to higher level services through networked arrangements.

Integration between Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services will also be promoted via a common triage scale, as explained in section 8.3. This will be used to record key information, including decisions made after the initial support discussion about whether the person will receive mental health and wellbeing services or be referred elsewhere. The new triage scale will complement policies to avoid 're-triaging' of people assessed in a different part of the system.

Close relationships across services will be further fostered through both Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services providing support for primary and secondary care providers. As discussed in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*, these services will maintain close links with local GPs—who are often the first point of contact for people seeking mental health care—and will support them to identify, assess and treat people with mental illness or psychological distress or connect them with higher intensity services as required.

In addition, there is work being undertaken by Primary Health Networks to improve service linkages between primary care providers and mental health services.[84]

Other important resources supporting system integration include:

- digital technology and other supports for information sharing between services, as discussed in Chapter 34: *Integrating digital technology*
- a website, described in section 8.4, providing information for the community, including service providers, about the mental health system and pathways for people to have their needs assessed and be connected with treatment, care and support.

8.2.6 Statewide mental health number

The Commission expects that the Department of Health will establish a statewide phone number for mental health and wellbeing services. Callers to this number may choose to have their calls diverted after listening to a brief automated message about mental health and wellbeing services in Victoria. Call detection technology could be used to divert the call to the relevant Area Mental Health and Wellbeing Service. Callers will be diverted to Triple Zero (000) in the case of a life-threatening emergency.

The statewide phone number will provide a visible point of entry to the system for referrers and, in crisis situations, for the general community.

The promotion of this number to the Victorian community—for example, via the website described in section 8.4—will be carefully considered to ensure it does not increase demand from people whose needs can be better met by other services. Communications related to the number should state that unless the consumer needs an immediate crisis response, there are other services, such as Local Mental Health and Wellbeing Services, general practices and helplines, that can respond to less acute needs.

8.3 Identifying needs and providing initial support

The following statement from Dr Denborough illustrates a wealth of feedback to the Commission about the need for change in how mental health services respond to people when they ask for help:

> Victoria's mental health system needs to be sophisticated enough to allow people to be linked to the right person and service from the very beginning to ensure they can tell their story and receive help, rather than just be assessed for eligibility and not receive help or be passed on to another service. In order to create such a sophisticated system you need experienced people on the 'front line' … The system needs a default position of trying to help everyone who asks for it rather than trying to limit the help to people who the system determines is bad enough to need it.[85]

The Commission has designed a transformational 'front-end' model for mental health and wellbeing services.[86] Compared with the current system, Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services will have more capacity to support consumers, families, carers and supporters in their first contact with community-based services, when they re-enter these services after previously being discharged or after a period in inpatient or residential care. Each contact will be treated as an opportunity to help people, even if they are unlikely to need more involvement with the service.

Initial responses to people seeking services will focus on understanding their needs and how these could be met, rather than just assessing their risk and eligibility for the service. There will be more resources at the front end of the system so people get what they need from the outset. This reflects advice to the Commission that more effort should be put into understanding people's needs early in their journey so that future efforts to help them are well directed.[87]

Assessment of people's needs will be done by practitioners with the skills and experience to make decisions with consumers about the best path forward. Currently, people may have to wait a long time, or until they are acutely unwell, before they can see a practitioner with the level of expertise they require. In the Finding and Accessing Care, Treatment and Support Roundtable, Associate Professor Moylan informed the Commission:

> high-quality specialist input early in the process will pay off big dividends in multiple different ways throughout the entire process. So if we can support that, to make it simple for people to get to high end specialist input early, I think we will save huge amounts of money in efficiency and have a much better consumer experience than the current system …[88]

8.3.1 How front-end assessment will support staged care

As described in Chapter 5: *A responsive and integrated system*, the Commission has developed a system design drawing on the merits of both 'stepped care' and 'staged care'—that is:

- a stepped approach to system design through five streams of treatment, care and support that respond to increasing intensity of need
- staged care for service delivery to individuals, emphasising prevention, early intervention and support for people to recover and stay well.

The front-end components discussed in the next section—in particular the 'initial support discussion' and the 'comprehensive needs assessment and planning discussion'—are the points at which services and supports are matched to people's needs. This matching occurs not only for consumers who are new to the system but for those re-entering community-based services after a period of absence. Periodically and as needed—for example, after a major life event or mental health crisis—the 'comprehensive needs assessment and planning discussion' will also be used to review the treatment, care and support needs of current consumers.

In the model anticipated by the Commission, consumers may be matched to services of any level of intensity—that is, they do not have to complete lower steps to reach higher steps. For example, a new consumer referred from primary care might be directed to ongoing, high-intensity supports at the area or even the statewide level.

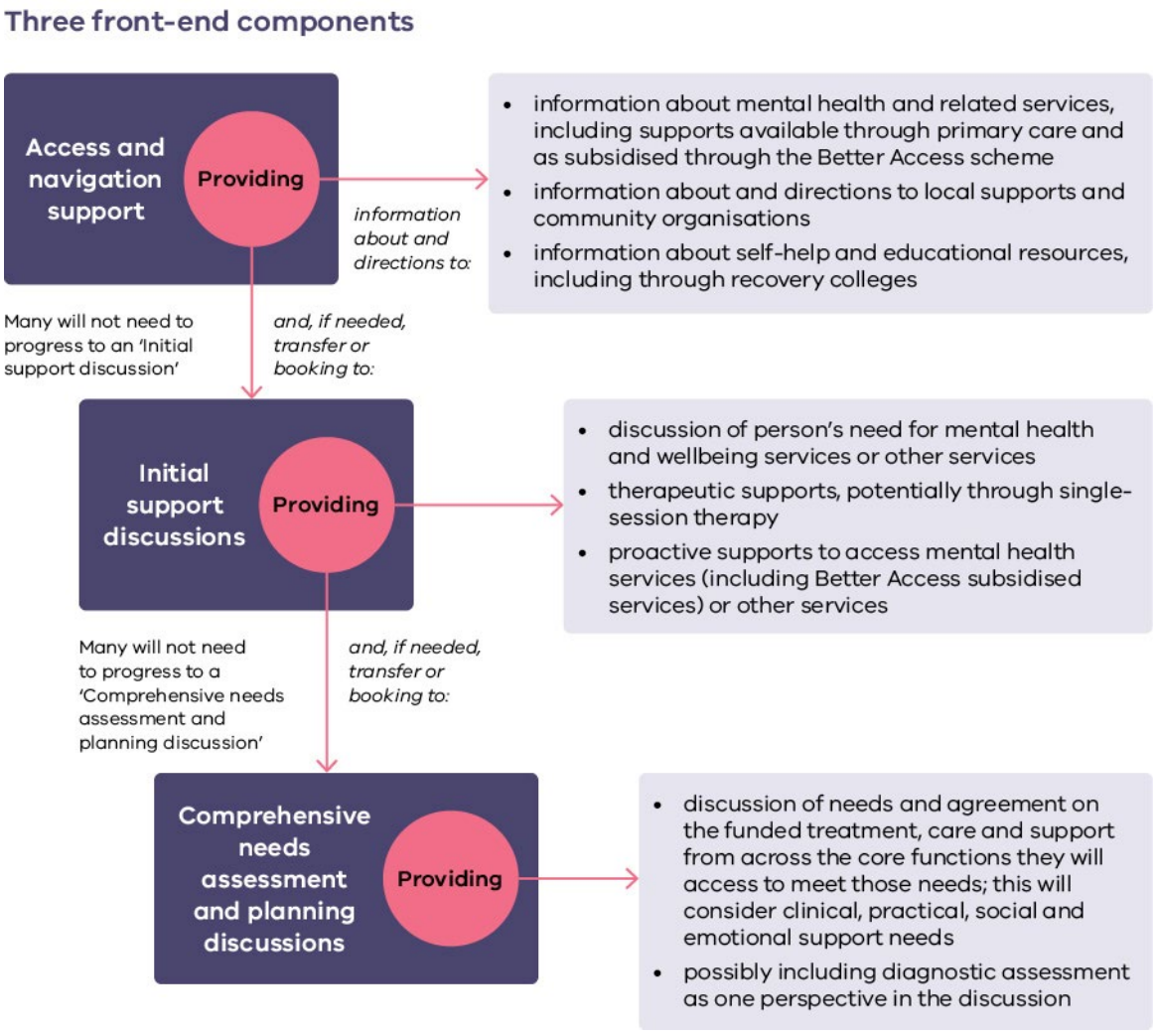
To ensure services in the new mental health and wellbeing system facilitate a staged model of care for consumers, the right interventions must be identified at the right time. This will require appropriate resourcing of front-end service components so that consumers and referrers do not face long waits for assessment and connection to services.

8.3.2 Three front-end components

The Commission has recommended three front-end components of Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services. These are depicted in Figure 8.4 and described in the following section. They are:

- access and navigation support
- initial support discussions
- comprehensive needs assessment and planning discussions.

Figure 8.4: Overview of three front-end components



Access and navigation support

This component offers a warm welcome, compassionate listening and information about services and pathways. It is provided by well-trained and supported peer workers, volunteers or other staff. People will be able to speak with access and navigation support workers without requiring a referral. The inclusion of this front-end component in the recommended service model is based on evidence that similar roles have been successful in mental health services in other countries.[89]

The role of access and navigation support workers may include:

- greeting people who come to the clinic
- providing information about mental health and related services
- connecting people to local supports and community organisations

- helping people organise an appointment if they are looking for treatment, care or support from mental health and wellbeing services
- in pressing cases, collecting basic information—such as contact details and information about what the consumer is asking for—and transferring the person to an initial support discussion.

This support will be present in all Local Mental Health and Wellbeing Services. It is optional in Area Mental Health and Wellbeing Services.

Initial support discussions

Initial support discussions seek to understand people's concerns, determine their need for further mental health and wellbeing services or other services, and offer an initial response (for example, through empathetic listening, brief therapeutic interventions and referral to appropriate services and supports). These discussions will occur in Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services.

This is like the current role of triage clinicians in area mental health services, in that it involves a clinical assessment of the person's need and priority for services offered by the mental health and wellbeing service. However, the initial support discussion will provide a higher level of therapeutic engagement and will more proactively facilitate access to necessary mental health services and/or other services—including GPs, mental health services available through the Better Access scheme and community-based organisations—or self-help tools.

The initial support discussion is intended to provide people with support right away. One form of support that may be provided is single-session therapy. Single-session therapy is a specific approach to supporting people and discussing their needs in their initial meeting with mental health services. It does not necessarily mean the consumer will not go on to receive further mental health support. However, it aims to make the best use of the first encounter, on the basis that this might be the only contact that the person wants or needs at that stage, and because even a brief encounter—delivered when people are most ready to accept help—can be therapeutic.[90]

Initial support discussions will be delivered face to face, over the phone or through video telehealth discussions with referred individuals, families, carers or supporters, referring service providers and/or other professionals. They can be delivered in a scheduled appointment or as an immediate response to requests for assistance.

For some referrals—for example, of people already assessed in another service—services in the new mental health and wellbeing system may choose to bypass the initial support discussion and proceed directly to the comprehensive needs assessment and planning discussion, as outlined in detail below.

The rapid adoption of video telehealth services during the COVID-19 lockdown offers an important opportunity for this sort of front-end service.[91]

Ms Sandra Keppich-Arnold, Director of Operations and Nursing, Mental and Addiction Health at Alfred Health, told the Commission:

> **The use of telehealth at triage has been especially useful and will be maintained as an option … The capacity of triage workers to have video chat calls to clients calling in aids the assessment and engagement with the caller. Until COVID-19, callers would be provided with advice and support in a one off intake call if they were not deemed as requiring follow up. However through this period, triage workers have continued to provide telephone counselling and anxiety management to a number of callers that have been of enormous benefit and value.**[92]

Ms Keppich-Arnold also mentioned that telehealth services 'may be the most effective way to assess remote or rural consumers who are in crisis or deteriorating, and to provide intervention and support'.[93] Chapter 34: *Integrating digital technology* discusses the opportunities and challenges for using telehealth technology to deliver mental health services.

Comprehensive needs assessment and planning discussions

Comprehensive needs assessment and planning discussions are designed for consumers who would benefit from an opportunity to intensively work through their treatment, care and support needs. These discussions will be held for people with more complex support needs who are likely to require further involvement with Local Mental Health and Wellbeing Services or Area Mental Health and Wellbeing Services.

Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services will provide comprehensive needs assessment and planning discussions. They will typically be delivered in a scheduled face-to-face or video telehealth appointment. This discussion may take place over a number of visits or meetings, sometimes involving staff with specific skills.

The comprehensive needs assessment and planning discussion considers the consumer's needs across multiple life domains. It may include diagnostic assessment, but clinical needs are just one perspective. The discussion will also consider practical, social and emotional support needs. This will typically involve a range of clinical and other staff, including peer workers, as part of a multidisciplinary team, and the consumer's family, carers or supporters.

The discussion includes agreeing and articulating a plan for the funded treatment, care and support that consumers will access across the core functions of community-based mental health and wellbeing services, and across a range of domains such as substance use or addiction and physical health. The purpose of these discussions is to agree on an approach to treatment, care and support that will help the consumer to live well in the community. This plan will be shared with the consumer and, with consent, with others involved.

For National Disability Insurance Scheme participants, the discussion will consider supports that are funded through the scheme and will then look at what else is needed.

This approach to a comprehensive consideration of a person's needs is aligned with the expectations set out in the National Safety and Quality Health Service Standards—most specifically, the content of the Comprehensive Care Standard.[94]

As well as new consumers, this component may be used to support care planning and coordination for consumers re-entering the system after previously being discharged or transitioning from an inpatient or residential setting, or for other consumers who require a review of their needs.

8.3.3 Involving families, carers and supporters

Families, carers and supporters emphasised that they play a critical role in helping the people they have a care relationship with to navigate the mental health system.[95] They want to be better supported in these roles and to have their voices listened to in assessment and care planning processes.[96]

Single-session therapy is an example of a model of care that has an emphasis on involving families, carers and supporters in consumers' initial interactions with mental health services.[97] The Bouverie Centre has developed a specific approach to single-session therapy, called Single-Session Family Consultation, to help mental health practitioners engage with consumers' families, carers and supporters:[98] Dr Brendan O'Hanlon, Mental Health Program Manager at La Trobe University's Bouverie Centre, explained that:

> for consumers, single session family consultation creates a context where family involvement is more likely to be positive and supportive of recovery, because it makes a point of negotiating the process of meeting with the family. It tries to create an environment where the consumer feels more comfortable about family involvement by acknowledging that a family meeting can be a daunting experience for a lot of consumers …[99]

The Bouverie Centre highlights that for families:

> SSFCs [Single-Session Family Consultations] usually help families in the following ways:
>
> - Hearing the family's story and acknowledging the impact of the illness / problem on all family members
> - Creating greater understanding through sharing information about the nature of the illness /problem
> - Helping families work out how to best support their relative within the resources they have available
> - Problem solving inevitable day to day difficulties which are linked to what family members want to achieve during the session
> - Achieving clarity about the nature of family involvement in the person's treatment
> - Planning to help families access additional resources including other family interventions that may be available to them.[100]

Despite its name, single-session therapy does not necessarily mean the consumer will not receive further mental health and wellbeing supports.[101] It aims to make the best use of the first session to fully understand the person's concerns and the perspectives of their families, carers and supporters.[102] It is one of a range of approaches suitable for engaging with people's families, carers and supporters. Other models for engaging with families, carers and supporters are discussed in Chapter 19: *Valuing and supporting families, carers and supporters*.

8.3.4 Connecting consumers to other services

As described in section 8.1, people contacting area mental health service triage lines are currently often not connected with, or even directed to, appropriate supports within or outside the mental health system.[103]

In the future mental health and wellbeing system, all front-end components will focus on connecting consumers to the services and supports they need to improve their mental health. As explained earlier, these services and support will be in proportion to individual need. Consumers contacting mental health and wellbeing services whose needs can be met by GPs or other primary care providers will be referred to those providers after the initial support discussion.

The connections facilitated by mental health and wellbeing services will encompass a wide range of services and supports, including programs delivered by local councils and community organisations. Where the consumer can afford it, options for referral to private services should always be considered. Feedback from a group of leading clinicians and mental health academics indicated that public specialist mental health services currently have poor connections with the private sector and should do more to connect people to these services.[104]

Comprehensive online service information, as discussed in section 8.4, and greater availability of mental health services and supports, will help services identify referral options. For example, the Scottish Distress Brief Intervention program recommended by the Commission in Chapter 17*: Collaboration for suicide prevention and response* might be a good option for someone experiencing a situational crisis who does not want or need treatment for a mental illness.

8.3.5 Policy and practical resources to help services implement the reforms

The Commission notes that the process of implementing major government reforms has often been made more difficult by a lack of detailed policy and practice guidance for service providers. For example, a recent evaluation of the Victorian Government's family violence reform, The Orange Door, identified that better operational and practice guidance was required for the workforce to understand and implement the intended model.[105]

To implement the Commission's recommendations in this chapter, it is expected that the Department of Health will lead development of policies and practical resources to support the proposed reforms.

These resources will be developed in collaboration with Primary Health Networks and relevant Commonwealth agencies to support integration between primary, secondary and tertiary mental health services.

As discussed earlier, the Commission has concluded that the Victorian and Commonwealth governments must work together to simplify and clarify how people access and enter mental health and wellbeing services. The development of common policies, practices and tools is consistent with the advice of experts such as Mr Buckingham, whose witness statement highlights 'the need for the Commonwealth and state systems to be thought of in an integrated and interdependent way'.[106]

New access policy

The Department of Health will develop and promote an access policy for Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services. This will facilitate a clear and consistent approach to managing referrals and people's initial contact with the services. It will complement the service capability framework described in Chapter 5: *A responsive and integrated system*.

The access policy will provide:

- a description of the role and targeting of Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services
- guidelines for collaborative arrangements between Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services, and examples of referral pathways
- guidelines for developing referral templates and communicating with potential referrers (this communication should include mechanisms for giving feedback about poor-quality or inappropriate referrals)
- guidelines for managing referrals and communicating with referred individuals
- guidelines for supporting people who do not commence an episode of treatment, care and support
- guidelines for improving front-end service efficiency—for example, in relation to scheduling of urgent and routine appointments and reducing rates of 'failure to attend' clinic appointments
- data collection requirements.

The access policy will clearly describe expectations of services in terms of delivering the three front-end components described earlier—that is, access and navigation support, initial support discussions, and comprehensive needs assessment and planning discussions. This will include a description of the processes through which plans for treatment, care and support will be agreed through the comprehensive needs assessment and planning discussions.

Implementation of the access policy will make the most of digital technologies to ensure referral and service entry processes are streamlined. As explained in Chapter 35: *New approaches to information management*, Victoria's new mental health and wellbeing system will be underpinned by modern information technology and processes for referral management, information sharing and data collection.

Revised triage scale and minimum dataset

The Department of Health will develop a revised version of the current statewide triage scale to record outcomes of the initial support discussion.[107] This will be a shorter and simplified version of the current scale so it is flexible for different consumer groups. Separate scales and associated guidelines may be considered for services for adults and older people, youth, and infants and children.[108]

The scale will be part of improved data collection about people who contact or are referred to Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services. This was a recommendation of the Victorian Auditor-General's 2019 report on *Access to Clinical Mental Health Services in Victoria*, which said that information collected about referrals to mental health services must allow the government to monitor services' responsiveness to demand, including from diverse communities.[109]

Currently, due to the minimal nature of triage data collections, very little is known about people who try to get help but who are either unable to get through to or not accepted by area mental health services. The improved triage minimum dataset will provide information about people who are not accepted for service provision beyond an initial support discussion. It will also collect information on non-answered calls to Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services, and the length of time people wait on the phone or for a response to an electronic referral.

Subject to appropriate consent from the consumer and the privacy provisions of the *Health Records Act 2001* (Vic), services will capture data on Aboriginality, ethnicity, language, gender identity, sexuality and intersex variation status. The new data collection will also record information about the nature of the person's concerns and the services and supports to which they are referred.

As discussed in Chapter 35: *New approaches to information management*, a new information and technology system will be implemented across the mental health and wellbeing system. This will start capturing person-level information when a consumer, or referrer on a consumer's behalf, has an initial support discussion. The information captured at this stage will comprise the triage minimum dataset, as discussed above, including the triage decision made after the initial support discussion (as recorded on the revised triage scale). Consumers will be accepted into the community mental health and wellbeing system after a comprehensive needs assessment and planning discussion and when a decision is made that an episode of care is required—that is, when the person is to receive one or more types of 'integrated, treatment care and support' described in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*. Once a person is accepted into the system, data collection will include clinical notes and measurements of their mental health outcomes.

While this is similar to the current system of collecting data about 'unregistered' and 'registered' clients in Victoria's specialist mental health services, it supports more comprehensive data collection about people not accepted into the system and a more consistent approach to determining when someone becomes a client of the system. Under the new approach, the collection of basic service and referral information about all people contacting the system, including those not accepted into the system, will also enable service providers to offer safe, effective and coordinated service delivery responses (for example, by allowing them to identify if a person has previously contacted a service or attended an emergency department).

Standardised referral tools

The Department of Health, where possible in collaboration with Regional Mental Health and Wellbeing Boards, will work with Primary Health Networks to ensure all Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services have access to practical tools to improve and streamline referrals. To ensure usability, these tools should be co-designed and implemented with practitioners who refer people to these services.

There are opportunities for the state-funded mental health and wellbeing system to capitalise on tools and resources that are being developed by the Commonwealth Government and Primary Health Networks. The Commission notes the Productivity Commission's recommendation for referral tools that can be used by GPs, and a Medicare item to enable GPs and paediatricians to get advice from a psychiatrist relating to a consumer in their care.[110] The Productivity Commission has called on the Commonwealth Government to fund, and provide as part of a national digital mental health platform, a free mental health assessment and referral tool to be used by GPs to refer patients to mental health services and online supports.[111]

Tools already in existence to help primary care providers identify and manage mental illness or psychological distress and refer people to more specialised services include:

- newly developed national guidance for Primary Health Networks, *Initial Assessment and Referral for Mental Healthcare*, which provides information and resources to guide initial assessment and referral of people presenting with mental illness or psychological distress in primary healthcare settings[112]
- HealthPathways Melbourne, a program currently run by the Eastern Melbourne Primary Health Network and North Western Melbourne Primary Health Network—this is a free, web-based portal for health professionals that includes evidence-based information about assessing and managing common clinical conditions, including referral guidance.[113]

8.4 Improving whole-of-system navigation and connections

In Victoria's future mental health and wellbeing system, online navigation, self-help tools and enhanced helpline services will improve access to a wide array of services and supports. These include services outside Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services—for example, independently governed primary and secondary care providers, Primary Health Networks, local councils and community support organisations. Digital tools and helplines will also assist people with higher intensity needs to connect with mental health and wellbeing services.

The specific initiatives explained below will complement reforms to other universal supports—especially primary care services—which the Commission believes are essential to meeting the community's needs for mental health and wellbeing treatment, care and support. The initiatives are additional to the Commission's recommendations on the use of digital technologies to deliver services or complement face-to-face care, as discussed in Chapter 34: *Integrating digital technology*.

8.4.1 A new mental health and wellbeing website

The Commission's recommendation for a new mental health and wellbeing website responds to extensive feedback about the difficulty of finding online information about how to access mental health services and supports. It also responds to feedback about the need for a well-promoted, high-quality central site to help people understand and navigate the mental health system.[114] Miss Denna Healy, a witness, told the Commission:

> It would be amazing if there was an online, centralised database for people who were looking for these services, to access and find carer support services, or even hotline numbers, depending on whatever it is you may be looking for at the time. It would be great to just look online and see all the different services in one website.[115]

Many organisations in the government and private sectors have established high-quality, user-friendly websites that help people identify their needs and make informed choices about services. For example, the Commonwealth Government's online platform for connecting older Australians to government-funded aged care services, My Aged Care <www.myagedcare.gov.au>, has recently been named Australia's best designed website.[116] Sources quoted in a public sector newsletter announcing the win said the website 'offers an online experience that's simple, supportive, intuitive and empowering'.[117]

The Commission believes this type of experience should be available to Victorians searching for mental health services and supports. It has reviewed evidence suggesting that high-quality online experiences are important in building people's trust in government services.[118]

The Commission notes that many people it consulted were enthusiastic about the potential of emerging digital technologies to help people find and connect with services. For example, clinical leaders offered their views on the kinds of technology that could potentially be incorporated into future online platforms:

> **Triage could not be safely or robustly conducted via Chatbot, however helpful prompting, and supportive encouragement to reach out could be of benefit to those reluctant to do so. These could also be helpful in directing the person to the right service to make their enquiry.**[119]
>
> **[We need a] digital platform that can utilise the latest high-tech, machine automation, artificial intelligence to, you know, get people to the right place at the right time.**[120]

Figure 8.5 shows the website structure the Commission recommends. The website will be easy to use and will capture information that consumers, families, carers and supporters most care about. It will be designed to help people find the right services and supports easily, with functionality that lets the user search for services by location, age group and type of need. It will be well maintained and modern.

The Department of Health will fund the website and take overall responsibility for it. This responsibility will include regular review and continued improvements that capitalise on new digital technologies. Resources and accountabilities will support the specific features and implementation approaches described in this section. A fundamental design principle will be that the website will complement, not replicate, the content of other major mental health websites such as the Commonwealth Government's Head to Health platform.

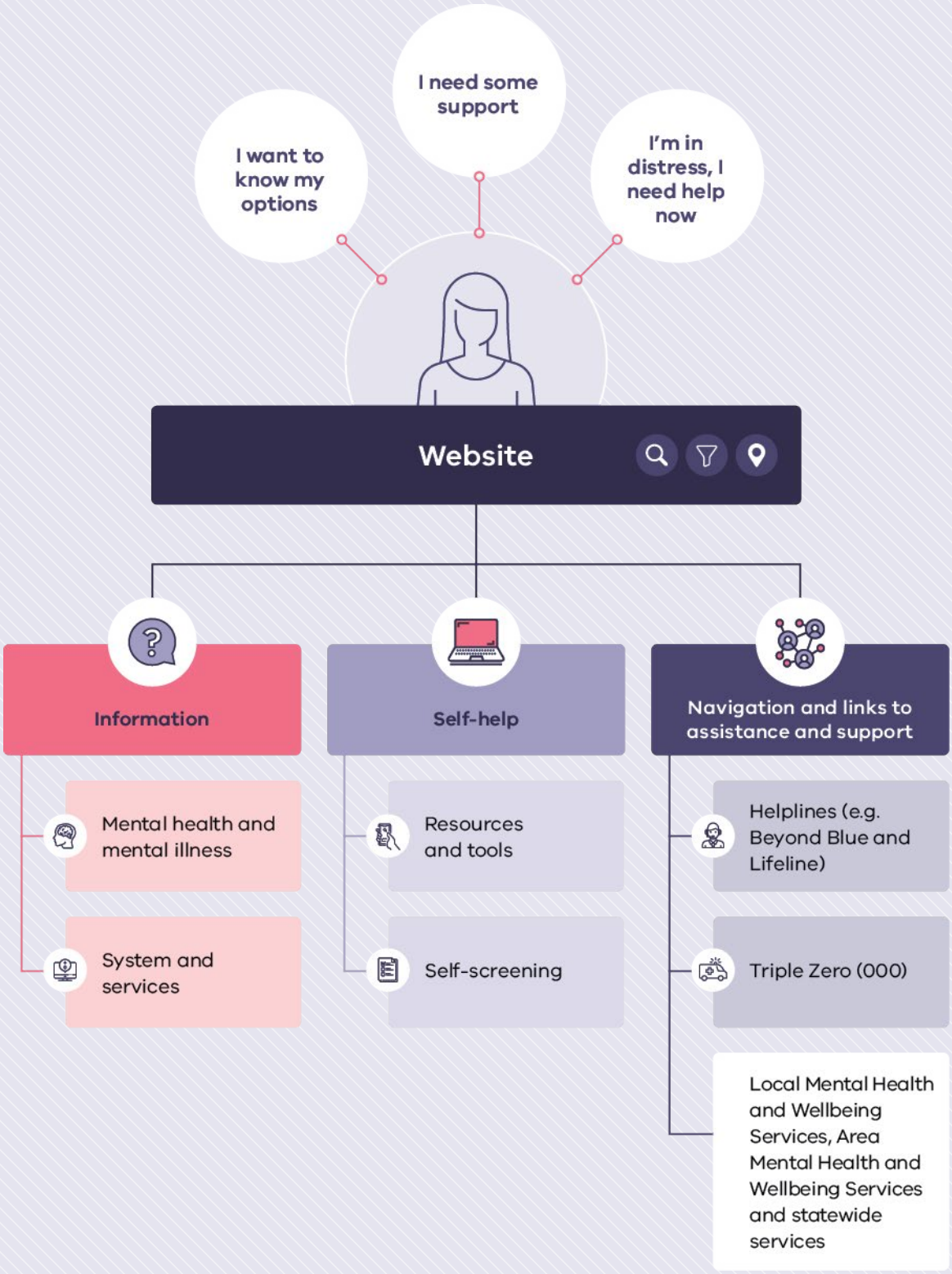
Making the system easier to understand

An important objective of the website is to educate the community about Victoria's mental health and wellbeing system. The website will provide high-level information including broad service types, their role and focus, and how the main sectors connect with each other. There will be prominent information about mental health emergencies and crises, and links to emergency services, Local Mental Health and Wellbeing Services, Area Mental Health and Wellbeing Services and helplines.

Government reviews have highlighted the need for public communications to use plain language and standardised terminology.[121] Consumer and carer advocates also raised with the Commission the need for more attention to the language used when describing mental health services. Dr Melissa Petrakis, the Chair of Tandem, said that carers find certain language about mental illness and mental health services confronting and confusing—for example, when language is used inconsistently across services and acronyms and shorthand expressions are used without explanation.[122] The website will classify and describe different mental health services and supports using simple, consistent descriptions and jargon-free language that makes sense to the community.

In Chapter 21: *Responding to the mental health and wellbeing needs of a diverse population*, the Commission notes the importance of information being available in a wide range of languages.

Figure 8.5: Victorian Government mental health and wellbeing website



Links to comprehensive service information

An effective website must be supported by comprehensive and easily searchable service information.[123] While online directories of mental health services exist now, they are spread across multiple websites and generally focus on specific service types such as helplines provided by non-government agencies or public specialist mental health services.

Two national directories—the National Human Services Directory and the National Healthcare Provider Directory—try to provide information about a broader range of services. However, a 2018 review found that these directories have several major shortcomings. Most notably, they are 'opt-in' for service providers and, therefore, incomplete and lacking in consistent terminology and clear governance standards.[124]

People should be able to search for services in their local areas directly from the proposed website rather than via links to external websites. This does not mean that the Department of Health (or an agency it commissions to build and maintain the website) should collect and maintain the service information. In the short term, the new mental health website should bring together existing directory resources. For example, many local councils already have digital community directories and the Commission has recommended in Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect* that the Municipal Association of Victoria oversees the development of user-centric and culturally responsive digital community directories/noticeboards in all councils. Some Primary Health Networks also have—or are developing—comprehensive service directories. For example, the Eastern Melbourne Primary Health Network has developed an Integrated Mental Health and AOD Service Atlas—a tool that describes services specifically targeted to people with a lived experience of mental illness and those with alcohol and other drug issues.[125]

As discussed in Chapter 5: *A responsive and integrated system*, one of the responsibilities of Regional Mental Health and Wellbeing Boards will be to establish, coordinate and maintain service directory information to help people find and access services. Once the various regional directories are in place, they can be incorporated into the statewide website.

Mental health service information on the website will be augmented with information about other services that consumers could find helpful, including advocacy, legal rights and complaints resolution agencies, as well as information about non–mental health services likely to be useful to consumers (such as Centrelink, The Orange Door and housing support agencies). Over time, new information sources could be developed, such as sites that provide consumers and carers with an opportunity to review services.

The Commission has also recommended that online information be developed for families, carers and supporters in Chapter 19: *Valuing and supporting families, carers and supporters*. A link to this information should be clearly positioned on the homepage of the mental health website.

Links to self-help and online therapies

A growing number of smartphone apps and online programs provide information about mental health and help people assess, monitor and manage their symptoms.[126] There is a need for greater awareness and use of these resources, especially for people living with mild symptoms of mental illness or psychological distress.

Witnesses Ms Nicole Bartholomeusz, CEO of cohealth, and Mr Buckingham, commented on the importance of self-help resources:

> A key feature that should be considered in terms of the new system is the availability of self-management programs. When considering early intervention and changing demand, enabling people to self-manage is a key requirement. People need to be supported to know what they need to do to look after themselves and their mental illness—this will significantly reduce the demand on mental health services.[127]
>
> It is important to acknowledge that many mental health issues resolve themselves through self-management and with support from friends, family and other non-clinical sources such as self-help books or self-help online programs.[128]

As discussed in Chapter 34: *Integrating digital technology*, there is a growing body of evidence indicating that supported digital services and self-help supports may be an effective means of expanding access to quality treatment, care and support for some consumers, especially those with mild or moderate depression and anxiety.[129] There are several evidence-based, supported digital services available that research indicates are as effective as face-to-face therapy of the same nature.[130] Some examples include THIS WAY UP and MindSpot.[131]

Mission Australia's 2018 Youth Survey found that nearly one in five young people who responded to the survey used the internet to access an online quiz or assessment tool (19 per cent) or for personal stories or testimonies (19 per cent). One in six respondents had used the internet to chat one-on-one with someone who had a similar experience (16.5 per cent) and for information about available services (16.5 per cent).[132] In 2018, more than 650,000 young people in Victoria accessed mental health information, including about how to access services from the ReachOut website.[133]

The Victorian mental health website will provide links to self-help resources and supported online therapies. The Commission expects that the Department of Health will establish a robust process for ensuring the quality of linked resources. It notes that the Commonwealth Government's Head to Health platform has extensive tools to help people manage various mental health challenges. The Commonwealth Government has committed to a certification framework to use resources listed on Head to Health.[134]

Visibility and accessibility of the website

Awareness of the website will be fundamental to its success. It must be well promoted and easy to find online. It is possible to work with online platforms such as Google, Twitter and Facebook to make the website the first site to appear when people use certain search terms. This would make the website highly visible to the community.

The Commission expects that implementation of the website will be supported by a communications campaign for the Victorian community, service providers and organisations representing mental health consumers, families, carers and supporters. Links to the website should be established on all relevant government and service provider websites, as well as in other directories of health and social services and Primary Health Networks.

The website will be readily accessible to anyone who has access to the internet, and its resources will be free of charge. While this will promote equality across geographic and most sociodemographic groups, the Commission is aware that not all Victorians have equal access to the internet. For some people, the costs of technology and data charges are too high, while other people have low levels of digital literacy.[135] For these groups, the existence and promotion of free phone helplines, as described further in this chapter, will be important.

It will also be important for the website to include software that allows text on the site to be translated into other languages and for the site to be accessible to people with visual impairments who use screen readers.

Co-design with users

Websites are most useful and trusted when they are co-designed with potential users.[136] The developers of the award-winning My Aged Care website worked with hundreds of Australians from various rural and metropolitan areas, with a range of different needs, backgrounds and abilities. The Good Design Award judges suggested that this bolstered the success of the website, which they said was a 'great example of the use of human-centred design to make a complex domain more accessible to people'.[137]

Co-design and human-centred design strategies will be critical to creating the new mental health and wellbeing website. The Commission expects that the site will be developed and continuously improved based on co-design processes, which take specific steps to make collaborative decisions with consumers, families, carers and supporters, service providers, and other potential users.

Recognising that co-design takes time, the Commission suggests that the Department of Health reviews its existing mental health websites to improve their content and visibility while the new website is developed.

8.4.2 Non-government helplines

Telephone helpline services, such as Lifeline, MensLine Australia, Kids Helpline and the Beyond Blue Support Service, have had a longstanding role in providing free support, information and referral for people experiencing mental health crises or distress.

While many helplines respond to the general population, others are targeted to specific cohorts. For example, the Victorian Government's funding of the Switchboard service responded to advocacy from the LGBTIQ+ community and evidence that some LGBTIQ+ people will not use the mainstream crisis services for fear of discrimination.[138]

Helpline and related digital services provide an important pathway to care, offering accessible, non-judgemental, anonymous support and referral for hundreds of thousands of Australians each year. They are important in supporting Australians living in rural or remote areas and for people who find it difficult to access support during business hours.[139] Provided they have the funds to employ interpreters or bilingual workers, helplines can help overcome the service access barriers experienced by many people from culturally diverse communities.[140] Further, and as noted by the Productivity Commission, online support programs could be translated and adapted for differential cultural groups.[141]

Like Ms Sutherland, whose story is presented in section 8.1, some consumers prefer to use helplines rather than clinical services. In her original submission to the Commission, Ms Sutherland wrote, '[h]elplines, I honestly think have been a lifesaver and are working.'[142] Others value the anonymous nature of helpline services.

Many helplines now offer digital alternatives to telephone responses, such as text and online chat functions. A few go beyond providing immediate support and offer planned call-back services, such as counselling and coaching sessions with clinicians or trained non-clinical staff. For example, the Suicide Call Back Service offers six free counselling sessions with a psychologist, social worker or counsellor, without the need for a referral.[143]

Some of the well-known helplines are increasingly seen as trusted partners and experts within the broader business sector. Their expertise is being called on to help extend the reach of mental health and wellbeing support in new and innovative ways. For example, a number of major technology companies, such as Google, are partnering with trusted non-government organisations, including Beyond Blue and Lifeline, to develop resources for consumers, families, carers and supporters.[144] This potentially extends the reach of digital supports to millions of Australians.

Research supports the effectiveness of helpline services. Studies of crisis helplines have reported measurable reductions in suicidal thoughts and ideas of self-harm,[145] and recent Australian evaluations have supported the effectiveness of Beyond Blue's phone and online psychological support and referral services.[146] One service from Beyond Blue, called New Access, provides low-intensity cognitive behaviour therapy, achieving clinically meaningful improvement in depression and anxiety symptoms.[147]

Opportunities and challenges for helplines

Non-government helplines have the potential to be a stronger and more effective part of the mental health system.[148] In his second witness statement, Dr Coventry supported helplines as one component of a comprehensive mental health system.[149]

In response to the COVID-19 pandemic, both the Commonwealth and Victorian governments have provided considerable new funds for helplines.[150] The Commission welcomes these new resources. It also hopes that both levels of government will assist helpline providers to tackle some of the challenges those providers have identified. These include:

- lack of capacity to transfer callers 'seamlessly' (that is, while they are still on the phone) to follow up mental health services or other helplines that might be better suited to their needs[151]
- the need to improve call-answer rates[152]
- the need to better support repeat callers with more complex mental health needs and connect them to other services when needed[153]
- the existence of too many helplines with overlapping roles.[154]

Areas for immediate improvement

As a priority, the Department of Health should fund and support work to build better connections between helplines and the state's mental health and wellbeing system.

Lifeline and Beyond Blue could lead this work together, in collaboration with providers of smaller, specialist helplines. The helpline partnership will collaborate with Regional Mental Health and Wellbeing Boards and mental health sector experts, including consumer and carer representatives, to develop protocols and procedures for:

- transferring callers to Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services, when needed and wanted by the consumer
- accurately identifying people who need urgent in-person responses and transferring these callers to crisis or emergency services
- collaboratively responding to people with more complex mental health needs, including those who call helplines frequently. For example, Mr John Brogden AM, Chairman, Lifeline Australia, indicated that with more resources, Lifeline could expand its online crisis counselling, provide suicide aftercare programs and deliver better responses to frequent callers.[155] The World Health Organization suggested that opt-in follow-up calls to high-risk helpline callers are possible and successful in preventing further suicidal behaviour[156]
- tailored support programs for people who call helpline services frequently. Many frequent callers are involved with clinical mental health services, but they contact helplines to get additional support—often after hours. Providers should consider the findings of research on effective models of collaboration between helplines and mental health services when responding to frequent helpline callers.[157]

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Chapter 9

Crisis and emergency responses

Recommendation 8:

Responding to mental health crises

The Royal Commission recommends that the Victorian Government:

1. ensure each Adult and Older Adult Area Mental Health and Wellbeing Service delivers a centrally coordinated 24-hours-a-day telephone/telehealth crisis response service accessible to both service providers and to members of the community of all ages that provides:
    - **a.** crisis assessment and immediate support;
    - **b.** mobilisation of a crisis outreach team or emergency service response where necessary; and
    - **c.** referral for follow-up by mental health and wellbeing services and/or other appropriate services.
2. expand crisis outreach services in each Adult and Older Adult Area Mental Health and Wellbeing Service to provide treatment, care and support from a clinician and non-clinical worker such as a peer worker.
3. improve emergency departments' ability to respond to mental health crises by:
    - **a.** establishing a classification framework for all emergency departments and urgent care centres, based on their capability to respond to people experiencing mental health crises;
    - **b.** using the classification framework to ensure that health services are appropriately resourced to perform their role in a regional network of emergency departments and urgent care centres; and
    - **c.** ensuring there is at least one highest-level emergency department suitable for mental health and alcohol and other drug treatment in each region.

Recommendation 9:

Developing 'safe spaces' and crisis respite facilities

The Royal Commission recommends that the Victorian Government:

1. invest in diverse and innovative 'safe spaces' and crisis respite facilities for the resolution of mental health and suicidal crises which are consumer led and, where appropriate, delivered in partnership with non-government organisations.
2. in collaboration with the new agency led by people with lived experience of mental illness or psychological distress (refer to recommendation 29) and non-government organisations that deliver wellbeing supports, establish:

    a. one drop-in or crisis respite facility for adults and older Victorians per region (refer to recommendation 3(3)); and

    b. four safe space facilities across the state, comprising a mix of drop-in spaces and crisis response services, co-designed with and for young people.

3. establish a crisis stabilisation facility, in consultation with people with lived experience, led by a public health service or public hospital in partnership with a non-government organisation that delivers wellbeing supports.

Recommendation 10:

Supporting responses from emergency services to mental health crises

The Royal Commission recommends that the Victorian Government:

1. ensure that, wherever possible, emergency services' responses to people experiencing time-critical mental health crises are led by health professionals rather than police.
2. support Ambulance Victoria, Victoria Police and the Emergency Services Telecommunications Authority to work together to revise current protocols and practices such that, wherever possible and safe:
    a. Triple Zero (000) calls concerning mental health crises are diverted to Ambulance Victoria rather than Victoria Police; and
    b. responses to mental health crises requiring the attendance of both ambulance and police are led by paramedics (with support from mental health clinicians where required).
3. ensure that mental health clinical assistance is available to ambulance and police via:
    a. 24-hours-a-day telehealth consultation systems for officers responding to mental health crises;
    b. in-person co-responders in high-volume areas and time periods; and
    c. diversion secondary triage and referral services for Triple Zero (000) callers who do not require a police or ambulance dispatch.

9.1 Mental health crises and emergencies

Implementation of the Commission's full suite of recommendations will improve people's access to community-based care and other supports, helping to prevent escalation of mental illness or psychological distress. However, even the best mental health and wellbeing system will need to respond to crises and emergencies.

This chapter begins by considering the nature of mental health crises and emergencies, and current crisis response pathways. It then explains the reforms the Commission believes are required to establish a comprehensive and effective system of mental health crisis and emergency responses.

