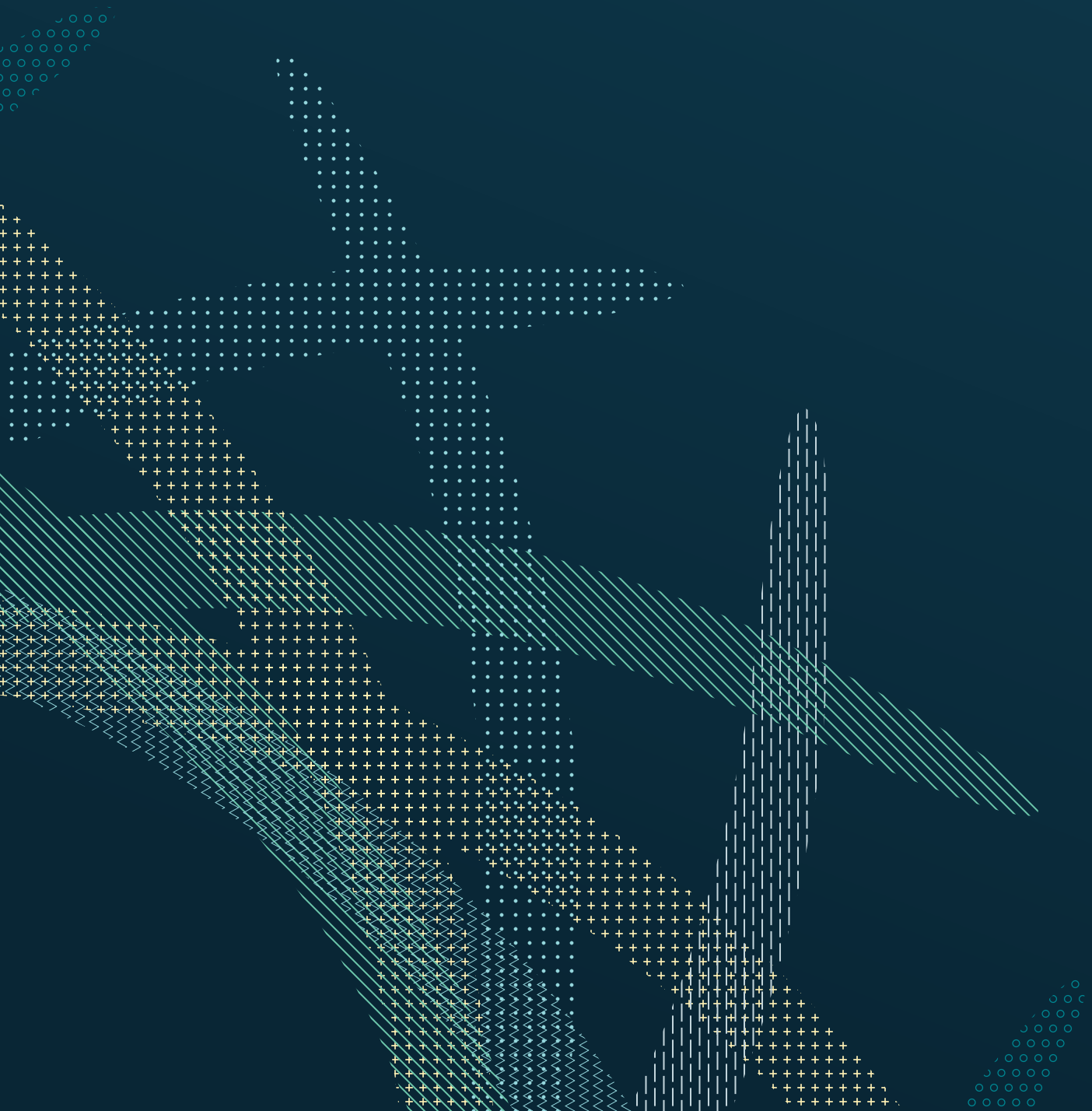
Royal Commission into
Victoria's Mental Health System

Final Report

Volume 4

The fundamentals for enduring reform



Royal Commission into
Victoria's Mental Health System

Volume 4
The fundamentals for enduring reform

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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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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

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 may contain information that could be distressing. You may 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 phone-based support contact **Beyond Blue** on **1300 224 636**.
- If you are looking for a mental health service, visit **betterhealth.vic.gov.au**.
- **For situations that are 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 of mental illness or psychological distress, families, carers 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 or psychological distress 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 and wellbeing 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.

Introduction

As required by the Commission's letters patent, the Commission was a policy-based inquiry. This report presents the findings from this process and sets out recommendations to inform the design of a new mental health and wellbeing system.

The Victorian community made more than 12,500 contributions to inform the Commission's work. This included almost 3,000 survey responses from frontline workers across the mental health system. The Commission has listened to this diversity of voices and analysed a wide variety of data and research. These inputs have illustrated the factors that shape people's experiences of mental health and wellbeing and have formed the basis for the design of the future system and services.

Volume 1 of this report outlines a new approach to providing Victorians with the right mental health treatment, care and support at the right time, and in the right places across the state. Volume 2 describes the collaboration needed to support good mental health and wellbeing. Volume 3 outlines reforms to promote inclusion and address inequities in the mental health system. Volume 5 sets out the enablers of system transformation, including the technology, information and expertise needed to make the system work effectively, and how it will drive continuous improvement.

This volume 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.

New system architecture

Victoria's mental health system is large and complex. As it grows to meet demand and becomes locally accessible and responsive, new arrangements are essential to make sure it functions effectively.

The Commission recommends changes to how the system is governed, funded, monitored and held to account.

With the future system's broad focus on promoting good mental health and wellbeing, a new Mental Health and Wellbeing Act will provide the legal framework for the new system—one that is accessible and provides for a diverse range of high-quality services. The Act will reset the legal framework to focus on promoting good mental health and wellbeing; provide greater clarity over roles and responsibilities within the mental health and wellbeing system; strengthen accountability mechanisms; and promote and protect human rights. Refer to Chapter 26: *Rebalancing mental health laws—a new Mental Health and Wellbeing Act* for a detailed description of these reforms.

Perhaps most importantly, the legislators in drafting the Act will respond to the views, values and perspectives of people with lived experience of mental illness or psychological distress, families, carers and supporters that have been collated by the Commission in these volumes.

Several new entities will be established, with different but complementary roles. Refer to Chapter 27: *Effective leadership and accountability of the mental health and wellbeing system—new system-level governance* for details. These new entities will work together and with existing organisations in the system. The roles and responsibilities of each entity will focus on ensuring the system functions to deliver beneficial mental health outcomes and experiences.

A new statutory Mental Health and Wellbeing Commission will be established. It will be an independent and impartial body that will hold the government to account, reinvigorate system leadership, report on how the system is operating, monitor the implementation of the Royal Commission's recommendations and have powers to initiate its own inquiries and provide advice to ministers. This Commission will have a clear and unwavering focus on quality and safety. It will receive and investigate complaints about service delivery and require services to make changes in response to complaints.

A Chief Officer for Mental Health and Wellbeing, whose role will be defined in legislation, will lead the Mental Health and Wellbeing Division in the Department of Health. The department will develop and implement mental health strategies and policies—setting new expectations for mental health and wellbeing service providers. Dedicated offices in the department will plan and lead statewide approaches to preventing suicide, and preventing mental illness and promoting good mental health and wellbeing.

The Premier will chair a dedicated Mental Health and Wellbeing Cabinet Subcommittee, supported by a board of department secretaries from across government, to deliver the Royal Commission's recommendations.

A Suicide Prevention and Response Secretaries' Board Subcommittee will be co-chaired by the Department of Premier and Cabinet and the Department of Health, comprised of all state government departments represented at the Secretary or Deputy Secretary level, and attended and supported by the State Suicide Prevention and Response Adviser. Recognising the role that other bodies play in preventing and responding to suicide, it will include Victoria Police, the Coroners' Court and WorkSafe Victoria.

An Interdepartmental Committee on Mental Health and Wellbeing Promotion, co-chaired by the Department of Premier and Cabinet and the Department of Health, will be established, comprising all state government departments and relevant agencies, and attended and supported by the Mental Health and Wellbeing Promotion Adviser.

As detailed in Volume 1, eight new Regional Mental Health and Wellbeing Boards will be established to enable treatment, care and support to be planned and resourced in a way that recognises and responds to the needs of different communities. The Department of Health will work with Regional Boards to develop mental health and wellbeing services and capital plans, to distribute funding to services, and to monitor the outcomes and experiences of the people who use them. For details on the functions of Regional Boards, refer to Chapter 28: *Commissioning for responsive services* and Chapter 29: *Encouraging partnerships*.

The new Collaborative Centre for Mental Health and Wellbeing will lead and facilitate translational research for the future mental health and wellbeing system. It will bring people with lived experience of mental illness or psychological distress together with experts and researchers to develop and translate research into world-leading practice in all services.

Reflection, quality improvement and practice leadership will be important features of the future system. A Mental Health Improvement Unit will be set up within Safer Care Victoria—the peak state authority for quality and safety improvement in health care—to help services establish and maintain strong and effective quality management systems, respond to issues that are identified, and adopt contemporary ways of improving service delivery. The Chief Psychiatrist will continue to issue guidelines and monitor key practices. Chapter 30: *Overseeing the safety and quality of services* provides details.

Lived experience will feature prominently in leadership positions and other influential roles across new and existing entities. The Mental Health and Wellbeing Commission will promote and model the leadership and the full and effective participation of people with lived experience of mental illness or psychological distress across the policies and programs that affect their lives. It will also elevate the leadership and promote the valued role of families, carers and supporters across the system.

Driving the delivery of responsive and integrated services

A future mental health and wellbeing system will see consumers, families, carers and supporters getting treatment, care and support when and where it makes the most difference to them. It will be a system that provides people with choice over the services and supports they need to live their life.

Achieving these aspirations requires a new approach to commissioning responsive and innovative mental health and wellbeing services. The Commission's reforms, described in Chapter 28: *Commissioning for responsive services*, support this endeavour by establishing a contemporary approach to planning, funding and monitoring the performance of mental health and wellbeing services. These reforms will ensure the future system is well funded, adaptive and accountable to the people it seeks to support.

Delivering a more diverse and responsive service offering to meet the individual needs and preferences of individuals will require collaboration between services that are funded by the Victorian Government, the Commonwealth Government and the private sector. Chapter 29: *Encouraging partnerships* sets out structural reforms to support genuine collaboration between these levels of government and the providers which they fund. It also recommends achieving greater integration by supporting providers to work together, including via a co-commissioning approach to commonwealth- and state-funded mental health and wellbeing services in conjunction with Primary Health Networks.

Ensuring safe and effective care

The Victorian Government will be accountable for the quality and safety of services provided across the state, and services will be required to continuously improve service delivery. They will also need to greatly reduce the use of compulsory treatment so it is only used as a last resort; and work towards eliminating the use of seclusion and restraint in the mental health and wellbeing system, including emergency departments (refer to Chapter 31: *Reducing seclusion and restraint* and Chapter 32: *Reducing compulsory treatment* for details). The Mental Health and Wellbeing Commission will have powers to seek data and information, to report publicly, and to highlight changes to protect the safety and rights of consumers.

The Mental Health and Wellbeing Commission will make it easy for people to raise concerns about their experiences. The Department of Health and the Mental Health and Wellbeing Commission will collaborate with existing bodies that support safe, fair and effective services to Victorians, including the Mental Health Tribunal, the Office of the Public Advocate, Safer Care Victoria, the Victorian Equal Opportunity and Human Rights Commission, VicHealth and the Victorian Agency for Health Information.

Supporting a sustainable workforce

The mental health workforce will be strengthened and supported. More people with diverse experience and expertise will join the workforce to provide new and enhanced services. People working in the system will receive professional and wellbeing supports to provide high-quality treatment, care and support in safe and therapeutic environments. Multidisciplinary teams will share skills to respond to individuals' needs, supported by technology. Through the Collaborative Centre for Mental Health and Wellbeing, the workforce will have access to a high standard of professional learning. Refer to Chapter 33: *A sustainable workforce for the future* for details.

Together, the reforms outlined in this volume establish the fundamentals for enduring reform.

Chapter 26

Rebalancing mental health laws—a new Mental Health and Wellbeing Act

Recommendation 42:

A new Mental Health and Wellbeing Act

The Royal Commission recommends that the Victorian Government:

1. repeal the *Mental Health Act 2014* (Vic) and enact a new Mental Health and Wellbeing Act, preferably by the end of 2021 and no later than mid-2022, to:

    a. promote good mental health and wellbeing;
    b. reset the legislative foundations underpinning the mental health and wellbeing system; and
    c. support the delivery of services that are responsive to the needs and preferences of Victorians.

2. ensure the Mental Health and Wellbeing Act:

    a. includes new objectives and mental health principles, with its primary objective to achieve the highest attainable standard of mental health and wellbeing for the people of Victoria by:

        - promoting conditions in which people can experience good mental health and wellbeing;
        - reducing inequities in access to, and the delivery of, mental health and wellbeing services; and
        - providing a diverse range of comprehensive, safe and high-quality mental health and wellbeing services.

    b. clarifies the roles, responsibilities and governance arrangements of the new mental health and wellbeing system;
    c. establishes the bodies and roles referred to in other recommendations, including the Mental Health and Wellbeing Commission (refer to recommendation 44), the Chief Officer for Mental Health and Wellbeing (refer to recommendation 45(1)) and Regional Mental Health and Wellbeing Boards (refer to recommendation 4(2));
    d. strengthens accountability mechanisms and monitoring arrangements for service delivery;
    e. specifies measures to reduce rates and negative impacts of compulsory assessment and treatment, seclusion and restraint;
    f. simplifies and clarifies the statutory provisions relating to compulsory assessment and treatment such that they are no longer the defining feature of Victoria's mental health laws; and
    g. specifies the ways in which information about mental health and wellbeing may be collected and used.

Recommendation 43:

Future review of mental health laws

The Royal Commission recommends that the Victorian Government:

1. commission an independent review of Victoria's mental health laws five to seven years after the enactment of the Mental Health and Wellbeing Act.
2. co-design terms of reference for the review that focus on ensuring mental health laws remain contemporary, effective and responsive to the needs and preferences of consumers, families, carers and supporters.
3. as part of this review, consider the role and functions of the Mental Health Tribunal and Chief Psychiatrist to ensure they remain appropriate.

26.1 Legal foundations for change

Law is an essential piece of the foundations of the mental health system. Legislation not only regulates the legal relationships in the mental health system, but also shapes the ways in which services are accessed and delivered.[1]

British legal academic and Emeritus Professor at King's College, London, Genevra Richardson, argues that the purposes of mental health legislation are generally to pursue one or more of three broad goals: providing access to health care; protecting consumers; and protecting others.[2]

Most comparable legal systems around the world have legislation dedicated to mental health.[3] In Victoria, the main legislation is currently the *Mental Health Act 2014* (Vic). The primary purpose of this Act is, however, a narrow one, for it focuses on the compulsory assessment and treatment of people living with mental illness. This regime is explored further in Chapter 32: *Reducing compulsory treatment*.

There are many factors that contribute to the content and application of mental health laws. As described by Emeritus Professor of Law at the University of Sydney Law School, Terry Carney AO, '[m]ental health laws … like all laws, are a product of many forces'.[4]

In Victoria's under-resourced and crisis-driven system, a risk management lens often colours the content and application of mental health laws. For example, while compulsory treatment was intended to be reduced under the Mental Health Act, it is often used as the default approach and similarly, supported decision making practices are not commonplace—despite requirements contained within the Act.[5] For consumers, this has adverse consequences, such as severe limitations on human rights, and increased stigma and discrimination that may flow from being placed on compulsory treatment orders.[6]

The Commission's interim report highlighted a need for close examination of Victoria's mental health laws to determine how they can deliver what people living with mental illness or psychological distress, families, carers and supporters respectively value and seek; be flexible enough to respond to changing community needs and expectations; and protect and promote human rights.[7]

While legislation on its own will not cure Victoria's broken mental health system, a legal framework that promotes good mental health and wellbeing is essential to support people living with mental illness or psychological distress, families, carers and supporters to live a life that they value.

This chapter explains why new mental health legislation is needed to rebalance the existing legal framework and support the Commission's aspirations for a responsive mental health and wellbeing system that focuses on promoting good mental health and wellbeing. In resetting the legal framework, it is important that new legislation enables Victorians to achieve the highest attainable standard of good mental health and wellbeing.

The Commission was told that the current Act, which permits compulsory treatment and 'restrictive practices' (which are explored in Chapter 31: *Reducing seclusion and restraint*), can have damaging impacts on people. Ms Indigo Daya, Consumer Academic at the Centre for Psychiatric Nursing, University of Melbourne, giving evidence in a personal capacity, said:

> The recovery process of empowerment is a challenge in mental health services because of mental health legislation and the system's focus on deficits in individuals. It is not possible to feel empowered when your fundamental human rights are restricted and sometimes severely breached. Even within the context of Victorian mental health law, the most basic aspects of supported decision making have not been implemented, further limiting the potential for people to feel empowered.[8]

Similarly, Ms Elizabeth Porter, a witness, spoke about the distress and confusion she experienced.

> having compulsory treatment was a feeling of being incarcerated. I felt confused because I was pretty sure I hadn't committed a crime – so why was I being locked up? Hospital was a distressing place, where male patients touched me and assaulted me; and there were clinical staff who were trying to make me do confusing things that I didn't want to do, and I didn't understand why they wanted me to do them. I didn't get to see a lawyer, and no one explained to me why I was there or how long I would be there for.[9]

The Commission has been told that families, carers and supporters also experience challenges with the legislation and how it is applied in practice.[10] While there are different views on the nature and extent of information that can be shared with families and carers, Tandem, an advocacy group for families and carers, told the Commission that despite intentions of the current legislation to clarify and enable information sharing, this was not the common experience for families, carers and supporters.

> Families consistently report being told that they do not have any rights to basic information around the patient. They report this as incredibly disempowering, and preventing recovery, and often making difficult situations worse. This extends to all aspects of care, whether it is mental health tribunals, admission and discharging in hospitals, challenges with the legal sector and the medication provided. The Mental Health Act currently holds an exemption that families can be communicated with, but all too often, they are not.[11]

The Commission was also told that a combination of factors affecting mental health practitioners—including limited resources, unclear accountability structures, inadequate education and training on the Mental Health Act, as well as service capacity pressures limiting quality time with consumers—was preventing the intentions behind the legislation from being translated into practice.[12] For example, a participant from the workforce compulsory treatment roundtable described that these factors can contribute to gaps in some mental health workers' understanding of the legislation.

> I think there's a real knowledge deficit. I think there's still a lot of inappropriate application of the Act for compulsory treatment. It takes a lot of strength on the part of those in the clinical workforce, who understand the intent, the objectives of the Act, to then challenge an existing culture.[13]

Moreover, the narrow focus of the Mental Health Act on compulsory assessment and treatment reinforces a focus on pharmacological interventions, the treatment of symptoms, and clinical recovery from symptoms, without taking into account social factors, such as housing, cultural background or socioeconomic factors.[14]

A workable legal framework that promotes good mental health and wellbeing needs to go beyond permitting compulsory treatment. New mental health legislation should: reflect the views, values and preferences of people living with mental illness or psychological distress, families, carers and supporters; protect and promote human rights; enable strong governance; and communicate how the intentions behind the legislation should apply in practice.

The success of legislative reform will rely, in part, on the successful implementation of the Commission's other reforms, such as ongoing education and training to build capability in the mental health workforce as described in Chapter 33: *A sustainable workforce for the future*.

Any legal framework that goes beyond compulsory assessment and treatment needs to be broadly accepted and well understood by people living with mental illness or psychological distress, families, carers and supporters, as well as mental health workers and the general public. Achieving this acceptance and understanding will not stop with the passage of legislation. Concerted and ongoing effort will be required to realise the aspirations behind new legislation that aims to promote good mental health and wellbeing.

26.2 The current mental health legal framework

Many laws, regulations, agreements and treaties made at state, federal and international levels combine to make up the current legal framework for the governance and delivery of mental health services in Victoria.

At the international level, Australia is a party to core international human rights conventions, including the *International Covenant on Economic, Social and Cultural Rights*, the *Convention on the Rights of Persons with Disabilities*, and the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* and its accompanying *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*.[15]

Under these conventions, Australia is obligated, among other things, to protect and promote 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'[16] and to recognise 'that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability'.[17] The *Convention on the Rights of Persons with Disabilities* clarifies that 'disability' includes 'mental impairments'.[18]

The *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* requires Australia to establish a system of regular inspections by national and international bodies 'to places where people are deprived of their liberty in order to prevent torture and other cruel, inhuman or degrading treatment and punishment'.[19] Places of detention include where people are deprived of their liberty in order to be compulsorily assessed or treated.[20]

It is noted that domestic laws, that is, federal, state and territory laws, may need to be changed to ensure that the rights and obligations set out in international conventions are implemented in Australia.

At a national level, the main pieces of legislation relevant to the delivery of mental health services, and mental health and wellbeing are the:

- *National Health Act 1953* (Cth)
- *Health Insurance Act 1973* (Cth)
- *My Health Records Act 2012* (Cth)
- *National Disability Insurance Scheme Act 2013* (Cth)
- *Disability Discrimination Act 1992* (Cth)
- *Carers Recognition Act 2010* (Cth)
- *Australian Institute of Health and Welfare Act 1987* (Cth).

In Victoria, the main mental health–related pieces of legislation are the *Mental Health Act 2014* (Vic), which falls within the Minister for Mental Health's responsibilities, and the *Health Services Act 1988* (Vic), for which the Minister for Health is primarily responsible.

26.2.1 *Mental Health Act 2014* (Vic)

The main purpose of the Mental Health Act is to establish a scheme that allows for the compulsory assessment and treatment of people[21] when all the following treatment criteria under section 5 of the Act are met:

> *(a) the person has mental illness; and*
>
> *(b) because the person has mental illness, the person needs immediate treatment to prevent:*
>
> *(i) serious deterioration in the person's mental or physical health or*
>
> *(ii) serious harm to the person or another person; and*
>
> *(c) the immediate treatment will be provided to the person if the person is subject to a Temporary Treatment Order or Treatment Order; and*
>
> *(d) there is no less restrictive means reasonably available to enable the person to receive the immediate treatment.*[22]

On its enactment, the Mental Health Act was heralded by some as providing a much-needed, major overhaul of Victoria's previous legislation.[23] Following a consultation process that extended for more than five years, the then Minister for Mental Health, the Hon. Mary Wooldridge MP, said that the changes enacted in 2014 sought to minimise the use and duration of compulsory treatment, endeavoured to support family and carer involvement, and were underpinned by human rights, and frameworks of supported decision making and recovery-oriented practice (explained below).[24]

The then Minister said:

> **People with a mental illness and their families should be able to actively participate in decisions related to their care and have a range of choices about the types of support they need to achieve optimal wellbeing … working with individuals and their families to meet their own recovery goals is central to the government's approach.**[25]

The Mental Health Act sought to strengthen the oversight of compulsory treatment by abolishing the Mental Health Review Board and replacing it with the Mental Health Tribunal. This was considered noteworthy because it 'externalised' some decisions about compulsory treatment orders to the Mental Health Tribunal. This was a shift from the *Mental Health Act 1986* (Vic), where such decisions were made by the authorised psychiatrist and not the Mental Health Review Board.[26]

The legislation included a suite of mental health principles that were intended to guide decision making. These principles included that people receiving mental health services should be assessed and treated in the least restrictive way,[27] and that carers should be involved in decisions about treatment, care and support, whenever this is possible.[28]