Consumers who participated in a Commission focus group on crisis responses were asked what the term 'mental health crisis' meant to them. Some typical responses were:

> It's when I get into a situation of panic and paranoia, and when I look back on it, I realised that my thoughts were delusional. Yeah that's basically it … And also, I wasn't able to help myself in practical ways. Like feeding myself and stuff.[1]
>
> you're vulnerable, you need support … feeling at risk and you know, you can't get that support either on your own or through family or anything else at that point … [and] maybe things are going to happen …[2]
>
> For me, I guess it's when I get really suicidal … But can also be like just very, very distressed and can't quite figure out what to do.[3]

The themes raised by consumers—distress and feelings of suicidality; risk of harmful consequences; inability to resolve the situation alone or through personal supports; escalating experiences of psychosis or other mental illness symptoms—were echoed by clinicians who were asked the same question. For example:

> A person in crisis is generally considered to be someone who is at risk of causing serious harm to themselves or to another person, or who is at risk of experiencing a serious deterioration in their mental or physical health … Often these people find that the relationships or resources they would normally use for support are unavailable to them.[4]
>
> I think a crisis response occurs when the patient is thought to be unsafe in their current environment. This may be secondary to evolution of illness, or precipitated by factors that may be psychological, social or substance related, or a 'cry for help' …[5]

As well as the distress and risks for the person experiencing the crisis, crisis services must recognise and respond to the effects on families, carers and supporters. As the personal stories and examples in this chapter highlight, families, carers and supporters are often exhausted from trying to get support for the person they care for and, in crisis situations, may themselves be feeling desperate, frightened, unsafe and deeply distressed. An effective system of crisis services must also recognise that mental health crises are not all alike—they are caused by different things, have different manifestations and potential impacts, and need different responses. At its most extreme, a mental health crisis is an emergency requiring an immediate response.

The Commission defines a mental health emergency in the same way that the Emergency Services Telecommunications Authority defines any type of emergency, '[a]n emergency is a serious, unexpected and often dangerous situation that requires immediate action. This includes danger to life, health and/or property.'[6]

9.1.1 Relationship between acute suicidality and other mental health crises

Acute suicidality constitutes a mental health crisis, whether or not the person has a mental illness, and the use of the term 'mental health crisis' encompasses suicidal crises. However, not all people in crisis are suicidal and, conversely, some people experience suicidal ideation (suicidal thoughts or intent) over a long period and need continuing support rather than crisis interventions.

The Commission considers that responding to people in suicidal distress is core business for mental health crisis response services. Suicide prevention and response is also the focus of a broader set of recommendations discussed in Chapter 17: *Collaboration for suicide prevention and response*.

9.1.2 Existing pathways to crisis and emergency care

Currently, there are a range of ways in which people get crisis and emergency care for mental illness or psychological distress. The main existing pathways are via:

- **Helplines**—these are run by various non-government organisations, such as Lifeline and Beyond Blue, and increasingly incorporate online and digital options.[7] Helplines have no direct entry pathway into mental health services, but operators may suggest that the person contact an area mental health service or go to an emergency department or urgent care centre. The Commission's recommendations about improving helpline services are discussed in Chapter 8: *Finding and accessing treatment, care and support*
- **Mental health clinical triage services**—all current area mental health services are expected to provide 24-hour, seven-day-a-week (24/7) telephone access to a triage clinician who assesses callers' concerns and makes decisions about their need for mental health and/or other services[8]
- **Attendance in the community by a Crisis Assessment and Treatment Team**—this only applies to areas where these teams still operate. Triage clinicians may refer callers to Crisis Assessment and Treatment Teams
- **Presentation to a hospital emergency department**—people can present to an emergency department by themselves or with family, carers or supporters; they may be referred there by a triage clinician or they may be taken to the emergency department by police, ambulance or a Crisis Assessment and Treatment Team. Presentation to an emergency department may lead to admission to an inpatient unit, located in public and private hospitals, where consumers can get overnight clinical treatment, care and support[9]
- **Police and ambulance services—** as mentioned, these services often transport people to an emergency department.[10]

9.2 Current challenges in the delivery of crisis and emergency responses

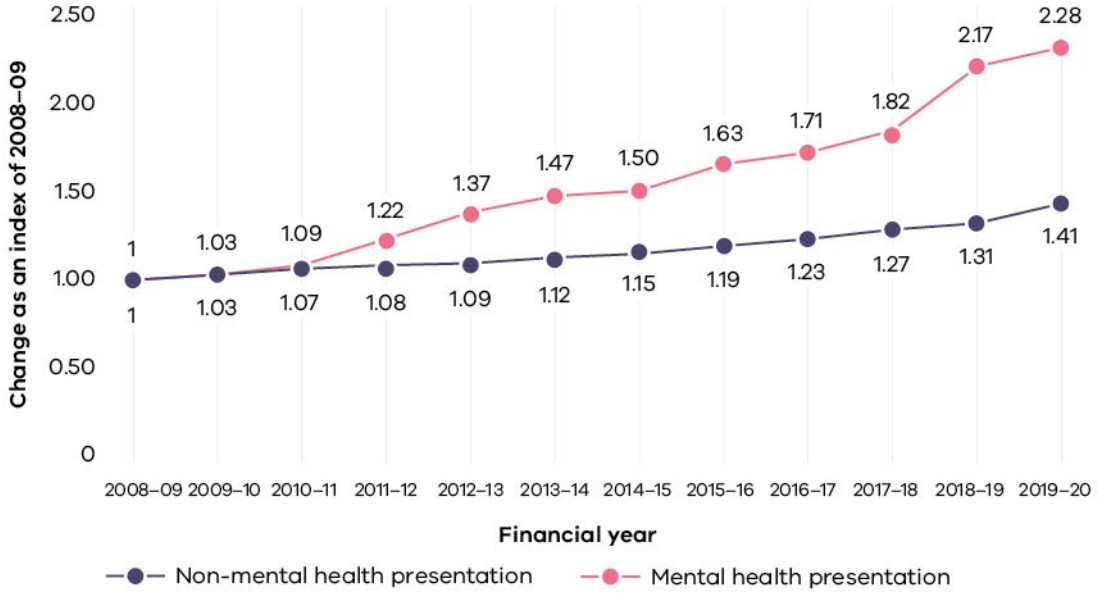
A central theme of the Commission's interim report was that the need for crisis responses is distorted by system failings: people must reach crisis point before they can get any response from mental health services.[11] The interim report showed that underinvestment in mental health services, at a time of growing demand, has led to people being turned away from services and receiving less treatment, care and support.[12] High thresholds for community-based clinical treatment and early discharge from inpatient units increase the likelihood that people with mental illness will experience crisis.[13] The impacts of this situation are discussed in section 9.2.1.

9.2.1 Increasing crisis presentations

As noted in the previous section, one way that people seek treatment, care and support is by calling a mental health triage telephone line in an area mental health service. Chapter 8: *Finding and accessing treatment, care and support,* presents data showing that demand for triage services has grown strongly in recent years. In 2019–20, there was considerable growth—13.8 per cent compared with the previous year—in calls triage clinicians rated (using the statewide mental health triage scale) as 'emergency—immediate referral' and 'crisis—response within 2 hours'.[14]

As shown in Figure 9.1, there has also been strong growth in the number of emergency department presentations by people needing mental health care, including—in some cases—admission to a mental health inpatient unit.

Figure 9.1: Change in the number of emergency department presentations, by mental health status, Victoria, 2008–09 to 2019–20



Sources: Department of Health and Human Services, Integrated Data Resource, Victorian Emergency Minimum Dataset 2008–09 to 2018–19; Department of Health and Human Services, Victorian Emergency Minimum Dataset 2019–20.

Notes: Mental health-related emergency department presentation defined as: (a) the presentation resulted in an admission to a mental health bed (inpatient or residential), or (b) the presentation received a mental health-related diagnosis ('F' codes, or selected 'R' & 'Z' codes R410, R418, R443, R455, R4581, Z046, Z590, Z609, Z630, Z658, Z765), or (c) the presentation was defined to be 'Intentional self-harm', or (d) the presentation involved interaction with a mental health practitioner. Data excludes the Albury campus of Albury Wodonga Health. The Commission's definition of mental health-related emergency department presentation may differ slightly from the definition used by the Department of Health and Human Services.

The Commission's analysis of emergency department data showed that people experiencing mental illness or psychological distress wait much longer than other emergency department patients for admission to an inpatient bed (where this is the outcome of their presentation) or to be discharged.[15] The average waiting time in the emergency department for people with mental illness or psychological distress who were subsequently admitted to a bed was 7.8 hours in 2019–20—compared with 5.6 hours for other patients—and has increased steadily since 2015–16 when the average time to admission was 6.6 hours.[16]

For mental health patients discharged from an emergency department without admission, wait times averaged 4.5 hours in 2019–20, compared with 2.6 hours for other patients discharged from emergency departments without admission.[17] In 2019–20, 523 people experiencing mental illness or psychological distress waited more than 24 hours in a Victorian emergency department, in breach of the government's waiting time rules.[18] They comprised 63 per cent of all 24-hour breaches in 2019–20.[19]

9.2.2 Increasing complexity of need

Not only are more people presenting to mental health crisis and emergency services, but their needs are becoming more complex and challenging for service providers to manage. Complexity of support needs can be associated with the severity of a person's mental health issues, as well as experiences of homelessness or unstable housing, co-occurring substance use or addiction and physical health problems.[20] Mr Simon Thomson, Regional Director at Ambulance Victoria, told the Commission that ambulance services are seeing more people with mental illness and that those people increasingly have more complex support needs and distress:

> We know that there are challenges about accessing—particularly accessing beds for acute mental health patients and accessing care. We think that is demonstrated in the data when we see patients that are presenting with more serious problems, we're seeing more people who are at risk of suicide, we are seeing more people who are unwell with psychosis in the community, and either they are, or other members of the community or their family or carers are calling 000 in an effort to access care for them.[21]

Professor George Braitberg AM, Executive Director of Strategy, Quality and Improvement at The Royal Melbourne Hospital, spoke of the increasing complexity of need among people in crisis who visit The Royal Melbourne Hospital's emergency department:

> The first trend is the number of patients presenting with chronic issues in addition to their mental health issues. When I first started as an emergency physician, I cannot recall seeing the complexity of presentations that are now seen in the Emergency Department. Rather than presenting with acute behavioural issues related to a single mental health issue alone, increasingly we see patients presenting with a dual or triple diagnosis, i.e. with an additional organic illness, a social vulnerability and/or substance-related issues. For example, individuals experiencing mental health issues may present with alcohol or drug issues, homelessness, etc.[22]

The impact of 'ice'

Professor Braitberg drew the Commission's attention to research showing that growth in presentations involving methamphetamine ('ice') intoxication have put pressure on emergency departments to manage very high levels of behavioural disturbance.[23] This is consistent with the findings of a New South Wales Special Commission of Inquiry into crystal methamphetamine and other amphetamine-type stimulants, which estimated that ice use in Australia resulted in 28,400–80,900 additional admissions to hospitals and an additional 29,700–151,800 emergency department presentations in 2013.[24]

Evidence to the Special Commission from paramedics indicated that the most common presentation of patients using ice were mental health and behavioural concerns including psychosis, agitation, aggression and violence.[25] People affected by ice can experience acute, severe behavioural disturbance, including violent behaviours that do not respond to normal verbal interventions or requests.[26] Multiple emergency department staff members may be required to support people in these situations.[27] The impact of ice on individuals and the mental health system more broadly is discussed further in Chapter 22: *Integrated approach to treatment, care and support for people with mental illness and substance use or addiction*.

9.2.3 Not knowing what to do

As discussed in Chapter 8: *Finding and accessing treatment, care and support*, the mental health system is complex and difficult to navigate for people experiencing mental illness or psychological distress, as well as for families, carers and supporters, and for service providers. The difficulty of identifying, navigating and gaining access to services is especially problematic in crisis situations. As Ms Karyn Cook, Executive Director of Mental Health Services at South West Healthcare, Warrnambool Community Health, explained:

> there is confusion as to where to refer consumers or where consumers can seek help themselves. Families or community organisations becoming concerned about a person's mental health do not necessarily have knowledge about where to refer that person for help (including to an [area mental health service]). People often access support through local and non-government organisations … which may or may not be appropriate for that particular consumer's needs and may or may not lead to referral to an [area mental health service].[28]

Similarly, Mr Thomson told the Commission:

> I speak to a number of families and a number of clients who talk about … knowing that things aren't going well, but not being able to access help, there's a huge gap in terms of being able to identify services who can provide help before it gets to that crisis point.[29]

As a result, many people attend emergency departments because they do not know where else to go.[30] However, the problem is not just that people do not know about crisis services. There are large gaps in the availability of services that can respond to people experiencing mental illness or psychological distress before they get to the stage of needing an emergency department or emergency service (police or ambulance).

Loss of crisis outreach capacity

One gap that has become wider in recent years is in the capacity of Victoria's mental health services to 'outreach' to people in their own homes or other environments. Crisis Assessment and Treatment Teams were a core part of the specialist mental health system specified in the Victorian Government's 1994 *Victoria's Mental Health Service: The Framework for Service Delivery*.[31] They were intended to provide a 24/7 mobile service to assess people in the community who were experiencing mental health crises and to determine whether they required admission to an inpatient unit or follow-up by Continuing Care Teams.[32]

The Commission heard that 24/7 crisis outreach has disappeared from many of Victoria's mental health services, with Crisis Assessment and Treatment Teams merged with office-based Continuing Care Teams.[33] Even in areas where Crisis Assessment and Treatment Teams still operate, they do not work 24 hours a day in the community. Associate Professor Simon Stafrace, Program Director of Alfred Mental and Addiction Health, Alfred Health at the time of giving evidence, noted:

> [Community-based] crisis care is unavailable between 10:00pm and 7:00am. Night time services are absent because cost is high, demand is low and risk to the safety of staff is not acceptable (i.e. people are more likely to be consuming alcohol or using drugs and home visits are not appropriate at that time).[34]

A lack of crisis outreach capacity means that more people experiencing mental health crises are involved with emergency services and seen in hospital emergency departments, which may cause them further distress.

Few places to go besides the emergency department

While some people in crisis need to be treated in an emergency department, many can be safely and effectively helped in less pressured environments. This includes people experiencing suicidal crises.

Families, carers and supporters who participated in the Commission's focus groups and community consultations spoke of the lack of alternatives to emergency departments when the people they care for are in crisis.[35] Families, carers and supporters said they often feel alone and unsupported: they talked about the challenges of managing crisis after crisis and having to see the person they care for get worse before they can get help.[36]

Several models of alternative crisis resolution services—such as drop-in spaces and residential crisis retreats, often led by peer workers—have demonstrated effectiveness internationally.[37]

Victoria has few examples of these services. St Vincent's Mental Health developed the first drop-in Safe Haven Café in Australia, staffed by mental health clinicians, peer workers with lived experience of mental illness and volunteers.[38] An independent cost-effectiveness analysis showed that the service is saving St Vincent's Hospital money by reducing presentations to its emergency department and that it improves consumers' experience of care and social connectedness.[39] A case study on the St Vincent's Safe Haven is presented in section 9.6.1.

The Commission has also heard from consumers, families, carers and supporters and mental health service providers that a range of flexible, short-term residential respite services would be a welcome addition to the system.[40] A witness with lived experience of mental illness told the Commission:

> **One such support that I'd like access to, that we don't currently have in Victoria, is a peer respite service. Peer respites are a voluntary service, staffed by consumer peer support workers, where people can come and stay for approximately seven days. During that time, they can also have full access to their life as well.[41]**

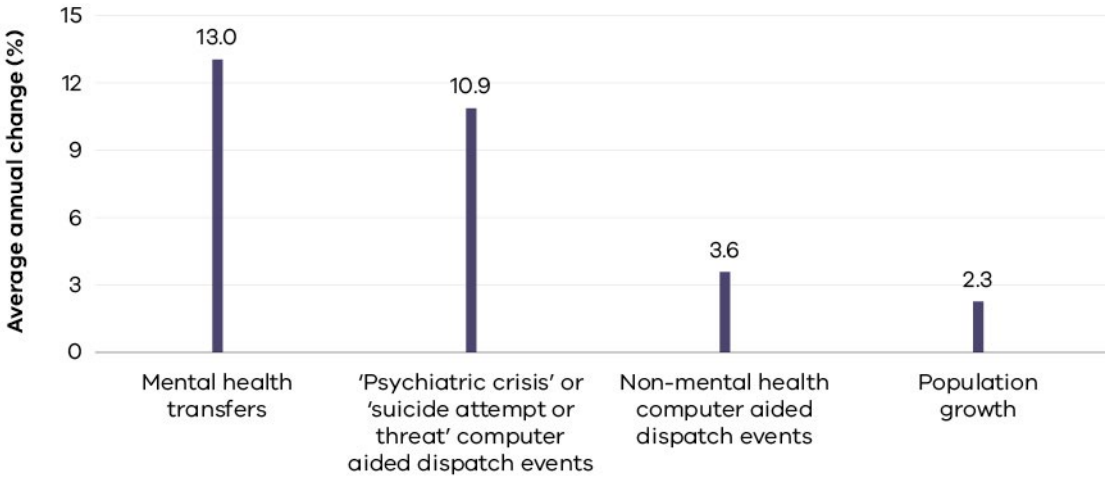
The Commission's recommendation to establish a range of short-term residential respite services is detailed in Chapter 10: *Adult bed-based services and alternatives*.

9.2.4 Reliance on police to respond to mental health crises

The Victorian Government has acknowledged that a lack of mental health services is contributing to an increased reliance on the police to respond to people experiencing mental illness or psychological distress.[42] The Commission's interim report presented data showing strong growth in mental health–related attendances and transfers by Victoria Police between 2014 and 2018.[43] This data, replicated in Figure 9.2, indicates that mental health–related attendances grew by an average of more than 10 per cent each year compared with a 3.6 per cent growth for non-mental-health attendances and general population growth of 2.3 per cent. Police-led mental health transfers to hospitals grew by 13 per cent in the same period.

Victoria Police's submission to the Commission noted that in 2017–18 police attended approximately 43,000 events relating to a mental health crisis, meaning that police responded to mental health callouts on average once every 12 minutes in that year.[44]

Figure 9.2: Annual growth in the number of police attendances for mental health–related events and transfers to hospital, Victoria, 2014–2018



Sources: Victoria Police, Law Enforcement Assistance Program and Computer Aided Dispatch system, 2014 to 2018; Australian Bureau of Statistics, Australian Demographic Statistics, July 2014 to June 2018, cat. no. 3101.0, Canberra.

Note: Average annual growth rate is based on the compound annual growth rate (CAGR)

Given that most people experiencing a mental health crisis have done nothing illegal, the involvement of police can be humiliating and traumatic.[45] Many consumers, carers and service providers—including Victoria Police itself—expressed dismay about the growing involvement of police in situations where people are experiencing a mental health crisis.[46] For example, in an anonymous submission to the Commission, one carer described the experiences of supporting her son:

> When I call [the Crisis Assessment and Treatment Team], they say call the police … My son has threatened to kill me before when he's been psychotic and off his medication and I have had to take out an [intervention order]. While I have had some good experiences with police and ambulance, not all understand mental illness and they shouldn't be the main point of call for people who need specialised treatment for mental illness. Police have fined my son for walking close to the freeway when he was suicidal. Instead of getting him help, he spent the night in jail. But without the police my son would be dead. I am grateful that the police were there, however it is not their job.[47]

9.2.5 Missed opportunities and poor experiences of care

While people experiencing mental health crises are vulnerable and distressed, a crisis can be a turning point for some people.[48] Dr Roberto Mezzina, former director of a network of alternative community mental health services in Trieste, Italy, writes that crisis should be seen as an opportunity to understand the underlying causes of the person's distress and connect them with family and community support systems to promote recovery. Along with his colleague, Dr Daniela Vidoni, Dr Mezzina writes:

> A number of theories describe crisis as a positive opportunity, an event which has the potential to bring about transformations … Even in the case of psychotic crisis there is the possibility of a "growth experience". But this concept of crisis, which seeks to reassess mental illness by investigating suffering in the individual's life, is often denied by intervention philosophies which immediately codify the crisis according to restrictive medical-psychological models and related practices which aim at containing and controlling it.[49]
>
> the links between the crisis and his life history must be identified, and significant existing relationships must be reconstructed and redefined while new ones are formed. The crisis can thus lose its characteristics of rupture and dissolution of the existential continuity, and acquire a dynamic value.[50]

However, as in all areas of mental health, outcomes for people experiencing mental health crises—and families, carers and supporters—depend on the quality of their interactions with people. Unfortunately, the Commission has heard too often that people in crisis, and families, carers and supporters, have experienced very poor practices and attitudes from those whose role it is to help them.[51] While the quote below, from a Commission witness, Lucy Barker, is one of the more disturbing accounts presented to the Commission, it echoes other feedback received:

> Once I went to an emergency department after self-harming and I needed stitches and some sort of medical attention. The doctor said to me, 'You will do it again anyway so I might as well staple you'. He did so with no anaesthetic.[52]

Examples of people's experiences of crisis care in other settings are highlighted throughout this chapter. In considering all the evidence before it, the Commission agrees with Professor Braitberg's conclusion that 'the current approach to dealing with individuals who are experiencing a mental health crisis can be quite punitive'.[53]

9.3 A reform pathway to improved services for people experiencing mental health crises or psychological distress

The Commission has presented an ambitious set of recommendations that, once fully implemented, will give Victoria one of the best and most comprehensive mental health crisis response systems in the world. The Commission does not underestimate the challenges involved in realising this vision and understands that some aspects of the reform agenda, such as those requiring legislative change, will take some time to implement. However, given the high stakes involved, full implementation of these recommendations must be a high priority for the Victorian Government. Figure 9.3 provides an overview of the crisis and emergency response options that will be available in the reformed mental health and wellbeing system.

9.3.1 Filling service gaps

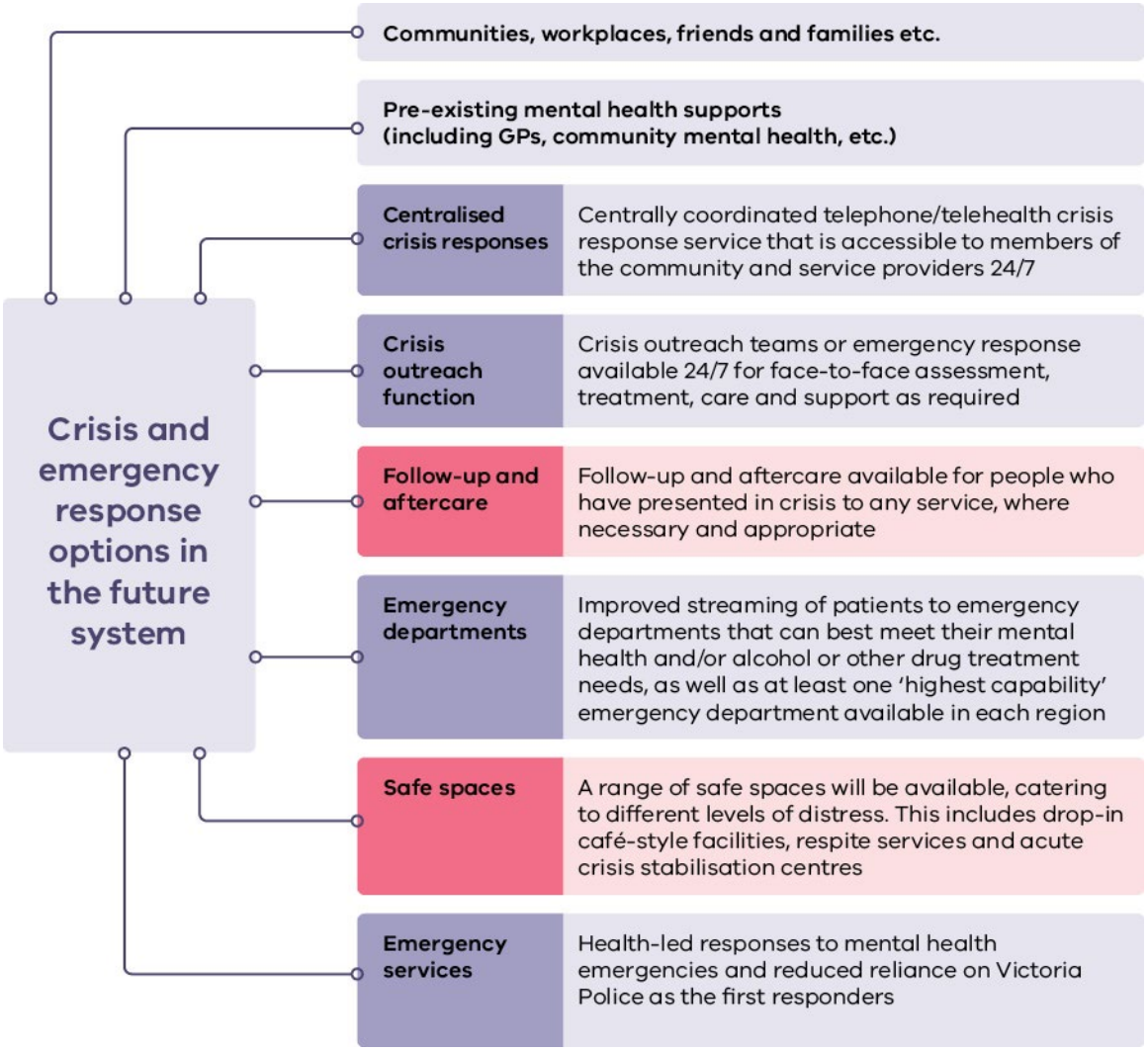
The Commission's recommendations have been shaped by evidence that Victoria does not have the continuum of services needed to respond to the volume and the wide spectrum of mental health crises and emergencies that occur each year in this state. The Commission's recommendations are intended to fill these gaps by creating new service options, such as drop-in and respite services, and by transforming existing crisis and emergency services.

Consumers and carers who participated in the Commission's focus groups on crisis responses said that the system should provide multiple options and channels of assistance—including digital, telephone and in-person responses—adjusted to different types of crises and the preferences of people seeking urgent support.[54] They emphasised that the community must be aware of the availability and role of different types of crisis services to ensure that, as far as possible, people contact the 'right' service in the first instance.

Clinicians and service managers at the Commission's roundtable meeting on crisis responses concurred. Mr Peter Kelly, Director Operations, NorthWestern Mental Health, Melbourne Health, The Royal Melbourne Hospital, commented:

> it is incredible, we should be able to go into this with five options at our disposal, you know, respite care, home-based treatment, admission, onwards referral, or no further action when, in fact, most of the time you are doing it with one hand tied behind your back and you don't have those five options. So, we've got large numbers of people queued up [in the emergency department] waiting for admission now and … it's trying to meet the threshold of risk that gets that person to the front of the queue.[55]

Figure 9.3: Future pathways for people experiencing mental health crises



One participant in the Commission's crisis response roundtable spoke of the need for good connections between different elements in a continuum of crisis services:

> [The system needs] a continuum of care that goes from the phone to the localised approach to the stabilisation unit to hospitalisation, all staffed by people who are trained to be there. The individuals are getting assessed at every one of those points that they may enter that continuum and therefore they should be being directed to the right place … irrespective of what that might be.[56]

9.3.2 Coordinating crisis responses and follow-up care

As well as the crisis-specific services discussed in this chapter, outcomes for people in crisis will be improved through better connections between crisis responses and services that can provide follow-up care. The Commission expects that in Victoria's new mental health and wellbeing system, crises will be an access point to meaningful involvement with mental health and wellbeing services and supports. Workers providing crisis responses will be encouraged to think about how people in crisis can be linked to services and programs that can provide follow-up, aftercare and—if necessary—longer-term care. This is especially important for people who use crisis and emergency services repeatedly: they should have their needs comprehensively assessed and receive support to respond to the underlying causes of their distress.

The Commission also expects that crisis response services will assess people's need for alcohol and other drug treatment and assist that treatment where required. In providing evidence, Associate Professor Stafrace identified that people experiencing mental health crises often have urgent needs relating to alcohol or other drugs.[57] In crisis situations, it is difficult to determine whether a person's difficulties relate primarily to mental illness, alcohol and other drugs, or both.[58] This means that crisis services must be able to support both sets of needs.

Contemporary ways of sharing information discussed in Chapter 35: *New approaches to information management* will be critical to create better coordinated crisis care across and within health services (emergency departments, crisis outreach units, inpatient units and community mental health), as well as with first responders (ambulance and police).

Mr Shane Solomon, Partner of Caligo Health but providing evidence in a personal capacity, noted that coordination of care in a crisis or emergency is hampered by disconnected data systems operating across Victoria's health services and other services. He said this means that 'no one is able to see … what the … others are doing', which creates inefficiencies and missed opportunities to respond to a person before the situation leads to harm or hospitalisation.[59] Mr Solomon said that the benefits of information sharing include the fact that it enables service providers to quickly identify people with escalating risks, allows them to avoid duplication and helps them identify gaps in a consumer's care plan.[60]

9.3.3 Reducing the need for emergency departments and police

While acknowledging the critical role of hospital emergency departments in assessing and treating some people experiencing a mental health crisis, the Commission recommends new and reformed service elements that will reduce the need for people to attend hospital emergency departments. These include a reformed, expanded crisis outreach function as a core element of the Area Mental Health and Wellbeing Services described in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services* and new 'safe spaces' for crisis resolution.

The Commission's strategy also aims to reduce police involvement in mental health crises. It has recommended a major shift away from police being the first responders in these situations, moving instead towards a health-led response. Wherever possible and safe, Ambulance Victoria will be the default emergency services responder when people call Triple Zero (000). Police will be involved only where necessary to ensure the safety of consumers, families, carers and supporters, workers and/or the community.

This reform will establish the comprehensive, networked system of crisis supports that is critical to ensuring people are not drawn unnecessarily into settings and situations that may worsen their illness and distress.

9.3.4 Tiered system of support resources

Across its recommendations, the Commission has focused on the need for greater mental health promotion, the prevention of mental illness and early intervention efforts with the intention of delivering a tiered system of support and reducing demand for crisis response resources. The following efforts will further support the Commission's crisis and emergency response strategy:

- **Lower cost alternatives and earlier intervention options to help reduce presentations to emergency departments**—the Commission encourages the Victorian Government to invest in several innovative models of 'safe spaces' for people experiencing a mental health crisis. These should be carefully monitored and evaluated, with successful models being embedded more widely in Victoria's future mental health and wellbeing system
- **Larger and better-resourced emergency departments to support smaller emergency departments and urgent care centres**—this will enable appropriate streaming of patients to the facility best suited to their needs
- **More effective use of paramedics**—there is an opportunity to make better use of Victoria's large, well-trained paramedic workforce to respond to mental health emergencies
- **Digital technology to improve outcomes for people in crisis and families, carers and supporters**—notably, telehealth or ambulance backup will be used where the physical presence of mental health clinicians is not feasible—for example, when travel would take too long
- **Identifying frequent users of crisis services and planning care to prevent their need for continuing crisis responses**—this will require better information sharing between different crisis services, as well as with other services and individuals involved in the person's treatment, care and support.

9.3.5 Effective and compassionate crisis care

Above all, the Commission expects that Victoria's future community-based crisis system will be compassionate, respectful of human dignity and aware of the trauma many consumers have experienced. Service providers will be expected to nurture the strengths of individuals rather than focusing on deficits. The least restrictive approaches will always be the starting point, with people's rights and agency (choice and control over what happens to them) upheld to the greatest extent possible. Families, carers and supporters will be engaged as partners in crisis resolution and will also receive help in having their own needs met.

Evidence-based crisis interventions

There is an assumption across all elements of the Commission's crisis recommendations that the workforce will be supported to deliver effective, age-appropriate and culturally sensitive treatment, care and support. This will include brief interventions that tackle people's immediate needs and identify their follow-up needs.

The Commission recommends that the Collaborative Centre for Mental Health and Wellbeing brings people with lived experience together with researchers and practitioners from a range of disciplines to identify and promote evidence-based, compassionate crisis responses. This is consistent with the many submissions and witness statements to the Commission that have identified a need to increase professional capability in effectively responding to suicide and other experiences of crisis.[61]

For example, Professor Alan Rosen AO, Professorial Fellow, Illawarra Institute for Mental Health, University of Wollongong and Clinical Associate Professor, Brain and Mind Centre, Sydney Medical School, University of Sydney, advised the Commission of the need to develop worker skills in de-escalating distress and aggression and the importance of using high-quality evidence-based brief interventions that respond to people's immediate and follow-up needs:

> There are evidence-based skills for interacting with people in ways that soothe emotions and aggression, elicit co-operation and create therapeutic alliances. That applies for people with mild to moderate conditions, all the way through to those with severe psychiatric or behavioural disabilities.[62]

Similarly, Ms Sandra Keppich-Arnold, Director of Operations and Nursing for Mental and Addiction Health at Alfred Health, told the Commission:

> Investment is required to implement a large range of psychological therapies, particularly in adult services. This is a vital component of providing crisis response services to all consumers. Notably there are specific programs that are occurring in certain [area mental health services]. The Alfred has established specific programs to support consumers therapeutically when they have a borderline personality disorder, including programs to support establishing and building social relationships (such as rel8) and cognitive remediation. This is not routine but needs to be.[63]

Valuable insights about improving the quality, safety and effectiveness of crisis interventions may be found in literature that considers:

- managing acute behavioural disturbances in emergency departments[64]
- brief interventions aimed at increasing people's tolerance of feeling distressed[65]
- solutions-focused counselling[66]
- the Scottish Brief Distress intervention, a supportive and problem-solving contact with an individual in distress.[67] This is discussed further in Chapter 17: *Collaboration for suicide prevention and response*
- psychoeducation for consumers[68]
- psychoeducation for families, carers and supporters[69]
- single-session therapy[70]
- crisis interventions that use a strengths-based perspective and a person's natural support systems to promote their recovery.[71]

Shifting cultures of blame and fear

It is the Commission's view that when consumer death or other serious incidents occur, Area Mental Health and Wellbeing Services should engage in collaborative and reflective processes with all those involved in the individuals' treatment, care and support to understand what happened, and how to prevent the same occurring in the future. This includes families, carers and supporters where appropriate and necessary. While a sense of accountability is essential, allocation of blame is not.[72]

Currently, many clinical mental health services use a method called 'root cause analysis' to investigate consumer deaths or other serious incidents. While this is intended to pinpoint the cause of the tragedy to prevent it happening again, senior clinicians told the Commission that root cause analysis has helped create an 'insidious' culture in which clinicians are afraid to make decisions or to involve family, carers and supporters in consumers' care.[73]

'Restorative just culture' has emerged as an alternative approach to decision- and blame-avoidance and investigating adverse incidents.[74] This approach shifts the focus from blaming individual clinicians when something goes wrong to looking at systemic and cultural factors that may have contributed. The Commission heard that the restorative just culture approach encourages clinicians to give consumers agency, even if this means taking some risks.[75]

Whilst mental heath and wellbeing services have an important role to play in investigating consumer deaths, there are other agencies that have statutory and regulatory functions to perform in these tragic circumstances. These include the Coroners Court of Victoria and Safer Care Victoria, refer to Chapter 30: *Overseeing the safety and quality of services* for further details on these roles.

Creating new roles for peer workers

Across its crisis response recommendations, the Commission has foreshadowed greater use of the mental health peer workforce. Evidence before the Commission suggests that many consumers and families, carers and supporters value support from people who have had similar experiences to themselves because they believe their peers will treat them with compassion and instil hope for recovery.[76]

The Commission's emphasis on peer involvement in crisis care also responds to extensive evidence, which is discussed in relevant sections of this chapter, that peer workers—including in crisis-specific roles—can increase people's involvement with mental health services and improve self-care, social functioning and quality of life.[77]

Many consumers and families, carers and supporters consulted by the Commission wanted to see peer workers employed as part of frontline crisis response services.[78] The thinking behind this advice is well explained in the witness statement of Mr Dave Peters:

> Peer support is vitally important, because it leads the way in providing people in crisis or distress with hope. If people with lived experience are sufficiently situated in their lives to be able to offer that support to others, and if they can learn the skills required to provide that support, then they are in an incredible position to offer their insight and support. The key skills that I think are required to provide that support include the ability to create a safe space for people to share their stories, being aware of vicarious trauma, knowing your own boundaries and engaging in self-care.
>
> The sharing of similar experiences allows a level of compassion and empathy that people who have not had the experience themselves cannot demonstrate. When someone who is supporting you declares openly that they have gone through similar experiences, it makes a significant difference. They can act as a personal demonstration of recovery—an embodiment of hope for your own future recovery. It's incredibly powerful to hear someone else articulate what it is that you're feeling, what it is that you've been going through. That is particularly important when you are struggling to express yourself.[79]

Chapter 33: *A sustainable workforce for the future*, outlines the Commission's commitment to employing peer workers in the mental health and wellbeing system and to building the leadership capability of the lived experience workforces. In this chapter, the Commission has recommended new roles for peer workers, including as part of crisis outreach teams and in a variety of 'safe spaces' for resolving crises. The Commission notes here that the implementation of these services should consider the specific needs of families, carers and supporters, who are themselves often deeply affected when someone they care for is experiencing a mental health crisis. Wherever possible, dedicated peer worker roles should be established for families, carers and supporters and others involved in the crisis. These roles are additional and complementary to the non-service specific supports recommended by the Commission for families, carers and supporters in Chapter 19: *Valuing and supporting families, carers and supporters*.

9.4 Crisis responses in mental health and wellbeing services

In the new system of mental health and wellbeing services recommended by the Commission, there will be clear points of contact for telephone and telehealth crisis responses. These services will be available to the community and service providers 24/7 and will coordinate crisis outreach teams and crisis aftercare as required.

The Commission expects that the Department of Health will oversee the implementation of the reforms, working together with Area Mental Health and Wellbeing Services and Regional Mental Health and Wellbeing Boards.

9.4.1 Around-the-clock crisis responses across all age groups

In the reformed mental health system, as described in Chapter 5: *A responsive and integrated system* through to Chapter 8: *Finding and accessing treatment, care and support*, responding to crises is a core function of Area Mental Health and Wellbeing Services. These services will respond to requests for crisis assistance from any member of the community, 24 hours a day, seven days a week.

The different age-based Area Mental Health and Wellbeing Services will collaboratively decide on the best service configuration to deliver age-appropriate crisis responses across the 24-hour cycle. In areas where there is enough demand, this may include dedicated infant, child and youth crisis responses (spanning 0 to 25 years) across the entire 24/7 cycle or for shorter periods around times of likely high demand. In most areas, adult and older adult services may provide whole of life crisis responses with clinicians and support workers drawn from infant, child, youth and adult specialties where possible. The Commission recognises that it is desirable to have specialised crisis responses for different age groups.

However, the Commission also acknowledges that significant resources are required to provide a 24/7 response and, in particular, that there is a high level of volume required to justify the costs of staffing associated with delivering a 24/7 response for infants, children and young people. Area Mental Health and Wellbeing Services should carefully consider, in consultation with the Department of Health, whether their service meets the level of volume to justify a specialist response for infants, children and young people.

Regardless of the service configuration established, it is essential that all crisis and emergency services can deliver age-appropriate services to children and young people. The following quote from a family member of a child experiencing a crisis illustrates why this is needed:

> On the call to triple zero we got asked a lot of questions, and, naively, I answered them. They asked me, 'Is he being violent?' And I said, 'Well, yes, you know, this Grade 4 kid is being violent.' Because of that, when they arrived, the ambulance paramedics would not enter the house without the police. The police took ages to arrive. When they did, they came into the house and restrained Matthew, and it got worse and worse. They said, 'Okay, he needs to go to the emergency department.' But the ambulance wouldn't take him without the police restraining him. So, there was a Grade 4 kid in the back of an ambulance being restrained.[80]

9.4.2 Centralised crisis responses within areas, subregions or regions

In the reformed system, Adult and Older Adult Area Mental Health and Wellbeing Services will provide a centrally coordinated crisis response function that is accessible to members of the community and service providers 24/7.

However, the Department of Health's implementation of the reforms should give Area Mental Health and Wellbeing Services the flexibility to combine their crisis assessment and response functions across multiple area services or even a whole region. This is consistent with evidence before the Commission that greater centralisation of triage functions over larger geographical areas promotes consistency of practice, strong clinical governance and accountability, and the development of a workforce that is highly skilled in assessing and responding to requests for urgent assistance.[81]

These services will be appropriately resourced to deliver high call-answer rates, with minimal waits to speak with a clinician. They will be equipped with technology to allow video as well as telephone consultations and high-quality collection of consumer information. As detailed in Chapter 35: *New approaches to information management*, new arrangements for sharing information between service providers, with consumer consent, will provide Area Mental Health and Wellbeing Services with greater access to information about the consumer's history. This will help clinicians make decisions in crisis situations.

The staff responsible for this function will be well trained to identify people who are at high risk of imminent harm, either to themselves or others. In this context, the Department of Health should assess the interview protocol used in Crisis Now call centres in the United States, which may be suitable as a standard tool supporting crisis responses in Victoria.[82]

In emergency situations, callers will be transferred to Triple Zero (000). The Area Mental Health and Wellbeing Service will collaborate closely with emergency services in these situations and provide necessary assistance. For example, where paramedics attend to a person who they believe can be safely left at home, it may be appropriate for the Area Mental Health and Wellbeing Service to send a crisis outreach team or arrange a same day or next day appointment at a clinic, where possible.

In non-emergency situations, clinicians will aim to stabilise the person's crisis on the telephone or via a telehealth consultation, and then arrange follow-up care if needed. Several features of Victoria's reformed mental health system will facilitate these responses. For example, clinicians will be able to:

- deliver brief solution-focused therapeutic interventions
- book consumers with urgent needs into same-day or next-day clinic appointments, where possible, in Local Mental Health and Wellbeing Services or Area Mental Health and Wellbeing Services (well-resourced 'initial support and needs identification' resources and strategies for efficiently managing demand, as discussed in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*, will create more capacity for urgent appointments)
- refer consumers to one of a range of new mental health and wellbeing programs offering limited-term treatment, care and support. This is described further in section 9.6.

In some cases—usually when there is a need for urgent review by a psychiatrist or medical treatment for physical injury or illness—clinicians will refer people to an emergency department. They will also be able to mobilise a crisis outreach team, as described in section 9.4.3.

9.4.3 Crisis outreach reformed for the 21st century

As mentioned in section 9.2.3, a crisis outreach function—known as Crisis Assessment and Treatment—was a core component of the system of community-based mental health services established in the 1990s.[83] However, it is no longer provided consistently in area mental health services across the state.