The Mental Health Act confers a number of responsibilities on the Secretary of the former Department of Health and Human Services, now Department of Health. This Act describes the role of the Secretary as:

- *to plan, develop, fund, provide and enable the provision of a comprehensive range of mental health services that are consistent with, and promote the objectives of, this Act and the mental health principles; and*
- *to perform the functions and exercise the powers conferred on the Secretary by this Act or any regulations under this Act; and*
- *to administer this Act, subject to the general direction and control of the Minister.*[29]

The Mental Health Act also redefined the role of the Chief Psychiatrist to include responsibilities to provide clinical leadership and expert clinical advice to mental health service providers; promote continuous improvement in the quality and safety of mental health service providers; promote the rights of consumers; and advise the Minister for Mental Health and the Secretary about the provision of mental health services by mental health service providers.[30]

Other provisions in the Mental Health Act seek to provide safeguards, such as:

- advance statements—these are documents that set out a person's treatment preferences, in the event the person becomes a 'patient' under the Act,[31] which is defined to cover 'compulsory, security or forensic patients.'[32] While advance statements must be considered by decision makers at various points,[33] they are not binding and may be overridden, for example, if they are regarded by the authorised psychiatrist to not be clinically appropriate[34]
- nominated persons—these are people who 'patients' may nominate to provide them with support, help represent their interests, and assist them to exercise their rights.[35] As with advance statements, the views and preferences of 'patients', as expressed by the nominated persons, are not binding on authorised psychiatrists under the Mental Health Act[36]
- the second psychiatric opinion scheme—this is a scheme that allows 'patients' who are subject to a Temporary Treatment Order or a Treatment Order, or are 'security or forensic patients',[37] to seek a second psychiatric opinion at any time.[38]

The Mental Health Act provides for the oversight of public mental health services; for example, by the Mental Health Complaints Commissioner and Chief Psychiatrist.[39]

Forensicare's status as a legal entity is also established under the Mental Health Act.[40] Forensicare is responsible for providing mental health services to 'forensic and security patients' and is accountable to the Minister for Mental Health.[41]

26.2.2 *Health Services Act 1988* (Vic)

The Health Services Act outlines the development of public health services (including some mental health services), hospitals and other healthcare agencies.[42] This Act gives governance responsibilities to the Secretary of the Department of Health, including functions to develop policies and plans, fund and purchase health services, monitor performance and collect data.[43]

This positioning of mental health service governance as part of the governance of the wider health system reflected the intention 'to incorporate the overall management of mental health services into the same framework as the rest of general health and welfare system'.[44]

26.2.3 Intersections with other relevant Victorian laws

While mental health laws in Victoria focus on compulsory assessment and treatment, there are other Victorian laws that are relevant to people living with mental illness or psychological distress, families, carers and supporters, as well as the workforce. For example:

- The *Charter of Human Rights and Responsibilities Act 2006* (Vic) sets out the human rights to be promoted and protected; ensures that laws are interpreted, so far as is possible in a way that is compatible with human rights; and obliges all public authorities to act in a way that is compatible with human rights.[45] Relevant human rights to mental health include the right not to be discriminated against on the basis of disability, including mental illness; the right to life; the right to protection from cruel, inhuman or degrading treatment; the right not to be subjected to medical treatment without full, free and informed consent; the right to privacy; the right to liberty; and the right to humane treatment when deprived of liberty.[46]
- The objectives of the *Equal Opportunity Act 2010* (Vic) include to eliminate discrimination, sexual harassment and victimisation to the greatest possible extent; to promote and protect the right to equality as set out in the Charter of Human Rights and Responsibilities; to encourage the identification and elimination of systemic causes of discrimination, sexual harassment and victimisation; and to promote and facilitate the progressive realisation of equality, so far as is reasonably practicable.[47]
- The objectives of the *Disability Act 2006* (Vic) include to promote and protect the rights of persons accessing disability services; to support the provision of high quality disability services; and to advance the inclusion and participation in the community of persons with a disability.[48] People living with mental illness or psychological distress and who also have a sensory, physical or neurological impairment or acquired brain injury, an intellectual disability or a developmental delay, fall within this Act's operation.[49]
- The purposes of the *Carers Recognition Act 2012* (Vic) are to recognise, promote and value the role of people in care relationships, recognise the different needs of persons in care relationships, and support and recognise that care relationships bring benefits to the persons in the care relationship and the community.[50]

- The primary objective of the *Guardianship and Administration Act 2019* (Vic) is to protect and promote the human rights and dignity of persons with a disability, in the context of making guardianship and administration orders.[51] Guardianship orders confer powers on appointed guardians to make personal decisions in relation to the represented person,[52] and administration orders confer powers on appointed administrators to make financial decisions in relation to the represented person.[53] Decisions on such orders are made by the Victorian Civil and Administrative Tribunal.[54]
- The *Medical Treatment Planning and Decisions Act 2016* (Vic) seeks to ensure that people are provided with medical treatment that is consistent with their preferences and values even if they lose capacity to make decisions.[55]
- The purpose of the *Public Health and Wellbeing Act 2008* (Vic) is to provide for a legislative scheme that promotes and protects public health and wellbeing in Victoria.[56] One of the objectives of this Act is to achieve the highest attainable standard of public health and wellbeing.[57]
- The purpose of the *Health Records Act 2001* (Vic) is to promote fair and responsible handling of health information by protecting the privacy of an individual's health information, providing individuals with a right of access to their health information and providing an accessible framework for the resolution of complaints regarding the handling of health information.[58]
- The *Health Practitioner Regulation National Law (Victoria) Act 2009* provides a national registration and accreditation scheme for health practitioners.[59]
- The purposes of the *Privacy and Data Protection Act 2014* (Vic) include to provide for responsible collection and handling of personal information and to establish a protective data security regime for the Victorian public sector.[60]
- The *Drugs, Poisons and Controlled Substances Act 1981* (Vic) regulates medicines and poisons in Victoria to ensure they are safely stored, that premises are licensed, and medical practitioners have the necessary permits to prescribe drugs of dependence.[61]

26.3 Narrow focus of the *Mental Health Act 2014* (Vic)

The emphasis of mental health laws on compulsory treatment is not unique to Victoria.[62] Professor Neil Rees, the former president of both the Mental Health Review Board and the Victorian Law Reform Commission, stated:

> The raison d'être [main reason] for existing mental health laws is to permit compulsory treatment and detention in some circumstances. Without these laws, people would be breaking the law when providing involuntary treatment because these actions would constitute assault and false imprisonment if the person was detained against their wishes.[63]

People living with mental illness or psychological distress and advocates, however, told the Commission that the narrow focus of the Mental Health Act on compulsory treatment can contribute to the dominance of a biomedical model of care. This model preferences the views of mental health practitioners over those of consumers, focuses on 'deficits' that need to be fixed or managed by medication, and is moulded around a flawed expectation that the system is responsible for managing short-term risk rather than emphasising recovery.[64] Ms Erandathie Jayakody, a witness, told the Commission that:

> we need to question and challenge the values that underpin the existing laws and the mental health system. We need a paradigm shift where the law and mental health services are driven on the presumption that people with mental health challenges are capable of managing their own mental health. A presumption of recovery.[65]

Victoria Legal Aid's *Your Story, Your Say* project shared the views of Susan Mahomet, who said that little weight was given to consumer opinions and preferences.

> Psychiatrists and mental health services don't listen to you. If I had a meeting now, the psychiatrist would have already made up their mind, because they had read the notes. They have run through the whole conversation in their head. They have their aims, and they will get those by either pushing the issue, or just lying and doing it behind your back. Meeting with you is just a formality.[66]

A report by the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health stated that 'mental health continues to be over-medicalized and the reductionist biomedical model … dominates clinical practice, policy, research agendas, medical education and investment'.[67]

In turn, the focus of provisions in mental health legislation on preventing serious harm to the person or another person can fuel stigmatising views that people living with mental illness or psychological distress are dangerous, or a risk to themselves or society.[68]

Ms Mary O'Hagan MNZM, Manager Mental Wellbeing at Te Hiringa Hauora, New Zealand, and former New Zealand Mental Health Commissioner, giving evidence in a personal capacity, said:

> The system is skewed towards a reliance on the short-term risk management tools of medication, hospitals and the Mental Health Act. This has led to a situation where the mental health system is very focused on making sure that someone who they're responsible for doesn't go and do something like kill themselves or do something anti-social. The system views itself as very accountable for that, and often unrealistic community expectations drive this accountability.[69]

Further, the narrow focus of the Mental Health Act on compulsory assessment and treatment means it has little relevance for people who are not subject to, nor at risk of being subject to, compulsory treatment orders. Interested parties and advocacy groups argue that mental health laws that focus on supporting the needs and preferences of all people would support an equitable and human rights–compliant approach.[70]

The Commission believes that the Mental Health Act is no longer fit for purpose and will not enable the Commission's aspirations for the future mental health and wellbeing system to be realised. Its narrow focus on compulsory assessment and treatment serves to support the current mental health system's crisis-oriented approach rather than promoting good mental health and wellbeing.

26.4 Unrealised aspirations of the *Mental Health Act 2014* (Vic)

A consistent theme emerging from the Commission's work was that the aspirations behind the Mental Health Act, including embedding concepts such as supported decision making and recovery-oriented practice, have not been realised.[71] This is despite the extensive consultation processes, the best efforts of many, and the careful, considered drafting of the legislation.

While there is no single definition of supported decision making, it is a contemporary and widely accepted concept in Victoria, nationally and at international levels.[72] The Office of the High Commissioner for Human Rights defines supported decision making as 'the process whereby a person … is enabled to make and communicate decisions with respect to personal or legal matters'.[73] Researchers at the University of Melbourne, Dr Magenta Simmons and Dr Piers Gooding, explain that 'just as people who use wheelchairs are entitled to ramps in order to access buildings, so too people with mental health-related disability … are entitled to support to exercise choices about their lives'.[74]

For consumers, supported decision making simply means having access to supporters, such as non-legal advocates and peer workers who assist to preserve choice and autonomy, and enable individuals to make their own decisions.[75] Substituted decision making, on the other hand, sits at the other end of the spectrum, where someone other than the individual, often a medical practitioner, makes decisions on their behalf. Such decisions are often claimed to have been made in the 'best interests' of a consumer.[76] However, such decisions may not always be in line with a consumer's views and preferences.

Supported decision making should be distinguished from shared decision making, which has origins in healthcare settings and generally refers to a collaborative decision-making process between the medical practitioner and consumer.[77] Supported decision making goes further than shared decision making, by reducing the power imbalance that exists in the mental health system between consumers and clinicians.[78]

One consumer told the Commission how supported decision making had benefited them.

> **A lawyer worked with me at length to develop my advance directive and she has also supported me to make sure clinicians abide by it. Before that, I felt completely disempowered. I had no say in what I had to put into my body; the medications I had to take; the treatment I had to comply with. Having previously been raped, the mental health system was retraumatising … I was saying no, and other people kept doing things to my body without my consent.[79]**

Ms Julie Anderson, Senior Consumer Advisor in the Office of the Chief Mental Health Nurse and the Office of the Chief Psychiatrist in Victoria, gave evidence in a personal capacity and explained, the value of supported decision making practices (refer to personal story for further information).

Personal story:

Julie Anderson

Julie Anderson is currently the Senior Consumer Advisor in the Office of the Chief Mental Health Nurse and the Office of the Chief Psychiatrist in Victoria. She was the President and Chair of the Board of Neami National, a community mental health service, a position she held for more than 10 years.

Prior to this career, when she was raising her two children, Julie was in and out of hospital. She said she was once described as a 'revolving door consumer'.

Julie explained how important consumer choice is for recovery.

> I think the choice around what services you receive and when is very important. I think you should be able to have the choice to have treatment and care in the home, not just in the hospital system, and I think that the choice around that treatment and care is really vital to a recovery journey.

Julie said the supported decision-making process is critical to providing this choice.

> A supported decision-making environment is important. For example, when I wanted to refuse treatment, it was an honest conversation with me saying, 'These are the alternatives and this is what my family thinks'. A supported decision-making environment helped me make a decision. While I wasn't happy with the choice I had, I was still able to make the decision with all the information presented to me.

She also advocates for more co-design and consumer participation in the future mental health system.

> I think with the National Mental Health Standards that the services partner with consumers very well, it's a standard that they're accredited with, but I don't think we know how to co-design or co-produce effectively, and I think that's a capacity that needs to be built into services around that co-design. There's some very good UK tools around how to embed co-design into service delivery.

Source: *Witness Statement of Julie Anderson*, 28 May 2020; RCVMHS, *Evidence of Julie Anderson*, 16 June 2020.

As with supported decision making, while there is no single description or definition of recovery-oriented practice, it incorporates concepts of connectedness, hope, choice, empowerment, identity and participation.[80] Dr Sarah Pollock, Executive Director of Research and Advocacy at Mind Australia, said:

> Recovery is—in my mind—a concept framed by notions of social justice and human rights. Self-determination is at the heart of recovery, and participation is the best means to achieve this. Participation has to be central whilst we still have mental health legislation that can deprive people of their liberty on the basis of illness status.[81]

Ms Anderson also described how recovery-oriented practice had benefited her, telling the Commission that 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'.[82]

The then Department of Health's *Framework for Recovery-oriented Practice* highlights a distinction between different types of recovery, explaining that 'personal recovery' should not be equated with 'clinical recovery'. It emphasises that 'personal recovery' encompasses ideas of self-management, personal growth, empowerment, advocacy, choice and meaningful social participation free from stigma and discrimination; while 'clinical recovery' focuses on lessening symptoms.[83]

Despite the benefits that supported decision making and recovery-oriented practice can bring, people living with mental illness or psychological distress and their advocates told the Commission that neither are routinely used in the delivery of treatment, care and support.[84]

Ms Rachel Bateman, a witness, stated:

> A huge barrier to person-centred care is the *Mental Health Act 2014* (Vic) … in general, and compulsory treatment, restrictive practices and risk assessments in particular. In my view, you can't really provide person-centred care if someone is being treated against their will—I think you can provide elements of it, but overall it's not really taking them, their beliefs and their needs fully into account.
>
> services have fallen short of delivering person-centred care. I have often felt ashamed for reaching out for support too much, or not enough, or in ways that don't suit the organisation and the people who work there. 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.[85]

Similarly, Ms Cath Roper, Consumer Academic at the Centre for Psychiatric Nursing at the University of Melbourne, said:

> there is no incentive for people to do the work of supported decision-making. This work requires organisations that can support their staff to undertake initiatives that may push the boundaries, and that will support staff to sit with discomfort of negotiating risks with consumers rather than using treatment orders to force consumers into treatment. We cannot keep putting people on treatment orders because we're scared that they might do something in the future.[86]

In summary, the failure to embed supported decision-making and recovery-oriented practice into treatment, care and support has been a significant reason why the aspirations behind the Mental Health Act have not been realised.

26.4.1 Challenges with accessing information

Families, carers and supporters, as well as nominated persons, told the Commission that despite the underlying intentions of the Mental Health Act to provide for the involvement of families, carers and supporters, there is often a lack of access to information about the treatment, care and support of the person they care for.[87]

Mr Jacob Corbett, a carer for his sister, Mary, told the Commission that:

> most carers desperately want to be included, not deliberately and wilfully excluded. If Mary is over-medicated, she can't express herself well, and she needs and wants me there to help her communicate with the doctors and nurses. But there have been multiple times when I have basically been told by medical doctors and especially psychiatrists, 'Go away, we don't want you here, we're the professionals'.[88]

This sentiment was supported by Dr Lynne Coulson Barr OAM, then Mental Health Complaints Commissioner, who said, '[f]amilies and carers are often … distressed about their own experiences, including the lack of effective communication with or inclusion of families and carers by services.'[89]

A variety of views were put to the Commission about the appropriate balance between families, carers and supporters being able to access information to support people perform their caring roles, and consumers' right to privacy and their choice about with whom, if anyone, their information is shared. Chapter 19: *Valuing and supporting families, carers and supporters*, examines information sharing with families, carers and supporters in more detail, including how the system's failure to do this effectively can impact how people carry out their caring role.

26.4.2 Factors that have hampered implementation

The Commission was told about a range of factors that have impeded efforts to realise the aspirations behind the Mental Health Act. One of these reasons is the under-resourced and crisis-driven nature of Victoria's mental health system,[90] as described by Dr Neil Coventry, Victoria's Chief Psychiatrist.

> 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 often resulting in increased severity of symptoms. This compromises the principles of … the Act.
>
> This increases the likelihood of the need for compulsory treatment. The numbers of consumers being treated compulsorily restricts the capacity of services to accommodate individuals who seek treatment voluntarily.[91]

The Commission heard that other contributing factors also include a lack of coordinated, system-wide leadership and culture to drive, promote and put into practice the legislative reforms,[92] a failure to set clear expectations on how reforms should be translated into practice,[93] and insufficient resources, including training and education, to support the Act's introduction.[94]

The combination of these factors means there is a limited understanding of the Mental Health Act among consumers, families, carers and supporters, as well as the workforce. Moreover, the potential positive effects of the 2014 reforms have been undermined. These problems persist today.

For many people, this has contributed to their experience with the mental health system being a negative one, involving a loss of autonomy and dignity, limitations on their human rights, and a lack of choice. In turn, this has led to diminishing levels of trust and confidence in the mental health system.

Witness Ms Lucy Barker described that:

> being part of the mental health system is kind of like being in an abusive relationship. You're being told that they care about you and they can help you and that they're there for you, but then they hurt you so much with restraints, seclusion, medications and talk about you in horrific ways. There's nowhere else for you to turn to … I'm stuck in that relationship with the system.[95]

Another consumer told the Commission that the mental health system was negatively affecting their human rights, stating, 'I've found my interactions with the acute mental health system to be incredibly traumatising and my human rights were ignored. My trust in the medical system has been eroded as a result.'[96]

Witness Ms Anna Wilson told the Commission that in caring for her son, Harold:

> I have often not been treated with dignity or respect. I have been pushed aside because staff are busy. Mental health workers have said to me 'I can't talk to you' or 'I'll let you go'.
>
> I have also not been believed. Usually, Harold will not open the door because he is afraid of being locked up and placed under a Treatment Order made under the Mental Health Act, which has happened many times.
>
> I have felt so disempowered and exhausted from constantly battling to get my son the support and care he needs. I believe strongly that we have to improve the mental health system. It is shocking what consumers and their carers are going through.[97]

The Commission was told that poor implementation and a lack of understanding of the Mental Health Act manifested in several ways. For example, there are reports that:

- the treatment criteria for compulsory treatment are not well understood or correctly applied by decision makers[98]
- safeguards set out in the legislation, for example, advance statements and nominated persons, are not well known or commonly used by consumers, families, carers or supporters[99]
- mental health practitioners are not complying with requirements under the Mental Health Act to seek informed consent of consumers before administering treatment and to presume that consumers have capacity to give informed consent[100]
- the mental health principles, which are meant to represent the fundamental beliefs and values underpinning treatment, care and support under the legislation, are yet to be embedded in clinical practice.[101]

In summary, an ineffective implementation strategy, combined with insufficient resourcing to support reforms, has hindered the realisation of the Mental Health Act's intent.

Mr Matthew Carroll, President of the Mental Health Tribunal, summarised that:

> **the current Act was intended to foster change and reform practice. It has achieved some success, but it is uncontroversial to say it has not met the expectations that accompanied it. The Act's (almost) six years of operation demonstrate that legislative reform is going to achieve little when the system that it is seeking to regulate or change is simply not equipped, not resourced and not structured to take the principles set down in the Act and translate them into day-to-day practices.[102]**

26.5 Contradictions with human rights frameworks

When introducing the Mental Health Bill 2014 (Vic), the then Minister for Mental Health asserted that the proposed laws were compatible with the Charter of Human Rights and Responsibilities.[103] Similarly, other inputs to the Commission contend that the Mental Health Act is compatible with both the Charter of Human Rights and Responsibilities and the *Convention on the Rights of Persons with Disabilities*, and continues to reflect contemporary practice.[104]

Others argue, however, that the continued existence of laws that permit compulsory treatment and substituted decision making in any form is fundamentally incompatible with human rights.[105]

This view has support at the international level. The *Convention on the Rights of Persons with Disabilities* obliges nations, including Australia, to ensure that the same quality of care is provided to people with disabilities (which include 'mental impairments') as others, including on the basis of free and informed consent;[106] while the United Nations Committee on the Rights of Persons with Disabilities has advised that states must replace substituted decision-making regimes with supported decision-making alternatives.[107]

In ratifying the *Convention on the Rights of Persons with Disabilities* in 2007, Australia issued a declaration to the Convention, however, stating that it understands that substituted decision making is permitted when it is necessary, when used as a last resort, and when subject to safeguards.[108] Some other countries have made similar interpretive declarations or reservations.[109]

Some legal experts, clinicians and academics argue that the definitive interpretation of the *Convention on the Rights of Persons with Disabilities* is not yet legally settled[110] and, while it is clear that supported decision-making mechanisms must be incorporated into mental health legislation and applied in practice,[111] it is not realistic to prohibit substituted decision making in all circumstances.[112] Interpretations of the law will continue to evolve as the values and views of society change.

What is clear is that recent Victorian laws, including the Medical Treatment Planning and Decisions Act and the Guardianship and Administration Act, strengthen the practice of supported decision making, and take into account the human rights protected under the Charter of Human Rights and Responsibilities and the *Convention on the Rights of Persons with Disabilities*.[113] This is discussed in more detail in the next section.

26.5.1 Crucial concepts have evolved

The Mental Health Act was considered an improvement on previous mental health legislation; for example, by accentuating consumer autonomy and choice through the introduction of advance statements, and strengthening checks and balances over compulsory assessment and treatment. However, while the Act reflected contemporary principles when it was introduced, thinking and practices in relation to supported decision making have since evolved.

Many people living with mental illness or psychological distress and their advocates told the Commission that legislation needs to respect their autonomy and promote supported decision-making principles and practices.[114]

The Victorian Mental Illness Awareness Council highlighted the discriminatory nature of mental health laws, calling on the Commission to:

> Bring the *Mental Health Act 2014* (Vic) into line with rights in the *Medical Treatment Planning and Decisions Act 2016* (Vic): introduce advance directives so that our preferences for treatment and care can be upheld, just like for other citizens.[115]

Similarly, Professor Penelope Weller from the Centre for Business and Human Rights at RMIT University, argued in a personal capacity, that supported decision-making measures fall behind mechanisms provided for under other legislation.

> Although the current form of the Act contains some innovative solutions compared with its predecessor, it is now significantly out of step with the legislative frameworks that apply to others, particularly those set out in the new *Guardianship and Administration Act 2019* and the *Medical Treatment Planning and Decisions Act 2016*.[116]

While laws such as the Guardianship and Administration Act and the Medical Treatment Planning and Decisions Act still permit substituted decision making in certain circumstances, they also incorporate some principles and practices of supported decision making that are not evident in current mental health laws. For example:

- The Medical Treatment Planning and Decisions Act enables a person to make a binding advance directive[117] and to appoint another person—a medical treatment decision maker—to make medical treatment decisions on their behalf when they do not have decision-making capacity.[118] Medical treatment decision-makers must make decisions that they reasonably believe are in line with decisions the person would make themselves if they had capacity.[119] In order to do this, medical treatment decision-makers must follow a hierarchy of considerations, such as whether there is a valid and recent directive from the person and whether they have expressed any preferences.[120]

- The Guardianship and Administration Act provides:
  - that the will and preferences of a person with a disability should direct, as far as practicable, decisions made for that person[121]
  - that the will and preferences of a person subject to a guardianship or administration order should only be overridden if it is necessary to do so to prevent serious harm to that person[122]
  - explicit recognition of the *Convention on the Rights of Persons with Disabilities*, noting that the primary objective of the Act is to protect and promote the human rights and dignity of people with a disability, by having regard to the Convention.[123]

In contrast, the Mental Health Act enables a person to make a non-binding advance statement that sets out their treatment preferences,[124] and to nominate a person to provide support and assist with representing their interests.[125] Importantly, decision makers, including authorised psychiatrists and the Mental Health Tribunal, only need to 'have regard to' the advance statements and the views of the nominated person; they are not obligated to follow them.[126] This means that people can be compulsorily treated in direct contradiction with their expressed preferences.