Along with many others, Professor Rosen called for the reinstatement of dedicated, mobile crisis outreach services in Victoria.[84] In his witness statement, Professor Rosen told the Commission:

> crisis teams are for acute situations; they try to keep people out of emergency and out of hospital. Crisis teams also make sure people receive intensive services at home while they're in crisis, and work with them and their families 'on their own turf and terms'.[85]

Professor Rosen argued that this function should be reintroduced as a dedicated service element rather than integrated with other mental health teams:

> We need to have active-response not passive-response or sedentary teams. The home visiting component results in positive outcomes. All community mental health teams that have good outcomes have home visiting as a component. Therefore, it is important that we retain that component and develop it further.[86]
>
> People do learn particular evidence based skills in dedicated teams … Properly resourced 24/7 crisis teams are often well trained in and organised for suicide prevention or self-harm repetition, including [dialectical behaviour therapy].[87]

In his witness statement, Mr Kelly explained why it may be important to have in-person contact with people in crisis, preferably in their own homes:

> In a consumer's house … so much more information can be gathered for example:
>
> (a) how the person is dressed—neatly kempt, dressed appropriate to weather etc;
>
> (b) their level of eye contact;
>
> (c) facial expression—affect;
>
> (d) their level of self-care;
>
> (e) how they are interacting with others in the house;
>
> (f) whether any dependent children [are] being adequately cared for or neglected.[88]

The Commission's examination of relevant literature identified consistent evidence in favour of mobile crisis outreach. A recent academic overview of service models for urgent and emergency mental health care concluded:

> For people who do not require immediate intervention (< 2 hours), acute community care provides a number of benefits over hospital based services. They are better able to connect patients to ongoing care as appropriate in the community; provide enhanced patient and carer experience and are more cost-effective.[89]

The Commission agrees with extensive feedback received about the need to rebuild mental health crisis outreach capacity. However, on the advice of several mental health sector leaders, the Commission has recommended a reformed version of this function. For example, Associate Professor Ruth Vine, Director, Forensicare' noting Associate Professor Vine's role capacity and role at the time, told the Commission that the crisis outreach function in Victoria's reformed mental health system cannot simply replicate the model of Crisis Assessment and Treatment established in the 1990s. Associate Professor Vine said:

> The idea of [Crisis Assessment and Treatment] is still attractive but issues such as cost, workforce availability and social change mean that it is probably not realistic to return to having [Crisis Assessment and Treatment] as described in the 1990s frameworks.[90]

The Commission expects the crisis outreach teams to be available 24/7 for face-to-face clinical assessment and treatment as required. Crisis teams will use telehealth video consultations or ambulance backup when the physical attendance of a crisis outreach team is not possible or would take too long.

Personal story:

Kiba Reeves

Kiba is 21 years old and has been a consumer of the mental health system from a very young age. He has diagnoses of borderline personality disorder and autism spectrum disorder.

Between the ages of 13 and 17, Kiba attempted suicide multiple times. He sought help at the local emergency department but was often told there were no beds available, or that it was better to deal with his issues at home. Kiba said this made him feel like he was being told nothing was wrong with him.

> When someone is telling me that, I kind of think 'okay nothing's wrong, so it's gotta be me'. It made me feel like maybe I was making it up … [T]hen I kind of go into self-destruct mode and spiral out of control and attempt to self-harm or suicide again. So I guess the more I got dismissed, the more vicious the cycle became.

While Kiba's experiences in the youth mental health system were more positive, he says that in the adult system he was made to feel like a 'burden to deal with.' Kiba feels that hospitals do not have a recovery focus.

> [In the adult mental health system] it was like they wanted me gone and wanted me gone quickly. And I would get out, but some stuff I had to deal with remained unresolved.
>
> When I was discharged from hospital, I was sent home with a temporary plan … However, these temporary plans did not work for very long because there was nothing long term in them that I could cling to and work towards.

Kiba's mental health is much better now, after he found support through a community-based organisation. This includes both wellbeing supports and care coordination.

> [The organisation] [provides] me with one-on-one support and group sessions, and they teach life skills like cooking. Having a … support coordinator has been the best thing that has ever happened to me because I can't find these resources on my own.

Since receiving this support, Kiba has become more outgoing and is often out socialising.

> I wouldn't be where I am now without [the organisation]. I was drowning for a long time and they threw me a lifeline and pulled me back aboard … I feel like they care about me and they want to work with me.

In a future system, Kiba would like to see more mental health beds so that people can get the care they need. He also thinks that hospital settings should be less sterile and 'more colourful and brighter'. Kiba had positive experiences with a sensory room in a paediatric ward, and would like to see more of these in mental health services.

> [I]t was a godsend because it provided me somewhere where I could go, 'Okay, I'm overwhelmed. I can come in here and I can talk to the staff. I can pull a blanket over myself. I can use some sensory tools to help ground myself back into reality a bit more'.

Following a recent inpatient experience, Kiba would also like to see greater follow-up care.

> There was very little follow up and I think that needs to change. I was thrown to my mum, got one phone call and that was the end of the care that they provided me.

Source: *Witness Statement of Kiba Reeves*, 29 May 2020; Kiba Reeves, *Correspondence to the RCVMHS*, 2020

The crisis outreach function in the reformed mental health and wellbeing system will also differ from traditional Crisis Assessment and Treatment Teams in the following ways:

- In contrast to the Crisis Assessment and Treatment Teams designed in the 1990s, which were explicitly a hospital alternative for people with severe mental illness, the new crisis outreach function will aim to reduce emergency department use and emergency services involvement for a broader group of people. The target group will include people with suicidal thoughts and intent, people experiencing psychological distress, and those whose mental illness or distress is complicated by alcohol and other drug use.
- The assessment of people's need for a crisis outreach response will focus on their level of psychological distress and risk and their need for a home-based assessment (for example, where it is important to see their living situation or where they cannot or will not attend a clinic).
- Rather than the entirely clinical staffing model of the old Crisis Assessment and Treatment Teams, people in the community will be visited by a clinician and a non-clinical support worker, ideally a peer worker. As mentioned earlier, peer workers have much to contribute to crisis responses. However, as Professor Rosen explained to the Commission, they may benefit from working alongside clinicians in potentially traumatic situations:

> If peer workers and mental health professionals work together with a particular person, there are likely to be synergistic benefits … In my view, it is important that peer workers synergise with mental health professionals.
>
> The peer workers need mental health professionals in the team that can help them feel supported and not to feel traumatised. The presence of professionals also allows for some pastoral mentorship and supervision. They can help put things in perspective and give peer workers the benefit of the more professional psychotherapeutic skills needed in such teams.[91]

The Commission believes that including peer workers in crisis outreach teams will help embed compassionate cultures and practices. Among consumers and carers consulted by the Commission, there was a strong perception that current Crisis Assessment and Treatment Teams are often less helpful than they should be; for example, they may focus on determining whether the person meets thresholds for compulsory treatment rather than helping with crisis resolution.[92] One witness told the Commission about her experiences with a Crisis Assessment and Treatment Team:

> In the lead up to my second psychotic episode, I called the [Crisis Assessment and Treatment Team] 11 times and asked for help, telling them that something was not right and that I was scared. They told me to go back to sleep and consistently dismissed my concerns … When my parents called the [Crisis Assessment and Treatment Team], they were taken more seriously than when I had called and the [Crisis Assessment and Treatment Team] eventually visited me. By that stage, I was psychotic and unaware of my surroundings. The [Crisis Assessment and Treatment Team] determined that I would not willingly get into an ambulance and called the police. Four police officers attended and escorted me into the ambulance.[93]

Linkages to other services

The reformed crisis outreach model will have strong pathways and linkages across the full spectrum of mental health and related services available in the area. This will ensure that consumers, families, carers and supporters experience continuity of care between crisis outreach responses and other services, such as other community-based mental health services, emergency departments and inpatient units. The Commission heard from Victoria's Mental Health Complaints Commissioner that responses by existing Crisis Assessment and Treatment Teams 'take people by surprise and don't reflect agreed plans or alternative treatment options', reflecting their lack of connection to treating clinicians.[94]

Professor Braitberg advocated for a model of crisis outreach in which the teams have good connections to other services:

> **There also needs to be an improved continuity of care plan between hospitals, emergency departments and crisis outreach services, general practitioners and other community health care providers. [Currently] there are limited links between emergency departments and crisis outreach services. To ensure as many people as possible are kept out of hospitals and institutions, we need clear pathways for communication and continuity of care planning and delivery.**[95]

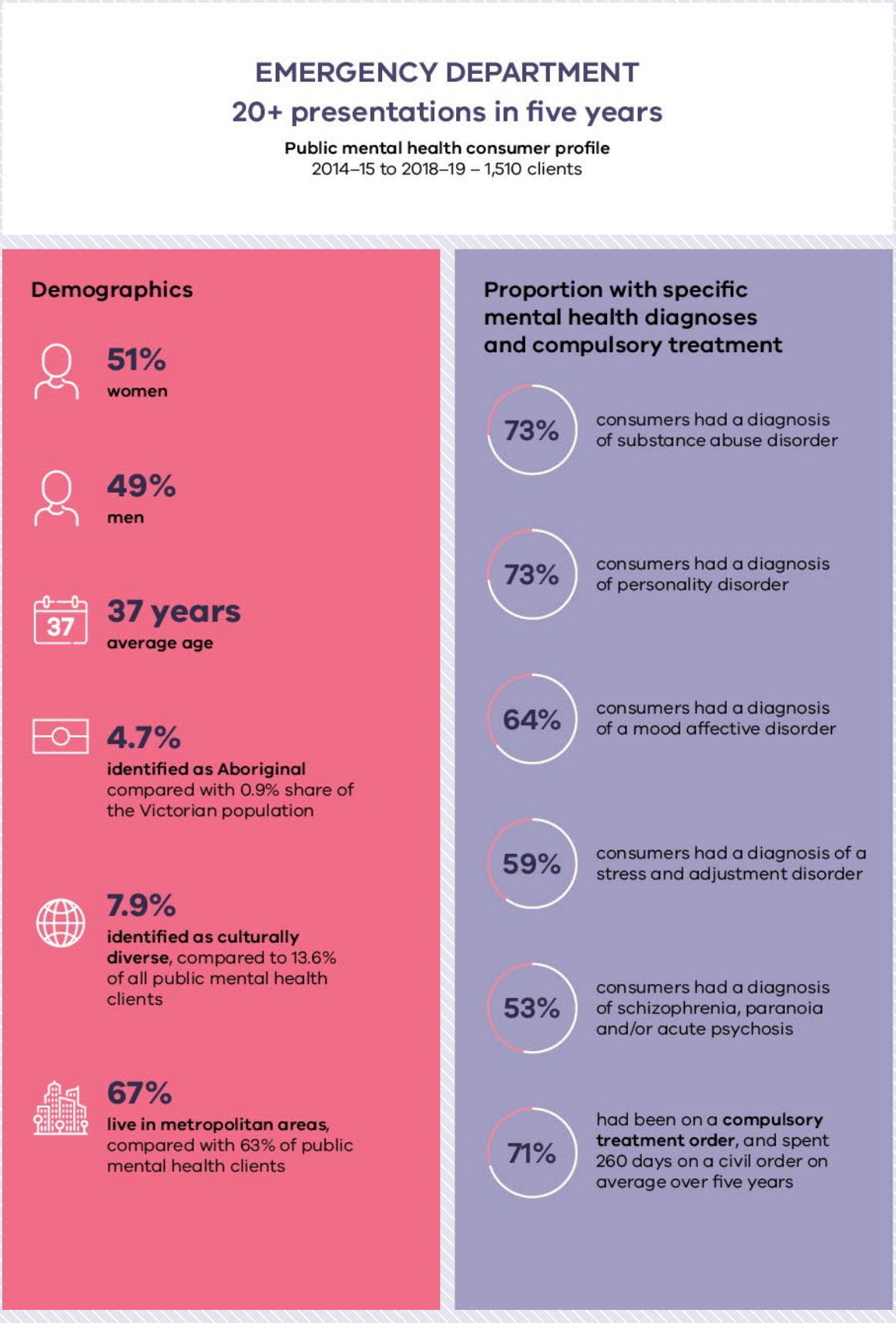
Finally, there will be partnerships between the new crisis outreach teams and emergency services (police and ambulance). Ambulance and police will of course provide backup for the crisis outreach teams, as they do now. However, crisis outreach teams will play an important role in achieving the Commission's vision that people experiencing mental health crises receive a health-led response—without the involvement of police—wherever possible and safe. While ambulance services will have improved capacity to respond to mental health emergencies as required, as explained in Section 9.7, rebuilt and reformed crisis teams in Area Mental Health and Wellbeing Services will reduce the need for involving both police and ambulance services in mental health crises.

9.4.4 Follow-up and aftercare as essential elements of the crisis response

While each crisis is an opportunity to provide something that will help the person, it is critical that the crisis is seen in the context of the factors that have contributed to the crisis occurring, or that could help to resolve it—that is, that the crisis is not seen in isolation. Without follow-up, opportunities may be missed to connect the person with services and supports that could help them with the issues that led to their crisis.

Mr Ivan Frkovic, Queensland's Mental Health Commissioner, told the Commission that crisis responses can be effective only in the context of a well-resourced system of community-based mental health services.[96] This is because people who present in crisis typically need to be linked to follow-up mental health services or—in the case of those already receiving mental health services—have their care plans reviewed. Currently, as the Commission has heard repeatedly, crisis responses are often disconnected from follow-up care.[97]

Figure 9.4: Profile of public mental health consumers who presented to an emergency department 20 or more times between 2014–15 and 2018–19



Use of health services

135 days average admitted length of stay, with **11 separations** on average

(compared with 60 days and 2 separations for all public mental health clients)

90% presented to ED for alcohol and drug related reasons, **80%** for suicide attempt/ideation and **63%** for self-harm related reasons

52% used alcohol and drug services

46% used community health services

39% used mental health community support services

48% are ongoing clients

32% had contact with an intensive community team (Intensive Mobile Youth Outreach Services, Mobile Support and Treatment Services)

34% bodily restrained and

23% secluded, compared with 4.1% and 2.7% respectively, for all public mental health clients

Health of the Nation Outcome Scales and Life Skills Profile measures: a high number of clients experienced and/or exhibited symptom severity and lower functioning scores. For example:

- overactive/aggressive/disruptive behaviour **(89%)**
- problem drinking or drug taking **(83%)**
- problems with relationships **(95%)**
- problems with occupation and activities **(91%)**

Use of human services

32% (under 25s) were the subject of a child protection allegation (21% were subject of a substantiated allegation)

41% on NDIS (only includes former Vic Gov supported disability consumers)

68% used homelessness services

36% on public housing waitlist

13% public housing tenant

17% used family violence services

21% used sexual assault services

Source: Commission analysis of Department of Health and Human Services, Integrated Data Resource, Client Management Interface/Operational Data Store, Victorian Emergency Minimum Dataset, Child Protection - Case Management, Victorian Housing Register, E-Justice, Family Violence Support Services Data Collection, Sexual Assault Services, Disability—individual support packages, Victorian Homelessness Services Collection 2014–15 to 2018–19.

Rachel Bateman, a witness, described to the Commission her experiences of being repeatedly turned away from services after presenting to emergency departments between 2017 and 2019:

> When going to [the emergency department] prior to harming myself, I often experienced six to eight hour waits before being moved into a cubicle, then waiting for a number of additional hours before getting brief conversations with a mental health clinician.
>
> After having a conversation with a mental health clinician, I am often turned away from services quite quickly. This makes me feel ashamed for having sought support in the first place.[98]

Dr Caroline Johnson, a GP, explained the importance of timely access to post-crisis care:

> sometimes a patient in crisis agrees to get help, but by the time the appointment comes through the crisis has subsided and the patient is no longer willing to follow through with help-seeking (until the next crisis appears and the cycle starts again).[99]

The personal story of Mr Kiba Reeves, witness, highlights that the services people may find helpful are not necessarily traditional clinical services. Kiba said the social activities and life skills support he received through a non-government organisation were critical to his continuing recovery from mental illness and periodic suicidal crises.

In Victoria's reformed mental health and wellbeing system, Area Mental Health and Wellbeing Services will coordinate follow-up responses with people who have presented in crisis to any service, where necessary and appropriate. There will be a wide range of services, programs and other supports that can be offered to people trying to recover from a crisis. For example, people could be offered a 'comprehensive needs identification and planning discussion' in a Local Mental Health and Wellbeing Service or Area Mental Health and Wellbeing Service, as described in Chapter 8: *Finding and accessing treatment, care and support*, or could be referred to:

- the 14-day program of Brief Distress Intervention recommended by the Commission, discussed in detail in Chapter 17: *Collaboration for suicide prevention and response*
- telephone and online programs offered by non-government helplines, such as Beyond Blue and the Suicide Call Back Service
- the Hospital Outreach Post-suicidal Engagement (HOPE) program (while HOPE is currently targeted to people who present to emergency departments, the Commission recommended in its interim report that referral and entry pathways into the program should be expanded)[100]
- the new crisis respite facilities discussed in section 9.6.2
- organisations providing practical and emotional supports.

Personal story:

Mary Pershall

Mary's daughter, Anna, is serving a 17-year prison sentence after killing her housemate in 2015.

Mary said Anna began to have social and emotional challenges when she started primary school, where she struggled to fit in with her peers. Anna developed an eating disorder at age 14 and in her early 20s turned to drugs.

Mary said Anna had an endless string of encounters with crisis and emergency services.

> I'm glad I couldn't know what 2014 would bring to us. The nights of screaming and pleading, begging her to choose life. The locking up of knives, the frantic calls to police, the ambulance trips to psych wards.

Mary and her husband, John, sought help from numerous places, but Anna did not receive an in-depth assessment or connection to the type of care she needed.

> I trawled the internet and called so many programs, always with hope in my heart that these might be the people who could save my daughter. She was granted a few hours of advice or therapy here or there, while she became increasingly suicidal and John and I became increasingly exhausted.

Mary tried to get Anna into rehab. She was given an appointment for a detox facility 10 days later, by which point Anna had disappeared from home, which Mary said was increasingly common.

> The window of opportunity for someone like Anna to be open to treatment is small—too small for the waiting lists of government-funded facilities.

Following a violent outburst at home and threatening suicide, the police took Anna to an emergency department, where Mary said she was devastated when she was told Anna would not be admitted.

Anna was admitted to detox programs on two separate occasions. Mary said it was a relief to have Anna in a safe location so Mary and John could have some respite.

Unfortunately, after detox, Anna reverted back to drugs. Mary said she became increasingly disturbed and delusional. Mary said it was at this point they made the difficult decision that Anna could no longer live with them.

Following another incident where the police were called, Anna was admitted to an involuntary ward and later discharged to a man, previously a respite carer for Anna and her family, with whom she had formed a relationship.

> I certainly wanted to tell the authorities at the psych ward what to do. 'Don't let her go! She is not capable of making a rational decision!' She was still desperately delusional. … She thought the man she had called … could protect her.

Anna was once again admitted to a secure inpatient ward. Mary went to visit and said Anna was clearly distressed.

> She didn't want to leave that place. She wanted to be kept there, contained, because she knew she couldn't control herself. But she told me the person in charge of making that decision had spoken harshly to her, saying the psych ward was not there to provide accommodation to people just because they wanted it.

Mary wishes authorities had consulted the people who knew Anna best: her family and long-term doctor. Mary thinks this was a key reason why they failed to recognise the severity of her mental illness and distress.

> It was not a straight line, and some days were worse than others; however, there was definitely a trend that could have been picked up had a profile of her with my regular input been developed of Anna along the way.

Ultimately, Mary believes that Anna, who was usually articulate, polite and well presented, and came from a loving, supportive family, lacked many of the red flags clinicians would look for in a brief risk-focused assessment.

Mary speaks of the anger she felt upon hearing of what Anna had done.

> I wanted to line up all the authorities we had met from the mental health system and scream at them, 'Again and again you turned her away. You refused to contain her. You said she wasn't bad enough. Well, now she's murdered someone. Are you finally convinced that she's BAD ENOUGH?'

Mary feels it is a tragedy that 'it took the life of a good and innocent man to deliver Anna to safety'. Mary has written a book about Anna's experiences that led to the 'unimaginable horror' of her child taking another's life.

> There were failings that happened into the lead up to it, but both Anna and us as a family absolutely believe that she deserves to be punished and she got a fair sentence.

Despite her history, Anna's mental illness was appropriately treated only after she had been jailed. In Mary's experience, drug and alcohol services thought Anna's mental health problems were too tricky for them to handle, while mental health services offered only brief crisis interventions and inpatient stays.

Mary often reflects on where things went wrong. Mary thinks they should have sought guidance when Anna was still a child, but 'at the time we had no idea how her life would turn out'.

In a future mental health and wellbeing system, Mary would like to see better information flow between services such as the police, hospitals, GPs, social workers and the families of people experiencing mental illness, and better integration of information from different presentations over time. She also believes that integrated care planning is critical to providing effective, timely support.

Source: *Witness Statement of Mary Pershall*, 9 July 2019; *Gorgeous Girl*, Mary K Pershall, Penguin Random House.

9.4.5 Pathways for people who are frequently in crisis

Appropriate follow-up responses are especially important for people who use crisis and emergency services repeatedly. They should have their needs comprehensively assessed and be proactively helped to get appropriate treatment, care and support.

In the personal story provided, Ms Mary Pershall, a witness, describes some of her experiences as the mother of a daughter, Anna, who used crisis services frequently before being jailed for killing her housemate. This story illustrates how people can experience a revolving door of crisis-focused interventions without receiving the longer-term care they need.

In her witness statement and evidence before the Commission, Ms Pershall said that the mental health system failed to recognise the severity and escalation of Anna's mental illness and distress, because they treated each crisis event in isolation and failed to engage with people who could have told them about Anna's history.[101] In her witness statement, Mary asks:

> **Why couldn't the authorities have taken a team approach and consulted people who actually knew this young woman? They could have talked to Dr D, who had spent hundreds of hours with Anna. They could have consulted John and Katie and me, who had loved and cared for her for 26 years.**[102]

Like Anna in the period leading up to her crime, many people who are repeatedly in crisis have very complex needs. Figure 9.4 shows the Commission's analysis of data about people who presented to Victorian emergency departments more than 20 times between 2014–15 and 2018–19. Compared with other consumers of mental health services, this group of people was far more likely to use alcohol and other drug services, homelessness and justice services, and the National Disability Insurance Scheme. Despite this, less than half were ongoing clients of public clinical mental health services and less than a third had been treated by an intensive care team or other specialised service for people with complex needs.[103]

Some people with frequent crisis presentations may require longer-term, high-intensity care, either in a residential setting or the community. Implementation of the Commission's recommended reforms for people living with mental illness who require ongoing intensive support, as explained in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services* and Chapter 10: *Adult bed-based services and alternatives*, will help fill gaps in the availability of services for this group of consumers. However, if people who use crisis services on multiple occasions are identified earlier, it is likely that fewer intensive services will be needed. For example, 73 per cent of the frequent presenters described in Figure 9.4 had a diagnosed personality disorder and 73 per cent had a substance abuse issue. There are treatment programs for these conditions that are backed by strong evidence.[104]

As part of implementing its crisis response recommendations, the Commission expects that the new Mental Health Improvement Unit in Safer Care Victoria will engage with clinicians, consumers, families, carers and supporters to develop a guideline for identifying and responding to people who use crisis and emergency services on multiple occasions. The proposed guidelines would specify requirements for reviewing the person's treatment, care and support by practitioners from a range of disciplines and, where needed, referral to necessary services, including specialist personality disorder services and programs for people with complex needs.

9.5 Timely and caring responses in emergency departments

Implementation of the Commission's broader set of recommendations will reduce the need for people to attend emergency departments, relieving pressure on these vital services. However, the Commission recognises that emergency departments have a critical role to play in a comprehensive crisis system and that assessment and treatment in these settings is necessary and appropriate for some people experiencing crises related to mental illness, psychological distress and/or drug intoxication. These include people with co-occurring physical injuries or acute illnesses, acute or rapidly escalating psychosis, and acute, severe behavioural disturbance.

As shown in Box 9.1, mental health presentations to emergency departments are known for high levels of clinical acuity (a need for urgent treatment).

Data presented earlier in this chapter showed that people experiencing mental illness or psychological distress are waiting longer in emergency departments due to pressures on both emergency departments and acute inpatient units. Waiting long periods in high-stimulus emergency department environments, often for little therapeutic contact, can exacerbate mental health crises.[105] Further, the growth in presentations involving ice intoxication is challenging emergency departments to manage very high levels of behavioural disturbance and to create safe spaces to observe patients while they wait for effects of the drug to wear off.[106]

The Commission recommends targeted investment to ensure people who need to be seen in emergency departments receive the best possible treatment, care and support. The recommendations respond to evidence that some consumers, families, carers and supporters experience very poor care in these settings, as well as a lack of connection with ongoing services.[107]

9.5.1 Building on existing resources

In recent years, the Victorian Government has invested in improving mental health responses in emergency departments.[108] In implementing the Commission's recommendations, the Department of Health will build on these resources.

Existing emergency department resources include short-stay psychiatric planning and assessment units at 14 hospitals and 'ECATT' (community-based Crisis Assessment and Treatment Teams based in emergency departments) in many mental health–designated emergency departments. Most HOPE services are also based in emergency departments, although they mainly provide outreach to discharged patients who have attempted suicide and families, carers and supporters.

Box 9.1: Characteristics of people who present to emergency departments

Only 5.9 per cent of mental health presentations to emergency departments in 2019–20 were triaged as 'non-urgent' and, compared with 18.4 per cent for non-mental health presentations. A greater proportion of mental health–related emergency department presentations were in the 'resuscitation', 'emergency' and 'urgent' emergency department triage categories than emergency department presentations not related to mental health.[109]

More than twice the proportion of mental health-related emergency department presentations arrived by ambulance (52.9 per cent) compared with non-mental health presentations (23.0 per cent) in 2019–20. 2.9 per cent of mental health–related presentations arrived with police (less than 0.1 per cent arrived with police for presentations not related to mental health).[110]

The age distribution of mental health–related emergency department presentations was strongly skewed towards younger people aged 12–25. Self-harm presentations (excluding suicide attempts) are markedly more common in young people aged 15–24 years, particularly young women.[111]

The share of mental health–related presentations linked to suicide risk or suicide attempt/ideation increased each year from 8 per cent in 2008–09 to 16 per cent of all mental health–related presentations in 2017–18, then decreasing to 12 per cent in 2018–19 before rising again to 13 per cent in 2019–20.[112]

Just over a fifth of all mental health–related emergency department presentations related to alcohol and other drug use in 2019–20. While there were increases in all primary drug types, the largest increases since 2008–09 were for cocaine and stimulants, which include methamphetamine.[113]

Following alcohol and other drug intoxication, social or psychosocial problems, suicide risk, suicide attempt or suicide ideation, anxiety, schizophrenia and mood disorders accounted for the next greatest proportion of all mental health-related emergency department presentations in 2019–20.[114]

In 2019–20, 53.9 per cent of all mental health–related emergency department presentations were treated and discharged to the person's usual place of residence. Of the 37.8 per cent that were admitted, 41.5 per cent of admissions were admitted to short-stay beds. 8.3 per cent left the emergency department without treatment.[115]

In its 2018–19 State Budget, the Victorian Government committed funding to establish 'crisis hubs' that will provide integrated mental health, alcohol and other drug and physical health care.[116] The hubs will be established in the emergency departments of six hospitals: Monash Clayton, St Vincent's, Geelong, Frankston, The Royal Melbourne and Sunshine.[117] The hubs will be part of these emergency departments, while offering a specific stream of care in a dedicated area for people experiencing a mental health or alcohol and other drug crisis. The service model includes a co-located short-stay unit for people who do not need admission to an inpatient unit but who require a period of stabilisation and crisis support.[118]

The government's investment in the mental health/alcohol and other drug hubs responded to strong stakeholder advocacy, plus evidence that a similar model in New South Wales has had good outcomes. Observed outcomes included reduced patient aggression, and thus the need for physical restraint and the use of certain medications, as well as the time people had to spend in emergency departments.[119] A 2012 review of the New South Wales services, called psychiatric emergency care centres, found that they worked best for patients, carers and staff when the mental health service and the emergency department collaborated to deliver services. There was less support for the model when it was not functionally integrated with the emergency department.[120]

The Victorian crisis hubs have been welcomed by mental health service and emergency department representatives.[121] However, the Commission understands there have been major implementation delays and at the time of writing, minimal progress has been made.[122] The Commission calls for urgent government action to operationalise the new crisis hubs. Not only are they essential to meet the needs of people attending emergency departments for mental health and/or alcohol and other drug treatment in the current system, they are fundamental to the success of the Commission's reforms recommended in this chapter.

Health service representatives and the Australasian College of Emergency Medicine have also told the Commission that continued effort and investment is required to meet the needs of the increasing number of people attending emergency departments for mental health and/or alcohol and other drug treatment.[123] Ms Keppich-Arnold said:

> **Additional resources are still required in the emergency department to treat and contain mental health patients, and to ensure they do not deteriorate or require sedation or restraint. Investment in more welcoming, private, less chaotic, yet safe environments would be of benefit [and] the inclusion of peer models would be advantageous.[124]**

Similarly, a recent report commissioned by the Australasian College for Emergency Medicine recommended that:

> **Emergency department resourcing must provide for adequate clinical care and accommodation by including mental health expertise in emergency department staffing; providing ongoing mental health education, training and professional support for all staff; developing new workforce models including peer workers within emergency department teams; and applying emergency department design principles that create low stimulus, reassuring environments for people in mental health crisis.[125]**

9.5.2 Classifying and networking emergency department and urgent care centres

The Commission recommends that the Department of Health lead development of a classification framework in which all Victorian emergency departments and urgent care centres are classified according to their level of mental health capability and role in a regional network of services. The purpose of the framework would be to support sharing of emergency department resources across regions and streaming of patients to services that can best meet their needs.

Ms Cook advised the Commission to consider networks of emergency departments and urgent care centres in which larger and better resourced services provide support, advice and consultation to others:

> We should develop a model for capacity building mental health clinicians in [emergency departments] and [urgent care centres] that is consistent across Victoria, similar to the state-wide model for stroke treatment. We could enhance emergency and urgent care clinicians' capacity in the area of mental health triage by training them in the model approach and providing resources such as specialists' contact numbers … [However, South West Healthcare Mental Health Services] would not be able to staff that type of model without significant funding boosts and delivery upon the Victorian Mental Health Workforce Plan.[126]

As described in section 9.5.3, there will be at least one highest-level emergency department in each mental health and wellbeing region. These emergency departments will provide clinical consultation, training and other activities to build the capability of other emergency departments and urgent care centres in their region and will accept patient transfers from services with lower classifications in defined circumstances (for example, where a person with severe behavioural disturbance requires facilities not available at the referring emergency department). This will enable patients to be streamed to emergency departments with appropriate resources and improve the quality and safety of patient care.

The recommended classification framework for mental health and alcohol and other drug services in emergency departments will:

- specify minimum standards of care (and related workforce, practices and facilities) that all emergency departments and urgent care centres are expected to deliver to people with mental health and/or alcohol and other drug issues and families, carers and supporters
- designate Victorian emergency departments and urgent care centres according to the extra services and facilities they are expected to provide, and their role in a regional network of emergency department/urgent care centre services
- concentrate high-level resources, such as short-stay beds, behavioural assessment units and addiction medicine specialists, in a subset of emergency departments
- specify agreed triage, patient transfer and consultation-liaison protocols within each region so that lower capability services are supported by higher capability services
- guide the development of new education, training and research programs, both within regions and statewide
- outline general policies for best practice and cultural change in emergency departments, especially in relation to developing linkages and referral pathways with community-based services and employing peer-support workers.

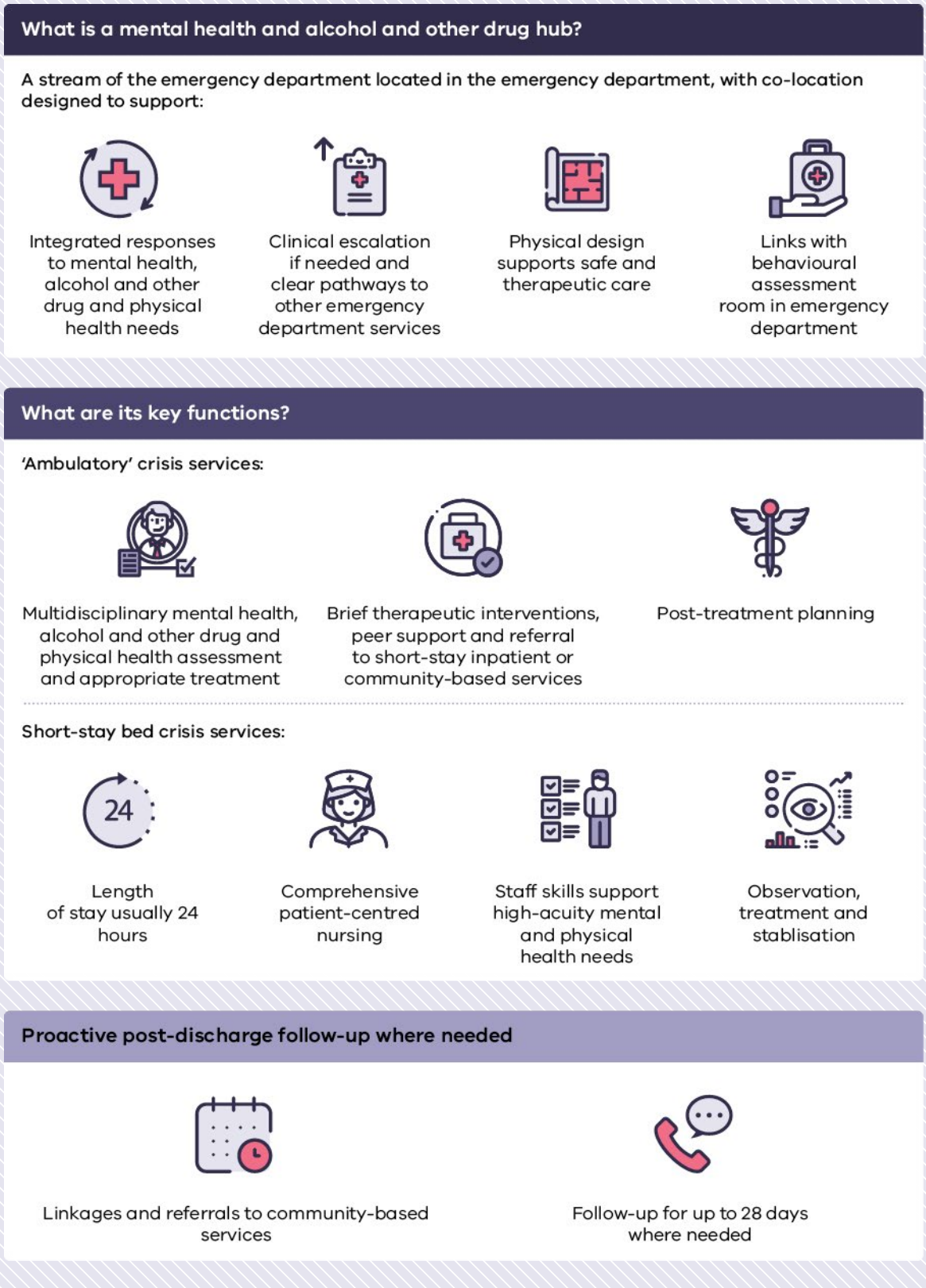
Health services will be encouraged to use resources from multiple sources flexibly to meet their required standards under the classification framework. Currently, funding for mental health responses in emergency departments comes from a range of different sources—some services already use this funding flexibly to deliver innovative and efficient emergency and crisis services.

The Department of Health will also support health services to establish the technology and workforce required for telehealth-enabled clinical consultation. In New South Wales, the Mental Health Emergency Care—Rural Access Program provides telepsychiatry services to emergency departments and crisis services in rural and remote western New South Wales. A 2015 qualitative study reported that the program had led to better patient care in rural and remote locations and increased staff confidence in caring for emergency mental health patients locally.[127] Dr Ravi Bhat, Divisional Clinical Director of Goulburn Valley Area Mental Health Service, Goulburn Valley Health, told the Commission that the Goulburn Valley Area Mental Health Service is trialling video triaging and assessment from its main emergency department in Shepparton to small rural hospital emergency departments.[128] This allows people to get services while remaining in their hometowns.[129]

9.5.3 At least one highest-capability emergency department in every region

While the Commission expects all emergency departments and urgent care centres to be suitably resourced to provide high-quality support to people experiencing mental illness or psychological distress, there will be some that represent 'highest capability' emergency departments that occupy the top tier of the new classification framework.

Figure 9.5: Mental health/alcohol and other drug 'crisis hubs'



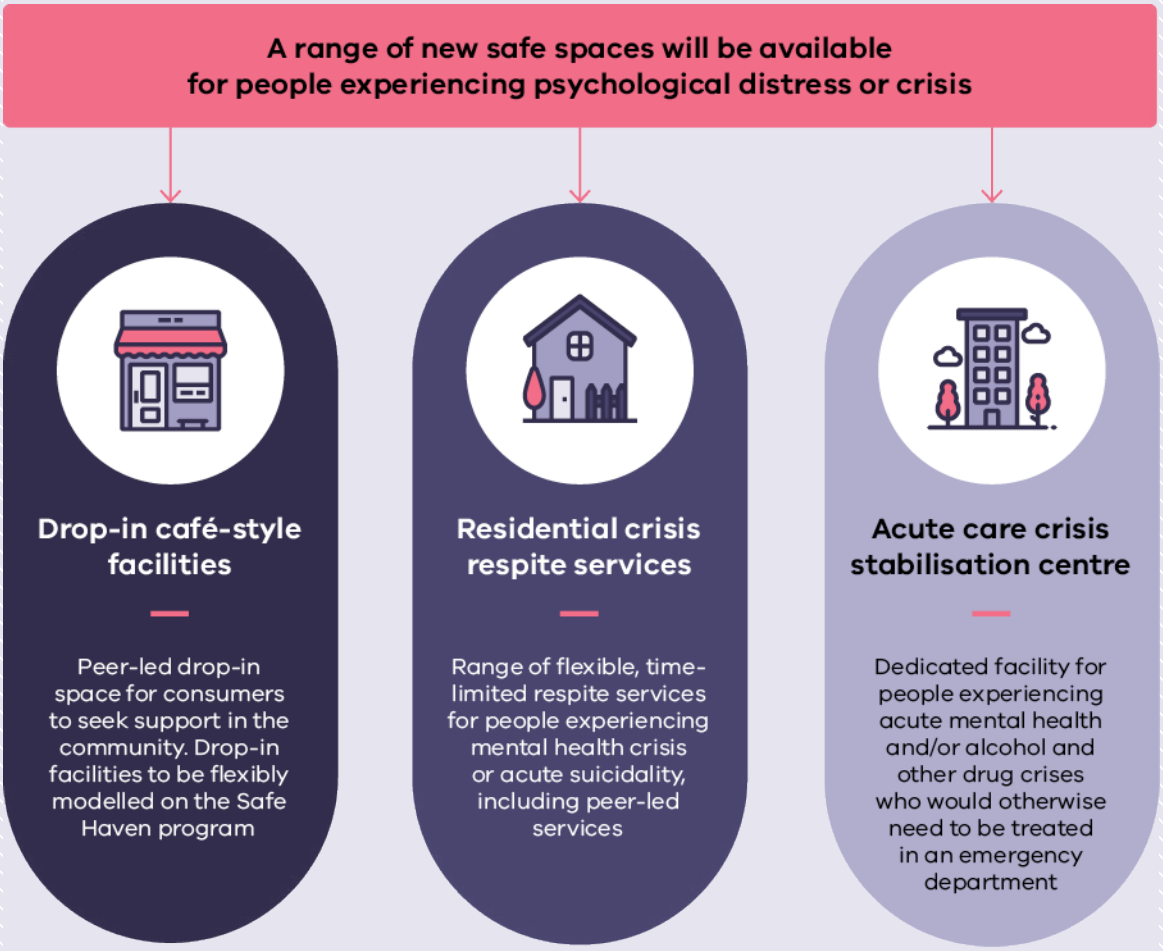
The 'highest capability' emergency departments are those that have therapeutic crisis hub facility, that were funded in the Victorian Government 2018–19 Budget as previously discussed.[130] These emergency departments are expected to have separate areas for managing people with severe behavioural disturbance who are, at least when they first come into the emergency department, unsuitable for the therapeutic crisis hub environment.

The Commission considers that at least one emergency department with a fully functioning crisis hub, including short-stay beds, is needed in every mental health and wellbeing service region. In metropolitan Melbourne, where there are high numbers of mental health presentations across the three regions, there may be a need for two or even more crisis hubs in each region. The classification framework will give emergency services, GPs and other services that may refer people to emergency departments clarity about the level and type of mental health care provided at each emergency department.

Where new crisis hubs are established to ensure that each region has at least one 'highest capability' emergency department, the Commission expects the designated hospital to lead workforce training and development for other emergency departments and urgent care centres in their region. Like the therapeutic crisis hubs funded in the 2018–19 State Budget, which are depicted in Figure 9.5, the additional crisis hubs recommended by the Commission must:

- operate 24/7
- be in a separate area of the emergency department, with careful consideration to facility design to ensure a therapeutic, low-stimulus environment, including access to natural light and sensory modulation equipment such as weighted or tactile objects that can support people to manage distress or aggression[131]—patients identified at emergency department triage as having mental health and/or alcohol and other drug needs will be streamed directly to this area, unless they require high-level medical attention (such as resuscitation) or stabilisation in a behavioural assessment room
- offer best-practice and evidence-based approaches to crisis treatment, care and support—consumers will receive a full assessment, brief therapeutic interventions and referral to appropriate community-based clinical mental health services
- integrate mental health and substance use or addiction services (with alcohol and other drug workers embedded in the team) in addition to physical health responses
- include a co-located short-stay unit (four to eight beds) for people who require a short period, ideally up to 24 hours, of stabilisation and crisis support
- ensure continuity of care by linking consumers, and information collected during their stay in the crisis hub, to follow-up services.

Figure 9.6: Safe spaces for adults and young people experiencing crisis or psychological distress in the future mental health and wellbeing system



The Commission encourages the Victorian Government to consider the following refinements to the original crisis hub model:

- flexibility for the Department of Health and Regional Mental Health and Wellbeing Boards to adapt the model in non-metropolitan areas, given lower demand and a greater need to support rural emergency departments and urgent care centres
- a requirement for the crisis hub to have close links with and, ideally, be physically close to an area for assessing and managing people with acute, severe behavioural disturbance
- flexibility in the original requirement for the crisis hubs to provide outreach for up to 28 days after the person's discharge from the hub, where necessary and appropriate (as part of the crisis response functions outlined in section 9.4.2), Area Mental Health and Wellbeing Services should offer this service to consumers referred from emergency departments
- employment of peer workers to work alongside mental health clinicians, alcohol and other drug clinicians, social workers and emergency department staff. The Commission notes the findings of a recent study suggesting that peer support at St Vincent's Hospital Melbourne is valued by patients, families, carers and supporters, and emergency department staff.[132] A consensus statement by the Australasian College for Emergency Medicine and The Royal Australian & New Zealand College of Psychiatrists recommends that the role of people who have lived experience of mental illness or psychological distress should be explored as a way of improving the care of emergency department patients experiencing mental health crisis.[133]

Health services funded for a crisis hub should also develop rapid handover protocols to minimise the time that police and ambulance services' officers need to spend with mental health patients they have transferred to an emergency department. The model currently in place at the Alfred should be considered. Ms Keppich-Arnold described this model to the Commission:

> Every mental health presentation to the [Alfred's] emergency department, whether by ambulance, police or self-presentation, is responded to and fast-tracked in the same manner as a major trauma. An emergency department consultant, triage nurse and security are paged to attend, and a mental health triage nurse conducts an assessment … In circumstances where the person has been transported to the [emergency department] by police, an immediate response is provided that allows for immediate risk assessment and a determination of safe disposition of the person to an appropriate clinical area. This allows police officers to leave the emergency department without waiting.[134]

9.6 Somewhere else to go—drop-in, respite services and acute crisis stabilisation

The Commission heard that Victoria needs a range of 'safe spaces', catering to different levels of psychological distress. For some, a drop-in style 'café' may provide the compassionate setting they need to stay safe and well. Others experiencing more acute crisis may require a residential stay or a clinical facility operating near an emergency department.