Overall, recent legal reforms in Victoria in related sectors highlight that the current legislation does not represent the 'gold standard' in terms of promoting and protecting human rights, respecting dignity and autonomy, and enabling supported decision-making practices.

26.6 Unclear accountability structures

Existing challenges in the mental health system and legislation related to funding, stigma and discrimination have contributed to problems with oversight of the mental health system. These challenges include a lack of priority given to mental health in government decision making; limitations in system-wide improvement and identifying contemporary best practice across services; and a lack of planning across the system.[127]

While the Mental Health Act gives the responsibility for oversight of the mental health system to the Secretary, the full range of responsibilities and accountability mechanisms from the system to the service level is not clear under the Mental Health Act or other laws.

An example of this is the lack of structural clarity and accompanying accountability mechanisms regarding how the mental health principles are to be embedded in treatment, care and support. The Mental Health Act requires the Secretary to plan, develop, fund and provide mental health services that are consistent with, and promote, the mental health principles.[128] Similarly, mental health services must have regard to the principles in the provision of services.[129]

The Commission has been told there are pockets within the mental health system where mental health principles are being applied. The Mental Health Complaints Commissioner has made recommendations to mental health services that policies and procedures should be amended to make them compliant with the principles,[130] and the Mental Health Tribunal advised that the principles reflect community expectations and are an important point of reference in its work.[131]

Principles are also important at the point of service delivery. For example, Dr Ravi Bhat, Divisional Clinical Director of Goulburn Valley Area Mental Health Service at Goulburn Valley Health, said that one of his duties was to ensure the mental health principles were applied, both in practice and in spirit.[132]

However, as described earlier in this chapter, core concepts in the legislative objectives and mental health principles—such as supported decision making, recovery-oriented practice, and least restrictive treatment—are yet to be routinely embedded in treatment, care and support. Encapsulating this point, one consumer explained that 'I have never been supported to make decisions about my own mental health or treatment.'[133]

The Commission was told that one of the factors inhibiting realisation of the objectives and principles of the Mental Health Act is that there are few incentives or mechanisms in the Act or related implementation strategies, such as reporting requirements, to drive the cultural change among the workforce that are necessary to embed new approaches and ways of working.[134] In line with this, Professor Richard Newton, Clinical Director of Peninsula Mental Health Service, told the Commission that cultural change is needed to reduce compulsory treatment, and one way to achieve this is by delivering services that are more consumer-centred.[135] Bendigo Health submitted to the Commission that providing recovery-focused care requires time, skill and training.[136]

The crisis-driven and reactive nature of the mental health system is compounding these challenges, and contributes to a culture of 'risk management', rather than one that promotes consumer autonomy and choice.[137]

There is no public information about how service providers or other decision-makers act in accordance with the objectives or principles set out in the legislation.

Challenges with embedding mental health principles in treatment, care and support are not unique to Victoria. A recent review of the *Mental Health Act 2013* (Tas) identified accountability issues with how services apply the Act's mental health principles.[138] However, other jurisdictions and systems have accountability mechanisms that flow through to the service-delivery level.

An example of this can be seen in Western Australia. Legislation in that state provides that a person performing a function under the *Mental Health Act 2014* (WA) must have regard to the objectives of that Act,[139] and establishes a complaint process to deal with allegations of service providers' non-compliance with the principles.[140] Similarly, other legislative schemes in Victoria require decision makers to report on compliance with objectives or principles in legislation, such as the Carers Recognition Act,[141] or have action plans that describe how goals and objectives will be realised, such as the Disability Act.[142]

Gaps in accountability and the lack of transparent mechanisms to ensure implementation of the Mental Health Act's objectives and principles have contributed to the system's failure to routinely embed these aims in treatment, care and support. For consumers, this may mean they are often not supported to make decisions and access services in line with their own will, preferences and rights.[143]

Dr Christopher Maylea, Senior Lecturer in Social Work at RMIT University and the then Chair of the Committee of Management of the Victorian Mental Illness Awareness Council, giving evidence in a personal capacity and as a representative for the Victorian Mental Illness Awareness Council, asserted that systems and structures need to focus more on consumer experience.

> **Systems should be geared around choice, consumer control and human rights, most importantly systems that support consumers to make their own decisions and are incapable of restricting their autonomy.[144]**

26.7 A new Mental Health and Wellbeing Act

A consistent theme emerging from the Commission's work was that the Mental Health Act is not delivering what it was intended to deliver for people living with mental illness or psychological distress, families, carers and supporters, nor the mental health workforce.

People living with mental illness or psychological distress and their advocates told the Commission that the Mental Health Act:

- embeds a dominant biomedical model that does not consider the social factors that affect mental health and wellbeing[145]
- entrenches stigma and discrimination against people living with mental illness or psychological distress[146]
- does not reflect contemporary 'best practice' nor fully align with the *Convention on the Rights of Persons with Disabilities*[147]
- does not provide enough protection for people's rights.[148]

Similarly, families, carers and supporters have identified problems with how the Mental Health Act is being applied, including that they are regularly shut out of decision making and not provided with the information they need to perform their caring role.[149]

Meanwhile, mental health workers have told the Commission that several factors are impeding their ability to embed supported decision making and recovery-oriented practices. For example, the crisis-driven nature of the mental health system means that clinicians have little time to foster recovery-focused, therapeutic relationships with consumers; and the limited workforce training on the Mental Health Act can limit supported decision making and recovery-oriented practice frameworks.[150]

Fundamental change across many parts of the mental health system is needed to realise the Commission's aspirations for a redesigned system. To this end, a new Mental Health and Wellbeing Act is urgently needed. The new Act will support the new mental health and wellbeing system to be contemporary and adaptive with a focus on community-based mental health and wellbeing services. The new Act will also rebalance the legal framework and broaden the focus beyond compulsory treatment towards the attainment of good mental health and wellbeing.

26.7.1 A focus on good mental health and wellbeing

On its own, a new Mental Health and Wellbeing Act will not deliver accessible mental health and wellbeing services, provide high-quality treatment, care and support, nor properly equip the mental health workforce with the required skills. It will, however, form an important piece of architecture in Victoria's new mental health and wellbeing system that will support and enable people to attain good mental health and wellbeing. For the workforce, appropriate resourcing of the new Act during the implementation phase will mean that mental health workers have access to a range of supports that enable them to translate new laws into practice and have clarity about legislative roles and accountabilities under the Act. New legislation will contribute to removing some of the systemic factors that have historically constrained the mental health workforce.

A new Mental Health and Wellbeing Act with a broad focus on attaining good mental health and wellbeing among Victorians can help enable the Commission's aspirations for a mental health and wellbeing system that is equitable, responsive and adaptable[151] to be realised. Further, the Act can help enable good practice and new service models, encourage a human rights-based culture to flourish, and support efforts to reduce restrictive practices and compulsory treatment.[152]

The important role law can play was highlighted in a 2019 report by the Lancet Commission, which recognised that the law can be a 'powerful enabler' or a 'formidable barrier' to good health.[153] The report emphasised that while law 'is only a tool and its effectiveness depends on how this tool is used',[154] evidence-based laws have the potential to clarify and strengthen governance arrangements, promote equity and support legal interventions that have a positive impact on health.[155]

It has been highlighted to the Commission that the 'law can be a powerful tool for change'.[156] If properly implemented, the law can lead to new standards and ways of doing things that are in line with current values, human rights and the best available evidence. In the mental health and wellbeing system, it can help to improve the experience of people living with mental illness or psychological distress, families, carers and supporters, and the workforce. An evidence-based legal framework can shape the way mental health and wellbeing services are accessed and delivered.[157]

A new Mental Health and Wellbeing Act is needed to reset the legislative foundations underpinning the mental health and wellbeing system, reflect contemporary human rights practice and thinking. The new legislation will also put the views, preferences and values of people living with mental illness or psychological distress—as well as families, carers and supporters—that have been put to the Commission—at the forefront of mental health laws, and the policies, programs and services that flow from them. Moreover, a new Act will provide clarity to the workforce on their roles and responsibilities and how to embed supported decision making and recovery-oriented practice frameworks in treatment, care and support.

Accordingly, a new Mental Health and Wellbeing Act that has as its purpose 'to promote good mental health and wellbeing in Victoria' is needed.

26.7.2 A new primary objective to reflect the aspirations of the future mental health and wellbeing system

In Victoria, as in many other jurisdictions, mental health laws have focused primarily on compulsory treatment. Mental health laws, like many laws, age and become out of date as values, approaches and technology change. Mental health laws have moved over time from being based on a 'best interests' model,[158] where the focus was on whether a person was 'mentally ill and requires care or treatment',[159] to laws that include frameworks of supported decision making and recovery-oriented practice, in addition to human rights protections, while continuing to permit compulsory treatment.

The Commission has been encouraged to think differently about the role of legislation in the mental health and wellbeing system and what the aims of mental health legislation should be.[160]

Objectives generally set out the broad aims of an Act, illustrate how the purpose of an Act should be achieved, and are used as an aid for the courts and other decision makers to interpret the law and resolve any uncertainties in it.[161] Legislative objectives that go beyond the administration of compulsory assessment and treatment are needed, to support and align with the Commission's reform aspirations.

The Commission recommends the primary objective of the new Mental Health and Wellbeing Act is to achieve the highest attainable standard of mental health and wellbeing for the people of Victoria by:

- promoting conditions in which people can experience good mental health and wellbeing
- reducing inequities in access to, and the delivery of, mental health and wellbeing services
- providing a diverse range of comprehensive, safe and high-quality mental health services.

This primary objective echoes that of section 4 of the *Public Health and Wellbeing Act 2008* (Vic), aligns with the Convention on the Rights of Persons with Disabilities and with the Commission's aspirations for a future mental health and wellbeing system that is built on compassion and equity. Moreover, such an objective would give Victorians, including people living with mental illness or psychological distress, families, carers and supporters and the workforce, clarity about the vision and policy settings for the future mental health and wellbeing system.

The new Mental Health and Wellbeing Act should include a range of other aspirations in its objectives or principles. In preparing these, the Victorian Government and Parliamentary Counsel should look to the Charter of Human Rights and Responsibilities' Preamble, which espouses notions of dignity, equality and freedom,[162] and the Convention on the Rights of Persons with Disabilities, which embraces concepts of participation, independence, inclusion and services that are available, accessible and acceptable.[163]

The Commission emphasises that any additional objectives or mental health principles to be contained in the new Act should include concepts of autonomy, supported decision making, recovery-oriented practice, the protection and promotion of human rights, and the use of compulsory treatment as a last resort. These provisions should also seek to elevate the perspectives of people living with mental illness or psychological distress, families, carers and supporters.

The Commission has consulted extensively on these themes (refer to Box 26.1) and as such the Victorian Government and Parliamentary Counsel should draw on this report to craft the objectives rather than construct an extensive consultation process, noting the urgent need to progress this component of the reform agenda.

Box 26.1: Aspirations of the new Mental Health and Wellbeing Act

The Commission considers that the Mental Health and Wellbeing Act must include a primary objective to achieve the highest attainable standard of mental health and wellbeing for the people of Victoria by:

- promoting conditions in which people can experience good mental health and wellbeing
- reducing inequities in access to, and the delivery of, mental health and wellbeing services
- providing a diverse range of comprehensive, safe and high-quality mental health services.

In addition, proposed objectives or principles to be drafted should focus on:

- the full, effective and equal participation in society of people living with mental illness or experiencing psychological distress
- the protection and promotion of human rights of people who access mental health and wellbeing services
- supporting people living with mental illness or experiencing psychological distress to make decisions for themselves, and to lead and be involved in decisions that affect them
- the recognition and promotion of the value of the role of families, carers and supporters
- the promotion and enablement of supported decision making and recovery-oriented practice
- the provision of appropriate compulsory assessment and treatment only as a last resort.

26.7.3 Features of the new Mental Health and Wellbeing Act

The broken state of Victoria's mental health system and the need for new legislation to support the realisation of critical elements of the future system means that the Mental Health and Wellbeing Act should be introduced into Parliament as soon as possible, ideally by the end of 2021, and by no later than mid-2022. To achieve this, it is vital that work on recommended legislative reforms starts immediately.

Considerable consultation with people living with mental illness or psychological distress, families, carers and supporters, and the workforce has already been undertaken by the Commission. As much as possible, their views and perspectives have been built into the Commission's recommended approach. This means that drafting the new Act can progress at pace.

Legislative reforms will play an important role in establishing the legal foundations that underpin the new mental health and wellbeing system. The new Mental Health and Wellbeing Act is needed to provide clarity regarding the rights, roles and responsibilities of people and organisations who manage, and interact with, the mental health and wellbeing system, and to describe the legal relationships that exist within the system, including between consumers and service providers.

The new Mental Health and Wellbeing Act will replace the current Mental Health Act. The Mental Health Act should therefore be repealed upon enactment of the new Mental Health and Wellbeing Act. Careful consideration should be given as to which provisions from the Mental Health Act need to be carried across to the new Mental Health and Wellbeing Act, noting that the Commission considers that provisions relating to compulsory assessment and treatment should no longer be the defining feature of Victoria's mental health laws, and provisions that are brought across from the Mental Health Act should be simplified.

The Commission notes that while some provisions could start upon attaining Royal Assent, other amendments may need a longer lead-in time before starting. This would give the Victorian Government, the mental health workforce and service providers enough time to properly lay the groundwork for major change.

To put the necessary legal foundations in place that support the realisation of the Commission's aspirations for the future mental health and wellbeing system, the new Mental Health and Wellbeing Act would give effect to, among other things, the following essential changes referred to in Box 26.2.

Box 26.2: Components of the new Mental Health and Wellbeing Act

The new Mental Health and Wellbeing Act should include the following components:

- a purpose to promote good mental health and wellbeing in Victoria
- new objectives (with the primary objective and aspirations described in Box 26.1) and the requirement that the Department of Health and mental health and wellbeing services funded by the Victorian Government make decisions in line with the objectives
- new mental health principles that reflect the Commission's aspirations and ambition of the new Mental Health and Wellbeing Act, accompanied by compliance mechanisms
- the creation of the bodies and roles referred to in other recommendations, including the Mental Health and Wellbeing Commission, the Chief Officer for Mental Health and Wellbeing, and Regional Mental Health and Wellbeing Boards
- a reallocation of the role of the Mental Health Complaints Commissioner to the Mental Health and Wellbeing Commission, and renewal of its powers and functions, including changes to how complaints are made
- the powers and functions of the Department of Health in overseeing the new mental health and wellbeing system
- strong accountability and reporting arrangements for service providers regarding the delivery of the Commission's aspirations, including the core functions of community mental health and wellbeing services
- the creation of Regional Multiagency Panels to coordinate as needed the delivery of multiple mental health and wellbeing services for people, including children and young people, who are living with mental illness and require intensive treatment, care and support
- provision for the amendment of other Acts to facilitate the implementation of recommendations to support people living with mental illness who may be in contact with the justice system or at risk of contact with the justice system, for example the *Corrections Act 1986* (Vic) and the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic)
- effective and safe collection, use and sharing of information for the purposes of service provision, system administration, accountability, research, evaluation and enabling the other functions noted in this report
- measures to reduce rates and negative impacts of compulsory assessment and treatment, including to:
  - provide for non-legal advocacy for consumers who are placed on, or at risk of being placed on, compulsory treatment orders, if they wish
  - enable greater adoption of supported decision-making practices

- simplified provisions from the Mental Health Act regarding compulsory assessment and treatment, so this is no longer the defining feature of Victoria's mental health laws
- strong monitoring arrangements for restrictive practices and regulating chemical restraint, including by defining 'chemical restraint' and articulating the requirements regarding the use of chemical restraint.

26.7.4 New mental health principles that are embedded in practice

The Commission considered whether principles were needed in the new Mental Health and Wellbeing Act. Any concerns regarding the mental health principles under the Mental Health Act related to them not being routinely embedded in treatment, care and support—not because they are confusing, unclear or unnecessary. The Commission considers that mental health principles will be useful for decision-makers under the new Mental Health and Wellbeing Act and recommends that they be retained, with refinement, in the new Act.

In this context, 'decision-makers' include the Department of Health, the new Mental Health and Wellbeing Commission—a new independent statutory authority to provide strong system leadership and hold government to account—new Regional Mental Health and Wellbeing Boards to support a more responsive approach to the way mental health and wellbeing services are commissioned, the Mental Health Tribunal, and mental health and wellbeing service providers funded by the Victorian Government.

Principles are generally included in legislation to describe the values of the Act and, together with the objective, provide guidance to individuals, organisations and the public on how to interpret and apply the Act. Principles are common to many pieces of Victorian legislation, including laws that intersect with the Mental Health Act, such as the Carers Recognition Act,[164] the Guardianship and Administration Act,[165] and the Public Health and Wellbeing Act.[166]

The Commission has been told that the mental health principles set out in the Mental Health Act can play an important role in:

- providing guidance to people living with mental illness or psychological distress, families, carers and supporters, and mental health workers, on how to understand and apply the legislation, including on people's rights and responsibilities
- promoting consistency and accountability in decision making, particularly in contexts where someone's human rights are limited by compulsory assessment and treatment
- influencing the design and delivery of mental health and wellbeing services, policies and programs
- conveying community expectations about how mental health and wellbeing services should be accessed and delivered
- assisting in the resolution of complaints.[167]

In addition, principles can be used by the courts to help interpret legislation and decide how laws should be applied.[168] For example, in the 2018 Victorian Supreme Court case of *PBU & NJE v Mental Health Tribunal* [2018] VSC 564, the Honourable Justice Bell referred to both the objectives and principles of the Mental Health Act in his decision, in which he clarified how the electroconvulsive treatment provisions of the Act should be interpreted and applied.[169]

This decision resulted in the Mental Health Tribunal developing an electroconvulsive treatment guideline for processes and matters to be considered in tribunal hearings relating to compulsory treatment orders.[170] Victoria Legal Aid submitted that this has led to practice improvements, including in the work of mental health services, the Mental Health Tribunal and the Office of the Chief Psychiatrist.[171]

New mental health principles will set out the rights that people living with mental illness or psychological distress, families, carers and supporters hold under the new Mental Health and Wellbeing Act and provide guidance to decision-makers and service providers on how treatment, care and support should be delivered. The principles will complement the objectives of the new Mental Health and Wellbeing Act, which in turn will illuminate how promoting good mental health and wellbeing is to be achieved.

The development of a new Mental Health and Wellbeing Act presents an ideal opportunity to redraft the existing mental health principles to enable the Commission's reform aspirations to be met; to appropriately protect and promote human rights; to ensure that the mental health principles are fit for purpose for a contemporary mental health and wellbeing system; and to reflect the values of a compassionate society.

The Commission considers that while the new mental health principles should be set out at the front of the new Act, specific principles and accountability mechanisms may also be needed for different parts of the new Act, for example, compulsory assessment and treatment.

Together, the objectives and principles in the new Mental Health and Wellbeing Act will reflect the views, preferences and values of people living with mental illness or psychological distress, families, carers and supporters; set the minimum standards to be met in the access to, and delivery of, mental health and wellbeing services; and realise the Commission's aspirations for a future mental health and wellbeing system that is accessible, equitable and offers a diverse range of high-quality mental health and wellbeing services.

As described by Justice Bell in *PBU & NJE*:

> the objectives and principles [of the *Mental Health Act 2014* (Vic)] are intended to alter the balance of power between medical authority and persons having mental illness in the direction of respecting their inherent dignity and human rights.[172]

As described earlier, although it is a requirement for mental health service providers and other decision makers to have regard to the mental health principles in their work, the principles are not widely embedded in treatment, care and support at present.[173]

Strong, clear and transparent mechanisms are needed to embed mental health principles in treatment, care and support, as well as the policies, procedures and decision-making processes that sit behind them.[174]

To this end, the Commission considers that the new Mental Health and Wellbeing Act should provide that:

- the current compliance level of 'must have regard to' the mental health principles be strengthened. The new compliance level will provide that service providers and decision makers 'must make all reasonable efforts to comply with' the principles. This extends the level of compliance from considering the principles to taking positive steps to uphold the principles in providing treatment, care and support, and is more in line with other pieces of legislation, such as the Charter of Human Rights and Responsibilities, which requires decision makers to only limit human rights when this can be justified as being reasonably necessary[175]
- mental health and wellbeing services be required to report publicly, through their annual reporting, on how they are embedding the mental health principles in their work
- formal complaints can be made when it is believed a service provider or decision maker has not made every reasonable effort to comply with a principle
- the new Mental Health and Wellbeing Commission, as the body responding to complaints in the new system, will receive, investigate, respond to and mediate complaints and conduct system-wide inquiries into matters relating to its objectives. Complaints can also be made, for example, about non-compliance with other parts of the new Act or about an unsatisfactory experience with mental health and wellbeing services.

Guidance should be provided by the Department of Health to service providers and decision makers on how to comply with and embed the mental health principles; for example, on how to apply supported decision-making principles and recovery-oriented practice in the delivery of treatment, care and support.

A relevant framework to draw on is the Charter of Human Rights and Responsibilities, which requires that the following steps be taken by public authorities when making decisions or taking actions:

- identify human rights that are relevant to the act or decision at hand
- if there are rights relevant to the act or decision at hand, consider whether they are being limited by the proposed action or decision
- consider the possible impact of a decision on a person's rights
- assess whether any limitations on rights are reasonable, justified and proportionate (in making this assessment, a range of factors may be considered or balanced against one another; for example, whether there are competing rights and interests, public interest considerations, or less restrictive approaches that could be used to achieve the sought objective).[176]

Ensuring that these changes are implemented in practices, culture and approaches to treatment, care and support will require significant support for the mental health workforce.

The Commission has made several recommendations relating to a mental health workforce for the future to ensure this support is available. This includes the recommendations for the Victorian Government to develop a Victorian Mental Health Workforce Capability Framework and approaches that ensure the workforce's access to professional development tools and resources. Priority areas for workforce capability development will include understanding mental health legislation, information about human rights, and how to routinely apply core supported decision-making principles in treatment, care and support.

It is important that training and education is provided to the mental health workforce on an ongoing basis to manage changes in the workforce; reinforce learning and understanding of the new Act; and to enable workers to be updated on legislative amendments or practice changes.[177]

Similar to the ways in which the Charter of Human Rights and Responsibilities considerations are built into policies and services, it is expected that service providers and decision makers will consider how the mental health principles are built into policies, procedures and service delivery. For the mental health principles to become embedded in service delivery, it is essential that service providers and decision makers are properly resourced to give effect to these requirements.