The Victorian Mental Illness Awareness Council undertook a consultation process involving more than 200 people living with mental illness and psychological distress.[135] The places that most people spoke about as 'safe and comforting' were run and led by peers. These included peer respites, recovery houses, crisis centres, peer support groups, recovery colleges and retreats. Participants also spoke about the importance of nature and community spaces.[136]

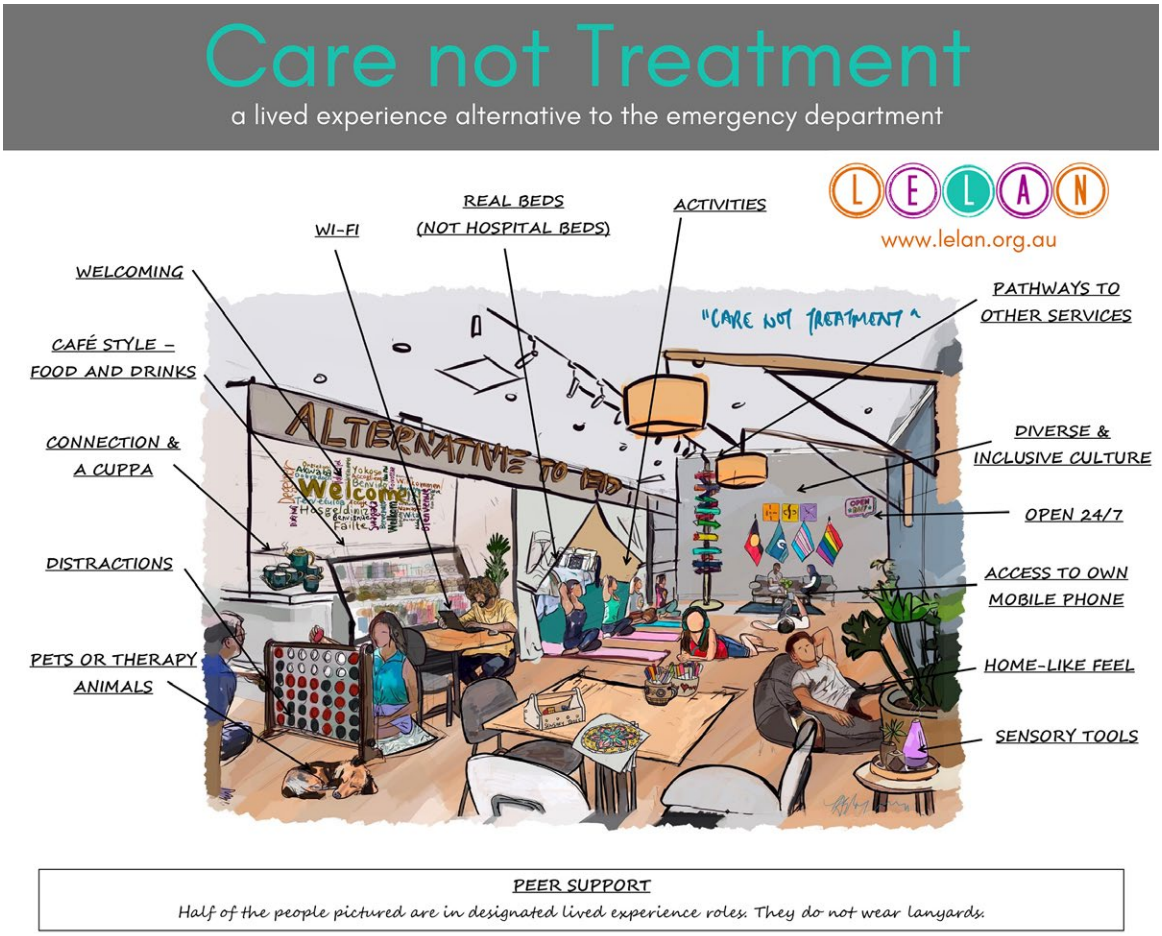
The Lived Experience Leadership and Advocacy Network of South Australia asked its community to help design an ideal alternative space for people experiencing suicide distress or crisis. A project worker turned their ideas into a sketch (refer to Figure 9.7).[137] This summarises extensive evidence put to the Commission and is used here with the network's permission.

There are several pilots under way across Australia that build on models of crisis resolution that have demonstrated effectiveness internationally, such as acute crisis stabilisation centres,[138] drop-in crisis centres[139] and residential retreats.[140] The last two service types are often peer-led, but some have a combination of clinical and peer staff. The Commission has recommended that these three types of safe spaces be available in the reformed system for people experiencing psychological distress or crises, as illustrated in Figure 9.6. In implementing innovative consumer-led safe spaces the Victorian Government should look to partner with the new agency led by people with lived experience of mental illness or psychological distress. As established in Chapter 18: *The leadership of people with lived experience of mental illness or psychological distress*, the agency will support the establishment of organisations, including services led by people with lived experience. This will be enabled through the provision of accredited training and organisational supports, sharing skills and resources to aid these services to develop and mature over time.

9.6.1 Drop-in café-style facilities

The Commission recommends that the Department of Health establishes peer-led drop-in spaces in Victoria, flexibly modelled on the Safe Haven program established at St Vincent's Hospital.

Figure 9.7: A hypothetical safe place designed by the Lived Experience Leadership and Advocacy Network of South Australia



Source: Lived Experience Leadership and Advocacy Network of South Australia, Care not Treatment: Lived Experience Contributions for Understanding and Responding Better to Suicide Distress/Crisis, 2020.

The Safe Haven facility at St Vincent's is based on a model that has been used in the United Kingdom since 2014, where its introduction led to a one-third reduction in mental health hospital admissions.[141] The Commission notes that the Queensland Government's 2019–20 Budget committed funding to establishing eight similar cafés, and the New South Wales Government is establishing 20 such services.[142]

The Commission recommends that there is at least one new drop-in facility for adults or crisis respite facility, discussed further below, per region—excluding the Eastern Metropolitan region, which already has the café at St Vincent's. However, the St Vincent's Safe Haven will receive additional recurrent funding so it can open every day. These facilities will be developed by local communities and flexibly designed to meet the needs of local consumers.

Case study:

Safe Haven Café

Photo credit: St Vincent's Hospital Melbourne

Few mental health services operate out of business hours in central Melbourne, meaning people experiencing mental health issues often have to rely on emergency departments (ED) for support. St Vincent's Hospital identified a need to provide people with an alternative, non-clinical service, and opened the Safe Haven Café. Based on a successful UK model of the same name, the service provides a safe place for consumers to seek support in the community.

Fran Timmins, Safe Haven Café Project Manager, said that consumers often find ED a 'cold and clinical place' and the busy environment can be intimidating. At Safe Haven Café, relationships between staff and consumers are built to make consumers feel equal. This helps them build trust in the service, express themselves, and feel like they have a sense of control. Ms Timmins noted this is in contrast to the power imbalance that consumers can feel in a clinical setting.

> We try really hard in our clinical spaces to make people feel welcome but everything we do in our clinical spaces puts us on an unequal footing with the people that come to us and that power position never shifts. The really interesting thing about the café is how that power doesn't exist so that people engage with you on a level that we don't normally have engagement with.

Staff at the café include clinicians, peer support workers and volunteers. A clinician described her role as 'more like that of a peer worker; sitting with people, having one-on-one conversations or as a group' and supporting other staff who work in the café.

The Safe Haven Café was designed by people with lived experience. Michael, a peer worker, said:

> We didn't come in with the assumption of this is what people need, we asked the people what they would like and it is just much more of an equalising environment.

In an evaluation of the Safe Haven Café, consumers said the café builds a sense of social connectedness and provides an improved consumer experience. It also found the café is a cost-effective alternative to ED and that it reduced ED presentations.

Sue, a consumer at Safe Haven Café, spoke of the effect attending the café had on her life more broadly:

> I definitely don't get as lonely as when I started coming here. To the point that I actually might not even come here as regularly as I used to come … I actually quite enjoy … leading my own life a bit more. If Safe Haven hadn't been here, it's quite possible I would have been presenting to emergency.

The Safe Haven Café is open 20 hours per week. Since it opened in April 2018, there have been more than 1,500 visits, with 80 per cent of consumers visiting more than once.

One way consumers hear about the café is through the lived experience peer worker in St Vincent's ED, who introduces consumers to the café as an alternative support setting. 50 per cent of those visiting the café for the first time come across from ED with the peer support worker.

With the success of Safe Haven Café, Ms Timmins would like to see the model expanded to other hospitals and evolve into the 'Safehaven plus' model that exists in the UK

> It would be good to see the UK model where clinical and non-clinical services are fully integrated and can accept people directly from emergency services as well as direct referral rights to acute teams and inpatient units.

Consumers would also like to see the model expanded, with increased café opening hours. A consumer from one of the Commission's focus groups said:

> I really like the Safe Haven Café. I definitely prefer it over calling a helpline and definitely over going to emergency. I think having more of them is important. I like the idea of a drop-in centre because you don't plan your crisis. It's not like, 'okay, I'm having my crisis at two o'clock on Thursday.'

During Melbourne's stage four lockdown, St Vincent's Mental Health partnered with the hospital's telehealth team to make sure consumers still received the support they need, remotely. Ms Timmins noted that this is important at a time of increased isolation.

> We deal with a lot of people who are socially isolated at the best of times, and being in lockdown would isolate them even further and deprive them of perhaps the only contact they have.

As part of its remote service, the café has provided mobile phones to people who might need help most, to ensure they can reach out if they want to.

Source: Safe Haven Café Customer Experience Review, October 2019; Better Care Victoria, A Safe Haven Cafe for Mental Health Consumers, <www.bettercare.vic.gov.au/resources/Videos/safe-haven-cafe-mental-health-consumers>, [accessed 4 November 2020]; RCVMHS Meeting with Safe Haven Café, 31 March 2020; RCVMHS, *Consumer Human Centred Design Focus Group—Crisis Response: Record of Proceedings*, 2020; St Vincent's Hospital, Safe Haven Café provides virtual mental health support during lockdown, <www.svhm.org.au/newsroom/news/safe-haven-cafe-provides-virtual-mental-health-support-during-lockdown>, [accessed 31 July 2020].

One or more youth versions of the Safe Haven café model will be part of the recommended four youth safe space facilities across the state, which will also include youth specific crisis respite services, as described in section 9.6.2. The youth drop-in spaces would be available for young people aged 12–25 years, regardless of the underlying reasons for their crisis and including those experiencing a suicidal crisis. The youth drop-in facilities would be co-designed with and led by young people who have lived experience of mental illness and families, carers and supporters.

The recommendation for youth-specific services is supported by data indicating high and increasing youth presentations to emergency departments (refer to Box 9.1). As far as the Commission is aware, a youth version of a drop-in facility modelled on the Safe-Haven café would be a world first.

9.6.2 Residential crisis respite

Crisis respite is a core element of the *National Mental Health Service Planning Framework* but no longer exists in any meaningful way in Victoria's mental health system. Respite programs are currently only available through the National Disability Insurance Scheme for eligible participants as 'short-term accommodation packages'. This service offering recognised that, from time to time, participants may require temporary supports that are different from their usual arrangements.[143]

The Commission has heard from consumers, carers, families, supporters and service representatives that a range of flexible, time-limited respite services would be a welcome addition to Victoria's mental health system. For example:

> People who are in distress or who are feeling on the edge of suicide often feel much more comfortable going to respite centres than to places where they are likely to be locked up and possibly secluded. There are many people who will do anything to stay out of an inpatient unit, but who will willingly approach a respite centre. They will come in under their own steam if they are allowed to, because they feel that there will be people there who understand them, and see it as a place of refuge. The UK studies have shown that people with similar levels of psychopathology and risk find respite centres more acceptable environments to receive treatment in, and the clinical outcomes are at least as good.[144]

Witness Elizabeth Porter who reflected on her experiences of mental illness as a young person, highlighted the transformational potential of respite programs:

> I feel like these kinds of models are hard for the current system to comprehend, because the system is so focussed on pathologising, medicating and getting people out the door. So it is hard to convey how different and transformational it can be to have a non-clinical space where people can physically go and take themselves away from whatever chaos is happening in their lives. A key feature also is that peer spaces are not coercive … I have recently set up networks to run informal peer respite.[145]

The Commission's recommendation to establish crisis respite services is informed by evidence of good outcomes in other states and internationally. Reports have suggested that peer-led respite services may lead to: reduced hospital admissions;[146] reduced emergency department presentations;[147] reduced utilisation and expenditure on health services generally;[148] reduced feelings of stress and suicidality;[149] and improvements in carers' resilience and ability to cope with the demands on them.[150]

A 2016 evaluation by the University of New South Wales found major reductions in emergency department presentations and acute mental health admissions for people who had taken part in a South Australian residential respite program, as well as highly statistically significant improvement in psychological distress. This program was also cost-effective, saving the South Australian Government more than it cost to run the program.[151]

In commissioning the new service models, the Commission encourages the Department of Health to allow a high degree of local independence and ensure that services are genuinely co-designed with a broad group of consumers. The services should be carefully evaluated so the Department of Health can identify the best models for further investment. Crisis respite services represent just one type of residential respite to be established in the future system. The Commission's recommendation to establish a wide-range of time-limited and flexible residential respite services is discussed in Chapter 10: *Adult bed-based services and alternatives*.

Peer-run residential respite services for adults

In its interim report, the Commission recommended that the Victorian Government establish Victoria's first residential mental health service designed and delivered by people with lived experience. This will be modelled on New Zealand's Piri Pono service, which offers an intensive peer-led residential crisis response service in the outskirts of Auckland. It is run by Ember (a non-government organisation) and its services are delivered in collaboration with the Waitemata District Health Board. It is set up as a home, providing a comfortable environment and an alternative to an acute mental health inpatient admission.

In contrast to the Piri Pono model, the additional adult crisis respite services to be established in the reformed mental health and wellbeing system will be independently led and governed by consumers. These services will employ a workforce consisting mainly of people with lived experience of mental illness or psychological distress. The board and governance structures of these organisations will also be led by people with lived experience of mental illness or psychological distress.[152]

In this context, it is important that new peer respite services are not established until appropriately qualified and skilled peer workers can be recruited to leadership roles. As consumer advocates recognise, peer workers must have—in addition to lived experience of mental illness or psychological distress—relevant skills and personal attributes for the roles they are employed to perform.[153] The Commission's recommendations for building the capability of the peer workforce are discussed in Chapter 33: *A sustainable workforce for the future*.

The adult crisis respite service model will offer voluntary, short-term and flexible residential programs. The main objective of the services will be to provide a period of 'time out' to stabilise people's experiences of crisis. The facilities will provide care in a safe and homelike environment. While they will provide mainly non-clinical treatment, care and support, leaders of the service may choose to contract with clinicians to provide:

- evidence-based brief treatment interventions
- consultation and escalation pathways in the case of considerable deterioration of a person's mental health during the program.

The Commission expects that a range of different models will be established, including separate services for people experiencing mental illness and people in severe psychological distress due to situational crises and/or suicidality.

It is envisaged that people suitable for the program are those who are:

- not at high, imminent risk of harm to themselves or others
- likely to benefit from a short period away from their usual living or caring arrangements in a safe and welcoming environment
- not acutely affected by alcohol or other drugs and who have the ability to abstain from drugs and alcohol for the duration of the program
- not requiring or likely to require more intensive intervention in a hospital or longer-term residential setting
- wanting to participate in the respite program.

Development of the peer-led respite services would be based on careful review of the literature and evidence on alternative crisis services in other jurisdictions, an intensive co-design process with consumers, a capability-building program to prepare peer workers for leadership roles, and consideration of the opportunities and challenges of integrating peer-led services into mainstream mental health systems.[154]

Residential crisis respite for young people

Specifically, the Commission recommends the establishment of four safe space facilities for young people across the state as an initial step, comprising a mix of drop-in spaces as described in section 9.6.1 and crisis respite services.

The crisis respite programs must be co-designed with a broad group of young people who have experienced mental health crises. However, while the Commission has recommended peer-led respite programs for adults, it suggests that the youth programs are led by a non-government organisation with experience in this area. The agency would commission clinical input if required and would need to demonstrate commitment to working with other services that might assist young people with resolving their crises and with post-program follow-up (for example, the alcohol and other drug and sexual assault support).

Each facility will accommodate a small group of young people (indicatively 8 to 10) for a period of around one week. The physical location of the facilities will make connection with nature and green spaces a priority. Every aspect of the service will be designed to create a safe, therapeutic environment. Strong attention to physical and emotional wellbeing will be reflected in the design of the facilities, appropriate matching of young people in the facility at any point in time, and adherence to an agreed model of care.

The respite programs will provide structured activities that focus on resolving the young person's crisis and, if necessary, transition to continuing treatment, care and support in the community. The service offering will include individually tailored clinical and psychosocial interventions and activities designed to help the young person identify and meet their goals in important life domains. It is also expected that the programs will engage and support the young person's family (broadly defined to include foster carers, siblings, kinship carers and so on).

It is expected that staff will be skilled and experienced in working with young people experiencing psychological distress so that all day-to-day interactions between young people and workers reinforce the therapeutic aims of the program.

The delivery model and target group could vary between the youth respite services. For example, as part of the commissioning process, the Department of Health could consider programs targeted to a specific cohort (for example, young women with a diagnosis of borderline personality disorder) rather than taking a 'one-size-fits-all' approach with a mixed cohort of young people.

9.6.3 An acute care crisis stabilisation centre

Both in Australia and internationally, there is increasing interest in dedicated facilities for people experiencing acute mental health and/or alcohol and other drug crises who would otherwise need to be treated in an emergency department. While these facilities have a high level of capability for clinical assessment and treatment, their location away from the potentially stressful and confronting environment of the emergency department is intended to provide a better environment for recovery-oriented mental health care treatment, care and support.[155]

In a roundtable meeting on crisis responses, the Commission heard that the Queensland Government is well advanced in planning for a mental health crisis stabilisation centre near the Gold Coast University Hospital emergency department, and that the Tasmanian Government is planning two stabilisation centres for that state.[156]

Dr Kathryn Turner, Clinical Director of Mental Health and Special Services at the Gold Coast Hospital, explained the rationale for the proposed crisis stabilisation centre:

> If we want to get people out of the emergency department, we need to provide a facility that will take really quite unwell people … [but] not medically compromised … we were looking at a site off [the hospital site]. But in the end, we decided to have it very close to the emergency department because of that medical risk … If we really do want to divert people from the emergency department, we need to do that.
>
> We want it to be a truly different model of care. A very strong peer-led, peer-first, peer-last model and we believe implementing those strategies that [we will see] a significant reduction in the number of people receiving restrictive practices but still take on the most unwell people.[157]

Ms Susan Murray, Managing Director of the Zero Suicide Institute of Australasia, clarified that crisis stabilisation centres in the United States are not peer-led and, although peer workers are an integral part of the model, the services have the 'full gamut' of clinical staffing, including psychiatrists (potentially off-site), psychologists, social workers and mental health workers.[158]

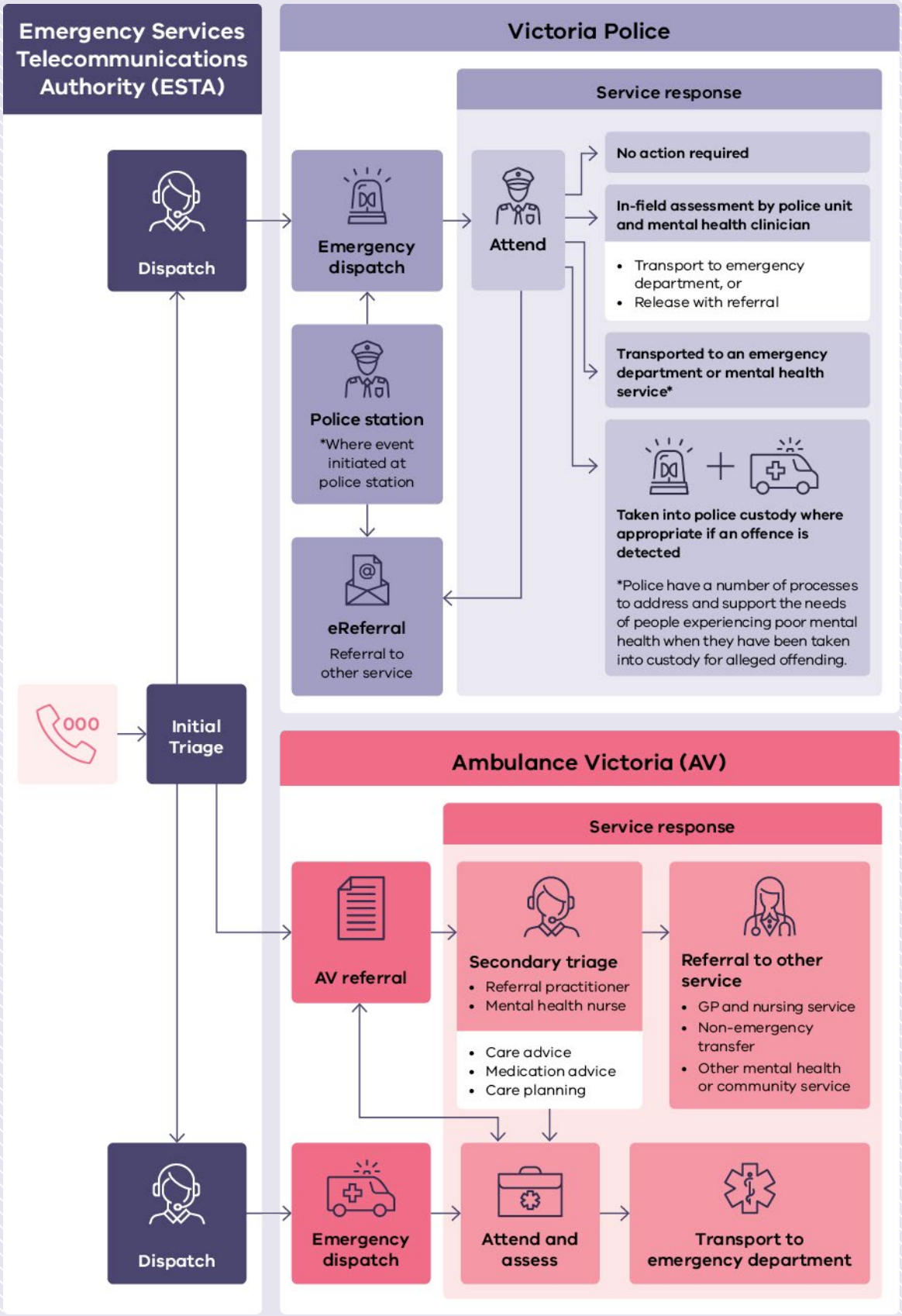
The Commission has recommended that the Department of Health trial an acute care crisis stabilisation centre in a metropolitan region. Ideally, the stabilisation centre would be in a region that already has an emergency department crisis hub (as set out above) but that has enough demand to warrant an alternative acute crisis care service at another hospital.

The recommended crisis stabilisation service is intended to support people who would otherwise be treated in an emergency department but who do not need the medical facilities and expertise of that setting. Importantly, the service will be located within a short distance of an emergency department, to support the transfer of consumers who are admitted to the facility but then require treatment in an emergency department (for example, due to physical deterioration).

The facility will be co-designed with consumers and families, carers and supporters. It will aim to provide a warm, calm environment where people can receive help from trained and specialist staff, comprising a mix of peers, staff from non-government organisations and clinical workers. There would be a strong emphasis on compassionate, evidence-based crisis resolution practices.

This recommendation is consistent with the evidence noted in section 9.6, which suggests that recovery-based alternatives to hospital emergency departments may be helpful for people experiencing psychological distress and may reduce demand for emergency department and inpatient care. However, the Commission recommends that the centre is established as a trial in one location rather than being more comprehensively rolled out across Victoria. This decision is based on the fact that, while early evidence is promising, standalone facilities providing crisis care for people who would otherwise require emergency department care have not been comprehensively studied.[159]

Figure 9.8: Overview of the current Triple Zero ambulance and police callout process



Source: Prepared by the Commission based on information from the Emergency Services Telecommunications Authority, Victoria Police and Ambulance Victoria.

9.7 Health-led responses to mental health emergencies

Victoria Police noted in its submission to the Commission that police are 'increasingly relied upon to operate as gatekeepers to the mental health service system'.[160] This is consistent with the data presented in section 9.2.4, which show a considerable increase in police responses to mental health crises in recent years.

The Commission heard that Victoria's mental health system has defaulted to police as the first responders to mental health crises and that police are often at the frontline due to a lack of alternative services. Many consumers, families, carers and supporters told the Commission about the distress and embarrassment caused by the involvement of police. Some examples are:

> a series of police officers came to a church where I was playing piano. I was not bothering anybody. I was doing what I do often. They just arrived unannounced, in numbers … How do you live this down in a small community when your self-employment depends on reputation?[161]
>
> They told me I'd broken the [community treatment order] by not taking my meds so I was taken back to the ward.[162]

As Victoria Police submitted, police involvement can increase the likelihood that people will become involved in the criminal justice system:

> greater emphasis on mental health interventions in community and primary care [could] both reduce the reliance … and prevent the escalation of circumstances that result in an emergency law enforcement intervention.[163]

In his evidence, Assistant Commissioner of Victoria Police, Glenn Weir told the Commission about the effect that responding to people in crisis has on policing resources and the need to find alternatives to police-led responses:

> It is not unusual for police to be waiting two hours. It is not unusual for multiple police units to be at one [emergency department] with multiple people needing assessment, and the service delivery impediments for the rest of the community, by us having all our available resources tied up there, is significant …
>
> We realise there is always going to be a role in dealing with people experiencing mental health [issues] for the police, we realise that. However, I'm not sure that, as things have changed over time, that there's been a broader more strategic piece of thinking done about what all the impacts are …[164]

The Productivity Commission's draft report on mental health noted that police responses are limited by 'bounce back'. This is when people police have referred to mental health services are unable to get appropriate treatment, care and support and are discharged without support. Police sometimes respond multiple times to the same people experiencing mental health crises.[165]

Figure 9.9: Ambulance and police responses where at the point of Emergency Services Telecommunications Authority call taking, mental health was classified as the primary problem, Victoria, 2019–20

Source: Emergency Services Telecommunications Authority 2019–20.

Note: *Data is captured at the point of Emergency Services Telecommunications Authority call taking.

Event type 594–Victoria Police psychiatric events; Card 25 events–Ambulance Victoria psychiatric events. The analysis above excludes Card 23 events – Intentional poisoning/overdose which is generally responded to by Ambulance Victoria only.

9.7.1 Reducing the involvement of police as first responders to Triple Zero calls about mental illness

The Commission's consultations on crisis responses revealed universal agreement that people experiencing mental health crises should receive a health-led response in the community wherever possible. Although some participants recalled positive experiences with police, they noted that police are not—and should not be expected to be—experts in responding to people experiencing mental illness or psychological distress. As a result, police may have limited options besides transporting people to an emergency department.

Figure 9.8, replicated from the Commission's interim report, shows the different pathways that can be taken when a Triple Zero (000) call is made about a person experiencing a mental health crisis. Although the dispatch operator can direct calls to either Victoria Police or Ambulance Victoria, current protocols mean police attend most events. Joint paramedics and police responses are also quite common, as shown in Figure 9.9. The Commission's interim report noted that ambulance attendances with a police escort increased by nearly 26 per cent between 2015 and 2018.[166] This occurs when there is a perceived likelihood of threat or harm, or where paramedics require police to use their powers under the *Mental Health Act 2014* (Vic) to apprehend a person and transport them to hospital.[167]

In the reformed mental health and wellbeing system recommended by the Commission, Ambulance Victoria will—wherever possible and safe—be the lead responder to Triple Zero (000) calls identified as being primarily about mental illness or psychological distress. When ambulance services' staff take calls about people experiencing mental illness or psychological distress, it will be up to them to decide if police involvement is necessary and, if so, in what capacity (for example, to secure the scene before entry by paramedics; as backup on scene; or on standby).

The Commission does not underestimate the extent of change required to successfully implement this recommendation. As the basis of the reform, Victoria Police, Ambulance Victoria and the Emergency Services Telecommunications Authority will work together to rearrange current emergency protocols so that as many calls involving mental health emergencies as possible are diverted to ambulance services rather than police. This change is technically straightforward, but there is a range of legal and industrial issues to be worked through before it can be implemented. Further, the changes must be accompanied by the practical supports for paramedics recommended by the Commission. These include the mental health clinical inputs described in this section, greater availability of mental health crisis outreach teams as described in section 9.4.3 and closer links and better information sharing with Area Mental Health and Wellbeing Services generally.

While the effect of this reform will be powerful, its full impact will occur with the passing of the new mental health legislation recommended by the Commission in Chapter 26: *Rebalancing mental health laws—a new Mental Health and Wellbeing Act*. The new Act will include provisions to give Ambulance Victoria access to consumers' mental health records, which will help in their decision making about the person's care. Chapter 35: *New approaches to information management*, outlines new arrangements to safeguard consumers' privacy and confidentiality when their information is shared between service providers.

9.7.2 Leveraging Ambulance Victoria's large, health-trained workforce

The crisis service elements of the mental health and wellbeing system will be backed up by increased mental health capacity, resources and skills within Ambulance Victoria, the state's largest health service and the only health service that can coordinate a consistent statewide model of mental health emergency response.

Where ambulances require police to be on the scene, paramedics—consulting with mental health clinicians where necessary—will take the lead role in supporting the person in crisis, wherever possible and safe.

There is considerable scope for well-supported paramedics to divert people in crisis away from emergency departments. Even though Ambulance Victoria currently diverts some callers to its secondary referral service, most are taken to a hospital emergency department. However, in 2019–20 only 26.9 per cent of people transported to an emergency department by ambulance for a mental health–related reason were admitted to a public hospital bed, with 19.2 per cent assessed and/or treated in a short-stay bed. The remaining patients were discharged to their usual place of residence (48.5 per cent) or left at their own risk (5.4 per cent). Almost 50 per cent of those patients transported to emergency departments were discharged within less than four hours and almost a third were referred to general primary care services.[168]

Compared with what happened in the past, when it had few options except to send an ambulance and transport the person to an emergency department, Ambulance Victoria is already helping more people in crisis to avoid a trip to hospital. Mental health clinicians in Ambulance Victoria's secondary triage service help people who are assessed as not requiring an ambulance dispatch. Further, representatives of Ambulance Victoria have told the Commission that paramedics dispatched to the homes of people experiencing mental health crises are increasingly providing support to enable them to remain at home safely, rather than taking them to hospital.[169]

Reforms recommended by the Commission will give paramedics more resources and more options for helping people experiencing mental health crises or psychological distress. Whether or not they decide to take someone to hospital, and whether or not they need police support, paramedics will have more support from mental health clinicians. This will be enabled through:

- statewide access to 'in-field' telehealth (video and telephone) consultation from mental health clinicians
- mental health co-responders in high-volume areas and shifts
- improving Ambulance Victoria's secondary triage service.

In-field telehealth consultation for in-field paramedics

For the first time in Victoria, paramedics who attend to people experiencing a mental health crisis in the community will have access to 'in-field' telehealth consultation from senior mental health clinicians. These clinicians will provide real-time video or telephone consultation to help paramedics assess and respond to the person's mental health support needs and the risks to them, with the aim of stabilising the person's crisis on scene and referring them to appropriate community-based services.

The Commission anticipates that mental health clinicians will be employed in a telehealth service co-located with Ambulance Victoria. The clinicians must have the seniority, skills, knowledge and experience to provide expert in-field consultation to paramedics, as well as training and support for Ambulance Victoria's triage staff and clinicians who provide Ambulance Victoria's secondary triage function (that is, supporting Triple Zero (000) callers assessed as not requiring an ambulance dispatch).

Mental health clinicians providing these functions will need access to mental health consumers' records, where relevant, as this will allow better assessment of people being seen by paramedics and connection to the right follow-up care. In the short- to medium-term, Ambulance Victoria will need to contract clinicians from designated Victorian health services to ensure they can legally access mental health services' records. In the longer term, legislative changes recommended by the Commission in Chapter 26: *Rebalancing mental health laws—a new Mental Health and Wellbeing Act* will enable Ambulance Victoria to have direct access to mental health client data and to share its own data with mental health services.

The proposed telehealth consultation service will give paramedics, wherever they are in Victoria, access to specialist mental health input when responding to mental health emergencies. This would be an extension of a new pilot program in which two clinicians from Eastern Health have been embedded in Ambulance Victoria. The pilot, which is partly funded by the Department of Health, is understood to have begun in November 2020.[170]

The Commission's recommendation for the telehealth service is based on evidence, noted in the following sections, that in-person mental health responses to crisis may not be sustainable in all areas of the state due to low demand and large physical distances between workers and people in crisis. In its October 2019 report, the Productivity Commission highlighted the efficacy, cost-effectiveness and travel savings associated with using digital technologies to deliver mental health services in rural and remote areas—for example, providing services via videoconference consultation with clinicians based in regional or metropolitan health services. These services can be made available on a 24-hour basis and may reduce privacy concerns.[171]

Mental health co-responders in high-volume areas and shifts

The Victorian Government has funded a trial of an in-person mental health–ambulance co-responder model in the Geelong area. The Pre-hospital Response of Mental Health and Paramedic Team (PROMPT) initiative is being trialled as a partnership between Ambulance Victoria and Barwon Health. The initiative involves mental health clinicians from the Barwon Area Mental Health Service joining paramedics when they attend callouts where mental illness may be a factor.[172]

The government's funding of the trial was based on positive experiences of similar initiatives in other Australian states and overseas.[173] For example, a Psychiatric Emergency Response Team was established in Sweden in 2015 to respond to mental health crisis situations that would typically be managed by police. The team comprised two mental health nurses and a paramedic, who work together with police, ambulance and other emergency services to deliver optimal crisis responses to people experiencing an acute episode of mental illness or suicidality.[174] A one-year follow-up study of the program concluded that it was:

> **a unique prehospital service that provides the psychiatric patients with a high quality prehospital assessment and reduces the workload of the police department as well as the ambulance services. It contributes to reducing the stigmatization of psychiatric illness.[175]**

A preliminary report on the PROMPT trial indicated that paramedics and clinicians working together were able to successfully divert more than 70 per cent of the people they attended from needing to go to an emergency department.[176] Despite this positive result, the Commission considers that a full statewide rollout of PROMPT is not warranted, due to the low volume of mental health emergencies in many areas. Of note, the number of patients seen by PROMPT clinicians in Barwon was very low—an average of just 1.4 per 7–7.5-hour shift.[177]

The telehealth service recommended by the Commission will provide many, but not all, of the benefits of PROMPT in connecting paramedics to the mental health and wellbeing system and providing advice and support. Recognising the value of physical mental health–ambulance responses, the Commission recommends that the telehealth service is accompanied by a limited expansion of PROMPT to areas and times of the day/week where there is a high volume of mental health emergencies. This will help build paramedics' skills by enabling them to see mental health clinicians working directly with patients. Depending on the operational model, it could also give clinicians working in the telehealth service an opportunity to maintain first-hand experience of mental health crisis situations, which is important for maintaining their skills.

Improvement of Ambulance Victoria's secondary triage service

Since 2014 Ambulance Victoria has operated a secondary triage service to assist people who do not require an ambulance dispatch.[178] More recently, it has employed private mental health clinicians specifically to support people experiencing a mental health crisis.[179] While this service has enabled approximately 18 per cent of Ambulance Victoria's Triple Zero (000) calls involving mental health issues to avoid needing an ambulance dispatched, its effectiveness is limited by lack of access to client records from mental health services and lack of connection with area mental health services.[180]

To overcome these barriers, the Commission proposes that the secondary triage service be embedded in the statewide telehealth service, which—as described above—will employ mental health clinicians who can access the records of mental health consumers and organise pathways into the mental health and wellbeing system where required. The senior mental health clinicians responsible for providing telehealth consultations would then also be available to support staff in the secondary referral service.

9.7.3 Improving police contact with people experiencing mental health crises

While the Commission's recommendations call for less police involvement in mental health crisis situations, it is inevitable that police will need to attend some situations in which people are experiencing mental illness or psychological distress. These situations are mainly where there is a considerable risk of harm to the person or others, but in some cases police powers may be required to enter property or to transport people to hospital involuntarily under mental health legislation. In the Commission's view, unless there is an evident risk of harm, all alternatives should be explored before police are involved.

Despite considerable and sustained investment in mental health training for its workforce, Victoria Police noted in its submission to the Commission that police are not clinicians and that their officers need more support from mental health professionals.[181]

The Commission agrees with this view. It recommends that Victoria Police commits funding for the following:

- **a telehealth consultation service for in-field police officers**. This would be like the model recommended for Ambulance Victoria and, subject to further discussion between Victoria Police, Ambulance Victoria and relevant government departments, could even be part of the same service. The service will give police across the state access to mental health clinical consultation and better pathways for referring people to mental health and wellbeing services
- **a secondary triage telephone service** to assist people assessed as not requiring a police dispatch. As with the recommended improvement of the Ambulance Victoria secondary triage service, this would include protocols and pathways for referring to mental health and wellbeing services and other mental health supports.

The Commission also expects that Victoria Police, together with the Department of Health, will:

- **maintain Victoria's current police and mental health co-responder model** but with refinements—as discussed in the next section—based on the findings of a recent evaluation by the (then) Department of Health and Human Services[182]
- **continue to improve mental health training and education for police officers**, with specific attention given to any cultural or procedural issues that may lead to avoidable harm to people experiencing mental health crises.

Joint mental health and police responses

In Victoria, interstate and internationally, models of police and mental health clinician partnership have consistently demonstrated considerable improvements in response times to people experiencing a mental health crisis, and interactions with and the outcomes for people in crisis, when compared with usual services.[183]

Western Australia, for instance, launched a Police Force Mental Health Co-Response Commissioning trial where mental health practitioners were involved at each stage of a police response to and management of people experiencing a mental health crisis. An independent evaluation of the joint police–mental health trial found that it had improved the safety and wellbeing of police and mental health consumers and increased collaboration between the relevant services.[184] Mental health consumers and families, carers and supporters liked the model and saw it as a considerable improvement over the traditional police crisis response. One participant in the evaluation said:

> now the response teams can focus on their policing issues, and allow the mental health team, who have the capacity and capability of spending a lot more time, and have a lot more expertise because they have the practitioner with them, to actually deal with the jobs effectively and make a difference.[185]

Based on the success of the trial, in 2019 the model was expanded to cover the whole Perth metropolitan area.

The Police Ambulance Crisis Emergency Response (PACER) program—in which mental health clinicians accompany police to callouts involving people believed to be experiencing mental illness or a mental health crisis—has operated in Victoria for many years. Although the Victorian Government changed the name of the initiative to Mental Health and Police in 2014, the term PACER has continued to be used in practice—the recent departmental review suggested that the original name be restored.[186]

Consumers and carers who attended the Commission's community consultations spoke favourably about PACER services.[187] An independent evaluation in 2012 indicated the model worked well and found that it was likely to be cost-effective compared with usual service provision.[188] The recent departmental evaluation also indicated the effectiveness of the model, reporting that:

- Consumers and carers value the timely access to mental health assessment and referral.[189]
- PACER units are effective in diverting people from emergency departments.[190]
- The co-response model helps improve the skills and knowledge of the police who work alongside mental health clinicians.[191]

However, the evaluation noted that the effectiveness of the PACER program is hampered by workforce shortages, especially in rural areas. In the context of mental health workforce and system challenges, PACER clinicians may be needed by their employing health services and withdrawn from PACER shifts at short notice.[192] Related to this, there are limitations on what the program can realistically achieve. In 2018–19, there were 3,036 PACER responses in Victoria, comprising only 6 per cent of the 49,099 mental health–related Triple Zero (000) calls requesting police for the same period. The report concluded:

> Although a [PACER] unit can make a very real difference to people and communities who avoid unnecessary transport to hospital, it is a relatively small-scale contribution to resolving the overall issue of managing mental health crisis in the community. In addition to expanding [PACER], other responses for example mental health triage function at the police call centre, and a 24-hour mental health clinical support line for police could help people experiencing mental health problems.[193]

The evaluation report presented data suggesting that resources for PACER are currently misaligned, with 54 per cent of services in metropolitan areas struggling to meet demand and 52 per cent in rural areas either under-utilised or not at capacity. While the report stated that there is scope to expand PACER units in high-demand areas, it recommended that the Department of Health conduct a feasibility check before funding more rural PACER units and explore adaptations of the model specific to rural areas to increase implementation success and sustainability.

If the Commission's proposed telehealth service is available in areas where PACER units cannot be fully utilised, overall expansion of PACER may not be required. The Commission encourages the Department of Health and Victoria Police to realign funding for the PACER initiative to match varying levels of demand across the state. It also supports the findings of the departmental evaluation that the program requires stronger governance and accountability. As part of implementing the recommendations of the evaluation, the Commission expects that people with lived experience of mental illness or psychological distress and families, carers and supporters, will be involved in developing new guidelines and oversight measures for the program.

Mental health telehealth support for police

The Commission's decision to recommend a statewide telehealth clinical consultation service for police, rather than considerable new investment in PACER services, is based on evidence of workforce challenges facing the program and the cost of these services relative to their scale and reach.

The recommendation is also informed by evidence that digital technology is being used successfully in other parts of the world to improve police responses to people experiencing a mental health crisis. For example, the Commission is aware of a telehealth model being piloted in Houston, Texas—called Cloud911—that enables police to directly connect a person experiencing a crisis with a psychiatrist or clinical worker through a mobile digital application.[194] The Commission notes also that the (then) Department of Health and Human Services' recent evaluation of PACER found that even when mental health clinicians were unable to attend in person and provided advice to police by telephone, this 'could be the difference between police "cordon and contain" or a mental health appointment'.[195]

The recommendation accords with the suggestions of several people consulted by the Commission. Referring to the potential for telehealth to complement physical police and ambulance co-responder models, Associate Professor Steven Moylan, Clinical Director for Mental Health, Drug and Alcohol Services at Barwon Health, pointed out that similar models are used in other areas of health:

> These infield service responses [PACER and PROMPT] could be further improved through the use of telehealth capability in partnership with emergency services, similar to the secondary consultation services available to the care of consumers who potentially experience a cerebrovascular event (stroke).[196]

In her witness statement, Ms Cook suggested that:

> Mental health clinicians cannot always respond to calls alongside police - it may be too dangerous, or there may not be enough clinicians on the ground. However, police could take an iPad or similar device to these callouts so that mental health clinicians can see the consumer and the environment in context and either assist the police with suggested measures on how to de-escalate the situation (particularly if the consumer's history is known to mental health services), or advise the police to transport the consumer for assessment and treatment to the most appropriate setting. This would be better than being on the phone, as the clinician could see all of the context.[197]

As a result of recommendations handed down to government by the Royal Commission into Family Violence in 2016, body-worn cameras are already being deployed by frontline police to digitally record evidence from family violence incidents and of victim statements. In the 2016–17 State Budget, the Victorian Government committed $227 million to purchasing body-worn cameras for police.[198] In accordance with the *Justice Legislation Amendment (Body-Worn Cameras and Other Matters) Act 2017* (Vic), Victoria Police has since deployed more than 11,000 body-worn cameras across the state.[199] The Commission considers that, subject to appropriate legislative and policy reform, similar measures could be taken to improve police responses to mental health emergency situations in the reformed system—for example, by offering new avenues to bring mental health expertise to the frontline.

Police training, education and culture

As previously noted, while the Commission's recommendations call for less police involvement in mental health crisis situations, it is inevitable that police will be needed at some events involving people experiencing mental illness or psychological distress. As is the case currently, police in these situations will have to make difficult decisions that balance the rights and needs of the person in crisis with the safety of others at the scene.

While the mental health clinical input described in the previous section will help police respond to mental health crises, Victoria Police has the fundamental responsibility for training its workforce to respond appropriately to mental health crises and for ensuring police officers are accountable for their interactions with vulnerable members of the community.

Throughout the Commission's term, there have been several incidents in which people with mental illness have been harmed and, in at least one case, killed in interactions with police.[200] At the time of writing this report, these tragic events were still under investigation, and the Commission is unable to comment on them.

On 19 November 2020, the Coroners Court of Victoria delivered the findings of its coronial inquest into the deaths of six individuals when they were struck by a vehicle during the 'Bourke Street incident' in 2017. It was concluded that the offender was most likely experiencing an acute mental health crisis at the time of the event and that the police response was inadequate.[201] Specifically, it was reported that:

> some of these [response] deficiencies included poor planning; a lack of assertive leadership, supervision … ; inflexible attitudes and policies; a staunch believe that negotiating with a delusional person was the best chance of bringing the incident to a conclusion; and, ultimately a reluctance to act assertively.[202]

The Coroner recommended that Victoria Police expands its incident management curriculum, noting that 'such training should incorporate an immersive, interactive training environment to support decision making in critical incidents and emerging critical incidents'.[203]

The Commission acknowledges that Victoria Police has made considerable efforts in recent years to improve its workforce's understanding of and responses to people experiencing mental illness or psychological distress. It welcomes the new training program that Victoria Police was rolling out across its workforce from late 2020.[204] It has reviewed the program and believes it is a step forward in confronting the issues that may lead police to use excessive force against people experiencing mental illness or psychological distress.

The Commission encourages Victoria Police to work closely with mental health and wellbeing services and the lived experience community on the continued development of police training, education and practice. These efforts need to support a solid foundation of trust and respect between Victoria Police and Victoria's Aboriginal, culturally diverse and LGBTIQ+ communities, for example, through continued training and deployment of community liaison officers.

The Commission advises Victoria Police to re-examine Project Beacon, an initiative introduced in 1994 to train police officers to work effectively and safely with people experiencing mental illness, but in a way that carries minimal risk of harm to any person.[205] Under Project Beacon, the use of minimum force and preservation of life were top priorities. Its implementation resulted in fewer violent incidents involving police officers.[206] Professor Patrick McGorry AO, Professor of Youth Mental Health, the University of Melbourne and Executive Director, Orygen, advised the Commission that, although the commitment to Project Beacon fell away over the years, it was an approach to police–mental health sector collaboration that was 'evidence-based' and 'comprehensive'.[207]

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Chapter 10

Adult bed-based services and alternatives

Recommendation 11:

New models of care for bed-based services

The Royal Commission recommends that the Victorian Government:

1. review, reform and implement new models of multidisciplinary care for bed-based services that are delivered in a range of settings, including in a person's home and in fit-for-purpose community and hospital environments.
2. deliver a broad range of bed-based services, including as a matter of immediate priority:
    a. expanding Hospital in the Home services as an alternative to acute hospital-based treatment, care and support where appropriate;
    b. investing in a wide range of time-limited and flexible residential respite services informed by local priorities, including establishing a peer-led residential respite service at a demonstration site; and
    c. developing new bed-based rehabilitation services (refer to recommendation 12).
3. build on the interim report's recommendation 2 about the need for the expansion of acute mental health services and deliver at least 100 additional beds in settings that reflect optimal allocation and distribution across Victoria.
4. periodically review the allocation of new beds as part of the statewide and regional planning processes recommended by the Royal Commission (refer to recommendation 47) and audit the outcomes.

Recommendation 12:

Developing new bed-based rehabilitation services

The Royal Commission recommends that the Victorian Government:

1. implement the new whole-of-system rehabilitation pathway described by the Royal Commission in its final report, which includes two new bed-based rehabilitation models of care, for people living with mental illness who require ongoing intensive treatment, care and support.
2. consistent with the 'design and quality features' described by the Royal Commission in its final report, co-design with consumers, clinicians and relevant non-government organisations and services:

    a. the new community rehabilitation model of care and deliver it at a community care unit demonstration site; and

    b. the new intensive rehabilitation model of care and deliver it at a secure extended care unit demonstration site.

3. subject to the evaluation and required adaptation of the new rehabilitation models of care, apply these models to existing community care and secure extended care units and enhance and expand infrastructure accordingly.

Recommendation 13:

Addressing gender-based violence in mental health facilities

The Royal Commission recommends that the Victorian Government:

1. ensure that all new mental health inpatient facilities:
    a. are built and designed with the necessary scale and flexible infrastructure to enable gender-based separation in all bedrooms and bathrooms; and
    b. provide separate communal spaces as required.
2. by mid-2022, ensure that existing high dependency units in inpatient facilities allow for gender-based separation.
3. review and retrofit existing inpatient facilities on a case-by-case basis to:
    a. achieve gender-based separation where possible; and
    b. as a matter of priority, ensure that each facility meets the minimum standards for gender safety set out in the Chief Psychiatrist's guideline: Promoting sexual safety, responding to sexual activity and managing allegations of sexual assault in adult acute inpatient units.
4. ensure that the Mental Health and Wellbeing Division supports mental health and wellbeing services to eliminate sexual and gender-based violence in bed-based service settings.

Recommendation 14:

Supporting mental health consultation liaison services

The Royal Commission recommends that the Victorian Government:

1. work with the Independent Hospital Pricing Authority and the Commonwealth Government to:

    a. ensure mental health consultation liaison services for consumers admitted for physical health reasons are formally recognised and adequately funded as part of routine care; and

    b. ensure mental health consultation liaison services are incorporated, costed and priced in the relevant classifications and standards.

2. ensure public health services and public hospitals:

    a. receive adequate temporary funding to embed and deliver in-hospital mental health consultation liaison services as part of routine care until joint funding arrangements between the Commonwealth and Victorian Governments are established;

    b. are accountable for delivering in-hospital mental health consultation liaison services and, whenever required, provide such services to consumers admitted for physical health reasons; and

    c. are accountable for providing the sustained delivery of high-quality integrated mental health treatment, care and support across the hospital system.

10.1 Bed-based treatment, care and support in the future system

In its interim report, the Commission recommended creating 170 additional acute mental health beds (or equivalent) for adults and young people to address an urgent deficit in acute beds numbers. Since the interim report, the Department of Health and Human Services, Mental Health Reform Victoria and the Victorian Health and Human Services Building Authority have made progress in implementing that recommendation.

Sites for the new beds have been identified, Hospital in the Home services are being developed and a prototype design for a new bed-based setting has been commissioned. At the time of writing, people with lived experience of mental illness or psychological distress were visiting the prototype bed-based setting in Melbourne's west as part of an extensive consultation process seeking feedback on the prototype design.

The Commission also recommended the establishment of Victoria's first residential mental health service designed and delivered by people with lived experience of mental illness or psychological distress. Drawing on the Piri Pono model, the Commission expects this service, and those that follow, to operate as a true peer-led alternative to acute hospital-based care in a residential community setting.[1]

This chapter builds on the interim report recommendations. It provides further guidance about the future nature of bed-based services and alternatives in the adult mental health and wellbeing system. It also sets out the Commission's reform agenda to deliver high-quality, therapeutic and safe bed-based mental health treatment, care and support for consumers, their carers and supporters, and the mental health workforce.

Reforms to bed-based services for infants, children and young people aged 0 to 25 years in the future mental health and wellbeing system are set out in Chapter 12: *Supporting perinatal, infant, child and family mental health and wellbeing* and in Chapter 13: *Supporting the mental health and wellbeing of young people*.

The Commission uses the term 'bed-based services' to describe various settings where residential mental health treatment, care and support is delivered. This might be in a person's home, in a community residential setting or in a hospital environment.

Central to the Commission's aspirations for Victoria's mental health system is the focus on providing treatment, care and support through new community-based service models. This requires a shift away from care in acute inpatient treatment options as a first port of call for people experiencing mental health crises. In some cases, however, there does remain a need for targeted, high-quality and therapeutic bed-based service options for some consumers with complex or higher intensity support needs.[2]

As is the case for bed-based care for other health services, all bed-based mental health services must function as safe places for individuals experiencing mental illness who require more intensive and specialised mental health treatment, care and support. When consumers use bed-based services, they must feel adequately supported, listened to, cared for and protected. The safety of all consumers, families, carers and supporters, and mental health staff, must also be a priority.

Personal story:

Sandy Jeffs OAM

Sandy Jeffs is an author and poet and has been an advocate in the mental health system for many years. She was diagnosed with schizophrenia in 1976 and was in and out of Larundel psychiatric hospital during the 1970s and 1980s, with her last admission in 1991. Larundel closed in the 1990s.

Sandy reflected on the therapeutic benefits of Larundel compared with today's mental health system, and the care she received from the staff.

> At Larundel, I had time and space in which to form a therapeutic alliance with nurses. I had some great nursing at Larundel because their whole working notion was to get out into the wards and spend time with the patients—which is what happened.

Sandy authored the book *Out of the Madhouse: From Asylums to Caring Community?* with Margaret Leggatt, describing the experiences of Larundel, which recently won the Oral History Award (2020) from the Victorian Community History Awards. She discussed the notion of 'asylum' and the need to have space to recover.

> At Larundel, you had time and space to get better, gardens to wander around in, and at least a languid time in which to find yourself. When you're in these situations, your mind is fractured, and you need to somehow get it together again, and you need peace and quiet in which to do it, not a place to be harassed. Asylum has gone—there's not a shred of it now.

Sandy also describes the need for people with mental health issues to have stable accommodation along with support.

> What we addressed in the book is the importance of affordable supported accommodation; a place to call home is the missing link in the mental health system. Where people are offered clinical support for their mental illness and social support to help them stay in the accommodation.

Sandy discussed the challenges for people with a mental illness to have recovery and healing in the current system.

> Hospitalisation should be a last resort—we should keep people out of hospital by keeping them well. But if people are hospitalised, they shouldn't be discharged still unwell to the street or to stressed carers.

Sandy advocates that people should have access to psychosocial rehabilitation and with a sense of belonging.

> a chance to have decency in life where we feel wanted, respected and valued.

Sandy was given the Order of Australia Medal in 2020 for her service to mental health organisations such as SANE Australia, of which she is a peer ambassador.

Source: *Witness Statement of Sandy Jeffs*, 5 July 2020.

The process of deinstitutionalisation was a turning point for Victoria's mental health system. Poor treatment practices were exposed, large psychiatric institutions were closed and greater emphasis was placed on the delivery of community-based mental health treatment, care and support. [3] As noted in the interim report, the Commission does, however, recognise some failings in the realisation of deinstitutionalisation.[4] Reflecting on her previous experiences in bed-based mental health services and on the notion of 'asylum', witness Ms Sandy Jeffs OAM stated that:

> There is no longer a sense of asylum—we don't even pretend to offer it—it's about contain, medicate and then discharge. The loss of asylum is a huge loss to our system … So, the whole idea of providing a safe retreat, a safe haven for someone to regather themselves, and find their equilibrium and their sanity has been lost in the system … When you're in these situations, your mind is fractured, and you need to somehow get it together again, and you need peace and quiet in which to do it, not a place to be harassed. Asylum has gone—there's not a shred of it now.[5]

Professor Alan Rosen AO, Professorial Fellow at the University of Wollongong's Illawarra Institute for Mental Health and Clinical Associate Professor at the Brain and Mind Centre as part of the University of Sydney's Medical School, shared a similar perspective on the need for places that offer 'asylum in the best sense not in the old sense of psychiatric hospital asylums', noting that:

> The best definition of 'asylum' that I know of is from John Wing, former Professor of the Institute of Psychiatry, Psychology and Neuroscience, a school of King's College London (formerly the Institute of Psychiatry). He said that asylum is two things. It is a haven in which to take refuge, and it is a harbour from which to set out again. The haven is the refuge part, where a person feels that it is a place of safety, a place where they will be looked after, a place of peace and serenity.[6]
>
> The second part of the definition is often left out, though it is just as important:, the idea of having a harbour from which to set out again. If you are moored in a harbour, you need to prepare your boat before you can set sail, and you may need help with that. The challenge for us is to develop that sense of asylum in the community.[7]

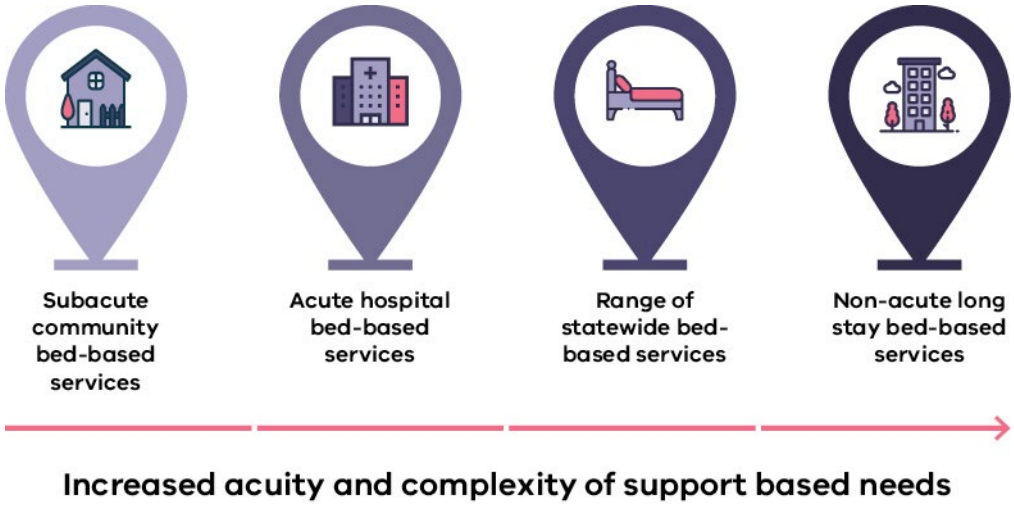
Each person who enters a bed-based service will bring their own experiences, preferences and circumstances. Consumers will therefore need to be given opportunities and supports to make decisions about their treatment, care and support in bed-based settings, all of which must be holistic, multidisciplinary and integrated.[8] Consumers must have access to a broad range of supports beyond medication-based interventions. This includes access to various evidence-based and informed psychological therapies, wellbeing supports, physical wellbeing supports and addiction and substance use supports.

Above all, bed-based services in the future system must foster a sense of dignity, respect and autonomy for consumers as well as acknowledge and address the implications for consumers where their rights might be limited.[9] In the future, recovery-oriented, compassionate and holistic treatment, care and support provided in a safe, welcoming and modern environment must be the defining features of bed-based services.

10.2 The role and type of bed-based services in the current system

There are four broad types of bed-based services that exist in the current system. These are subacute community bed-based services, acute hospital bed-based services, non-acute long-stay beds in hospital settings and specialist statewide services.

Figure 10.1: Continuum of bed-based service types in the current system



Subacute community bed-based services offer time-limited treatment, care and support in a residential setting for people living with mental illness or psychological distress who would benefit from a period of intensive support and rehabilitation before returning to their usual living arrangements.

There are three broad types of subacute community bed-based services in the current system:

- **Prevention and Recovery Care services** offer short-term multidisciplinary, recovery-focused care delivered mainly by non-government organisations, with clinical support from an area mental health service. These services enable people to 'step-up' from the community if they need a period of intensive support without requiring an acute inpatient admission, and to 'step-down' following discharge from an acute hospital setting to recover more completely before returning home.[10]

  There are variants of Prevention and Recovery Care services in the current system, comprising women-only services, youth-only services and extended-stay services, where people can stay for up to six months.[11]
- **Community care units** operate as a longer term rehabilitation setting where adults experiencing mental illness or psychological distress can access treatment, care and support for up to two years in a homelike residential setting. This service is intended to assist a person's transition back to independent living.[12]

- **Dual-diagnosis residential rehabilitation services** offer residential rehabilitation to adults experiencing co-occurring mental illness and substance use and addiction problems, also called dual diagnosis. These services are provided in a structured and therapeutic live-in environment and include 28 dual-diagnosis rehabilitation beds located in Bendigo (8 beds) and Sunshine (20 beds), providing treatment, care and support for up to 12 weeks.[13]

Acute hospital bed-based services, or acute inpatient mental health beds, are located in mental health units in public and private hospitals. These services predominantly provide clinical treatment, care and support to people experiencing an acute episode of mental illness who have high-intensity support needs that cannot be adequately supported in the community.[14]

There are three forms of acute inpatient beds in the current system:

- **Psychiatric assessment and planning units**, or short-stay psychiatric emergency beds, are located in some hospital emergency departments or in acute inpatient units. These units provide direct access to specialist psychiatric assessment for people who may not require an inpatient admission.[15]
- **General acute inpatient services** for adults and older adults provide short- to medium-term clinical treatment, care and support to adults aged up to 64, and adults aged 65 years or older.[16]
- **High dependency units**, or psychiatric intensive care units, deliver higher intensity support and supervision in a secure area of an acute inpatient unit.[17] Consumers receiving treatment, care and support in a high dependency unit are transferred to 'a less restrictive environment as soon as indicated or appropriate'.[18]

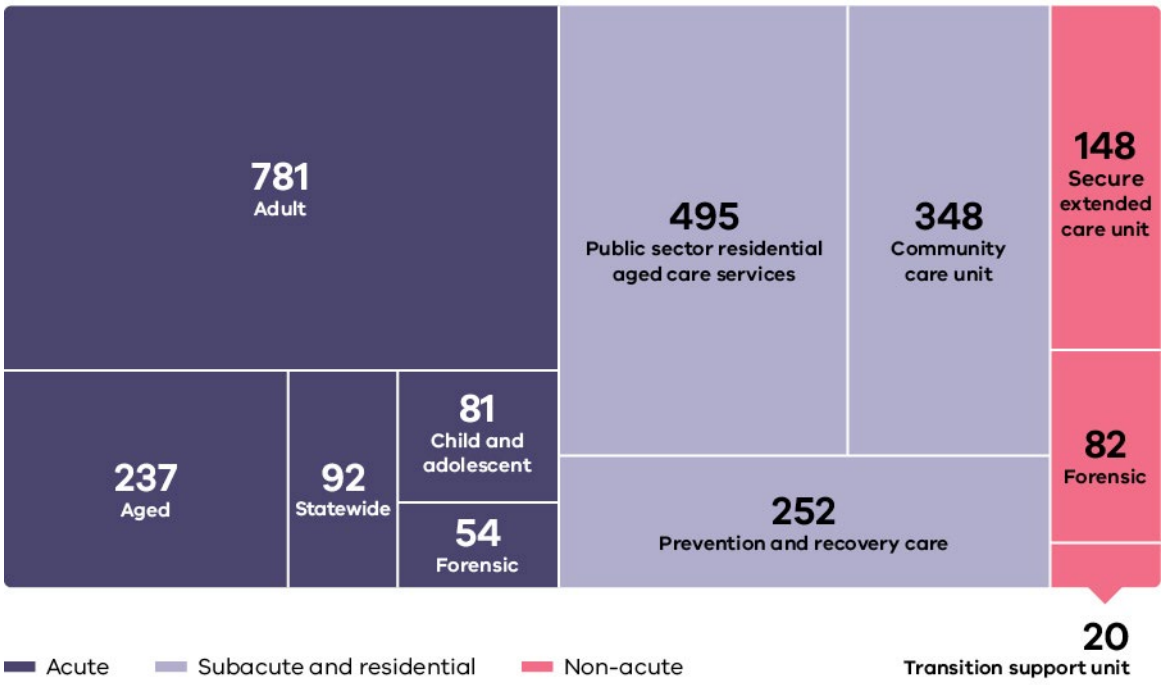
Statewide bed-based services comprise a range of highly specialised, targeted hospital bed-based services that operate on a statewide basis, including (for example):

- **Parent and infant units**, located at Austin Health, Bendigo Health, Ballarat Health Services, Latrobe Regional Hospital and Mercy Health, provide specialist mental health care to mothers experiencing mental illness during the perinatal period.[19] The perinatal period is the time during pregnancy and after birth.[20]
- **Eating disorder inpatient services**, delivered at Austin Health, Melbourne Health and Monash Health, are designed and operated to meet the specific support needs of adults experiencing an eating disorder.[21]
- **Forensic mental health services**, through the Victorian Institute of Forensic Mental Health at Thomas Embling Hospital, provide treatment, care and support to people living with mental illness who have been transferred from prison, those who have been ordered by courts to be detained for psychiatric assessment and treatment and, in very limited circumstances, people who have been referred by area mental health services.[22]
- **The Box Hill Hospital addiction medicine unit** consists of eight beds delivered by Turning Point. This service offers crisis support and withdrawal management, as well as treatment for co-occurring mental or physical illness.[23]
- **The Royal Melbourne Hospital neuropsychiatry unit** is an eight-bed service that specialises in mental illness associated with disorders of the nervous system. Services include cognitive neuropsychiatry, neuroimaging and neuropsychology of mental illness.[24]

- **Transition support units** support consumers with highly complex support needs, including people with dual disability, to transition between services. Two such units have been established, and the model of care evolving, at Austin Health and Monash Health.[25]
- **Extended stay hospital bed-based services, or secure extended care units**, provide medium- to long-term inpatient treatment and rehabilitation in a secure environment.[26] Secure extended care units are located on general hospital sites. There are currently 148 secure extended care unit beds in Victoria.[27] The high-intensity and complex support needs of consumers using this service type may not be adequately supported in less restrictive settings, such as community care units.

The current types and number of each bed-based service are set out in Figure 10.2.

Figure 10.2: Types of public specialist mental health beds, Victoria, 30 June 2020



Sources: Calculation by the Commission using the Department of Health and Human Services, Client Management Information/Operational Data Store 2019–20; Department of Health and Human Service, Policy and Funding Guidelines 2019–20.

Notes: 20 veterans' beds and 10 brain disorders beds at Austin Health are counted as statewide.

Includes 34 beds purchased from private providers in 2019–20.

Adult includes Orygen youth beds.

The Box Hill Hospital addiction medicine unit consists of eight beds delivered by Turning Point.

Eating disorder inpatient services, delivered at Austin Health, are designed and operated to meet the specific support needs of adults experiencing an eating disorder.

Parent and infant units, located at Bendigo Health, Ballarat Health Services, Latrobe Regional Hospital and Mercy Health, provide specialist mental health care to mothers experiencing severe mental illness during the perinatal period.

Prevention and recovery care includes adult and youth services.

Totals do not include beds recommended as part of the Commission's interim report as they are yet to be operational as at 30 June 2020.

10.2.1 A system under pressure

The Commission's interim report outlined how Victoria's acute mental health system is operating in a state of crisis. Chronic underinvestment in mental health services has resulted in limited community-based support options and a relative undersupply of hospital mental health beds. Combined with rapid population growth, this has given rise to several interrelated problems that are having a negative impact on consumer experiences and outcomes in bed-based settings.[28] These problems are:

- demand for acute inpatient services that outweighs supply[29]
- increased access thresholds as service providers must give priority to admission for those who are the most severely unwell and for whom treatment cannot be held off for any longer[30]
- reduced lengths of inpatient stays as staff are pressured to create bed availability for waiting consumers[31]
- high occupancy rates of consumers with highly acute mental health presentations, contributing to more volatile inpatient environments and increased rates of interpersonal violence, restrictive practices, compulsory treatment and staff turnover.[32] The *Mental Health Act 2014* refers to restrictive practices as bodily restraint that prevents a person from having free movement of their arms or limbs, and seclusion, which is when a person is isolated to a room or any other enclosed space.[33] The Commission's recommendations regarding reducing the use of restrictive practices in bed-based services are detailed in Chapter 31: *Reducing seclusion and restraint*.

Professor Patrick McGorry AO, Professor of Youth Mental Health, The University of Melbourne and Executive Director of Orygen, giving evidence in a personal capacity, noted how dire the situation has become:

> **The relative shrinkage and retreat in the face of escalating demand in the current system means that services are rewarded for waiting until people get really sick before they treat them.**[34]

From the perspective of some consumers, it can seem as if getting access to a bed-based service is 'impossible'.[35] For example, one individual told the Commission 'if you can get a bed it is like winning the lottery. If you had a broken leg then you would get in right away'.[36]

When access to essential mental health services is delayed, the consequences can be profound and far-reaching, affecting the individual, their family members, carers and supporters, and also the community more broadly. Delayed access to essential mental health treatment, care and support is associated with poor mental health outcomes, including higher risk of suicide, increased contact with the criminal justice system, housing instability and poor social and economic outcomes.[37]

When people are finally able to secure a bed, they do not receive the care they need, nor for the length of time they need, as staff face unrelenting pressure to deliver beds to waiting consumers.[38] The average length of stay in acute inpatient settings has progressively declined over the past decade, from 11.0 days in 2010–11 to 9.7 days in 2019–20 (excluding long-stay consumers, where the length was more than 35 days).[39]

Eastern Health reported to the Commission that:

> When there is insufficient bed capacity in the unit, consumers can be discharged based on an assessment of who is least likely to experience a significant negative outcome (to self or others) in being either discharged, or transitioned into a community service.[40]

The consequences of some discharges are evident in the high rates of acute readmission across the system. Consumers have no choice but to cycle back through the system in an effort to receive the care they need.[41] For example, in 2019–20, 15 per cent of people in adult inpatient units were readmitted within 28 days.[42]

As one consumer told the Commission:

> It just kept repeating itself in the sense I'd go into hospital, I'd come home, I'd go into hospital, I'd come home. And over about 10 years, I've probably been in and out of the hospital … 12 times.[43]

As noted in the Commission's interim report, another consequence is that families, carers and supporters are becoming increasingly relied on to fill the service gap created by limited bed capacity and shorter lengths of stay.[44] This finding is dealt with in more detail in Chapter 19: *Valuing and supporting families, carers and supporters*. This chapter also contains the Commission's recommendations regarding improved supports in the future system for families, carers and supporters of people living with mental illness.

Limited bed supply also means that acute inpatient settings are consistently operating at maximum occupancy, limiting the opportunity for services to adequately stream consumers on an age, gender or diagnostic-needs basis.[45] High occupancy rates have been shown to have a negative impact on the safety and efficiency of operations in acute inpatient units. They also contribute to access issues for those entering services.[46] Ms Jeffs commented that:

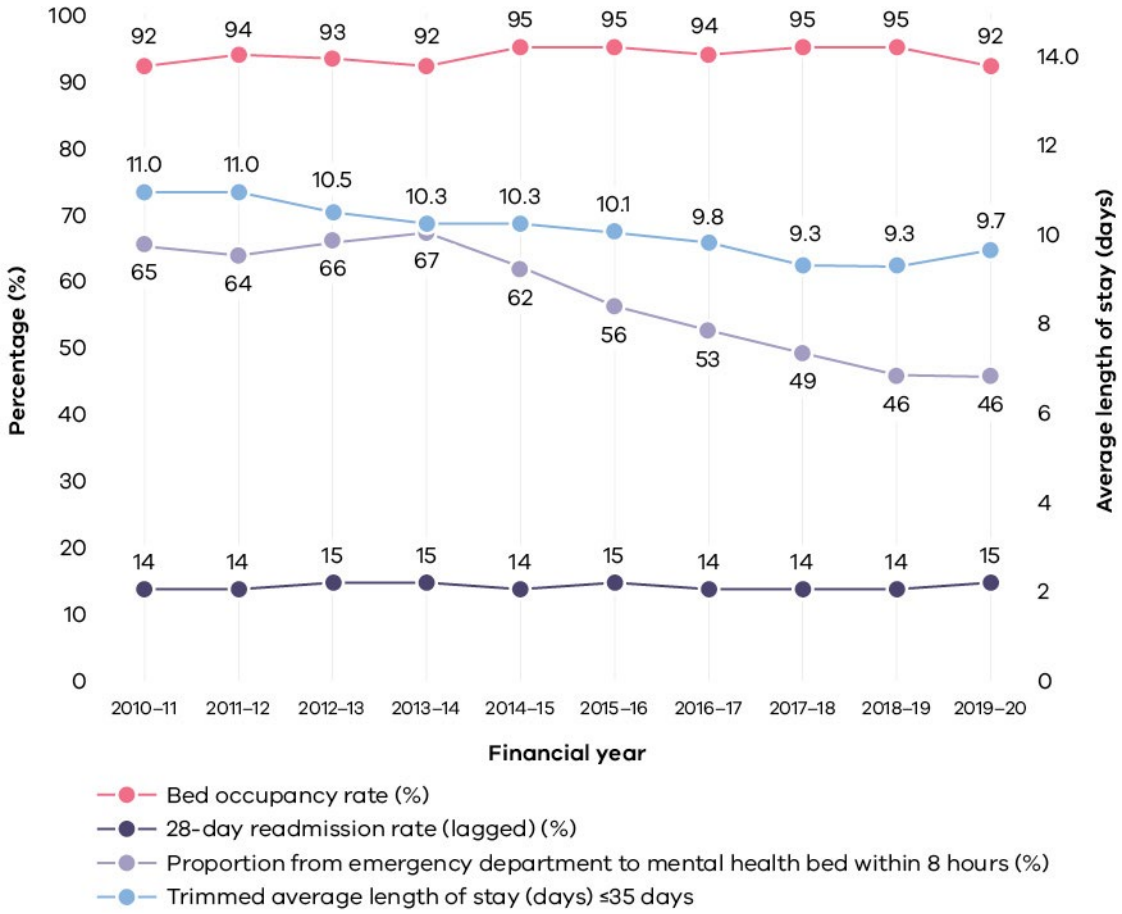
> This is not a suitable place for healing—a small environment where people are squashed on top of each other, and there is no place to find solitude or peace, or to get away from people. That sort of environment—small, without those places—increases people's tension and anxiety, and fuels a toxic environment where people are setting each other off, and that becomes unmanageable.[47]

Professor Shitij Kapur, the Dean of the Faculty of Medicine, Dentistry and Health Sciences and the Assistant Vice-Chancellor (Health) of the University of Melbourne, advised the Commission in a personal capacity that:

> Around the world, as the number of beds for inpatient care has decreased, the character of inpatient units has changed. Having worked in these units for over 25 years, I have noticed they have become increasingly riskier, more dangerous and threatening places.[48]

The combined impact of all these factors, summarised in Figure 10.3, has undermined the therapeutic nature of acute inpatient settings. These settings have become places where recovery is near impossible for many people.

Figure 10.3: Selected adult inpatient performance indicators, metropolitan health services, Victoria, 2010–11 to 2019–20



Source: Department of Health and Human Services, Client Management Interface/Operational Data Store 2010–11 to 2019–20.

Notes: Bed occupancy rate is the total number of bed hours (excluding leave) in inpatient units divided by the total number of funded bed hours.

For further information, please refer to <www.health.vic.gov.au/mental-health/research-and-reporting/mental-health-performance-reports/adult-performance-indicator-reports>.

Unresolved demand pressures in the acute service system and associated problems are also detracting from the therapeutic capacity of subacute services in the community, including Prevention and Recovery Care services and community care units.[49] These services are being pressured to support more consumers with high-intensity and complex support needs.[50] This is also undermining their ability to provide a meaningful step-up service from the community as demand skews the focus to consumers requiring more intensive support.[51]

NorthWestern Mental Health reported that:

> [Community care units] and [Prevention and Recovery Care services] are being forced to admit increasingly complex individuals who are still acutely unwell which impacts the recovery and rehabilitation prospects of co-residents.[52]

The consequences of the COVID-19 pandemic and the associated restrictions are expected to further exacerbate pressures on Victoria's acute mental health system.[53] Aftershocks will likely be felt in the form of job loss, increased rates of anxiety and distress, homelessness, and alcohol and other drug use following the periods of isolation imposed as part of global lockdown strategies.[54]

In its interim report, the Parliamentary Inquiry into the Victorian Government's response to the COVID-19 pandemic concluded that 'the COVID-19 pandemic has exacerbated the mental health impact of the December 2019 and January 2020 bushfires in regional Victoria'[55] and that:

> **While the Government's response has been welcomed by stakeholders in the shortterm, there is a need to develop longterm strategies to improve access to appropriate levels of mental health care across the state post the pandemic.**[56]

Building on the interim report's recommendation about the need for targeted expansion of acute mental health services, the Commission has identified a need to invest in at least a further 100 mental health beds to address critical demand pressures and support the Commission's reform agenda. This recommendation is based on a wide range of inputs to the Commission, including modelling and demand estimation tools, including the *National Mental Health Service Planning Framework*, national and global comparisons, and the 'observed outcomes approach' from The Adult Psychiatry Imperative submission to the Commission.[57] Over time, the realisation of the Commission's suite of reforms, particularly the maturation of the new integrated community model, is expected to reduce demand for hospital bed-based mental health services as people are able to obtain access to mental health treatment, care and support earlier in the community. In the future, statewide and regional plans recommended by the Commission will be used to measure current and future demand and detail what resources will be required. This is discussed in Chapter 28: *Commissioning for responsive services*.

The Commission is recommending substantial reforms to acute mental health services. Given the scope of its reform agenda, the Commission has sought to recommend sufficient new beds in settings that reflect optimal allocation and distribution across Victoria. These new beds are intended to facilitate and support the implementation of these reforms. By way of example, one of the reforms impacting the need for further mental health beds is the need for streaming, outlined in section 10.7 of this chapter. In particular, the Commission's recommendation is that young people aged 18–25 years will no longer be admitted to acute inpatient settings with adults and older adults. Further, gender-based separation is required, as described in section 10.7.1. Achieving these two reforms will require a combination of improvements to existing facilities, reconfiguration of existing facilities, and investment in new mental health beds.

The creation of a new stream of beds for young people aged 18–25 is a major reform. As described in Chapter 13: *Supporting the mental health and wellbeing of young people*, the Commission estimates that in 2019–20 there were the equivalent of 112 adult acute inpatient beds used by young people aged 18–25 years old. The introduction of the new stream of acute inpatient beds for young people responds to the concerns of young people, families, carers and supporters, and clinicians about the potentially detrimental and traumatic impacts on young people when they are treated in adult acute inpatient beds

Over time, the realisation of the Commission's suite of reforms, particularly the maturation of the new integrated community model, is expected to reduce demand for hospital bed-based mental health services as people are able to obtain access to mental health and wellbeing treatment, care and support earlier in the community.

Going forward, statewide and regional plans recommended by the Commission will be used to measure current and future demand and detail what resources will be required. This is discussed in Chapter 28: *Commissioning for responsive services*.

10.2.2 Suboptimal bed-based treatment, care and support

Building on the Commission's findings set out in Chapter 3 of the interim report, people's experiences in bed-based services are not universal. For some, overnight care provides them with the necessary time and space to recover and heal in an environment where they feel safe and supported with other people around them who are going through similar experiences.[58]

These experiences are more commonly reported in community bed-based services, particularly in Prevention and Recovery Care services.[59] The strengths of Prevention and Recovery Care services were set out in the Commission's interim report.[60] In these services, treatment, care and support is delivered in more homelike residential settings, and greater emphasis is placed on recovery activities that emphasise consumers' strengths and overall wellbeing.[61] The Commission considers them to be an integral component of a comprehensive mental health and wellbeing system.

For example, the Commission has been told that:

> [Prevention and Recovery Care] is the sole reason I'm still here. It's incredible—you have freedom, they focus on your optimal health; there are support workers who take care of you while you're there. I felt safe and a feeling of community.[62]

For others, bed-based services can feel intimidating, isolating and unsafe. The Commission has heard of these experiences occurring in hospital-based settings in particular.[63] A heavy reliance on medication,[64] limited opportunities to engage in meaningful activities and social interactions,[65] a high prevalence of interpersonal violence,[66] and cold and sterile hospital environments[67] are just some of the reported reasons for negative experiences in acute inpatient settings. As one consumer reported:

> Inpatient environments are restrictive and unappealing—these inpatient environments feel unsafe, restrictive, and lifeless. There is no music or activities that people can do. You may get something interesting once a week.[68]

Many families, carers and supporters spoke of similar problems with acute inpatient settings. For instance, one mother of a consumer shared that:

> At times where I've had to drop my son off in those different environments there was limited, if any, contact with me as an individual. There was limited understanding of him as a person … it almost feels like he's processed rather than he's greeted and welcomed as a person. The mechanisms in themselves are dehumanising. I think it took almost two years when my son was on a ward that I ever got a cup of tea from someone, and just have someone meet you as a person and be with you and say, how are you going?[69]

Chief Executive of cohealth, Ms Nicole Bartholomeusz, explained why she thinks so many consumers and carers are reporting negative experiences in hospital bed-based settings. In her evidence, she noted that:

> Attending a major acute hospital is a significant barrier to people experiencing mental illness. Having to walk into a big building and being confronted with all of what is happening—the noise and busyness of an emergency department, having to wait for often substantial periods of time—is completely overwhelming, so people will choose not to seek the care they need to avoid walking into a hospital setting.[70]

The highly pressurised environment of inpatient settings can also keep staff from being able to provide the care they have been trained to deliver.[71] Compassion, communication and collaboration are often casualties of the unrelenting pressures staff face on a daily basis. Professor McGorry AO emphasised that:

> the degree of difficulty faced by mental health professionals in doing their professional roles is very high much of the time especially in acute settings. This is especially so these days when only the most acutely ill people are accepted and then in a stage of illness when distress, anger, hopelessness and suicidal behaviour is at a peak level … To engage such acutely ill psychiatric patients in a compassionate, skilled and effective way requires a level of personal commitment and rare skill that rivals that seen anywhere in health care. The culture in which this is attempted is often demoralised, the facilities dilapidated and the clinical leadership weak and inconsistent. This makes it hard to live up the ideals and training that are necessary for such care to be optimal.[72]

One community witness who has engaged in the system as a peer support worker also shared that:

> Clinicians who come into the system with a heartfelt wish to heal and bring positive change end up with a near unbearable amount of 'moral discomfort', and heartbroken. I believe that compulsory treatment, robbing consumers of the 'flight' option in our 'fight or flight' response, causes many of the problems that it is supposed to remedy. The system does not work for nurses on Intensive Care Areas / High Dependency Units. It doesn't work for doctors who are too busy to help in the way they would like to. It doesn't work for allied health professionals who are sidelined and marginalised by the dominance of [the] medical model, and undervalued. I believe that when the system works for consumers, it will work for everyone else. This is how to retain the mental health workers, including peer support workers.[73]

Witness Mr Kiba Reeves reflected on how this culture affected his experience as a consumer, noting that:

> In the adult mental health system, I was made to feel like I was a burden to deal with … I understand that hospitals don't have many resources and that they cannot keep me if there are no beds available. But it would have made a huge difference for me if the staff had listened to me and acted a bit more compassionately and were more sympathetic. I often felt like they didn't realise they were talking to a person who was hurting and not just a number or an attention-seeker.[74]

The Commission's reform agenda, and associated recommendations, will help ensure that bed-based services function as enabling environments for high-quality, safe and therapeutic mental health treatment, care and support.

10.3 Delivering the highest quality bed-based services

When it comes to the provision of residential mental health treatment, care and support, a one-size-fits-all approach does not work, even for those who have been admitted to the same bed-based service type.[75] All bed-based services must operate on this understanding.

Professor Suresh Sundram, Head of the Department of Psychiatry at Monash University and Director of Research of Monash Health Mental Health Program, summarised in a personal capacity why this approach does not work:

> Mental health is generally addressed as a homogenous concept. As a result, the current mental health system delivers homogenised and generic services. However, mental health encompasses a wide variety of different disorders, of varying levels of severity of illness, each of which require different types of responses or treatments.[76]

Reflecting on his experiences as a father and carer for his daughter, Jessica, and the care that she received in Victoria's acute mental health system, the Honourable Professor Kevin Bell AM QC, Director of The Castan Centre for Human Rights Law, Monash University, giving evidence in a personal capacity, noted that:

> A mental health system was there to help Jessica when she needed treatment for her mental illness, although it was not targeted specifically to the needs of young people generally or young females in particular … . This is a universe away from the asylum era. But it was and is a one-size-fits-all system … one that does not generally apply an age and gender perspective …[77]

Different presentations and mental illnesses require different treatment responses, and people's mental health can neither be assessed, nor supported, in isolation of their experiences, living circumstances, relationships or support networks, and any other health problems they may be experiencing.[78] In line with the Commission's expectations for the new community model, mental health treatment, care and support delivered in bed-based service settings must be multidisciplinary, integrated and individualised.

While variation in treatment, care and support that reflects informed choices by consumers is often desirable and necessary, variation due to other factors—such as consumers not having access to evidence-based treatment, care and support that is right for them—is undesirable. This notion is explored in Chapter 30: *Overseeing the safety and quality of services*. This chapter also contains the Commission's recommendations regarding the measures to be put in place to ensure unwarranted variation in service delivery is detected and managed appropriately.