26.7.5 Clear accountability structures that flow through the mental health and wellbeing system

As described earlier, a lack of clarity about how the objectives and mental health principles are to be applied in practice, along with unclear accountability structures to support this, are factors preventing the full development of a human-centred and rights-focused culture in the mental health system.[178]

The Commission was told there is a gap between law and practice. Therefore, a suite of strong, transparent accountability mechanisms is needed to build the levels of trust held by people living with mental illness or psychological distress, families, carers and supporters in the commitment of mental health and wellbeing services to make decisions, and deliver treatment, care and support that promotes the objectives and principles contained in legislation.[179]

First, the new Mental Health and Wellbeing Act should require decision-makers to operate in line with the Act's primary objective and any other objectives that are included in the legislation.

Second, to strengthen accountability and improve the transparency of decision making, two extra duties for the Department of Health, the Mental Health and Wellbeing Commission, Regional Mental Health and Wellbeing Boards, the Mental Health Tribunal, and mental health and wellbeing service providers funded by the Victorian Government should be included in the new Mental Health and Wellbeing Act.

Linking closely to the purpose and objective(s) of the new Act, the duties should:

- ensure that decisions are transparent, systematic and appropriate
- consider and promote good mental health and wellbeing when developing policies and programs, and when delivering services.

Public reporting requirements will mean that people are able to access information in appropriate forms to understand the reasons for, and processes behind, policy and program decisions about mental health and how service providers and decision makers have acquitted their duty to ensure that decisions are transparent, systematic and appropriate.

A focus on promoting good mental health and wellbeing across all levels of the mental health and wellbeing system—from system oversight right through to the point of service delivery—will mean that this aim is incorporated into a wider spectrum of policies, decisions, procedures and service delivery. Importantly, this will also contribute to improved outcomes and experiences for people living with mental illness or psychological distress, families, carers and supporters. For the workforce, clearer accountability structures that flow through the mental health and wellbeing system will foster a culture that promotes and embeds human rights and key concepts such as supported decision making and recovery-oriented practice within service delivery.

Moreover, imposing such a duty on the Department of Health, the Mental Health and Wellbeing Commission, Regional Mental Health and Wellbeing Boards, the Mental Health Tribunal and mental health and wellbeing service providers funded by the Victorian Government will contribute to a shift in approach—from one currently focused on delivering 'outputs', such as processes and program expenditure,[180] to one of delivering good 'outcomes' for people living with mental illness or psychological distress, families, carers and supporters, such as ensuring they have access to the right services at the right time.

Including these duties in legislation will bring accountability requirements in line with the duties set out in other comparable Victorian laws, such as the Public Health and Wellbeing Act 2008[181] and the *Gender Equality Act 2020* (Vic).[182]

To support decision makers in fulfilling these duties, it is essential that the Victorian Government appropriately resource the mental health and wellbeing system and service providers. Further accountability mechanisms will be built into the future mental health and wellbeing system, including through requiring the Department of Health, the Mental Health and Wellbeing Commission, Regional Mental Health and Wellbeing Boards, the Mental Health Tribunal and mental health and wellbeing service providers funded by the Victorian Government to publicly report on compliance with the additional duties through their annual reports to Parliament. The Commission notes that private providers or non-government organisations would report to the Department of Health as part of their funding contracts.

Another mechanism to strengthen accountability and compliance with the mental health principles is through the use of the Commission's proposed service standards for selecting providers, described in Chapter 28: *Commissioning for responsive services*. As part of this process, providers will be encouraged to demonstrate compliance with the provisions of the new Act, and, where they are unable, will be provided support to do so. The Mental Health and Wellbeing Commission will also be empowered to monitor and investigate complaints related to the duties and principles, and to take action to improve compliance.

In addition, the new Mental Health and Wellbeing Commission will, as described in Chapter 27: *Effective leadership and accountability for the mental health and wellbeing system—new system-level governance,* have functions to monitor the performance of mental health and wellbeing services in the delivery of treatment, care and support; receive, respond to, and investigate, complaints about mental health and wellbeing services; and conduct systemic inquiries into matters relating to the delivery of high-quality and safe services. The Mental Health and Wellbeing Commission will be able to consider and apply the mental health principles in its work.

The new Mental Health Improvement Unit in Safer Care Victoria will also play a role in enhancing the quality of treatment, care and support, and promoting the mental health principles, as outlined in Chapter 30: *Overseeing the safety and quality of services*. The unit will bring contemporary quality improvement approaches to mental health and support services, through advice, tools and resources, and communities of practice.

It is not proposed that the inclusion of the new duties in the Mental Health and Wellbeing Act will give rise to legal rights above those that are currently available through legislation or common law, for example, through claims of medical negligence.

Strengthening and clarifying the accountability of decision-makers across different levels of Victoria's mental health and wellbeing system by ensuring that funding and planning decisions, and a service delivery focus on promoting the good mental health and wellbeing of all Victorians, will support the realisation of the Commission's aspirations.

26.8 Implementing the new Mental Health and Wellbeing Act

It is essential that crucial features of the new Mental Health and Wellbeing Act are broadly supported and well understood by people living with mental illness or psychological distress, families, carers and supporters, as well as the workforce and the broader public. To achieve this, the views and perspectives of those who are affected by the legislation must be considered throughout the development and implementation of the new Act.[183]

The effectiveness of the legal reforms will depend on how well the new laws are implemented and applied in practice. As described earlier, one of the main reasons why the aspirations behind the current Mental Health Act have not been realised and why a human rights culture has failed to develop, is poor implementation of the reforms.

Implementation is an important part of the legislative process and will be the subject of continued consideration and assessment. Some of the contributing factors to effective implementation include:

- identifying who has responsibility for implementing legal and policy changes
- assessing whether the people with responsibility for implementing legal and policy changes understand what the changes are, and if they have the skills and resources needed to translate changes into practice
- setting implementation milestones, including to ensure there is enough lead-in time to lay the ground work for change, and processes for monitoring and reviewing progress
- identifying implementation risks and developing strategies to lessen risks and manage change
- ensuring the workforce is of the necessary size and has the requisite skills to comply with the new Act
- engaging people or groups that need to be involved in, or aware of, new laws and policies.[184]

The Honourable Professor Kevin Bell AM QC, Director of the Castan Centre for Human Rights Law at Monash University and former Justice of the Supreme Court, gave evidence in a personal capacity and communicated some of the lessons to be learned from the implementation of the Mental Health Act.

> **Back then, the legislative changes were very positive. But they were helicoptered into a system that was organised along legacy lines [existing structures] and did not receive operational reform and upscaled funding to match the legislative expectations. The message to be learnt is that you can have legislative reform, you can have operational reform (including major cultural change) … and you can have upscaled funding. However, to have system reform you need to have all three of these together …**[185]

Lessons from the implementation of the Mental Health Act highlight that, as well as having the right legal frameworks in place, it is equally important that adequate resources and supports come with reforms, such as ongoing education and training programs, to boost workforce capability and ensure that the intent of the reforms is well understood. Acknowledging the significance of the human rights issues that flow from mental health legislation and to manage natural workforce turnover, it is essential that training and education is provided on an ongoing basis.

26.9 Future review of mental health legislation

Given the considerable impact that mental health legislation may have on human rights, autonomy and dignity, it is important that such legislation is regularly reviewed to assess whether it is working as intended. Victoria's mental health legislation has generally been strengthened, reviewed and updated every 20–25 years between 1867 and 2014.[186] The Commission considers that this period is too long and that there should be frequent reviews of mental health legislation.

The Victorian Government acknowledged the importance of reviewing mental health legislation. It noted that:

> Future review will explore how the Act can be strengthened, drawing on innovations in mental health law in national and international jurisdictions, changes in the local legislative environment, and developments in clinical practice, quality and safety.[187]

Similarly, in her second reading speech, the then Minister for Mental Health foreshadowed that a review of the current Mental Health Act should be undertaken five years after commencement.[188]

The Commission believes that the Victorian Government should commission an independent review of mental health legislation and report back to the Minister within five to seven years of the new Mental Health and Wellbeing Act being enacted. This will enable the review to be carried out with objectivity. The independent review should be empowered to gather the necessary experience and expertise and implement processes to support public consultations, including with diverse communities.

As described by Professor Rees:

> Mental health legislation is one of the areas where it is helpful to float ideas, let people respond to them, and then try to come up with something that is both broadly acceptable and workable.[189]

Consumer leadership in the future review of mental health legislation will also bring benefits to the process and outcomes of the review, including through the sharing of first-hand knowledge and expertise about the needs and preferences of consumers, and insights about any gaps in legislation and opportunities for legal reform.[190]

As one person told the Commission:

> People with a lived experience bring a particular perspective and set of expertise that is essential in being able to better understand how to establish services that will better meet the needs of service users.[191]

It is essential that the future review of mental health laws creates the space for people to share their stories, and have their experiences heard and acknowledged. This will be an important part of the evidence-gathering phase, creating a shared understanding of the impact of the legislation on the outcomes and experiences of consumers, and identifying opportunities for improvement.

The Commission also recommends that the terms of reference of the future review are co-designed with consumers, families, carers and supporters, as well as the workforce and service providers. The terms of reference should focus on ensuring that mental health legislation remains contemporary, effective and responsive to the needs and preferences of consumers, families, carers and supporters. Among other things, the future review should consider the roles of the Mental Health Tribunal and Chief Psychiatrist, and whether their roles remain appropriate in the context of an evolving mental health and wellbeing system.

The need for a collaborative process was supported by Dr Piers Gooding, Research Fellow at the Melbourne Social Equity Institute and the University of Melbourne Law School, who gave evidence in a personal capacity. He argued that:

> a robust regulatory framework will only emerge when service users, patients, persons with disabilities, clinicians, and providers collaborate to design a forward thinking, future proof, and credible regulatory framework that can be trusted by all parties.[192]

The future review of mental health legislation is an important part of law reform and enables the reviewer(s) to carefully consider the impacts of the new Act on the mental health and wellbeing system.

26.10 An opportunity to reset and rebalance

While it is not possible for Victoria to 'legislate' its way out of a broken mental health system, and it is clear that new laws will not cure all existing system-wide and structural problems, a new Mental Health and Wellbeing Act does present a real opportunity to reset and rebalance Victoria's legislative framework.

The new Act will establish an important part of the system's architecture and it is therefore vital that legislative provisions support the Commission's aspirations for a mental health and wellbeing system that is accessible; provides for a diverse range of high-quality services; reflects the views, preferences and values of people living with mental illness or psychological distress, families, carers and supporters; and promotes and protects human rights.

With a broad focus on good mental health and wellbeing, the new Mental Health and Wellbeing Act will be relevant to all Victorians, for as the Commission's interim report noted, '[m]ental illness has an impact on every Victorian in some way, directly or indirectly.'[193] The Act will communicate an ambitious but achievable new primary objective; provide clarity over roles and responsibilities within the mental health and wellbeing system; strengthen accountability mechanisms; and promote and protect human rights. Perhaps most importantly, the new Act will be responsive to the views, values and perspectives of the public, including those of the people living with mental illness or psychological distress, families, carers and supporters, that have been put to the Commission.

Lessons learned from the implementation of the current Mental Health Act indicate the importance of properly laying the groundwork for change. Ensuring that people living with mental illness or psychological distress, families, carers and supporters, as well as the workforce and the broader public, accept, understand and apply the new Act, will be crucial if the intentions behind the new Mental Health and Wellbeing Act are to be fully realised. To achieve the necessary cultural and behavioural change, the reforms must be resourced appropriately, supported by leaders in the system and championed by mental health workers on the ground.

1 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 92; *Rethinking Rights-Based Mental Health Laws*, ed. by Bernadette McSherry and Penelope Weller (Oxford and Portland, Oregon: Hart Publishing, 2010), p. 10; *Witness Statement of Kym Peake*, 4 October 2020, para. 18.

2 Genevra Richardson, 'Balancing Autonomy and Risk: A Failure of Nerve in England and Wales?', *International Journal of Law and Psychiatry*, 30.1 (2007), 71–80 (p. 71).

3 Richardson, p. 71; *Witness Statement of Professor Neil Rees*, 15 June 2020, para. 25; McSherry and Weller, p. 266; *Witness Statement of Associate Professor Ruth Vine*, 29 April 2020, para. 7.