Australia has ratified the *Convention on the Rights of Persons with Disabilities*. In turn, the Victorian Government has a duty to promote the right of people with 'mental impairments' to the enjoyment of the highest attainable standard of health without discrimination and on the basis of free and informed consent.[79] In compliance with the *Australian Charter of Healthcare Rights*, all consumers in bed-based settings have a right to safe and high-quality mental health treatment, care and support where they are treated as an individual, and with dignity and respect.[80]

Individually tailored service delivery requires open, respectful and continued communication between multidisciplinary care teams, the consumer, and carers. Consumers must be supported to make informed decisions about their care pathway wherever possible.[81] This means they need to have access to information in a form that they understand and clarity about the full suite of treatment options available to them, including information regarding any associated risks.[82]

Dr Tricia Szirom, former Chief Executive Officer of the Victorian Mental Illness Awareness Council, gave evidence that:

> Each consumer is the expert of their life and their needs. They need to be listened to. Service providers and staff should not assume that their truth is the consumer's truth. As consumers, we know what we need; we just need to be listened to … Consumers should be given the right to inform decisions, options and choices. Feeling disempowered is the opposite of the recovery process. It is important to acknowledge that not all consumers want the same things.[83]

Lack of good communication is a concern in the current operations of bed-based services. Many consumers, carers and family members directed the Commission's attention to this deficit, which has left many feeling alienated from their own care.[84] As one consumer told the Commission:

> Consumers are never a central part of the conversations that are had about them, and often aren't even aware that these conversations are taking place … At the moment, the perspectives of clinicians are privileged because they are the ones who write in the medical records, and who lead conversations about consumers when they're not present. There needs to be a shift in ensuring that consumer perspectives are held central in the individual care that they receive.[85]

All bed-based services in the future system must deliver holistic, individualised and integrated treatment, care and support. This will require the establishment of multidisciplinary care teams to work collaboratively to achieve the best outcomes for each consumer.[86] Evidence before the Commission suggests that effective multidisciplinary teams in bed-based services include psychiatrists, psychologists, nursing staff, allied health professionals and peer workers.[87]

Many have emphasised the value that peer workers can bring to bed-based service settings for the consumer, their supporters and also for staff themselves. For many consumers, peer workers can be a source of comfort, security and hope for their own future.[88]

This is particularly the case in hospital settings, where the clinical and pressurised environment can be intimidating and overwhelming.[89]

Mr Douglas Holmes OAM, General Manager of MH-worX in New South Wales, a consultancy service for hospitals and organisations who work with people experiencing homelessness and mental illness in New South Wales, gave evidence in a personal capacity and noted the value of peer workers:

> Peer work can improve a service or organisation's culture and enhance its recovery focus. Working with peer workers helps other mental health staff understand that the people they care for can and do recover; improving empathy and understanding towards the consumers and carers they support.[90]

10.3.1 Providing high-quality treatment requires a range of therapeutic options

Medication alone is not sufficient to adequately care for, treat or support a person experiencing an acute phase of mental illness.[91] Yet medication continues to function as the default treatment in many acute inpatient settings.[92]

Many consumers have raised concerns about the lack of treatment options in acute inpatient settings.[93] They often shared that the lack of choice and control over their care pathway undermined their autonomy, reduced their motivation for recovery and detracted from the overall efficacy of the care received.[94] For example, one consumer told the Commission:

> In the mental health hospital, the treatment is horrific. Patients have no choices. They are held against their will and given treatment they don't want. There are no psychologists, it's medication or nothing. Their trauma is not considered. It's just medicating the symptoms.[95]

This appears to be due to intense demand pressures, an emphasis on risk management, and limitations in current funding arrangements for bed-based services.[96] As reported by Associate Professor Simon Stafrace, Chief Adviser to Mental Health Reform Victoria giving evidence in a personal capacity, the priorities of adult hospital and emergency services have been shaped by several interrelated factors, including:

> A disproportionate share of the financial, legal, clinical and operational risk … [a] lack of capacity to meet incident demand for emergency care and early intervention … [and a] model of care that favours risk management, statutory process and patient flow in order to ensure timely access for patients presenting in crisis or requiring hospital treatment.[97]

In her witness statement to the Commission, Dr Szirom emphasised that:

> There should be a choice of treatment options at every point. We know that when people feel they have had legitimate control of their care options, recovery is much more likely and successful.[98]

Director of Operations and Nursing of Mental Health and Addiction Health at Alfred Health, Ms Sandra Keppich-Arnold shared the view that:

> If mental health services are serious about providing proper mental health care, they need to embed into routine practice a range of evidenced based therapies to ensure consumers are provided with resources that build resilience and capacity to self-manage.[99]

Many consumers have expressed a desire for including evidence-based and evidence-informed creative treatments and therapies as a standard service offering across acute and subacute bed-based services, including art therapy and music therapy.[100] For instance, one consumer told the Commission:

> I would like to see them bring back the return of art therapy … I think art therapy with really good people, which again, is your calling and your mindfulness at distraction techniques, garden therapy, a lot of the clinics [have] a walking area with a garden and people could just do something in the garden or be taught something about gardening …[101]

Two individuals, one carer and one consumer, noted in their joint witness statement to the Commission that:

> Mental health settings like hospitals and clinics should look at using more creative types of therapy, on a regular basis. For example, having a dog visit the ward can be very therapeutic. Royal Melbourne Hospital has volunteers bringing in dogs to various wards to cheer up the patients. Music is another therapy that can also do wonders for people—even just one person with an instrument playing live music would be wonderful therapy.[102]

Moreover, it is essential that all bed-based services in the reformed system, including acute inpatient services, have the necessary structures and resources in place to offer consumers a range of evidence-based and evidence-informed treatments and therapies in addition to medication.

10.3.2 Offering meaningful, motivating and engaging activities

Confronted by demand pressures and limited resourcing, the Commission heard that acute inpatient services have become increasingly 'lifeless'[103] and boring for those using them.[104] Many consumers have shared how dull, unmotivating and isolating these services can seem when there are limited opportunities to engage in meaningful activities.[105]

Reflecting on time she spent in an inpatient mental health setting, one consumer told the Commission:

> There is nothing to do in almost all of the adult wards I have been to. You just wake up and get your meds. A lot of them will have a timetable of all the fun things that they do, but the activities almost never run. The best activities of the day are breakfast, lunch and dinner because it's the only time there is something to do other than sitting around. In that sense, I don't think that adult wards are particularly therapeutic in any way, shape or form. They just seem to be a holding place for people until whatever crisis is over, or until people are so sedated that they're good to go out in the community again.[106]

As is the expectation for all future community mental health and wellbeing services, all bed-based services must be suitably resourced to provide a range of non-clinical wellbeing supports in the reformed system. These supports must emphasise community connection and peer support and promote overall wellbeing.

The Commission acknowledges that some community bed-based services are already doing this relatively well, particularly Prevention and Recovery Care services. Partnership arrangements between these services and non-government organisations have encouraged a more recovery-oriented approach to care.[107] In a research study conducted by Professor Carol and colleagues on Prevention and Recovery Care services in Australia, it was noted that:

> Although there is an expectation that clinical services will also adopt recovery-oriented practice, this is much more difficult to achieve when inpatient length of stay is so short and the focus of care is generally on diagnosis, medication, and maintaining safety in a crisis. Hence, [Prevention and Recovery Care] services widen the opportunity to offer recovery-oriented group programs and other related activities.[108]

The mode and intensity of wellbeing supports to be delivered will vary across bed-based settings. Greater emphasis must be placed on delivering these supports in subacute community bed-based services and extended rehabilitation settings, relative to acute hospital settings, given their intended purpose.

All bed-based services must facilitate opportunities for informal and formal social interactions among consumers, between consumers and staff, and with external visitors.[109] These opportunities must include providing a range of voluntary group activities, such as exercise and talking groups, and built environments that promote positive social exchanges. For instance, as Alfred Health told the Commission:

> Design should create formal and informal opportunities for socialisation between individuals through small and large communal zones, and dedicated activity areas. Sharing experiences and social connections supports recovery. The constructed environment should balance equally priorities of privacy, maintenance of safety, and prevention of loneliness and isolation.[110]

One consumer emphasised that access to even the most basic activities can create opportunities for meaningful and rewarding social interactions, which can have an enormous impact on consumer morale in acute inpatient settings. This consumer explained that:

> Staff assisting to play boardgames and getting … consumers to play boardgames with each other just as an alternative to the constant noise. All we had was one or two televisions on the ward. There was no other alternative.[111]

The Commission's expectations align with those set out by the Office of the Chief Mental Health Nurse in its *Mental Health Intensive Care Framework*, which states:

> Consumers must have access to a range of activities and interventions to support engagement, promote self-care and prevent feelings of boredom and frustration. Make activities available for open-source self-selection—for individual and group use.[112]

Consumers must also have access to a range of practical supports if they want them, designed to build day-to-day living skills and promote independence following discharge, particularly in subacute community bed-based services and extended rehabilitation settings. Again, these supports must reflect, to the greatest extent possible, each person's individual interests and recovery goals. They might involve budgeting advice, vocational training and skill building, and other independent living skills such as cooking, cleaning and shopping.[113]

10.3.3 Delivering integrated mental health and physical wellbeing supports

Though the physical health disparities between people living with mental illness and those who are not are extensively documented,[114] people living with mental illness or psychological distress are more susceptible to chronic health conditions and are more likely to smoke and to have a shorter life expectancy than the general population.[115] Despite this, bed-based mental health services continue to deliver suboptimal physical health treatment, care and support. As one consumer explained:

> Despite being in a hospital, mental health units don't care for people's physical health issues. Your access to medication that is not for mental health is very limited to non-existent.[116]

Mr Peters, who has lived experience of mental illness and severe persistent pain, also told the Commission that:

> There is a longstanding tradition and practice in the medical profession of the separation of mind and body. However, best practice is to treat people in a holistic way, where you see the person as a whole.[117]

In line with the Productivity Commission's *Mental Health Inquiry Report* recommendations, the Commission endorses the requirements of hospital and community bed-based mental health services set out under the National Mental Health Commission's *Equally Well Consensus Statement* and the adapted framework specific to the Victorian context titled *Equally Well for Victoria*.[118] These include providing physical health support that is consumer-centred; transparency with regard to the risks and side effects of treatment options, including medications; the promotion of a healthy lifestyle, including tailored supports to quit smoking; and the ability for outcomes to be rigorously monitored with clearly identifiable wellbeing outcomes.[119]

As summarised by Dr Neil Coventry, Victoria's Chief Psychiatrist:

> To help overcome these [physical health] barriers, it is imperative that mental health clinicians are mindful of consumers' physical well-being and take action to encourage screening, testing and treatment of physical health conditions where indicated. It is no longer acceptable to expect physical and mental health to be addressed by different health providers in different places at different times. Where consumers have limited access to health care, mental health clinicians must take an assertive role to help consumers overcome barriers to good health.[120]

10.3.4 Supporting people with co-occurring mental illness and substance use or addiction

Despite the prevalence of living with co-occurring mental illness and substance use or addiction, Victoria's bed-based mental health services have too often failed to provide integrated treatment, care and support for both conditions.[121] Experiences of substance use or addiction have barred many people from accessing essential mental health treatment, care and support in a bed-based setting.[122]

All bed-based services must provide integrated treatment, care and support for both mental illness and substance use or addiction. Bed-based services must welcome, rather than exclude, and be able to support consumers who have mental illness and substance use or addiction, including consumers who are actively using substances.[123]

As described by Mr Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association:

> *An ideal response* … is to first meet the person warmly when welcoming them into a service. The person should have both their [alcohol and other drug] and mental health problems considered as primary issues to be addressed simultaneously because co-occurring disorders would be considered the 'expectation not the exception'.[124]

While this is a general requirement for all bed-based services in the future system, the Commission acknowledges that using certain substances, particularly methamphetamines, can be less effectively managed in some community-based settings than in inpatient settings. But for the most part, all consumers must receive integrated treatment, care and support for their mental health and substance use or addiction in all bed-based service settings. This treatment, care and support must be delivered in parallel, not sequentially.[125]

This will require establishing multidisciplinary teams with the necessary skills and expertise to provide appropriate treatment, care and support for consumers with co-occurring mental illness and substance use or addiction. It will also require access to addiction specialists when more advice and expertise is necessary.[126] The essential components of integrated mental health and addiction supports in bed-based settings are expanded on in Chapter 22: *Integrated approach to treatment, care and support for people living with mental illness and substance use or addiction*.

10.3.5 Ensuring continuity of care across settings

Transition points between service settings can be a time of great instability for consumers, and effective and streamlined care coordination is essential. If poorly managed, the periods of transition into, or out of, a service setting can expose an individual to increased stress, fragmented care and service gaps. Yet many people are prematurely discharged from bed-based settings without adequate follow-up support.

A lived experience witness shared her experience of early discharge from an inpatient setting, reporting that:

> I was there for two weeks and then at 2 o'clock one afternoon I was told I was being discharged. I hadn't seen a doctor all day, discharge was thrown on me. That was so traumatic for me. I don't do well with change at all, and not instant change—I need a couple of days' notice … I was discharged on Friday, and the Saturday I ended up in emergency again.[127]

The turbulence of many service transitions has been perpetuated by unresolved problems in intersecting service sectors. These include the lack of adequate supported housing options and service gaps in the National Disability Insurance Scheme. Dr Coventry noted:

> As an example of the difficulties that arise with discharge planning, exiting from services presents a particular challenge for people whose combinations of developmental disability and mental illness result in behavioural symptoms that require one-on-one care in custom-built accommodation. Some of the young people in this situation have remained on inpatient units for 18 months waiting for the [National Disability Insurance Scheme] and community support service to make the necessary arrangements.[128]

As a time-limited setting, bed-based services have a duty to ensure continuity of care for consumers entering and exiting their service. This requires comprehensive care planning and coordination, proper use of relevant information from previous care providers and collaboration with the individual, their carers, family members and supporters where appropriate, in order to understand their support needs.

As described by Dr Sika Turner, Discipline Senior of Adult Mental Health at Monash Health:

> Collaboration between different parts of the mental health system is an issue needing urgent attention. It is patchy and area dependent. Services are often siloed and is it often unnecessarily difficult to refer between them with multiple gatekeeping in between services.[129]

Peer workers also play an essential role in this process, particularly at the point of discharge. One peer worker shared that:

> Putting aside the question of readmission, the time post discharge from an inpatient unit is often a time of increased distress, so additional connection and support was often welcomed by consumers.[130]

Comprehensive discharge planning must occur from the point of admission and reflect the recovery plans, goals and support needs of each consumer. Existing operational siloes between different service settings must be abolished and good communication channels and collaborative arrangements established to seamlessly carry consumers between service settings. Those channels and arrangements need to ensure there is no risk of communication failure. The Commission expects the development of modern infrastructure for information and communication technology systems will support the achievement of this in the reformed system. These reforms are set out in Chapter 35: *New approaches to information management*.

10.4 Diversifying the mix of bed-based services

Victoria's mental health and wellbeing system requires a broad and innovative continuum of bed-based service options, with a focus on bed-based services in the community.[131] All too often, acute inpatient services operate as the first and only option for people living with mental illness or psychological distress. In many cases, mental health treatment, care and support could more appropriately be delivered much earlier than is currently the case, and in less clinical bed-based settings in the community, such as residential settings.[132]

Professor Ian Hickie AM, Co-Director of Health and Policy at the Brain and Mind Centre at the University of Sydney, giving evidence in a personal capacity, told the Commission:

> The real challenge in Australia lies not in sourcing additional funding for more beds, but rather in achieving the right balance of traditional forms of hospital-based care and an appropriate range of specialised and community-based services, many of which are provided in ambulatory care settings, required to meet the ever-growing demand for mental health services.[133]

Ms Frances Diver, CEO of Barwon Health, told the Commission:

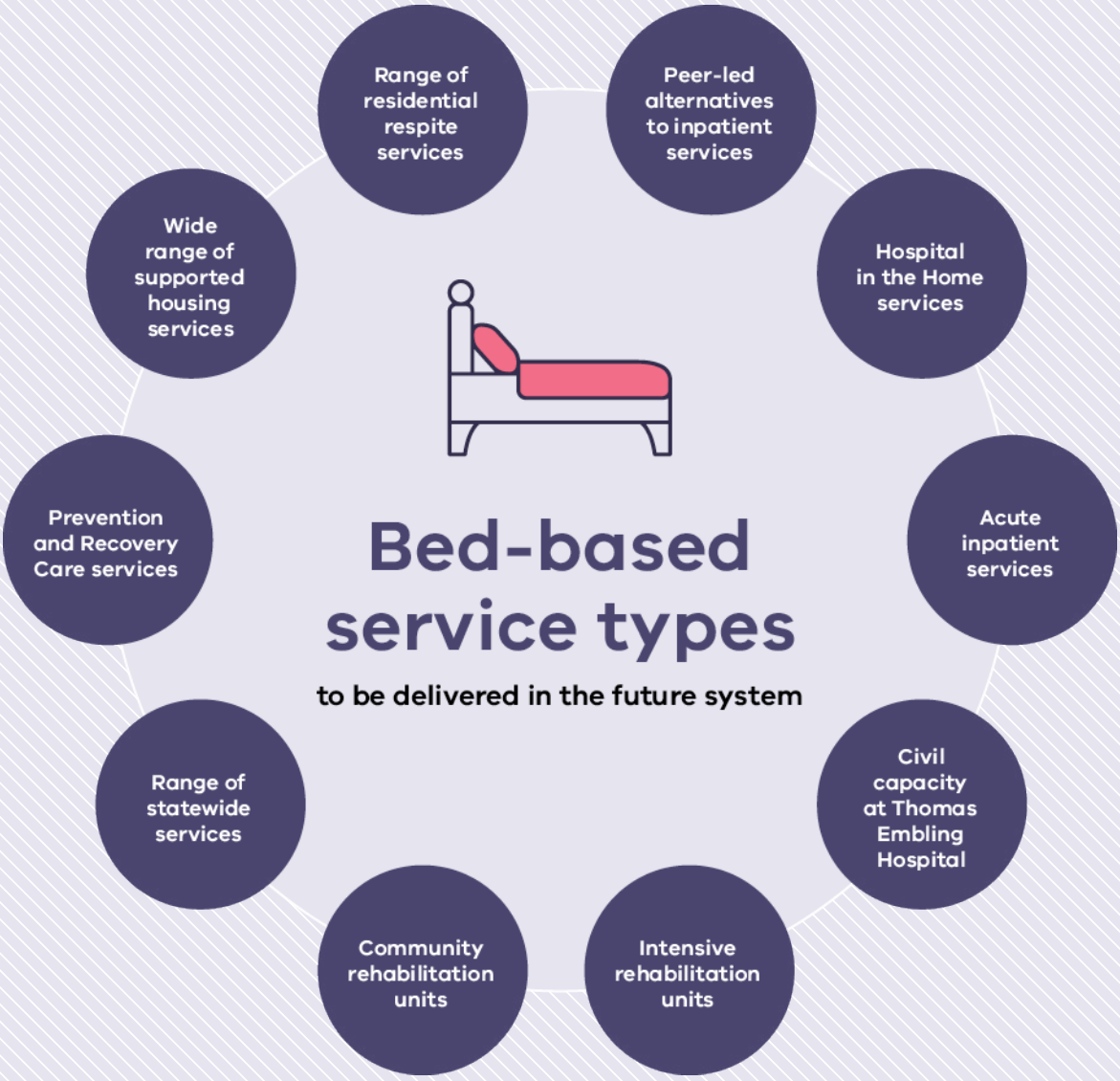
> We currently have the wrong people in the wrong beds at the wrong time because we don't have the right number and mix of beds across the continuum. We have a lot of people staying for too long in acute settings when they actually need subacute care. This creates a lot of tension in the system.[134]

Victoria's current continuum of bed-based services has large gaps, leaving many consumers without access to essential mental health treatment, care and support before or after an admission to an acute inpatient setting. For instance, consumer witness Erica Williams told the Commission that:

> I have found myself not quite sick and not quite well multiple times. On these occasions I tried to keep myself afloat alone, and I ended up in an emergency department. For me, mental illness extends as a permanent condition. It fluctuates, but it doesn't ever disappear. It would have assisted me if there was a system which accounts for that fluctuation—so I could have moved from sickness to health and in between, with services to meet me at each point.[135]

An innovative and diversified mix of bed-based services is needed. The Commission has identified four broad categories of bed-based service types that must be available across the state in the future mental health and wellbeing system. The best composition of these bed-based services will be determined at the statewide and regional levels as part of the broader planning process that the Commission has recommended. The bed-based service types to be delivered in the future system are illustrated in Figure 10.4.

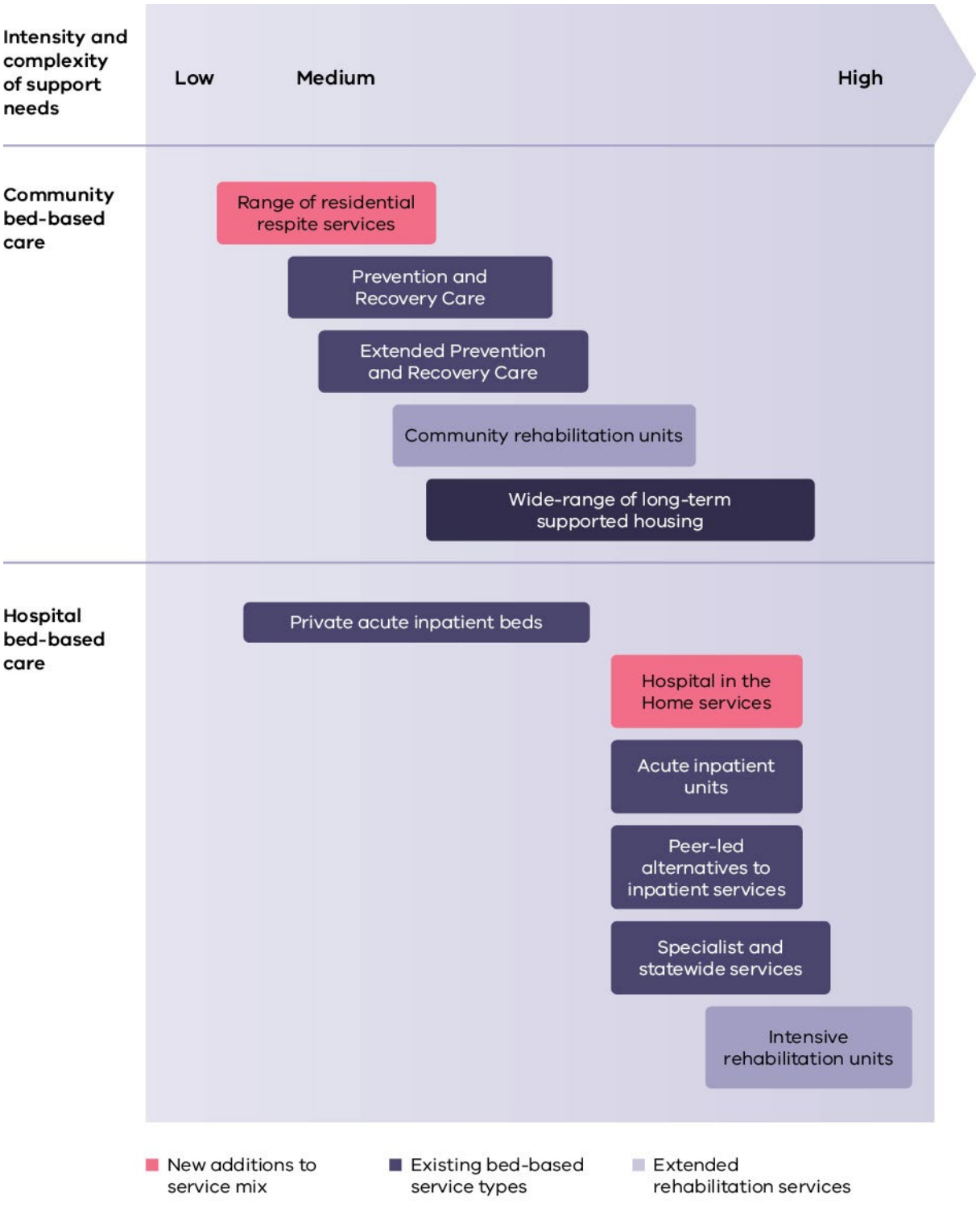
Figure 10.4: Bed-based service types to be delivered in the future system



The revised continuum of bed-based services, illustrated in Figure 10.5, can be categorised as the following:

- **Therapeutic respite and short-term recovery services** will provide a range of time-limited community-based support options for consumers living with mental illness who do not need an acute hospital admission but would benefit from a period of care in a supportive environment. These services include a range of time-limited residential respite services and Prevention and Recovery Care services.
- **Supported housing services** will deliver a wide variety of safe, secure and affordable housing options for certain mental health consumers with additional housing support needs, providing integrated, multidisciplinary and individually tailored supports on site. Supported housing models to be delivered in the future system are discussed in Chapter 16: *Supported housing for adults and young people*.
- **Acute treatment, care and support services** cover a broader spectrum of support options for people experiencing an acute phase of mental illness. These services comprise acute inpatient services, Hospital in the Home services and peer-led alternatives to inpatient care. In its interim report, the Commission recommended that the Collaborative Centre for Mental Health and Wellbeing be established. The Centre will also deliver acute inpatient services to its local population to reinforce the translation of research into high-quality service delivery.
- **Extended rehabilitation services** encompass three forms of longer-term care options for people living with mental illness or psychological distress and ongoing mental health support needs. These extended rehabilitation services comprise community rehabilitation units (or re-envisaged community care units), intensive rehabilitation units (or re-envisaged secure extended care units) and expanded capacity for civil consumers at Thomas Embling Hospital.

Figure 10.5: Continuum of overarching bed-based service types in the future system



Note: There is crossover between extended rehabilitation services and existing bed-based service types.

10.4.1 Expanding Hospital in the Home services

Hospital in the Home services will have an important role in Victoria's future mental health and wellbeing system. A fixture of Victoria's physical health system since 1994, Hospital in the Home schemes enable some people to receive the equivalent of hospital-based acute mental health treatment, care and support in the comfort of their home or usual place of residence.[136]

Hospital in the Home services are emerging as an increasingly common component of comprehensive mental health systems.[137] Western Australia, for example, has committed to expanding Hospital in the Home services, with a system target of approximately 20 per cent of all inpatient mental health beds operating as Hospital in the Home beds by 2025.[138]

Following the Commission's interim report recommendations, new Hospital in the Home beds for adults and young people are being developed by Barwon Health and Orygen Youth Health.[139] Associate Professor Steven Moylan, Clinical Director for Mental Health, Drug and Alcohol Services at Barwon Health, who is leading the implementation of Barwon Health's new Hospital in the Home capacity, told the Commission:

> If we are going to make programs such as this successful, we must view them as true models of bed substitution, and ensure that resourcing of them in terms of staffing and multidisciplinary input is the equivalent of, or even enhanced above, that provided for traditional inpatient care … If our ambition is to provide individualised care to consumers, with a view to partnering in their recovery, supporting programs like hospital in the home is in my view a great step to achieving this.[140]

Hospital in the Home services will be a welcome addition to Victoria's acute mental health and wellbeing system, providing another alternative to acute inpatient facilities. Ms Mary O'Hagan MNZM, Manager of Mental Wellbeing at New Zealand's Te Hiringa Hauora, giving evidence in a personal capacity, emphasised that:

> People in crisis need intimate, homelike, calm places where they feel safe and cared for. A large, locked hospital ward full of people experiencing different types of distress, being supervised by staff whose main role is containment of risk, will never work. There is good evidence that home and community based acute options are preferred by staff and guests and that they achieve better or the same outcomes.[141]

Hospital in the Home services will be available for adults and young people experiencing an acute episode of mental illness and complex support needs who would otherwise require an admission to hospital.[142] The Commission expects Hospital in the Home services to reflect the design and quality features set out in Box 10.1. Comprehensive models of care must be co-designed with people with lived experience and be reviewed periodically to ensure service delivery remains fit for purpose and operating as intended.

Box 10.1: Design and quality features of Hospital in the Home services for young people, adults and older adults

Victoria's Hospital in the Home services must:

- be available to consumers who are willing and able to receive this form of treatment, care and support; to receive this service, the consumer must have access to stable accommodation that is considered safe and appropriate for the consumer, staff and anyone the consumer is living with, including family members and friends[143]
- operate as a direct substitute for acute inpatient mental health treatment, care and support, not as a form of community-based outreach[144]
- be delivered by multidisciplinary care teams that reflect the workforce requirements of a standard acute inpatient unit[145]
- allow consumers to access the same breadth of therapeutic interventions and supports that they would have if they had been admitted to an acute inpatient facility[146]
- deliver face-to-face treatment, care and support daily, likely requiring at least three visits a day.[147]

The Commission recognises that there will be some cases where Hospital in the Home services are not suitable, and an acute admission will be required.[148] For instance, Hospital in the Home services may not be appropriate in some rural settings where staff members would be required to travel long distances to deliver treatment, care and support to an individual in their home multiple times a day.

The Commission also acknowledges that in some cases, the provision of acute mental health treatment, care and support in a person's home may not be preferable or appropriate for the consumer or for others in the household.[149] As Mr Peter Kelly, the Director Operations, NorthWestern Mental Health, Melbourne Health, noted:

> Hospital in the Home (HITH) type care is very palatable to consumers and their families as it puts the consumer back in control of their care … It has significantly better outcomes in terms of consumer engagement and thus longer term acceptance of treatment. HITH type care however is limited by the level of risk which can be acceptably managed in the community. At times, the risk of deliberate self-harm, suicide, disorganised behaviour, substance use or family violence may preclude HITH as an option.[150]

Critically, Hospital in the Home services must not compromise service equity for those for whom the service is not suitable. This includes consumers without access to safe and stable accommodation, those receiving a complex range of services, and those living in remote areas of the state.

10.4.2 Delivering a range of residential respite services in the future system

The absence of time-limited, flexible and non-clinical residential respite services is a critical gap in Victoria's adult mental health and wellbeing system. Many consumers spoke of the lack of adequate support options they could use in the community when they experienced deteriorating mental health.[151] Many found themselves with no choice but to present to an emergency department when they reached a point of crisis.[152]

Reflecting the views of many consumers, a lived experience witness told the Commission:

> One such support that I'd like access to, that we don't currently have in Victoria, is a peer respite service. Peer respites are a voluntary service, staffed by consumer peer support workers, where people can come and stay for approximately seven days. During that time they can also have full access to their life as well. For example, people can go home and see their pets, or they're allowed to go to work during the day if work is really supportive of them and then come back and stay the night there. Or they can stay there all week and not leave the place at all. It is just a place to be able to go to stay if you're feeling overwhelmed, and need that additional connection and opportunity to rest and feel supported, but you do not have to disconnect from life in order to do that.[153]

A consumer representative also encouraged the Commission to consider establishing non-clinical, peer-run residential respite services, noting that:

> I feel like these kinds of models are hard for the current system to comprehend, because the system is so focussed on pathologising, medicating and getting people out the door. So it is hard to convey how different and transformational it can be to have a non-clinical space where people can physically go and take themselves away from whatever chaos is happening in their lives.[154]

Dr Christopher Maylea, Senior Lecturer in Social Work, RMIT University and then Chair of the Committee of Management of the Victorian Mental Illness Awareness Council, informed the Commission that when the council was consulting with consumers to inform its Declaration:

> The places people most spoke about were peer-run services, and this included many variants: peer-run respites, recovery houses, crisis centres, peer support groups, recovery colleges and retreats. Many people dreamed about the importance of nature in an ideal healing space: gardens, trees, lawns, flowerbeds. Many also dreamed about light and windows … [a] minority of people told us that hospital was the best place for them in a crisis. But these people spoke about the need for hospitals to be nicer, cleaner, with more light and unlocked doors.[155]

Case study:

Resolve Program

Flourish Australia's Resolve Program is a peer-led program designed to support people experiencing mental health issues who have spent an extended period in hospital as a result of their illness. Since October 2017, Resolve has been operating as a partnership between the New South Wales Government, Flourish Australia and Social Ventures Australia to deliver the first social impact investment developed in Australia focused on addressing mental illness.

Mr Mark Orr AM, CEO at Flourish Australia, said Resolve is a free, two-year program delivering comprehensive, mental health support including a short-stay residential program. Its aim is to reduce the likelihood of readmission to hospital.

> The respite house offered as part of the Resolve Program is comfortable and quiet, and is a place where people can feel safe and supported by peer workers. They don't need to worry about food or any other things; they can focus on getting on top of what's going on. That may include accessing clinical support at times.

Mr Orr said the Resolve model is staffed by peer workers who have a lived experience of mental illness. It offers three tiers of support, which can be adjusted as required.

> [Resolve] includes access to 24/7 short term respite residential support, outreach for in home supports and opportunities for social connection with others during the week. It also provides access to a 24/7 warm line, which provides non-crisis supports on the phone when people feel distressed or just need to talk.

An evaluation of the Resolve Program in 2019 identified early evidence that the program is reducing the number or duration of hospital admissions for some consumers when compared to the year before they commenced in the program. Consumers using the respite element of the program reported it helps them to 'reset their routine' when they notice their mental health declining, and that 'the non-institutional nature of the program is a very welcome change'.

One resident commented that the support of peer workers was helpful during their time in the program:

> I didn't feel comfortable being identified with other people with mental illness. But guess what, while I've had residential stays, I've seen this group operate and I've met some of the people and they're as human as I am, because I feel safe around the peer support workers—I've allowed myself to feel comfortable in that environment and join in those activities, and that's helped.

Source: *Witness Statement of Mark Orr AM*, 6 May 2020; Urbis, *Resolve Social Benefit Bond Baseline Report*, 2019.

As set out in Chapter 9: *Crisis and emergency responses*, crisis and residential respite services are a core element of the *National Mental Health Service Planning Framework*[156] but do not exist to any meaningful extent in Victoria. In many other jurisdictions, consumers can access peer-led short-stay respite programs for care, support and resolution of suicidal or other mental health crises.[157]

Several residential respite programs highlighted as exemplar models can be replicated in Victoria's future mental health and wellbeing system. These include the mental health peer support, wellness and respite centres in the United States and the peer-led respite service and the Resolve Program in Queensland case study.

The mental health peer support, wellness and respite centres are run by certified peer specialists in the state of Georgia and function as alternatives to 'traditional mental health programs' or inpatient care.[158] The respite centres are available to anyone experiencing mental illness, and consumers can stay for up to seven nights within a 30-day period. Consumers cannot be referred to the respite centre; they must present voluntarily. The program gives consumers access to a range of non-clinical supports and activities including talking groups, creative art programs and independent living skill development activities.[159]

Mr Holmes visited the respite centres in 2018 and informed the Commission that:

> I was fortunate to have visited the network in 2018 and spent time in each of the respite centres for a period of two weeks observing how they are operated. I believe the service provided by [Georgia Mental Health Consumer Network] is the missing link in our own mental health services.[160]

Victoria's mental health and wellbeing system must deliver a wide range of short-stay, voluntary and flexible residential respite services informed by local priorities, including peer-led services and services for people experiencing a mental health crisis or suicidality, as set out in Chapter 9: *Crisis and emergency responses*. Chapter 9 also describes the crisis respite services that will be available for young people in the future system.

In its interim report, the Commission emphasised the important role that services led, designed and delivered by people with lived experience of mental illness have in a contemporary and comprehensive mental health system. Building on the interim report recommendation that a peer-led alternative to acute inpatient services—modelled on Piri Pono—be established, the implementation of peer-led residential respite facilities will ensure that Victoria's mental health and wellbeing system continues to evolve in this respect.

Increased brokerage funding will also be available in the reformed mental health and wellbeing system to support families, carers and supporters to access short-term respite and alternative care arrangements, as recommended in Chapter 19: *Valuing and supporting families, carers and supporters*.

Residential respite services can be delivered in a range of settings, including 'homelike' environments and in the form of a holiday. As described by Dr Melissa Petrakis, Chair of Tandem, the Victorian peak body for carers of people living with mental illness or psychological distress:

> We would take consumers away for a four-day holiday each year, fully staffed and fully catered. Every second week our team took a group away on vacation somewhere in the state. We had a site in Apollo Bay, owned by the organisation, shared with Western Respite Services and other programs, and other sites we rented.[161]

The design and quality features that must underpin all forms of residential respite are set out in Box 10.2.

Box 10.2: Design and quality features of residential respite services for adults and older adults

All residential respite services must:

- function as safe places for consumers aged over 26 years who are not experiencing an acute phase of mental illness or psychological distress who would be better supported in a clinical acute or subacute bed-based setting but would benefit from some additional support or time away from their usual living arrangements[162]
- be time-limited. This might be one day to three weeks
- deliver mainly non-clinical supports, but clinical support as part of streamlined escalation pathways should be available if the need arises[163]
- deliver a range of structured and unstructured recovery-oriented activities that consumers can choose to engage in as they wish, that promote healing, skill building, social connection and self-confidence[164]
- involve people with lived experience of mental illness or psychological distress in the design, delivery and independent evaluation
- reflect the local priorities of the communities in which they are delivered.

The Commission's conclusion is that residential respite services must function as mainstream bed-based services in the future system and that they must be designed, delivered and evaluated by people with lived experience wherever possible.

As recommended by the Commission in Chapter 9: *Crisis and emergency responses*, one drop-in or crisis respite facility will be established in each region as an initial step. In addition to these facilities, the Commission recommends that at least one non-crisis residential respite service is established in each region. This must follow the implementation of a peer-led residential respite service at a demonstration site. Going forward, the optimal allocation of residential respite services will be determined under the statewide and regional planning processes recommended by the Commission. This is detailed further in Chapter 28: *Commissioning for responsive services*.

Personal story:

Emma Dorn

Emma's professional background is as a team leader and an occupational therapist. Emma has worked at the Adult Mental Health Rehabilitation Unit (AMHRU) for NorthWestern Mental Health (a secure extended care unit) for over 10 years. She has been pleased to see the rehabilitation principles of occupational therapy implemented in practice at AMHRU, which operates with a focus on recovery for people with severe and persistent mental illness.

> AMHRU is very holistic, and focuses on more than medical management of illness. And so I find working here very rewarding, particularly working in my current team.
>
> Getting to work with clients over a longer period of time around their goals is the most rewarding aspect. Our clients' goals can be so diverse. A lot of the magic that happens is based on recovery goals and client stories that maybe seem so small or insignificant to others. It really fits with occupational therapy, and this can be where you can really make a difference.

Emma describes AMHRU as providing a more intensive rehabilitation than is otherwise available, given it is longer-term rehabilitation. She sees the culture as being person-centred and achieving positive outcomes for people.

> There's evidence that there's a sense of hope here. We try to talk about the positive things we're doing and the impacts we make. I think the culture is potentially what's different to other units. Staff are really satisfied by the case management model, because they get to work really closely with one individual. I think that makes a difference, helping one person to achieve their goals. The case management model means there's a bit more continuity and accountability for helping someone to address their recovery goals.

Emma's vision for the future mental health and wellbeing system is that it will have more opportunities for people to experience this kind of extended rehabilitation. Part of her vision is for more rehabilitation units that also have smaller numbers of people, and female or cohort-specific units.

> In an ideal world, I think there would be a female gender–only space or unit. We would have those smaller secure houses, with more intensive support in the community.

Emma recalls that previously, there were specific programs for people leaving AMHRU to assist them to live independently in the community. They included daily outreach and intensive support designed to help with the transition, and she hopes people will have access to this again in the future.

> The level of community support, and the type of community support that can be provided for our clients does limit our discharge options, or makes it more complex to get the right supports in place.

Emma has been able to see many people achieve their recovery goals at AMHRU, and she attributes much of this to the workplace culture.

> I think it's about a culture, about having a culture of hope and a culture of community, that really is what provides a difference.

She says this has meant that the program has become more innovative, and has been able to run activities, such as camps, which have been linked with consumers' recovery goals.

> Having those opportunities like a camp and the group outings where you go to the beach with the patients, and you take your shoes off to just put [your feet] in the water, it sounds like something small, but it just creates a sense that we're all just human, and helps make those connections.

Source: RCVMHS, *Interview with Emma Dorn*, November 2020.

10.5 Victoria's bed-based extended rehabilitation services

Victoria's extended rehabilitation services are an important element of Victoria's mental health system. They provide treatment, care and support for Victorians with some of the greatest ongoing needs.

10.5.1 Critical issues in Victoria's extended rehabilitation services

In their current form, systemic failures mean that these settings are not responsive to people living with ongoing mental health support needs, some of whom require support from multiple agencies. They deliver inconsistent models of care and are limited in their capacity to provide optimal recovery-oriented treatment and wellbeing supports.

The principal settings for extended bed-based rehabilitation in the current system are secure extended care units, located on general hospital sites, and community care units, located in community settings. The Commission has received evidence—set out in more detail below—regarding systemic failures leading to difficulties in meeting the high-intensity and complex support needs of consumers admitted to these settings.[165] With some exceptions, these difficulties are particularly evident in the operation of secure extended care units.

The Commission also heard evidence of positive experiences in connection with secure extended care units—an example is the Sunshine Adult Mental Health Rehabilitation Unit (AMHRU). One parent described the experience when her son was admitted to the Sunshine AMHRU, acknowledging both the time available for rehabilitation and the support of expert clinicians:

> it was life changing for him and for me.[166]

Mr Kelly, the Director Operations, NorthWestern Mental Health, the service responsible for the Sunshine AMHRU, told the Commission:

> I think the Sunshine [secure extended care unit] represents best practice not just in terms of diagnosis, treatment and clinical care but also in regard to the use of least restrictive practices and research undertaken with this consumer cohort. The success of this program has been in the recruitment of an excellent calibre of medical, nursing and allied health staff who are passionate about improving the quality of life of this cohort.[167]

Emma Dorn is a Team Leader and Occupational Therapist at the Sunshine AMHRU. She told the Commission about her experience working in a secure extended care unit, noting aspects of the service which are operating well and opportunities for improvement.

Where supported and enabled to function well, secure extended care units are a critical aspect of the current system. Originally, the function of secure extended care units was to 'deliver an extended rehabilitative treatment response to the needs of consumers with severe and often unremitting mental illness'.[168] Yet since they were established in the 1990s, the various changes described below have resulted in secure extended care units no longer meeting this aspiration.

Most simply, as Mr Kelly, acknowledged, 'demand exceeds supply and turnover of beds is slow'.[169] In turn, delayed admissions and discharges from secure extended care units limit access to them.[170] These delays are influenced heavily by limited access to supported accommodation[171] and a lack of safe housing and supported residential facilities enabling discharge.[172] These problems have been acknowledged in successive reviews.[173] As a result, some consumers remain in a secure extended care setting, even when they no longer need that level of support and may be better supported in alternative and less restrictive settings.[174] The Commission also heard that people with projected longer-term support needs may not initially be accepted by secure extended care units because options for eventual discharge are limited.[175]

Reflecting on the range of interrelated changes which have influenced the operation of secure extended care units over time, Associate Professor Ruth Vine, Director at the Victorian Institute of Forensic Mental Health (Forensicare), told the Commission:

> When SECU [secure extended care unit] services were first provided, they were intended to be a long-stay and secure clinical service. This role has changed since then because: (a) SECU services are not attached to large open spaces so it is difficult for consumers to have space and time to settle in a separate area; (b) drug use patterns have changed so it is harder to monitor substance use; (c) there is a need for throughput so people with very long projections for rehabilitation may not be accepted—this means that people living with dual disabilities or [who] have very severe substance [use problems] may not be accepted, or are given a trial of 6 months before being required to leave despite them not having fully recovered; (d) as a result of [these factors], the environment in SECU services is often more complex and acute than intended; and (e) the limited number of beds in SECUs mean that a single SECU has to manage consumers who may be both young and old, vulnerable and predatory, male and female, for an extended period of time.[176]

The Commission received witness evidence and a broad range of submissions emphasising the increasing complexity of consumer support needs and its negative impact on the capacity of secure extended care units to provide services.[177] Reflecting on the impacts of the unresolved demand pressures on all subacute services over the past decade, Dr Coventry noted that:

> All subacute services have reported increases in referrals, with both community and inpatient programs increasingly considering [Prevention and Recovery Care services], [Community Care Units] and SECUs as options to address a range of needs including homelessness. Services report an increasing level of acuity and behavioural disturbance in SECUs, which poses a significant challenge for maintaining safety within the existing physical design and model of care. In addition, SECUs are now commonly used as a 'step down' option from forensic services, which has compounded the effect of limited bed stock.[178]

Mr Kelly also noted that although a typical person supported in a secure extended care unit may need a nine-month admission, some consumers remain for over a decade with obvious impacts on bed turnover.[179] Victoria Legal Aid also noted its clients' reports that the liveability standards of secure extended care units would not meet community expectations, especially given how long some people live in these settings.[180] The location of secure extended care units on hospital sites also presents advantages and disadvantages. For example, limitations on space reduce opportunities for rehabilitation activities, though opportunities for the treatment of co-occurring physical illnesses may be improved.[181]

Professor Richard Newton, Clinical Director of Peninsula mental health service, emphasised that in order to operate more effectively, secure extended care units need to make more beds available, including to support people with different security needs. Professor Newton told the Commission:

> **The SECU model is run-down, does not work very effectively and is not able to match capacity with demand. SECUs are failing to rehabilitate those who can access treatment. Further, there are currently people living out of hospital in appalling conditions, who have severe mental illness and who avoid or resist treatment. This cohort needs long-term, secure residential care so they can learn how to live in the community. They cannot access support because there are not enough SECU beds. To operate more effectively, SECU services need to make more beds available, including secure and open beds. Very few consumers overall need SECU beds, but those who do need stabilisation and security.**[182]

The Commission also observed a divergence in the service delivery of secure extended care across the state, as different services have been forced to respond to different levels of demand and consumer support needs at the local level. Dr Coventry described how individual secure extended care units have adapted their service delivery models in line with local priorities and external pressures, giving rise to different service models, eligibility criteria, staffing profiles and staffing levels, and different infrastructure and environmental design.[183]

These adaptations have resulted in unintended consequences. For example, different eligibility criteria may give rise to different secure extended care unit environments and mental health outcomes. The consistent application of appropriate evidence-based service models in subacute settings helps to improve outcomes.[184] Conversely, the adaptation of models can compromise treatment outcomes.

In his evidence, Dr Coventry elaborated on the factors that have detracted from the therapeutic nature and safety of existing care options. Specifically, he noted growing numbers of consumers in acute inpatient units with 'limited rehabilitation options',[185] who may not appropriately be supported in these inpatient settings or secure extended care units.[186] He also indicated that models of care designed to support people with subacute needs are not as effective in instances of higher complexity needs.[187] In some cases, more time-extended rehabilitation options are required, but they may not be available.[188] Civil or non-forensic consumers requiring high-intensity support in a high-secure, safe environment at Thomas Embling Hospital cannot be admitted because of bed constraints.[189]

Dr Coventry suggested that extended rehabilitation models of care must be reformed to address the sometimes very different requirements of people with mental illness and highly complex support needs. He also emphasised the need for greater specialisation and flexible streaming capacity within these settings to ensure consumers have access to treatment, care and support that is specifically tailored to their individual support needs at any given time. For instance, he noted that:

> Models of care also need to be supported by investment into specialised training and supervision for the workforce to provide evidence-based treatment for complex needs and intensive psychosocial rehabilitation. Without a streamed approach, consumers with specific needs requiring specialist input are cared for alongside others with very different needs. This includes small numbers of young people with severe developmental disorders such as autism spectrum disorders, as well as involvement with child protection and youth justice; long-term forensic patients needing slow-stream rehabilitation into the community; adults with various conditions and risk of severe violence towards other consumers, visitors and staff; and small numbers of people who will be unlikely to be able to transition to less restrictive community care and need long term care options.[190]

Professor David Copolov AO, Professor of Psychiatry at Monash University and Pro Vice Chancellor Major Campuses and Student Engagement at Monash University, also told the Commission that people living with the highest intensity needs have been particularly overlooked since the Victorian mental health framework was introduced 27 years ago. In his evidence, he elaborates on the need for developing and expanding specific types of extended rehabilitation/recovery units.[191]

Similar concerns exist in relation to community care units. Associate Professor Vine noted that the community care unit environment 'leaves a lot to be desired'.[192] Carers also described their experiences with community care units and the ways in which a community care unit's strength (including its lack of security features) may also make it inappropriate for some people living with ongoing mental health and extra support needs. For example, one parent told the Commission that community care units were not suitable to support the needs of her daughter because they are not 'locked'.[193] But the Commission also heard evidence of positive experiences in connection with community care units. For example, Austin Health and MIND Australia operate the Community Recovery Program (funded as a community care unit). This program has been described as an 'innovative model' delivering recovery-oriented care.[194]

10.5.2 Improving Victoria's bed-based extended rehabilitation services

Improved rehabilitation and recovery services for Victorians who need ongoing intensive treatment, care and support will help ensure they can achieve and maintain their highest levels of independence. The reforms recommended by the Commission in this respect will also result in physical environments and infrastructure that meets modern standards.

Ensuring that bed-based rehabilitation services provide the services that people need, and should expect, will require:

- modern and consistent models of care for those who require access to extended rehabilitation and recovery services[195]
- increased focus on, and access to, intensive wellbeing (psychosocial) rehabilitation in extended recovery settings[196]
- new infrastructure that provides attractive, safe and modern physical environments with high levels of functionality that support effective treatment, care and support[197]
- where possible, services that are located in local and regional communities so consumers can maintain critical community connections.[198]

With these needs in mind, the Commission has recommended that new community-based rehabilitation and intensive rehabilitation models of care be co-designed by the Department of Health together with clinicians, consumers, families and carers, services and relevant government agencies. These new models of care will be established at demonstration sites selected by the Department of Health in close consultation with clinicians, consumers, families and carers, services and relevant agencies.

The models of care and related infrastructure must be consistent with both the new Victorian extended rehabilitation pathway—described in Figure 10.6—and the model design and quality features described by the Commission in Box 10.3. Existing infrastructure will most likely need to be improved and expanded to deliver these new models of care. The models of care will be evaluated, and if they are found to be successful, existing facilities must be upgraded to deliver the new models.

The new rehabilitation pathway draws on work conducted by the United Kingdom's Joint Commissioning Panel for Mental Health and adapts it for a Victorian context. The pathway highlights the critical interdependencies between different parts of the specialist mental health system and the broader health and housing systems.[199] The extended rehabilitation pathway also accounts for broader reforms proposed by the Commission. Critical elements of the pathway, including Regional Multiagency Panels and the housing and assertive community treatment elements of the pathway, are dealt with in Chapter 5: *A responsive and integrated system*, Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*, and Chapter 16: *Supported housing for adults and young people*.

Figure 10.6: Extended rehabilitation pathway

Source: Adapted from Joint Commissioning Panel for Mental Health, 'Guidance for commissioners of rehabilitation services for people with complex health needs', November 2016.

To determine what design and quality features must be reflected in the various settings of the extended rehabilitation pathway, the Commission looked to the UK's National Institute for Health and Care Excellence (NICE) guideline *Rehabilitation for Adults with Complex Psychosis*, published in August 2020. The Commission also commissioned a report from the University of Melbourne on appropriate evidence-based models of care to support people requiring ongoing intensive mental health treatment, care and support. This report directly considered extended rehabilitation needs of Victorians. It notes that the policy settings reflected in the NICE guideline represent the shift that has occurred over the past two decades:

> in the direction of recovery orientation, service integration aiming for holistic healthcare, and with a compelling goal to uphold human rights in mental health care by supporting citizenship and reducing use of compulsion.[200]

The Commission's recommended design and quality features for the extended rehabilitation pathway are adapted from the NICE guideline and from principles informing optimal models of care described in the University of Melbourne report.

Two key components of the rehabilitation pathway include the community rehabilitation model and the intensive rehabilitation model.

The community rehabilitation model will be based on the design and quality features listed in Box 10.3 and will:

- have services delivered by a multidisciplinary workforce (incorporating lived expertise including consumer and family/carer lived expertise, and wellbeing support and clinical workforces) through a single provider or partnership model
- have a strong focus on providing holistic clinical, wellbeing and peer supports
- maintain a support presence 24 hours a day, 7 days a week
- have a graduated range of residential options—from a more intensive residential experience through to more independent living—rather than a single-cluster housing model
- enable delivery of day programs that can also be attended by consumers who are not residents of new community rehabilitation units, providing a community access and connection point that does not currently exist.

The intensive rehabilitation model will also be based on the design and quality features listed in Box 10.3 and will:

- be delivered by a multidisciplinary workforce (incorporating lived expertise including consumer and family/carer lived expertise, and wellbeing support and clinical workforces) through a single provider or partnership model
- have a strong focus on providing holistic clinical, wellbeing and peer supports
- maintain a support presence 24 hours a day, 7 days a week
- be developed and delivered based on principles of least restriction.

Box 10.3: Design and quality features of extended rehabilitation services

Design features

All future Victorian extended rehabilitation models for consumers with high-intensity needs must:

- be embedded as part of Area Mental Health and Wellbeing Services (drawing on statewide services as required)
- provide a recovery-oriented approach that has a shared ethos and agreed goals, a sense of hope and optimism, and an aim to reduce stigma
- deliver individualised, person-centred care that:
  - is evidence-based and supports recovery, personal choice and goals through collaboration and shared decision making with consumers and carers
  - is culturally responsive, inclusive and addresses social factors influencing mental health
  - respects human rights and supports community connection, participation and citizenship
- be offered in the least restrictive environment possible—one that aims to help people progress from more intensive support to greater independence through the rehabilitation pathway
- recognise that not everyone returns to the same level of independence they had before their illness and may need supported housing in the long term.[201]

Quality features

Built resources

- Environmental design principles are applied to all residential components.
- Built environments enable physical activity and support for holistic health.
- Built environments enable social connection.[202]

Workforce

- A multidisciplinary workforce is part of extended rehabilitation service models—this means integration of the lived expertise (consumer and family/carer) workforce, community support workforce (including the psychosocial workforce) and clinical workforce.
- The clinical workforce includes substance use and addiction expertise and all mental health specialist disciplines.
- Consumer and carer/family expert roles include (but are not limited to) delivering peer support.
- Critical mass in the lived experience workforce (never one/solo worker with lived experience) within teams is the sustainable standard for the lived experience workforce.
- An enriched multidisciplinary workforce to address holistic health is integrated in every model of care—employment support, exercise physiology, nutrition, wellbeing/coaching and advocacy are relevant examples.[203]

Programs

- Models assume family inclusion, recovery orientation, trauma prevention, strengths focus, holistic health focus and respect for human rights.
- Integrated programs are part of all models—including peer-support, psychosocial (vocational, educational, housing) and clinical components.
- Models and mechanisms promote consumer choice concerning access and exit to each model/service type and avoid use of compulsion/coercion to the greatest extent possible.
- Consumer expert co-leadership is standard.
- Holistic health and wellbeing are integrated in every model.
- Processes and skills for supported decision making are evident.[204]

As a result of these reforms, extended bed-based rehabilitation services will look and feel different in the future. Community rehabilitation units and intensive rehabilitation units will provide consistent models of care across the state, working to a defined rehabilitation pathway. Under this pathway, the capacity of Thomas Embling Hospital to accommodate civil consumers (non-forensic patients) will also be expanded to support the needs of people who do not receive the level of support they require in other extended rehabilitation settings.

10.5.3 Expanding civil capacity at Thomas Embling Hospital

The new community rehabilitation and intensive rehabilitation models of care will support the rehabilitation of many people living with the highest intensity support needs. In some instances, however, an alternative and more secure form of extended bed-based rehabilitation is needed.

As highlighted by Dr Coventry, there are some cases where people may experience particularly complex and acute forms of illness where current acute inpatient, secure extended care and community care units may not be appropriate. Some of these consumers may exhibit threatening and/or violent behaviours towards others. In other instances, ongoing support needs may not accord with existing models of care.[205] Some consumers are admitted alongside others 'with very different needs' from other people accessing services in the same settings.[206] This means models of care may be less effective, and opportunities to achieve the best outcomes are more limited.

Historically, Thomas Embling Hospital was able to provide treatment, care and support to civil consumers with highly complex support needs, including increased security needs.[207] Bed availability constraints no longer allow for this. The Victorian Institute of Forensic Mental Health (Forensicare) has acknowledged this capacity has reduced as the number of longer-term forensic consumers has increased.[208] Distinguished Professor James Ogloff AM, Executive Director at Forensicare and Distinguished Professor of the Centre for Forensic Behavioural Sciences at Swinburne University, also informed the Commission that 'the capacity to assist the broader area mental health services' by admitting some patients with high-intensity needs has 'been lost'.[209]

As Dr Coventry described, this has not only prevented forensic patients and security patients (transferred from the prison system) from being admitted to Thomas Embling Hospital, it has also prevented civil consumers, who cannot safely be accommodated in adult acute or secure extended care unit settings, from being admitted.[210]

Distinguished Professor Ogloff also described the potential for locating a secure extended care unit within Thomas Embling Hospital. His evidence was that this would allow movement of consumers within the hospital, in addition to providing them with access to Thomas Embling Hospital's facilities and education programs (which are otherwise usually not available, for example, in current secure extended care units).[211]

To respond to the needs identified by Dr Coventry, and consistent with Distinguished Professor Ogloff's evidence, the Commission has recommended that the new Victorian extended rehabilitation pathway include increased civil capacity at Thomas Embling Hospital. The expanded capacity will ensure appropriate treatment, care and support is provided for the small group of people who require high-intensity supports that cannot be provided safely and effectively in other settings. This capacity must exist in addition to capacity reserved for forensic patients. In turn, this will allow the new intensive rehabilitation and community rehabilitation models of care to operate in the least restrictive way possible. The details of the recommended expansion of civil capacity at Thomas Embling Hospital are outlined in Chapter 23: *Improving mental health outcomes across the criminal justice, forensic mental health and youth justice systems*.

10.6 Establishing a specialist behaviour response team

In Chapter 23: *Improving mental health outcomes across the criminal justice, forensic mental health and youth justice systems*, the Commission has recommended establishing a forensic community model. This will help build capability in Area Mental Health and Wellbeing Services to provide treatment, care and support for patients who have committed, or are at risk of committing, an offence, and those engaged in violent, threatening or high-concern behaviours towards others.

Admission to an acute setting can be a time of extreme distress for consumers, who can become highly agitated. A small number of consumers may become threatening or violent and there is increased potential for harm to the consumer, other consumers and staff.[212]

Evidence before the Commission suggests there are multiple factors that can contribute to violence or threatening behaviours in acute inpatient or current secure extended care settings. According to Dr Coventry:

> Clinical and sociodemographic correlates include diagnoses of psychosis, substance abuse and antisocial personality traits coupled with male gender, youth, compulsory legal status, multiple previous admissions and unemployment. Staff characteristics and behaviour play a part too; trigger factors may include inexperience, fatigue, burnout, negative attitudes towards consumers and a lack of engagement with them, an emphasis on rule-keeping and inflexibility. Poor design, over-crowding and high turnover also contribute, as do unsupportive managers who fail to address staff members' concerns.[213]

While the majority of consumers in acute inpatient settings are not violent or aggressive, when these behaviours do occur, it can be highly challenging and distressing for all involved.[214] Services need the capacity to respond to the needs of each consumer and to keep staff safe. This includes the need for staff to have the skills to respond to these behaviours in the least restrictive and most therapeutic way possible.[215]

Inadequate care responses can be traumatic for the consumer and for others in the ward. Rather than receiving highly specialised therapeutic support, consumers in the current system who demonstrate violent or threatening behaviours are often subject to compulsory or restrictive practices.[216] As noted by Professor Newton:

> If consumers and carers are able to easily access adequate mental health services and receive effective treatment, then they are less likely to be distressed and to manifest that distress through aggression. The currently impoverished service system sets up many consumers and carers to feel more distressed as they try and obtain the right treatment or care.[217]

Evidence suggests that being subject to compulsory or restrictive practices can simply perpetuate the behaviours of concern, as well as trauma associated with the event. For others in the ward, witnessing such practices can be traumatising and undermine the therapeutic nature of what should be an environment for healing and recovery. The Commission also heard that mental health and wellbeing staff can find it challenging to work in cultures that sanction restrictive practices.[218] This is explored further in Chapter 31: *Reducing seclusion and restraint*.

Dr Coventry summarised the impacts of these incidents:

> Aggression on inpatient units poses multiple hazards. For those inpatients who behave aggressively, the consequences may include physical restraint, injected medications and seclusion, sometimes for lengthy periods. The consumer and staff members involved in the incident may be injured and the other consumers who witness it are likely to experience great anxiety. Repeated episodes of aggression are likely to result in feelings of mistrust and resentment by consumers toward staff and, for staff members, high levels of absenteeism and burnout. These sequelae make it difficult to provide a hope-filled, therapeutic environment for those admitted to the unit and a congenial, rewarding workplace for clinicians.[219]

While a recent study indicates there is 'limited evidence that mental health problems are independent predictors of violence when accounting for other factors, such as substance use or previous violence',[220] several submissions raised concerns about increasing rates of violence within acute mental health facilities.[221] As set out in Chapter 31: *Reducing seclusion and restraint*, there may be multiple factors associated with why this is the case. Skilled and appropriate responses can ensure that mental health service staff and other consumers experience minimal impact and are not harmed. Respect for a consumer's dignity and human rights during this time is also critical.[222]

The Commission has concluded that the ability to respond appropriately to these types of behaviours is an essential practice that is constrained in the current system. As stated by Dr Lynne Coulson Barr OAM, Victoria's former Mental Health Complaints Commissioner:

> it is critical to improve staff training, professional development and supervision. Complaints have included some instances where staff were ill-equipped to support a consumer experiencing an acute mental health episode, which should be a fundamental skill for staff working in public mental health services. A lack of skill to manage a person's behavioural symptoms can lead to the person's treatment being more restrictive than could be achieved if staff had a greater degree of skill.[223]

As part of its reforms, the Commission has recommended establishing a Mental Health Improvement Unit within Safer Care Victoria, to support Area Mental Health and Wellbeing Services to deliver high-quality and safe services. As part of its remit, the Mental Health Improvement Unit will work with services to identify ways each inpatient unit can strengthen its response to highly agitated and distressed consumers.

This will include supporting services to review critical incidents and identify specific, local changes required to improve responses to consumers, reduce and eliminate the use of restrictive practices, and keep consumers and staff safe. As set out in Chapter 31: *Reducing seclusion and restraint*, these changes may include additional training, further work to embed Safewards, or establishing response teams. This is outlined in Box 10.4.

Box 10.4: Response teams

When a consumer does become agitated or distressed, services can use a wide range of strategies to assist consumers, without resorting to seclusion and restraint.[224] This includes verbally de-escalating the situation or using sensory modulation to help people lower their levels of distress. Providing private, quiet areas, improving the cultural responsiveness of a service and understanding times when consumers may be more vulnerable—such as when delivering bad news—can also be helpful.

Having on-call assistance can also be helpful when staff are faced with an extremely agitated, distressed or threatening consumer. Response teams consist of experienced staff who can provide a non-coercive approach to difficult situations.[225]

Concerned with increasing rates of seclusion, Alfred Health has established a local response team that they called Psychiatric Response to Behaviours of Concern (Psy-BOC).[226] The team consists of a nurse or operations manager, a senior allied health staff member (an occupational therapist, social worker or psychologist) and the senior medical practitioner. When called to a unit, they discuss the current situation, consider what strategies have been tried already and evaluate what resources are required. They can also, in consultation with the treating team, work directly with the consumer to de-escalate the situation.

The approach is informed by an understanding of triggers that can cause an escalation of distress or agitation, or operational scenarios where the risk of needing to use seclusion or restraint are high. For example, Alfred Health require inpatient-unit staff to make a mandatory call to the Psy-BOC team when a consumer is arriving under transfer where mechanical restraint or seclusion are indicated, or where there is disinhibited behaviour. Staff are also encouraged to make calls in advance of bad news being delivered or when a consumer returns from absconding.[227]

The response team approach has reduced the use of seclusion.[228]

The Commission has also recommended creating a specialist behaviour response team, as part of the new forensic outreach model. This will be available to support Area Mental Health and Wellbeing Services where they need additional support to respond effectively to consumers who are at high risk of unsafe behaviours within inpatient units. How the program will support a service will depend on the supports required:

- where services have a local response team, the specialist behaviour response team can provide expert advice, secondary consultation and clinical or professional supervision to ensure skills and capabilities remain current and effective
- where services do not have capacity to establish a local response team, the specialist behaviour response team can provide direct support to meet the needs of consumers who are engaging in behaviour the service cannot successfully prevent or respond to.

The team will include experienced practitioners from a range of disciplines (psychiatry, allied health and mental health nursing) and the service will be run by Forensicare. Forensicare will coordinate the interaction between the specialist behaviour response team, the broader forensic community outreach teams and the expanded forensic community specialist program. The program will build the specialist capability of area mental health and wellbeing staff to respond to critical incidents in inpatient mental health settings.

The specialist behaviour response team will have capacity to deliver support to all eight area mental health and wellbeing regions and will provide the following as necessary:

- expert advice and consultation
- clinical/professional supervision
- support to implement local response teams
- direct support for services to respond to individual consumers (where services lack the capacity to implement a local response team or reach the extent of their capacity/capability)
- assessment of individual consumers, including when an alternative and more secure form of extended bed-based rehabilitation is needed
- co-case management on an as-needs basis.

The team will help ensure consumers with more complex support needs receive highly specialised care responses in the least restrictive way. The program will build on other initiatives expected to improve the therapeutic nature of inpatient settings. These other initiatives include the new crisis system response architecture, improved models of care in bed-based settings, the extended rehabilitation care pathway and reforms that will reduce the use of restrictive practices and compulsory treatment.

As the agency responsible for the program, Forensicare must work closely with the Mental Health Improvement Unit to ensure services are encouraged to take up the full range of supports available to build capability in preventing incidents, respond to distress and agitation and reduce their use of seclusion and restraint.

10.7 Improving streaming in acute inpatient settings

The ability to stream consumers on an age, gender and higher intensity support-need basis is a critical feature of safe and therapeutic acute inpatient environments. The Commission uses the term 'streaming' in this context to describe physically grouping consumers within a bed-based setting based on compatibility of need, the need to promote safety, and to facilitate specialised care delivery.[229]

From Associate Professor Vine's perspective, 'the purposes of streaming are to provide (a) appropriate amenities … (b) appropriate treatment modalities for both individuals and groups; and (c) a safe and therapeutic milieu'.[230]

In the 1990s, Victoria's acute mental health system underwent a major period of deinstitutionalisation, or 'mainstreaming'.[231] This saw a fundamental shift in the way mental health treatment, care and support was delivered across the state.[232] Large mental health institutions were closed, and area mental health services were established on a regional basis. Each service was linked to a general hospital, and mental health inpatient units were opened in public hospitals.[233]

While the principles of deinstitutionalisation were sound, there were a number of unintended consequences associated with underinvestment and poor planning that compromised the overall safety and therapeutic nature of acute inpatient settings, including:

- smaller units and low bed numbers, limiting flexibility for necessary consumer streaming[234]
- a highly clinical, sterile and rigid hospital infrastructure that is not sensitive to the unique needs of people living with mental illness or psychological distress, including limited space for outdoor areas and gardens[235]
- the loss of economies of scale required for comprehensive quality and safety.[236]

Many consumers and carers shared observations of overcrowding, safety threats and lack of adequate privacy in acute inpatient settings. For instance, one father told the Commission of his daughter's experience in an acute inpatient setting:

> She was then put in a psych unit. And the problems there were that she had her own room, which was fantastic, but mixed in with all sorts of different clients with mental health issues, different ages, different types of people and different sexes, so they're quite aggressive and overpowering [males]. And that was quite threatening, and she was already anxious, and she was already suffering enough.[237]

Associate Professor Stafrace also advised the Commission that:

> Hospitals are not consistently designed to be safe and therapeutic. This has an adverse impact on patients, families and clinicians. When some patients experience care in hospital that is traumatic or not responsive to their needs, this makes it less likely they will seek treatment and care in a timely way.[238]

The Commission concluded that a large proportion of existing inpatient facilities are no longer fit for purpose and require substantial renovation as part of a longer-term infrastructure and asset renewal plan. This is set out in greater detail in Chapter 28: *Commissioning for responsive services*.

When constructing new facilities, the Victorian Government must seize the opportunity to encourage innovation and to use best practice therapeutic design principles. Therapeutic design is the intentional design of the built environment with spaces that meet the mental health and wellbeing needs of consumers, families and carers, and promote healing and recovery.[239] Overcrowded, unsafe and inflexible hospital environments must no longer be a part of Victoria's mental health and wellbeing system, and eliminating them must be a priority.

Among other features, such as access to outdoor space and adequate privacy to comply with best practice therapeutic design principles, future hospital-based facilities will need to:

- be at an adequate scale, with sufficient bed numbers, to enable streaming of consumers on the basis of gender, age and higher intensity support needs as required.[240] The Commission acknowledges that this may not be possible in some regional and rural areas to the same extent as those located in metropolitan Melbourne
- not be so large as to compromise the ability for sufficient quality and safety regulation, oversight and monitoring, or attract stigma, as was evidenced in the standalone asylum-style institutions prior to the process of deinstitutionalisation in Victoria[241]
- comprise fit-for-purpose and flexible infrastructure that enables temporary reconfiguration or separation of bedrooms, wards and, as required, communal spaces to meet consumers' safety and therapeutic support needs at any point in time.[242]

As Dr Coventry told the Commission:

> Separating consumer cohorts is a necessary part of delivering specialised and safe healthcare … Design of spaces that emphasises safety and flexibility to meet consumer needs is paramount to engendering trust for vulnerable consumers. This is not solely a matter of creating gender sensitive areas, but also ensuring the use of spaces can be adapted for individual needs while ensuring safety and quality treatment.[243]

Mr Kelly also emphasised that:

> The possible advantages of streaming in the mental health system are obscured by budgetary constraints. The reality of the current mental health system is that every consumer is placed in a large pool. Inpatient units where all consumers with different diagnoses and different vulnerabilities are physically together is unhelpful for recovery. Mixed wards are often inappropriate for women, LGBTIQA+ people, people who have experienced trauma and people with an intellectual disability or an autistic spectrum disorder. In my view, it would be better to have flexible modules that could be used to cohort people with similar vulnerabilities.[244]

While the Commission's view is that all new acute inpatient facilities will be adequately designed, scaled and configured to enable targeted streaming of all consumers on a support-need basis, there is an urgent need for better streaming of two specific consumer groups in the current system—young people aged 18–25 years and female consumers.

This reflects key findings of the Productivity Commission's *Mental Health Inquiry Report*, which recommended that:

> **In considering the safety of children, adolescents, and women within inpatient services, State and Territory Governments should work to ensure that hospitals have the capacity to provide mental health beds for children and adolescents that are separate from adult mental health wards and configure adult wards to allow gender segregation.**[245]

The Commission's view is that young people aged 18–25 years can no longer be admitted to acute inpatient settings with adults and older adults. This is a major reform responding to concerns raised with the Commission by consumers, their supporters and service providers. The features of the new youth stream are contained in Chapter 13: *Supporting the mental health and wellbeing of young people*.

10.7.1 Addressing sexual and gender-based violence in acute inpatient settings

The Victorian Government must address the high rates of sexual and gender-based violence that women are experiencing in acute inpatient mental health settings. The Commission has adopted the definition of gender-based violence used by the Committee on the Elimination of Discrimination against women: 'violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering'.[246]

This observation as it relates to women does not contradict the Commission's broader observation that the prevalence of all forms of interpersonal and sexual violence remains too high in Victoria's mental health services, including in relation to male consumers and staff.[247] Rather, it reflects the fact that violence against women has become so entrenched and common in Victoria's inpatient mental health and wellbeing system that targeted action cannot be postponed any longer.

The Commission uses the term 'women/woman' inclusively to refer to any person who identifies as a woman, including transgender women. The Commission acknowledges that many people do not identify as male or female, including people who identify as gender non-binary, gender queer, agender or gender fluid/diverse.[248] This approach is consistent with the Victorian Government's 2019 *LGBTIQ Inclusive Language Guidelines*.[249] The guidelines acknowledge that transgender and gender-diverse people are also at high risk of gender-based violence.[250]

The Commission has taken a broad approach to gender safety. A lack of gender safety not only refers to experiences of rape, sexual assault, harassment, verbal harassment and threats but also to perceptions of a lack of safety in bed-based settings. Feeling unsafe or threatened in a health service is as unacceptable as violence.[251]

Australia has ratified the *Convention on the Elimination of All Forms of Discrimination Against Women* which means that it agrees to ensure that Australia's laws and practices comply with the Convention's provisions.[252] The Committee on the Elimination of Discrimination Against Women states that discrimination against women includes gender-based violence. As a result, the Victorian Government has a duty to protect women from gender-based violence including when receiving mental health treatment in bed-based mental health care.

Improving gender-based safety in Victoria's inpatient facilities has been an important policy challenge over many years.[253] Despite numerous investigations and reports, meaningful change to keep women safe in inpatient units has not been achieved.[254] In an article published in the *Australian and New Zealand Journal of Psychiatry*, gender-based safety experts Professor Jayashri Kulkarni and Professor Cherrie Galletly identified several reasons for this, including the fact that psychiatric units are 'hidden' to the broader public, false perceptions among staff that male-only areas would increase aggression and the scale of funding required to reconfigure existing units.[255]

Concerningly, there is also evidence to suggest that incidents of gender-based violence towards women in acute inpatient settings have become increasingly normalised in the mental health sector.[256] Professor Kulkarni notes that 'mental health professionals are [accustomed] to the issue because this is how wards have been structured and run for decades; change is too difficult'.[257]

Many consumers shared with the Commission experiences of violence, sexual assault and harassment in acute inpatient settings. For instance, one lived experience witness told the Commission:

> The mental health system is not safe for female patients. There is a lot of sexual harassment and sexual assault by male patients against women in compulsory admissions. In all three of my admissions, I have had a male patient come into, or try to come into, my room. … My experience though was that the hospitals didn't always respond adequately. Despite having an advance directive that talked extensively about safety and the need to feel safe, and the need to not be around men, I was put into a locked ward with men because the hospital didn't have any space where they can physically separate men and women.[258]

Another witness, Ms Erica Williams, informed the Commission that:

> I was one of two women in the unit. The rest of the patients were older men. I was 22. There was no segregation of men's and women's bathrooms. Men would come in to the bathrooms unannounced. (There were no locks on the bathrooms, which I understand, however there was also no attempt to stop men going in the bathroom while I was in there.)[259]

The prevalence of gender-based violence and sexual assault of women in acute inpatient settings in Victoria is so high that the Mental Health Complaints Commissioner has identified it as a priority. As at June 2017, of complaints received relating to sexual safety issues, the most frequently reported to the Commissioner were 'alleged sexual assault (46.7 per cent), followed by complaints regarding gender safety (37.8 per cent) and alleged sexual harassment (13.3 per cent)'.[260] In their 2018 report, *The Right to Be Safe*, the Commissioner also identified high dependency areas as particularly high-risk areas for sexual safety breaches against female consumers.[261] It must be noted that incidents of sexual assault and misconduct are inconsistently reported and recorded, and the data obtained is unlikely to reflect the true extent to which these are occurring in acute inpatient settings.[262]

Existing evidence highlights several factors that contribute to gender-based violence in acute inpatient settings. These include:

- bed availability pressures on acute inpatient services, which mean that areas designated for women are frequently used for male consumers, and so become mixed-gender wards[263]
- the lack of gender-separated inpatient units and other limitations in the built environment, including long corridors and communal areas that are difficult for staff to supervise[264]
- insufficient staff responses and the onus being placed on women to protect themselves in sometimes male-dominated spaces.[265]

Women's experiences of safety can also be compromised by a failure of mental health services to consider past histories of trauma such as sexual assault or family violence.[266] Research conducted by Australia's National Research Organisation for Women's Safety also identified troubling accounts of women feeling that their safety concerns, or actual experiences of gender-based violence, were ignored by staff.[267]

Aside from a very small proportion of acute inpatient facilities, including the Barossa Unit at Thomas Embling Hospital, most acute inpatient facilities in Victoria are mixed-gender.[268] There is evidence to suggest that gender separation in acute inpatient mental health settings reduces incidents of gender-based violence.

For instance, in 2012 Alfred Health obtained funding to create a six-bed women's-only area within its 28-bed mixed-gender ward.[269] An evaluation of this change revealed a notable reduction in the number of incidents relating to women's safety in the single-gender unit compared with the mixed-gender ward. The number of incidents recorded in the mixed-gender ward was six times higher than in the single-gender unit.[270] The evaluation also observed that women who were accommodated in the women-only unit felt safer than those accommodated in the mixed-gender ward; they felt their privacy was more respected and found the environment more therapeutic.[271]

Given the effect of mixed-gender facilities on gender safety in acute inpatient settings, all new acute inpatient facilities must be configured to enable gender-based separation in all bedrooms, bathrooms and, as required, communal spaces. All existing facilities must also be reviewed and renovated, on a case-by-case basis, to achieve the same level of gender-based separation to the extent this is possible. All facilities must also meet minimum standards for gender safety set out in the Chief Psychiatrist's guideline: *Promoting sexual safety, responding to sexual activity and managing allegations of sexual assault in adult acute inpatient units*. For instance, ensuring secure locks on bathroom facilities and adequate staff supervision in communal and outdoor areas.[272]

This mirrors the recommendation made by the Productivity Commission in its inquiry into mental health that 'when designing and renovating acute inpatient wards, State and Territory Governments should establish wards that can be configured to allow for gender segregation'.[273]

The Commission's view is that high dependency units within acute inpatient settings must not operate unless they are gender separated. The high-risk nature of these environments must no longer be tolerated in any acute inpatient facilities, particularly given they are designed to support consumers with higher-intensity support needs.

For example, in her evidence to the Commission, one witness reflected that:

> For me, given my cluster of conditions and history of symptoms, a female only ward is the only way in which I would feel safe. When I'm not psychotic enough to be in a locked ward, I can be around male patients, even if they are aggressive or violent. But when I am acutely psychotic, and acutely sick, I don't have the capacity to be around male patients, and I don't have the capacity to remove myself from a situation to make myself safe.[274]

In its policy position statement on sexual safety in psychiatric inpatient units, the Victorian Mental Illness Awareness Council highlighted high dependency units as particular areas of concern in acute inpatient settings, noting that '[women] are often placed in unsafe environments with men, such as [high dependency units] where rooms are unsecured, and consumers are required to share unisex bathrooms'.[275]

In her witness statement, Associate Professor Vine also described the nature of the infrastructure required:

> Units need to be well designed, have sufficient capacity, and allow appropriate streaming and gender segregation (especially in the intensive care or locked areas). Consumers who require inpatient care should not have their distress of being mentally ill compounded by being in a frightening and unsafe environment.[276]

The experience of the United Kingdom's National Health Service indicates that gender separation across all acute inpatient mental health settings can be achieved. In 2006, following an audit of violence in public hospitals, the United Kingdom mandated that all public hospitals must provide single-sex accommodation. Only emergency and general health intensive care units are exempt from this requirement.[277] All public hospitals are now required to report on all breaches of these requirements at regular intervals. Breaches can result in financial penalties and withholding of funding.[278]

The Commission also expects treatment, care and support delivered in women-only inpatient environments to be gender-sensitive.[279] Gender-sensitive responses include consideration of: reproductive influences on mental illness that are unique to women; how lived experiences of trauma may have affected a woman's support needs before entering the service, such as sexual assault and family violence; and ensuring that disclosures of violence are never trivialised, dismissed or met with disempowering responses from staff.[280] The Commission's recommended approach to responding to trauma is detailed in Chapter 15: *Responding to trauma*.

Building on the recommendations set out in this chapter, the Mental Health and Wellbeing Commission must, as a matter of priority, use its full suite of powers to monitor and address the incidence of gender-based violence in mental health facilities. Other matters of priority for the Mental Health and Wellbeing Commission include reducing the use of seclusion and restraint, the use of compulsory treatment and the incidence of suicides in healthcare settings. The Commission's recommendations regarding these powers are set out in Chapter 30: *Overseeing the safety and quality of services*.

Compromise is no longer acceptable when it comes to ensuring mental health facilities are free from sexual and gender-based violence.

10.8 Supporting mental health consultation liaison services

The Commission also considered the experiences of people with mental illness or psychological distress outside of mental health bed-based services, in general health bed-based services. There are many consumers who use general health services and need treatment, care and support for their mental health.

The Commission considers that the general health system has a responsibility to meet the holistic and multidisciplinary care needs of consumers who are admitted for physical health reasons. This includes the mental health of these consumers.

As set out above, a complex relationship exists between physical and mental illness, where one can trigger or exacerbate a person's experience of the other. Treatment in these circumstances requires integrated care responses.[281] In the current general health system, in-hospital mental health consultation liaison teams are relied upon to deliver mental health treatment, care and support to paediatric, adult and older adult consumers who have a primary physical health diagnosis but who also present with mental illness or psychological distress.[282]

Mental health consultation liaison is recognised as a formal subspecialty of psychiatry. It focuses on managing psychiatric illness presenting in general health settings, including hospitals.[283] Consultation liaison staff are typically embedded as either dedicated multidisciplinary teams or co-located staff members who respond to referrals from emergency departments and general inpatient wards as required.[284]

Alfred Health informed the Commission that:

> **At any given point in time, our [Consultation-Liaison Psychiatry and Addiction] service is engaged in the care of 25–40 patients a day within the hospital, some of whom have intensive psychiatric treatment needs and would be admitted to inpatient psychiatric units (IPUs) were it not for the complications of injury or medical illness. When beds are unavailable on adult IPUs, patients may be admitted to general medical units or transfer from medical/surgical wards may be delayed. Under these circumstances, there is a need to provide capacity in general hospitals for diagnostic assessment, risk management, and active treatment of mental illnesses.**[285]

Evidence suggests a significant number of people in a general hospital setting experience mental illness or psychological distress.[286] In adult hospitals, common reasons for referral to mental health consultation liaison teams include depression and anxiety, suicidality, confusion, behavioural disturbance, psychosis and advice regarding psychotropic medications.[287] In paediatric hospitals, common reasons for referral to paediatric mental health consultation liaison teams include eating disorders, psychosomatic symptoms, anxiety and lowered mood.[288]

Usually, in-hospital consultation liaison services are funded through acute health funding streams. This is not the case for in-hospital mental health consultation liaison services. Rather, in-hospital mental health consultation liaison services receive block funding from the Department of Health to provide a consultation service with no link to activity. Over time, this has contributed to:

- the general health system assuming that physical health patients will have their mental health care funded and delivered by the mental health system[289]
- funding for in-hospital consultation liaison mental health services not keeping pace with demand[290]
- the cost of providing consultation liaison mental health services not being well captured in the national activity-based funding model, because of poor data collections, noting that Victoria does not currently use this model to fund mental health services.[291]

Professor McGorry advised the Commission of the consequences of this siloed approach to mental health treatment, care and support in general hospital settings. He gave evidence that:

> There was great hope that merging with the general health system would result in a more modern system that could provide good medical and psychiatric care to patients, but as we know that did not happen. Over time psychiatrists have been marginalised within acute hospitals, their leadership and governance roles replaced by generic managers, something that has not happened to other medical units in these hospitals and have had no real chance of defending their turf and budgets against powerful executives and physical health interests within the hospital system.[292]

Recognising the limitations of available data, the Commission has nonetheless identified clear evidence of consumers being underserviced in terms of necessary mental health treatment, care and support in general hospital environments. Funding has not kept pace with demand.

As illustrated in Figure 10.7, in 2018–19, approximately 97,400 people admitted to hospital for a physical illness also had a mental illness recorded.[293] Yet in 2018–19, just 4,651 (less than 5 per cent) of these admissions received mental health consultation liaison services.[294] While acknowledging that not all physical health consumers who have a mental illness require consultation liaison, the percentage of patients who do require this service is very likely to be higher than 5 per cent.

Figure 10.7: Proportion of admissions, by mental health diagnosis, by length of stay type, Victoria, 2014–15 to 2019–20

Financial year	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20
Mental health diagnosis—Multi day stay	53,608	55,167	57,588	55,452	59,021	58,218
Mental health diagnosis—Overnight stay	12,430	13,105	13,796	13,110	13,889	14,093
Mental health diagnosis—Same day stay	19,137	21,382	22,980	23,677	24,483	23,348

Sources: Department of Health and Human Services, Integrated Data Resource, Victorian Admitted Episodes Dataset 2014–15 to 2018–19; Department of Health and Human Services, Victorian Admitted Episodes Dataset 2019–20.

Notes: Admission involving a mental health diagnosis comprises a person who during that admission has received an ICD-10-AM diagnosis that falls within the mental, behavioural and neurodevelopmental disorders F00 to F99. Only includes care-type 4 separations and excludes separations from private hospitals. Excludes Hospital in the Home separations.

The Commission has found an absence of mental health consultation liaison outpatient clinics across most general hospitals in Victoria. This is further limiting the effective delivery of integrated mental health treatment, care and support for general health consumers.[295]

Very few staff in hospital mental health consultation liaison teams currently have the capacity to follow up patients in an outpatient clinic. This includes patients they have seen in the emergency department and patients who have been on a ward. Outpatient clinics provide valuable opportunities for clinicians to monitor, re-assess and address any fluctuations in a consumer's support needs. This assists in preventing relapse or readmission to hospital for potentially avoidable mental health reasons.[296]

The Commission has identified the Peter McCallum Cancer Centre as an exemplar of a general health service that provides integrated mental health treatment, care and support to admitted patients , as described in the case study in this chapter. This has been enabled through funding arrangements unique to the Centre.

Case study:

Psychosocial Oncology Program (Peter MacCallum Cancer Centre)

The Psychosocial Oncology Program at the Peter MacCallum Cancer Centre (Peter Mac) delivers integrated mental health care, treatment and support to patients with cancer.

The program is delivered by an embedded multidisciplinary team made up of clinical psychologists, social workers, music therapists, psychiatric consultation-liaison nurses, and psychiatrists and psychiatric registrars. The multidisciplinary team is able to screen, assess, detect and respond to any pre-existing or emerging mental health issues, in the context of the cancer affecting the patient. Mental health care, treatment and support is delivered to patients as part of routine cancer care.

Professor Steve Ellen, Director of the Psychosocial Oncology Program at Peter Mac, said the multidisciplinary team approach allows patients' care to be assessed and adapted as needed.

> The multidisciplinary team approach brings all aspects of wellbeing, mental health and cancer together, and allows us to feed back to each other to make sure we are on the same page. The multidisciplinary teams are great because patient care is often fragmented and clinicians are so busy—one member of the team presents a quick summary and everyone gets the chance to see the files, add to the information, provide input and coordinate care.

Professor Ellen said patients are referred to the program from throughout the hospital, and they can access support for the duration of their cancer treatment, both while they are in hospital and as outpatients. Patients in need are identified in two ways—during a screening process when registering with Peter Mac, and if a clinician in the hospital notices distress. Patients are contacted once they have been referred, to establish whether they are already receiving help from a mental health professional.

> We take referrals from anyone within the hospital, including doctors, nurses and allied health workers, such as a physio or a nutritionist. Patients can also self-refer. We triage to determine the urgency, type of problem and most appropriate clinician for the patient's problem and according to their preference—we also look at their external supports to make sure we are not doubling up for patients who are already engaged with community services.

Professor Ellen explained that the four broad areas of the program focus on social work, music therapy, psychiatry and psychology, and that patients can access all or some services.

> The psychosocial program is also closely connected to the spiritual care team and the wellbeing program. Our aim is to match the care to the patient's preferences and problems in a seamless manner, with the ability to scale up and down according to their needs over time.

Professor Ellen said the psychiatric service can provide assessment and treatment, but can also work in conjunction with community clinicians to ensure patients get the best possible mental health care, as well as cancer care.

> People may have a pre-existing psychiatric disorder when they are diagnosed with cancer. Psychosocial clinicians at Peter Mac have the expertise to look after the psychiatric disorder in a way that allows them to get the cancer treatment they need.

The clinical psychology team offers a range of psychological therapies and interventions, such as cognitive behavioural therapy, mindfulness, acceptance and commitment therapy, and existential therapy. The team has also developed a number of online resources for patients whose cancer care limits their ability to attend appointments. Psychologists adapt their approach to meet a patient's needs, and offer individual, couple or family consultations.

The social work service helps patients, families and carers during the period of change associated with a cancer diagnosis, and provides support with legal and financial support services, home support services, childcare, housing and support groups. They also assist with supports to help patients once they have been discharged from hospital, and provide referrals to local services.

Music therapy has also been a key feature of the program at Peter Mac. Professor Ellen said the music therapy offered at Peter Mac provides patients with an alternative entry to psychological wellbeing and has proved helpful to many people.

> Music therapy has been one of the most successful components. It's incredibly good for cancer patients, especially younger patients who often feel less comfortable with psychiatrists and psychologists. It's a good entry point and may give people the opportunity to reflect and provide new ways to share positive experiences with family and friends.

Sources: RCVMHS, *Interview with Professor Steve Ellen*, October 2020; Peter MacCallum Cancer Centre, 'Psychosocial Oncology' <www.petermac.org/services/treatment/psychosocial-oncology> [accessed 27 October 2020].

The evidence of siloed approaches, under-servicing and inadequate funding arrangements for providing in-hospital mental health consultation liaison services can be contrasted with the requirements and expectations set out in the National Safety

and Quality Health Service Standards—most specifically, the content of the Comprehensive Care Standard.[297]

All public and private hospitals must comply with these standards.[298] The Comprehensive Care Standard aims to ensure that admitted hospital patients receive comprehensive health care that meets their individual needs, including mental health supports as required.[299]

Calling for the further development of the consultation liaison role in the treatment system, Mr Terry Symonds, Deputy Secretary of Health and Wellbeing at the then Department of Health and Human Services, noted that:

> **This would enable consumers to receive specialised treatment for a health or mental health diagnosis, without having to be sitting within that stream. This is particularly important for complex consumers and those with a dual diagnosis … in practice this would mean that a consumer receiving bed-based treatment for post-natal depression who also required treatment for bulimia would be able to have targeted interventions by a dietician and psychologist for an eating disorder in their current setting—rather than be moved to a setting that treated a stream of women with a dual diagnosis of bulimia and post-natal depression.[300]**

Noting that safety is always paramount, there will be situations where consumers, particularly those with co-occurring conditions, require care where they are located. In those cases, they still can and should receive excellent mental health treatment, care and support through properly funded and, where necessary, expanded mental health consultation liaison services. This does not take away from the situations noted above where streaming is required for safety or other reasons—for example, in relation to women and those vulnerable consumers who may have complex needs.

The Commission has recommended that the Victorian Government ensure in-hospital mental health consultation liaison services are formally recognised and adequately funded. To achieve this, the Victorian Government will need to work closely with the Commonwealth Government to ensure funding is sufficient, as the Commonwealth Government also provides funding for public hospital services. While the Victorian Government works with the Commonwealth Government, the Commission expects that adequate and sufficient state-based funding is provided to public hospitals by the Victorian Government.

The Victorian Government must also ensure that public hospitals receive sufficient and sustained advisory resources to embed and deliver in-hospital mental health consultation liaison services internally. This might involve workforce training and establishing Communities of Practice. Public hospitals must also be held accountable for the continued delivery of high-quality, safe and integrated mental health treatment, care and support. This must be an important priority of the new regulator of mental health service delivery, as recommended and described in Chapter 30: *Overseeing the safety and quality of services*.[301]

1 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, pp. 491–503; Waitemata District Health Board, *Piri Pono: Evaluation of the Peer Led Acute Alternative Service*, 2016, p. 4.

2 Productivity Commission, *Mental Health Inquiry Report, Volume 1*, 2020, p. 72.

3 *Witness Statement of Kym Peake*, 24 July 2019, paras. 25–27; *Witness Statement of Dr Ravi Bhat*, 4 July 2019, para. 65.

4 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 89; NorthWestern Mental Health (A Division of Melbourne Health), *Submission to the RCVMHS: SUB.0002.0030.0061*, 2019, p. 50; *Witness Statement of Dr Neil Coventry*, 29 July 2020, paras. 71–84; *Witness Statement of Professor Neil Rees*, 15 June 2020, paras. 48–51.

5 *Witness Statement of Sandy Jeffs OAM*, 5 April 2020, paras. 29 and 31–32.

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Glossary

The Commission notes that several of the terms within this glossary differ from phrasing used in its letters patent. Where this is the case, the Commission has either made a deliberate choice to provide greater clarity on a term, or to enable a more inclusive interpretation. The Commission has inquired into all matters as per the expectations set in the letters patent.

Aboriginal community controlled health organisation	A primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health services to the community that controls it, through a locally elected board of management. This definition is consistent with that stated by the National Aboriginal Community Controlled Health Organisation.[1]
Aboriginal people	We recognise the diversity of Aboriginal people living throughout Victoria. While the terms 'Koorie' or 'Koori' are commonly used to describe Aboriginal people of south-east Australia, we have used the term 'Aboriginal' in this report to include all people of Aboriginal and Torres Strait Islander descent who are living in Victoria. This approach is consistent with the language conventions of key Victorian frameworks such as the *Aboriginal Affairs Framework 2018–2023*.[2]
Activity-based funding	While similar to a fee-for-service funding model, an activity-based funding model distributes funding to providers for the number of times they provide services to a person, with the amount based on each person's individual needs.[3]
Acute mental health inpatient services	Acute mental health beds, or acute inpatient units, support people experiencing an acute episode of mental illness that calls for treatment in hospital. These services include acute mental health beds for young people, adults and older adults.

Adult and Older Adult Area Mental Health and Wellbeing Services	Future services that will provide tertiary-level, high-intensity and complex support responses via multidisciplinary teams to people aged 26 years or older in both community and bed based settings. Adult and Older Adult Area Mental Health and Wellbeing Services will deliver all the core functions of community-based mental health services for those requiring a higher intensity of treatment, care and support than can be provided through local services. Services will be delivered through a partnership between a public health service or public hospital and a non-government organisation that delivers wellbeing supports (currently known as psychosocial supports). Access to these services will require a referral from a medical practitioner or Local Mental Health and Wellbeing Service.
Adult and older adult community mental health and wellbeing system	Future system that will provide treatment, care and support to Victorians over the age of 26 years. The Commission has taken an expansive view of what makes up the community mental health and wellbeing system, beyond mental health and wellbeing services. The system can be considered to span six levels, where the top level engages with the most people and each subsequent level supports a decreasing proportion of the population. The six levels are: • families, carers and supporters, informal supports, virtual communities and communities of place, identity and interest • a broad range of government and community services • primary and secondary mental health and related services • Adult and Older Adult Local Mental Health and Wellbeing Services • Adult and Older Adult Area Mental Health and Wellbeing Services • statewide services. Within this system, there will be an older adult mental health and wellbeing service stream that provides treatment, care and support for people with complex and compounding mental health needs generally related to ageing who are over the age of 65.
Adult and Older Adult Local Mental Health and Wellbeing Services	Future services that will deliver treatment, care and support to people aged 26 years or older. They will be delivered in a variety of settings where people first access services and receive most of their treatment, care and support. People will access these services either directly or via referral, and services will operate with extended hours. Services will deliver the Commission's recommended core functions for community mental health and wellbeing services. Service delivery may involve Area Mental Health and Wellbeing Services.

Area Mental Health and Wellbeing Services	Future services that will provide tertiary-level, high-intensity and complex support responses via multidisciplinary teams in both community and bed based settings. Area Mental Health and Wellbeing Services will deliver all the core functions of community-based mental health services for those requiring a higher intensity of treatment, care and support than can be provided through local services or in partnership with them. Services will be delivered through a partnership between a public health service and a non-government organisation that delivers wellbeing supports. There will be separate Area Mental Health and Wellbeing Services for infants, children and young people and for adults and older adults. For infants, children and young people there will be two service streams: Infant, Child and Family Area Mental Health and Wellbeing Services (0–11); and Youth Area Mental Health and Wellbeing Services (12–25). There will also be Adult and Older Adult Area Mental Health and Wellbeing Services (for people over the age of 26).
Area mental health services	The current state-funded area mental health services provide clinical community-based and inpatient care. Seventeen of Victoria's public health services operate area mental health services. Note: For the purposes of clarity, the current system is referred to in lower case and elements of the new service system have been capitalised in this report.
Allied mental health service	A service delivered by a diverse workforce such as psychologists, social workers and occupational therapists, working in a range of public, private, community and primary care settings.
Ambulatory care	Care provided to hospital patients who are not admitted to the hospital, such as patients of emergency departments and outpatient clinics. The term also refers to care provided to patients of community-based (non-hospital) healthcare services.[4]

Assertive outreach	A term applying to a broad range of models of care delivered in different service contexts. Generally, assertive outreach recognises that some people may require services to be more proactive in engaging or following up with them. Traditionally, assertive outreach models have included low caseloads, a multidisciplinary team, availability outside business hours, team autonomy and psychiatrist input. A variety of assertive outreach models are now in operation in Australia and internationally.
Assessment Order	An order made under the *Mental Health Act 2014* (Vic) that authorises a person to be compulsorily examined by an authorised psychiatrist to determine whether the treatment criteria, specified in the Mental Health Act, apply to the person. The order can either be an Inpatient Assessment Order or a Community Assessment Order, which reflects the location of where the examination is to occur.[5]
Authorised psychiatrist	A psychiatrist appointed by a designated mental health service to exercise the functions, powers and duties conferred on this position under the *Mental Health Act 2014* (Vic), the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) or any other Act.[6]
Blended care	Providing care through integrating digital and face-to-face supports. In blended care, digital supports are used to complement face-to-face services and to build on the gains achieved in face-to-face delivery.[7]
Capitation funding	Under a capitation payment model, providers receive a fixed amount of funding for each person who registers with them for a specified period, usually a year.[8] Capitation funding is similar to block funding; however, the funding is based on the number and mix of people who are registered with the service.
Care	The provision of ongoing support, assistance or personal care to another person.[9]
Carer	A person, including a person under the age of 18 years, who provides care to another person with whom they are in a relationship of care.[10]

Clinical governance	'[T]he systems and processes that health services need to have in place to be accountable to the community for ensuring that care is safe, effective, patient-centred and continuously improving'.[11]
Coercion	The action or practice of persuading in a way that uses or implies force and threats—forcing someone to do something.
Commissioning	While there is no single agreed definition, commissioning can be understood as a cycle that involves planning the service system, designing services, selecting, overseeing and engaging with providers, managing contracts and undertaking ongoing monitoring, evaluation and improvement.[12] Co-commissioning or joint commissioning refers to the ways in which organisations work together and with their communities to make the best use of limited resources in the design and delivery of services and to improve outcomes.[13]
Community care unit	A unit that provides clinical care and rehabilitation services in a homelike environment.
Community health services and integrated care services	Services that provide primary health, human services and community-based supports to meet local community needs.
Community mental health and wellbeing services	Services provided outside a hospital setting—in community settings such as clinics or centres, in people's homes or other places, or delivered by phone or videoconferencing, or online.[14] Community mental health and wellbeing services delivered by hospitals are sometimes referred to as 'community ambulatory services' and include care delivered by hospitals, but not always in the hospital itself, such as through outpatient or day clinics.[15]

Community mental health and wellbeing services core functions	The core functions are recommended by the Commission to ensure consistency in treatment, care and support delivered across Victoria. The core functions, which are common across all age ranges, are: • integrated treatment, care and support proportionate to consumers' needs, consisting of: – treatment and therapies—including a broad range of psychological and psychiatric therapies, other therapeutic interventions, support for physical health, and support for substance use or addiction – wellbeing supports—including supports for community connection and social wellbeing, building life skills, securing and maintaining housing, and education, training and employment supports – education, peer support and self-help—through education, peer self-help and guided self-help – care planning and coordination—to ensure that treatment, care and support is proportionate to needs and to provide continuity of care • services to help people find and access treatment, care and support and in Area Mental Health and Wellbeing Services to respond 24 hours a day, seven days a week to people experiencing a mental health crisis • support for primary and secondary services (for example, GPs), including primary and secondary consultation and comprehensive shared care.
Comorbidity	A situation where a person has two or more health problems at the same time. Also known as multimorbidity.
Compulsory patient	Under section 3 of the *Mental Health Act 2014* (Vic) a compulsory patient means a person who is subject to an Assessment Order, Court Assessment Order, Temporary Treatment Order or Treatment Order under the Act. Compulsory patients are sometimes referred to as 'involuntary patients'.

Compulsory treatment	The treatment of a person for mental illness subject to an order under the *Mental Health Act 2014* (Vic), the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) or the *Sentencing Act 1991* (Vic). This can include the administration of medication, hospital stays, electroconvulsive treatment or neurosurgery for mental illness. Compulsory treatment is sometimes referred to as 'involuntary treatment'.
Consecutive order	When a person is placed on a new compulsory treatment order, in anticipation of the current order ending,[16] to create a continuous duration and includes an Assessment Order, a Temporary Treatment Order and a Treatment Order.
Consumer	People who identify as having a living or lived experience of mental illness or psychological distress, irrespective of whether they have a formal diagnosis, have used mental health services and/or received treatment, care or support.
Consumer-completed measures and family-, carer- and supporter-completed measures	These measures collect information on the effectiveness of mental health and wellbeing services directly from the people who access services. They are a direct measure of experiences or outcomes, as determined by the individual. This information can be collected using a range of tools including questionnaires or standardised surveys.[17]
Consumer streams	The Commission uses the streams to describe how, at any given point in time, a person experiencing mental illness or psychological distress will need one of: • support from their communities and primary care services (communities and primary care stream) • treatment, care and support from primary and secondary mental health and related services (primary care with extra supports stream) • short-term treatment, care and support from a Local Mental Health and Wellbeing Service or an Area Mental Health and Wellbeing Service (short-term treatment, care and support stream) • ongoing treatment, care and support from a Local Mental Health and Wellbeing Service or an Area Mental Health and Wellbeing Service (ongoing treatment, care and support stream) • ongoing intensive treatment, care and support from a Local Mental Health and Wellbeing Service or an Area Mental Health and Wellbeing Service (ongoing intensive treatment, care and support stream).

Co-production	This involves people with lived experience of mental illness or psychological distress leading or partnering across all aspects of an initiative or program from the outset—that is, co-planning, co-designing, co-delivering and co-evaluating.[18]
Cultural safety	An environment that is safe for people—where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening.
Culturally appropriate	'An approach to policy, intervention, service delivery and intergroup interaction that is based on the positive acceptance of the cultural values and expectations of Aboriginal people.'[19] Culturally appropriate care is important for people from a broad range of cultures.
Culturally diverse	Term used in this report to reflect the fact that the Victorian population is diverse and that culture and language can influence people's needs and their access to mental health services that meet their needs.
Designated mental health service	A health service[20] that is prescribed in the Mental Health Regulations 2014 (Vic) to provide compulsory treatment[21] (includes Forensicare).
Digital mental health technology	The use of online and other digital technologies to improve mental health and wellbeing, including access to information, service delivery, education, promotion and prevention. It encompasses a vast range of technologies including apps, portals, social media, smartphones, augmented or virtual reality, wearables, activity tracking, e-referral, notifications and artificial intelligence. Other common terminology includes 'e-mental health' (health services that are online), 'm-health' (mobile and app-based support) and 'virtual health'.[22] This report uses 'digital mental health technology' as an overarching term that encompasses many types of technology. Where relevant, however, the report names specific technologies.

Discrimination	At its most basic, discrimination refers to the prejudicial treatment of people based on their individual or collective characteristics. In Victoria, the *Equal Opportunity Act 2010* (Vic) makes it unlawful to discriminate on the basis of 'disability' (which is defined to include a 'mental or psychological disease or disorder')[23] in certain settings including health care, employment and schools. This can be through 'direct discrimination' such as when someone is treated unfavourably because of a personal characteristic like mental illness.[24] This could be a refusal to treat someone, provide them access to services or admit them to a school because they have a mental health diagnosis. The law also protects against 'indirect discrimination', where an unreasonable requirement, condition or practice disadvantages a person or group of people based on a characteristic.[25]
Dual diagnosis service	Term historically used to describe services in Victoria that provide treatment, care and support to consumers living with mental illness and substance use or addition.
Dual disability	Term defined in the Commission's interim report as people living with both mental illness and an acquired or neurodevelopmental disability (such an intellectual disability, autism spectrum disorder, attention-deficit/hyperactivity disorder or a communication disorder).[26]
Early intervention	Includes prevention and early treatment. Early intervention can involve equipping people to deal with the signs and symptoms of illness or distress and helping people as soon as possible once mental distress is identified in order to improve the prospect of recovery (for example, following exposure to trauma).
Electroconvulsive treatment	The 'application of electric current to specific areas of a person's head to produce a generalised seizure'.[27] Also known as electroconvulsive therapy.
Enrolment	Refers to a consumer voluntarily enrolling with a service provider who is responsible for coordinating their comprehensive care. The consumer is free to get care through this 'responsible' provider, or through alternative providers. Enrolment may or may not be associated with a 'capitated' payment that is linked to the number of consumers enrolled (refer to definition: 'Capitation funding').
Family	May refer to family of origin and/or family of choice.

Fee for service	Under a fee-for-service funding model, service providers receive funding based on the number and mix of procedures, treatments and services they deliver.[28]
Forensic mental health service	A service that provides treatment, care and support services to people living with mental illness who have come into contact with the criminal justice system.
Forensic patient	A person under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) through an order of a court and detained at a designated mental health service (usually at Forensicare's Thomas Embling Hospital).[29]
Good mental health	A state of wellbeing in which a person realises their own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to their community.
Harm minimisation	A health policy approach that recognises there are complex and interrelated health, social and economic consequences of substance use or addiction that affect individuals, families and the community. A harm minimisation approach recognises that drug use is individual and occurs from occasional use to dependency. The approach does not condone drug use but recognises a range of strategies are required to support a progressive reduction in substance-related harm. A harm minimisation approach is based on three pillars: • Harm reduction aims to reduce high-risk behaviours associated with substance use and providing safer settings such as smoke-free areas or free water at music festivals. • Demand reduction is about preventing uptake of substances. Demand reduction also involves helping people who use substances to recover through a range of evidence-based care, treatment and support options. • Supply reduction is about controlling the supply and availability of substances.

Indicators	Qualitative or quantitative measures that can help determine change or progress and can be used to determine whether short-, medium- or long-term outcomes are being achieved. When indicators are used to measure the outcomes of a particular program or intervention (for example, resulting from reforms) they are measured from a baseline (before the program or intervention), at regular intervals after the intervention starts, and at the end.[30]
Infant, Child and Family Health and Wellbeing Hubs	Future local mental health and wellbeing services for people aged 0–11 years that will take the form of Infant, Child and Family Health and Wellbeing Hubs. These hubs will take a one-stop shop approach to child health by prioritising infants and children with emotional (for example, mental health challenges), developmental (for example, intellectual disability, autism spectrum disorder, speech delay) and physical health challenges (for example, asthma, allergies, chronic disease) that have continued to affect their wellbeing despite previous support. The hubs will provide age-appropriate treatment, care and support, use a whole-of-family approach, conduct a range of assessments as needed and be supported by Infant, Child and Family Area Mental Health and Wellbeing Services.
Infant, Child and Family Area Mental Health and Wellbeing Services	Future services that will provide tertiary-level, high-intensity and complex support responses via multidisciplinary teams to people aged 0–11 years. Infant, Child and Family Area Mental Health and Wellbeing Services are a service stream of the 13 Infant, Child and Youth Area Mental Health Services. These services will deliver all the core functions of community-based mental health services for those requiring a higher intensity of treatment, care and support than can be provided through local services or in partnership with them. Infant, Child and Youth Area Mental Health Services will be delivered through a partnership between a public health service (or public hospital) and a non-government organisation that delivers wellbeing supports.

Infant, child and family mental health and wellbeing service stream	Future service stream that will provide treatment, care and support to Victorians under the age of 12 years. It is one service stream within the broader infant, child and youth mental health and wellbeing system. The Commission has taken an expansive view of what makes up this service stream, beyond mental health and wellbeing services. The service stream can be considered to span six levels, where the top level engages with the most people and each subsequent level supports a decreasing proportion of the population. The six levels are: • families, carers and supporters, informal supports, virtual communities and communities of place, identity and interest • a broad range of government and community services • primary and secondary mental health and related services • Infant, Child and Family Local Health and Wellbeing Services • Infant, Child and Family Area Mental Health and Wellbeing Services within Infant, Child and Youth Area Mental Health Services • statewide services.
Infant, Child and Youth Area Mental Health and Wellbeing Services	Future services that will provide tertiary-level, high-intensity and complex support responses via multidisciplinary teams to people aged 0–25 years in both community and bed based settings. The 13 Infant, Child and Youth Area Mental Health and Wellbeing Services will deliver all the core functions of community-based mental health services for those requiring a higher intensity of treatment, care and support than can be provided through local services. Within these services will be two service streams: Infant, Child and Family Area Mental Health and Wellbeing Services and Youth Area Mental Health and Wellbeing Services. Services will be delivered through a partnership between a public health service or public hospital and a non-government organisation that delivers wellbeing supports (currently known as psychosocial supports). Access to these services will require a referral from a medical practitioner or Local Mental Health and Wellbeing Service.

Infant, child and youth mental health and wellbeing system	Future health system that will provide treatment, care and support to Victorians aged 0–25 years. Within this broad system, there are two service streams—the infant, child and family mental health and wellbeing service stream for people aged 0–11 years and the youth mental health and wellbeing service stream for people aged 12–25 years. At the area level, there will be shared clinical governance across the age range of 0–25 years through the 13 Infant, Child and Youth Area Mental Health Services.
Information collection, use and sharing	'Information collection' refers to mental health information a service provider or entity may collect as part of its organisational functions. 'Use' refers to the use of information for the purpose of delivering services to consumers, or for directly related purposes, such as administration. 'Use' also refers to who can see and use this information, and in what circumstances. It includes the protections and securities put in place to ensure privacy standards are met. 'Information sharing' broadly refers to the disclosure of information to another worker, provider, organisation or person for the purposes of treatment, support or accountability.
Inpatient	Relating to an admission to an inpatient unit of a designated mental health service.
Integrated care service	A service that provides a range of services and supports, including primary care and mental health care.
Intersectionality	Drawing on the Victorian Government's 2019 *Everybody Matters: Inclusion and Equity Statement*, the Commission describes intersectionality as a theoretical approach that understands the interconnected nature of social categorisations—such as gender, sexual orientation, ethnicity, language, religion, class, socioeconomic status, gender identity, ability or age—which create overlapping and interdependent systems of discrimination or disadvantage for either an individual or group.[31]
Lived experience	People with lived experience identify either as someone who is living with (or has lived with) mental illness or psychological distress, or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness or psychological distress. People with lived experience are sometimes referred to as 'consumers' or 'carers'. The Commission acknowledges that the experiences of consumers and carers are different.

Lived experience workforces	A broad term to represent two distinct professional groups in roles focused on their lived expertise—people with personal lived experience of mental illness ('consumers') and families and carers with lived experience of supporting a family member or friend who has experienced or is experiencing mental illness. Within each professional discipline there are various paid roles, among them workers who provide support directly to consumers, families and carers through peer support or advocacy, or indirectly through leadership, consultation, system advocacy, education, training or research.
Local Mental Health and Wellbeing Services	Future services that will provide treatment, care and support in a variety of settings where people first access services. People will access these services either directly or via referral, and services will operate with extended hours. Services will deliver the Commission's recommended core functions. Service delivery may occur in partnership with area services. These services will be a combination of primary and secondary responses supported by some tertiary-level responses. There will be separate local services for each of three age groups: Infant, Child and Family Local Health and Wellbeing Services (0–11), Youth Local Mental Health and Wellbeing Services (12–25) and Adult and Older Adult Local Mental Health and Wellbeing Services (over 26).
Medicare-subsidised mental health-specific service	Service in which the Medicare Benefits Scheme and the associated Better Access Initiative provide subsidised access to GPs and other health professionals such as psychiatrists, psychologists and other allied health practitioners.
Mental health and wellbeing	An optimal state of mental health, including as it relates to people with lived experience of mental illness or psychological distress. It can also be used to refer to the prevention, avoidance or absence of mental illness or psychological distress.

Mental Health and Wellbeing Commission	A new independent statutory authority recommended by the Royal Commission to: • hold government to account for the performance and quality and safety of the mental health and wellbeing system • support people living with mental illness or psychological distress, families, carers and supporters to lead and partner in the improvement of the system • monitor the Victorian Government's progress in implementing the Royal Commission's recommendations • address stigma related to mental health.
Mental health and wellbeing information	Information or an opinion about a consumer's physical, mental or psychological health, a health service provided, a consumer's expressed wishes about future service delivery, and personal information collected to provide health services. Information from others, including families, carers and supporters may also be included in mental health information, where appropriate.
Mental health and wellbeing system	The Commission outlines in this report its vision for a future mental health and wellbeing system for Victoria. Mental health and wellbeing does not refer simply to the absence of mental illness but to creating the conditions in which people are supported to achieve their potential. As part of this approach, the Commission has also purposefully chosen to focus on the strengths and needs that contribute to people's wellbeing. To better reflect international evidence about the need to strike a balance between hospital-based services and care in the community, the types of treatment, care and support the future system offers will need to evolve and be organised differently to provide each person with dependable access to mental health services and links to other supports they may seek. The addition of the concept of 'wellbeing' represents a fundamental shift in the role and structure of the system.
Mental health system	Overarching term that takes in services (with various funders and providers) that have a primary function of providing treatment, care or support to people living with mental illness and/or their carers. This term is used to describe the current and historical system.
Mental Health Tribunal	Independent statutory tribunal established under the *Mental Health Act 2014* (Vic) to hear and determine the making of Treatment Orders and other applications, including applications to perform electroconvulsive treatment when a person does not have decision-making capacity or is under the age of 18 years and applications to perform neurosurgery for mental illness.[32]

Mental illness	A medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.[33] The Commission uses the above definition of mental illness in line with the *Mental Health Act 2014* (Vic). However, the Commission recognises the Victorian Mental Illness Awareness Council Declaration released on 1 November 2019. The declaration notes that people with lived experience can have varying ways of understanding the experiences that are often called 'mental illness'. It acknowledges that mental illness can be described using terms such as 'neurodiversity', 'emotional distress', 'trauma' and 'mental health challenges'.
Mental wellbeing	A dynamic state of complete physical, mental, social and spiritual wellbeing in which a person can develop to their potential, cope with the normal stresses of life, work productively and creatively, build strong and positive relationships with others and contribute to their community.
Neurosurgery for mental illness	Any of the following three procedures, provided to treat a person meeting the criteria for mental illness: a) 'any surgical technique or procedure by which one or more lesions are created in a person's brain on the same or on separate occasions for the purpose of treatment b) the use of intracerebral electrodes to create one or more lesions in a person's brain on the same or on separate occasions for the purpose of treatment c) the use of intracerebral electrodes to cause stimulation through the electrodes on the same or on separate occasions without creating a lesion in the person's brain for the purpose of treatment'.[34]
Nominated person	The formal nomination of a person under the *Mental Health Act 2014* (Vic) by a person to provide them with support and help and to represent their interests and rights at times when they are at risk of receiving compulsory treatment or are receiving compulsory treatment. The nominated person also receives information from the authorised psychiatrist at certain points and is consulted as part of decision-making processes under the Act.[35]

Older adult mental health and wellbeing service stream	Future service stream that will provide treatment, care and support to Victorians with mental health support needs generally related to ageing. It is a service stream within the broader adult and older adult mental health and wellbeing system. The Commission has taken an expansive view of what makes up this service stream, beyond mental health and wellbeing services. The service stream can be considered to span six levels, where the top level engages with the most people and each subsequent level supports a decreasing proportion of the population. The six levels are: • families, carers and supporters, informal supports, virtual communities and communities of place, identity and interest • a broad range of government and community services • primary and secondary mental health and related services • Adult and Older Adult Local Mental Health and Wellbeing Services • Adult and Older Adult Area Mental Health and Wellbeing Services, which will include older adult mental health and wellbeing specialist multidisciplinary teams • statewide services.
Outcome domains	Categories or groups of outcomes relating to broad areas of mental health and wellbeing. For example, outcome domains could relate to providing safe and high-quality mental health services or could relate to consumer satisfaction with service delivery and treatment and care.
Outcomes	Changes to the health or wellbeing of a person, group or population that results from some kind of intervention or multiple interventions. Interventions are defined very broadly and include particular models of care or treatment or making health services more accessible or acceptable to consumers.[36] Individual health outcomes are measures of individual health and wellbeing status. These can be measured in the short, medium and long term. Population-level outcomes are measures of aggregated data on the health of a population—for example, the population of Victoria or Australia.[37] Outcomes are measured using indicators.
Output funding model	The Victorian Government uses an 'output funding model' whereby departments use the investment allocated in the budget process to deliver on the government's objectives[38] and outputs.[39] Output performance measures are used to specify the expected performance standard at which these services are to be delivered,[40] covering measures such as the quantity of services provided, timeliness, quality and cost.[41]

Postvention bereavement support	A range of support services provided to people who have been bereaved by suicide.
Prevention and recovery care unit	Generally a short-term service (up to 28 days) that provides recovery-focused treatment in a community-based residential setting.
Primary care	Health services where consumers access care, treatment and support without the need for a referral or without needing to meet certain eligibility criteria. Primary care settings include general practices, community health services and some allied health services. Primary care services are widely distributed, are the most accessible form of health care and are provided in most local communities across Victoria. Typical primary care providers are GPs or allied health professionals such as social workers or mental health nurses. However, primary care can be offered by a wide range of professionals including psychologists, paediatricians and maternal child and health workers.
Primary consultation	A consultation between a mental health clinician or multidisciplinary mental health team and a consumer that may be conducted in person or through teleconferencing or phone. A primary consultation can occur following a referral—for example, where a GP makes a referral for a consumer to have a primary consultation with a psychiatrist.
Primary Health Networks	Networks that commission a variety of mental health, alcohol and drug, and suicide prevention services. Services commissioned can vary but may include: referral and support services; primary and specialist consultation services; prevention and early intervention services; services to reduce the harm associated with alcohol and other drugs; and capacity-building activities such as workforce education and training.[42] Refer to Box 29.4 in Chapter 29: *Encouraging partnerships* for detail.
Primary prevention	Strategies that aim to stop the onset of a health condition or disease from ever occurring by addressing the underlying causes or determinants of that condition. Primary prevention is distinct from secondary prevention, also referred to as early intervention, which aims to minimise the progress of a condition or disease at an early stage. It is also distinct from tertiary prevention, which aims to stop further progression of the condition and address the impacts that have already occurred.

Private hospital	Includes acute care and psychiatric hospitals, as well as private freestanding hospitals that provide day-only services.
Professional practice supervision	Refers to a formal professional relationship between two mental health practitioners that is designed to enable reflective practice, support professional self-care, maintain standards of professional practice, refine relational and clinical competencies and explore ethical issues. It is distinct from line management and performance management and is not a form of therapy.
Psychiatric assessment and planning unit	A unit that offers assessment and treatment for people experiencing an acute episode of mental illness and that minimises the need for an extended hospital stay in an inpatient unit.
Psychological distress	'One measure of poor mental health, which can be described as feelings of tiredness, anxiety, nervousness, hopelessness, depression and sadness.'[43] This is consistent with the definition accepted by the National Mental Health Commission.
Public specialist mental health services	Services that provide both clinical and non-clinical mental health services. These are largely delivered by area mental health services operated by 17 public health services in Victoria.
Quality assurance	A range of strategies, including regulation, used to provide assurance that services are meeting minimum quality or safety standards and expectations.
Quality and safety oversight	Monitoring either system or service performance to identify and report on the quality and safety of mental health treatment, care and support. This can include oversight of specific practices (such as monitoring the use of electroconvulsive treatment), of the performance of an individual service, or of the whole system. Oversight often involves a degree of independence from the practice or service that is subject to oversight.
Recovery-oriented practice	Practice that supports people to autonomously build and maintain a self-defined, meaningful and satisfying life and personal identity, whether or not there are ongoing symptoms of mental illness.[44]

Reflective practice	Interprofessional and collaborative group-directed processes of learning through and from experience to gain new insights via: • reflection on experiences of delivering care, treatment and support to consumers, families, carers and supporters • examining and critically reflecting on assumptions underlying everyday practices • reflecting on challenging interpersonal dynamics.
Regional Mental Health and Wellbeing Boards	Skills-based boards (rather than a representative board) recommended by the Commission that will include people with lived experience. Regional Boards will seek to support communities to achieve the highest attainable standard of mental health and wellbeing through achieving the following objectives: • Services respond to the needs of local communities. • Services respond to individual needs and preferences, with a focus on community-based service provision. • Services are integrated. • Safe services are incentivised. • Resources are allocated to improve outcomes. • Resources are allocated in a way that maximises value. Regional Boards will have a range of responsibilities. This includes being responsible for understanding need and planning services, supporting collaboration, funding and monitoring service providers, workforce planning and engaging with communities.
Regional Multiagency Panels	New coordinating structures recommended by the Commission in each region to bring together different service providers to support collaboration and accountability in providing services to consumers by multiple service agencies.
Restrictive interventions	May include 'bodily restraint', which is defined as a form of physical or mechanical restraint that prevents a person from having free movement of their limbs (excluding the use of furniture), or 'seclusion', which is the sole confinement of a person to a room or any other enclosed space from where the person is not free to leave.[45]

Seclusion and restraint

The *Mental Health Act 2014* (Vic) currently defines two forms of 'restrictive interventions':

- **Bodily restraint** is a form of **physical** or **mechanical** restraint that prevents a person having free movement of their arms or 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.[46]
- **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.[47]

Under the Act, seclusion and restraint can only be used in designated mental health services.[48]

The Act also prescribes that restrictive interventions (including seclusion and restraint) may only be used after 'all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable'.[49]

Restrictive interventions can also be called 'restrictive practices'. This term is used throughout the report when necessary to reflect the use of the term in source data or evidence.

Secondary care

Health services that require a referral from a primary care provider (usually a GP). A common example is a referral from a GP to a private psychologist under the Better Access scheme. Another common form of secondary care is where a GP refers a consumer to a psychiatrist for a mental health assessment.

Secondary consultation

A discussion between mental health clinicians about a particular consumer. This can enable different care providers to work collaboratively to discuss issues with the consumer's care. Other models of secondary consultation focus on the needs of consumers more generally—for example, consumers with particular mental health needs or a specific diagnosis. This model focuses on sharing knowledge and expertise between different care providers.

Secure extended care unit

A unit offering secure services on a general hospital site for people who need a high level of secure and intensive clinical treatment for severe mental illness.

Security patient	A prisoner who is placed on an order under the *Mental Health Act 2014* (Vic) or the *Sentencing Act 1991* (Vic) and detained at a designated mental health service (usually at Forensicare's Thomas Embling Hospital).[50]
Self-determination	In a collective sense, this term is used to refer to the 'ability of Aboriginal peoples to freely determine their own political, economic, social and cultural development as an essential approach to overcoming Indigenous disadvantage'.[51] Some materials referenced by the Commission also use the term 'self-determination' to refer to individual autonomy and each person's ability to make choices about themselves and their life.
Service and capital plan	A plan that 'identifies present and, as best as possible, future demand for services' and is intended to 'guide the future allocation of resources'.[52] Also called a 'service and infrastructure plan'.
Service standards	The Commission has developed service standards to assist the Victorian Government and Regional Mental Health and Wellbeing Boards to select service providers—including new providers, such as consumer-led providers—with adequate capacity and capability to deliver mental health services. Refer to Chapter 28: *Commissioning for responsive services* for detail.
Shared care	A structured approach between two or more health services that each take responsibility for particular aspects of a consumer's care. This responsibility may relate to the particular expertise of the health service. Shared care is supported by formal arrangements, including clear care pathways and clinical governance, and all health services involved share a joint and coordinated approach to the health and wellbeing of the consumer. Shared care approaches can also benefit health providers—for example, by providing them with access to expert advice, which can increase their capabilities over time.
Social and emotional wellbeing	Being resilient, being and feeling culturally safe and connected, having and realising aspirations, and being satisfied with life. This is consistent with *Balit Murrup*, Victoria's Aboriginal social and emotional wellbeing framework.

Social determinants of mental health	A person's mental health and many common mental illnesses are shaped by social, economic, and physical environments, often termed the 'social determinants of mental health'. Risk factors for many common mental illnesses are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk.[53]
Social housing	Term covering two distinct forms of subsidised rental housing: public housing, which is owned and operated by the Victorian Government, and community housing, which is owned and operated by community housing providers.[54]
Statewide services	Based on the evidence presented, the Commission characterises statewide services as those that usually involve: • a workforce with a high level of expertise and knowledge • a dedicated research focus • the provision of treatment, care and support to a proportionately small number of people, often with higher levels of needs.
Stigma	The World Health Organization defines stigma as a 'mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society'.[55] Stigma is a fundamentally social process—different characteristics or traits are not inherently negative, 'rather, through a complex social process, they become defined and treated as such'.[56] This process leads to social exclusion.[57]
Structural stigma	Refers to the 'societal-level conditions, cultural norms, and institutional practices that constrain the opportunities, resources, and wellbeing for stigmatised populations'.[58]
Substance use or addiction	Substance use means the use of alcohol, tobacco or other drugs (prescription or illicit). Substance use may become harmful to a person's health and wellbeing or can have other impacts on someone's life or that of their family and broader social network. Addiction to substances means compulsive substance use that is outside a person's control, even when it has harmful effects on that person or their family.
Substituted decision making	Where a third party makes treatment decisions for the consumer.

Supported decision making	The process that supports a person to make and communicate decisions with respect to personal or legal matters. This may be achieved by offering consumers access to a variety of tools and resources such as non-legal advocates and peer workers.[59]
Systemic discrimination	Term that 'describes patterns or practices of discrimination that are the result of interrelated policies, practices and attitudes that are entrenched in organisations or in broader society'.[60]
Telehealth	Video teleconferencing using some form of online software or phone-conferencing to deliver services and supports directly to a consumer.[61]
Temporary Treatment Order	An order made under the *Mental Health Act 2014* (Vic) by an authorised psychiatrist following an examination under an Assessment Order that requires a person to be provided with compulsory treatment. The order is either an Inpatient Temporary Treatment Order or a Community Temporary Treatment Order.[62]
Tertiary care services	Highly specialised medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities.
Treatment	When 'a person receives treatment for mental illness if things are done in the course of the exercise of professional skills to remedy the person's mental illness; or to alleviate the symptoms and reduce the ill effects of the person's mental illness'.[63]
Treatment, care and support	The Commission uses this phrase consistently with its letters patent. This phrase has also been a deliberate choice throughout this report to present treatment, care and support as fully integrated, equal parts of the way people will be supported in the future mental health and wellbeing system. In particular, wellbeing supports (previously known at 'psychosocial supports') that focus on rehabilitation, wellbeing and community participation will sit within the core functions of the future system.
Treatment Order	An order made under the *Mental Health Act 2014* (Vic) by the Mental Health Tribunal following a period of treatment under a Temporary Treatment Order that requires a person to be provided with compulsory treatment. The order is either an Inpatient Treatment Order or a Community Treatment Order.[64]

Value-based care	Care whose goal is to create more value for consumers by focusing on the outcomes that matter to them, rather than just focusing on cost-efficiency. Some funding approaches are designed to encourage greater value, such as bundled payments.[65]
Voluntary patient	A person who receives treatment for a mental illness or psychological distress who is not subject to a compulsory assessment or treatment order.
Wellbeing supports	Used to describe supports for wellbeing in the future system. Includes supports currently known as 'psychosocial supports'.
Whole of government	Although there is no universally agreed definition of 'whole-of-government' approaches (often interchangeably referred to as 'joined-up' approaches), the Commission uses this phrase to denote different areas of government (for example, health, human services, justice and corrections) working together to achieve shared outcomes.[66]
Whole of system	The Commission's terms of reference define the mental health system by reference to mental health services that are funded wholly, or in part, by the Victorian Government. When the Commission refers to 'whole of system' in relation to the mental health system, the reference is to a broader system. This includes not only public sector bodies and organisations at the federal, state and local government levels; it includes all people and organisations who participate in—or are connected with—the new mental health and wellbeing system recommended by the Commission.
Youth Area Mental Health and Wellbeing Services	Future services that will provide tertiary-level, high-intensity and complex support responses via multidisciplinary teams to people aged 12–25 years. Youth Area Mental Health and Wellbeing Services are a service stream of the 13 Infant, Child and Youth Area Mental Health Services. Youth Area Mental Health and Wellbeing Services will deliver all the core functions of community-based mental health services for those requiring a higher intensity of treatment, care and support than can be provided through local services or in partnership with them. Infant, Child and Youth Area Mental Health Services will be delivered through a partnership between a public health service (or public hospital) and a non-government organisation that delivers wellbeing supports.

Youth Local Mental Health and Wellbeing Services	Future services that will deliver treatment, care and support to people aged 12–25 years or older. The role of Youth Local Mental Health and Wellbeing Services in the youth mental health and wellbeing service stream will be predominantly played by the network of headspaces across Victoria, although, over time, other providers may also choose to deliver this level of service. Youth Local Mental Health and Wellbeing Services and Youth Area Mental Health and Wellbeing Services will be formally networked within each of the 13 areas. They will work together in partnerships to provide treatment, care and support to young people.
Youth mental health and wellbeing service stream	Future service stream that will provide treatment, care and support to Victorians aged 12–25 years. It is one service stream within the broader infant, child and youth mental health and wellbeing system. The Commission has taken an expansive view of what makes up this service stream, beyond mental health and wellbeing services. The service stream can be considered to span six levels, where the top level engages with the most people and each subsequent level supports a decreasing proportion of the population. The six levels are: • families, carers and supporters, informal supports, virtual communities and communities of place, identity and interest • a broad range of government and community services • primary and secondary mental health and related services • Youth Local Mental Health and Wellbeing Services • Youth Area Mental Health and Wellbeing Services within Infant, Child and Youth Area Mental Health Services • statewide services.

Shortened forms

The following shortened forms are frequently used in this report. Other shortened forms are explained where they are used.

AC	Companion of the Order of Australia
AM	Member of the Order of Australia
AO	Officer of the Order of Australia
CEO	Chief Executive Officer
DNA	deoxyribonucleic acid
GP	general practitioner
IT	information technology
LGBTIQ+	lesbian, gay, bisexual, trans and gender diverse, intersex, queer and questioning
MP	Member of Parliament
OAM	Medal of the Order of Australia
PSM	Public Service Medal
TAFE	Technical and Further Education

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