4 McSherry and Weller, p. 259.

5 *Witness Statement of Dan Nicholson*, 22 May 2020, para. 103; *Witness Statement of Professor Suresh Sundram*, 19 May 2020, para. 139; Victorian Mental Illness Awareness Council, *Submission to the RCVMHS: SUB.0002.0028.0645*, 2019, p. 9.

6 *Witness Statement of Erica Williams*, 1 July 2019, paras. 37–39; Victorian Mental Illness Awareness Council, *Submission to the RCVMHS: SUB.0002.0028.0645*, p. 4; S P Sashidharan and Benedetto Saraceno, 'Is Psychiatry Becoming More Coercive?', *BMJ*, 2017, pp. 1–2.

7 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 585.

8 *Witness Statement of Indigo Daya*, 12 May 2020, para. 42(f).

9 *Witness Statement of 'Elizabeth Porter' (pseudonym)*, 27 April 2020, para. 30.

10 Mental Health Complaints Commissioner, *Submission to the RCVMHS: SUB.4000.0001.0179*, 2019, p. 16; RCVMHS, *Bendigo Community Consultation—May 2019*; South West Healthcare, *Submission to the RCVMHS: SUB.0002.0029.0138*, 2019, pp. 37–39.

11 Tandem, *Submission to the RCVMHS: SUB.0002.0030.0088*, 2019, p. 9.

12 *Witness Statement of Dr Vinay Lakra*, 22 June 2020, para. 60; *Witness Statement of Dr Paul Denborough*, 11 May 2020, paras. 100–101; RCVMHS, *Doctors Roundtable: Record of Proceedings*, 2019; Northern Health, *Submission to the RCVMHS: SUB.0002.0028.0511*, 2019, p. 19.

13 RCVMHS, *Compulsory Treatment Roundtable: Record of Proceedings*, 2020.

14 *Witness Statement of Professor Lisa Brophy*, 29 April 2020, para. 25; *Witness Statement of Cath Roper*, 2 June 2020, para. 69; *Witness Statement of Dr Neil Coventry*, 29 July 2020, para. 448.

15 General Assembly, United Nations, *International Covenant on Economic, Social and Cultural Rights, Entry into Force: 3 January 1976, in Accordance with Article 27*, 16 December 1966; United Nations, *Convention on the Rights of Persons with Disabilities*, 6 December 2006; General Assembly, United Nations, *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Entry Into Force: 26 June 1987, in Accordance with Article 27(1)*, 10 December 1984; General Assembly of the United Nations, *Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 2002.

16 General Assembly, United Nations, *International Covenant on Economic, Social and Cultural Rights, Entry into Force: 3 January 1976, in Accordance with Article 27A,* Article 12(1).

17 United Nations, *Convention on the Rights of Persons with Disabilities*, Article 25.

18 United Nations, *Convention on the Rights of Persons with Disabilities*, Article 1.

19 General Assembly of the United Nations, Article 1.

20 *Witness Statement of Kristen Hilton*, 15 July 2020, para. 38; Castan Centre for Human Rights Law, *Submission to the RCVMHS: SUB.1000.0001.2641*, 2019, pp. 5–6.

21 *Mental Health Act 2014* (Vic), sec. 1(a).

22 *Mental Health Act 2014* (Vic), sec. 5.

23 *Witness Statement of Kym Peake*, 24 July 2019, paras. 45–47; *Witness Statement of the Honourable Professor Kevin Bell AM QC*, 26 August 2020, para. 28; Victorian Mental Health Tribunal, *Submission to the RCVMHS: SUB.1000.0001.0979*, 2019, p. 6.

24 Parliament of Victoria, Mental Health Bill 2014, Legislative Assembly Second Reading Speech, 20 February 2014, <hansard.parliament.vic.gov.au/?IW_DATABASE=*&IW_FIELD_TEXT=HOUSENAME%20CONTAINS%20(ASSEMBLY)%20AND%20SPEECHID%20CONTAINS%20(50355)%20AND%20SITTINGDATE%20CONTAINS%20(20%20February%202014)&Title=MENTAL%20HEALTH%20BILL%202014&IW_SORT=n:OrderId&LDMS=Y>, [accessed 5 March 2020].

25 Parliament of Victoria, Mental Health Bill 2014, Legislative Assembly Second Reading Speech.

26 *Witness Statement of Matthew Carroll*, 27 April 2020, para. 29(c); Parliament of Victoria, Mental Health Bill 2014, Legislative Assembly Second Reading Speech.

27 *Mental Health Act 2014* (Vic), sec. 11(1)(a).

28 *Mental Health Act 2014* (Vic), sec. 11(1)(k).

29 *Mental Health Act 2014* (Vic), secs. 117(a)–117(c).

30 *Mental Health Act 2014* (Vic), sec. 120.

31 *Mental Health Act 2014* (Vic), sec. 19.

32 *Mental Health Act 2014* (Vic), sec. 3.

33 *Mental Health Act 2014* (Vic), secs. 46(2)(a)(ii) and 48(2)(b).

34 *Mental Health Act 2014* (Vic), sec. 73(1)(a).

35 *Mental Health Act 2014* (Vic), sec. 23.

36 *Mental Health Act 2014* (Vic), sec. 46(2)(a)(iii).

37 *Mental Health Act 2014* (Vic), sec. 78.

38 *Mental Health Act 2014* (Vic), sec. 79(1).

39 *Mental Health Act 2014* (Vic), secs. 120 and 228; *Witness Statement of Dr Neil Coventry*, 28 June 2019, para. 22.

40 *Mental Health Act 2014* (Vic), secs. 328 and 329.

41 Forensicare, *Submission to the RCVMHS: SUB.0002.0030.0126*, 2019, p. 3.

42 *Health Services Act 1988* (Vic), sec. 1.

43 *Health Services Act 1988* (Vic), sec. 11A.

44 Department of Health and Community Services, *Victoria's Mental Health Service: The Framework for Service Delivery*, 1994, p. 6.

45 *Charter of Human Rights and Responsibilities Act 2006* (Vic), sec. 1(2).

46 *Charter of Human Rights and Responsibilities Act 2006* (Vic), secs. 8–9, 10(b)–10(c), 13 and 21– 22.

47 *Equal Opportunity Act 2010* (Vic), sec. 3.

48 *Disability Act 2006* (Vic), sec. 4.

49 *Disability Act 2006* (Vic), sec. 3.

50 *Carers Recognition Act 2012* (Vic), sec. 1.

51 *Guardianship and Administration Act 2019* (Vic), sec. 7.

52 *Guardianship and Administration Act 2019* (Vic), sec. 38(1).

53 *Guardianship and Administration Act 2019* (Vic), sec. 46(1).

54 *Guardianship and Administration Act 2019* (Vic), sec. 30(1)(a).

55 Parliament of Victoria, *Parliamentary Debates (Hansard). Legislative Assembly Fifty-Eighth Parliament, First Session (14 September 2016, Extract from Book 12)*, 2016, p. 3495.

56 *Public Health and Wellbeing Act 2008* (Vic), sec. 1.

57 *Public Health and Wellbeing Act 2008* (Vic), sec. 4(2).

58 *Health Records Act 2001* (Vic), sec. 1.

59 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic), sec. 1.

60 *Privacy and Data Protection Act 2014* (Vic), sec. 1.

61 *Drugs, Poisons and Controlled Substances Act 1981* (Vic).

62 *Witness Statement of Mary O'Hagan*, 16 June 2020, para. 56; United Nations, Human Rights Council, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, 2017, para. 12; Kay Wilson, 'The Call for the Abolition of Mental Health Law: The Challenges of Suicide, Accidental Death and the Equal Enjoyment of the Right to Life', *Human Rights Law Review*, 18.4 (2018), 651–688 (p. 651).

63 Witness Statement of Professor Neil Rees, para. 37.

64 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. 6; *Witness Statement of Professor Lisa Brophy*, para. 17; *Witness Statement of Indigo Daya*, para. 41.

65 *Witness Statement of Erandathie Jayakody*, 4 June 2020, para. 144.

66 *Personal Story of Susan Mahomet, Collected by Victoria Legal Aid*, 2020.

67 United Nations, Human Rights Council, p. 5.

68 *Witness Statement of Professor Penelope Weller*, 27 August 2020, para. 66; McSherry and Weller, p. 57; George Szmukler, 'Compulsion and "Coercion" in Mental Health Care', *World Psychiatry*, 14.3 (2015), 259–261 (p. 259).

69 *Witness Statement of Mary O'Hagan*, para. 56.

70 *Witness Statement of Professor Penelope Weller*, para. 65; *Witness Statement of Professor Lisa Brophy*, para. 67; Office of the Public Advocate, *Submission to the RCVMHS: SUB.0002.0029.0448 (Submission 1)*, 2019, pp. 11–12.

71 *Witness Statement of Louise Glanville*, 8 July 2019, para. 59(a); Victorian Mental Health Tribunal, pp. 4–5; The Centre for Psychiatric Nursing, *Submission to the RCVMHS: SUB.0002.0028.0284*, 2019, p. 2.

72 United Nations, *Convention on the Rights of Persons with Disabilities: General Comment No.1 (2014), Eleventh Session*, 19 May 2014, p. 6; M. B. Simmons and P. M. Gooding, 'Spot the Difference: Shared Decision-Making and

Supported Decision-Making in Mental Health', *Irish Journal of Psychological Medicine*, 34.4 (2017), 1–12 (p. 4); *Witness Statement of Professor Penelope Weller*, para. 28.

73 General Assembly, United Nations, *Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary-General, Human Rights Council, Tenth Session, Agenda Item 2*, 26 January 2009, p. 15.

74 Simmons and Gooding, p. 2.

75 *Witness Statement of 'Lucy Barker' (pseudonym)*, 29 June 2020, para. 67; *Witness Statement of Julie Anderson*, 28 May 2020, para. 52; Mental Health Legal Centre, *Submission to the RCVMHS: SUB.0002.0032.0106 (Submission 1)*, 2019, p. 11.

76 Simmons and Gooding, pp. 4–5; United Nations, Human Rights Council, p. 15; The Royal Australian and New Zealand College of Psychiatrists, *RANZCP Victorian Branch Position Paper: Enabling Supported Decision-Making*, 2018, p. 3.

77 Simmons and Gooding, p. 2; The Royal Australian and New Zealand College of Psychiatrists, p. 3.

78 Mental Health Complaints Commissioner, *Submission to the RCVMHS: SUB.4000.0001.0179*, p. 41; Simmons and Gooding, p. 7; The Royal Australian and New Zealand College of Psychiatrists, p. 3.

79 Anonymous 236, *Submission to the RCVMHS: SUB.0002.0021.0007*, 2019, p. 2.

80 *Witness Statement of Indigo Daya*, paras. 32–33; Scottish Recovery Network, Mary O'Hagan—Legal Coercion: The Elephant in the Recovery Room, <www.scottishrecovery.net/resource/legal-coercion-the-elephant-in-the-recovery-room/>, [accessed 28 January 2020].

81 *Witness Statement of Dr Sarah Pollock*, 14 May 2020, para. 71.

82 *Witness Statement of Julie Anderson*, para. 15.

83 Department of Health, Victoria, *Framework for Recovery-Oriented Practice*, 2011, p. 2.

84 *Witness Statement of Julie Dempsey*, 23 July 2019, para. 36; Victoria Legal Aid, *Correspondence to the RCVMHS: CSP.0001.0001.0151, Paving the Roads to Recovery: Building a Better System for People Experiencing Mental Health Issues in Victoria*, May 2020, p. 14.

85 *Witness Statement of 'Rachel Bateman' (pseudonym)*, 16 June 2020, paras. 118–119.

86 *Witness Statement of Cath Roper*, para. 80.

87 Brendan Gillespie, *Submission to the RCVMHS: SUB.0002.0028.0521*, 2019, p. 5; *Witness Statement of Dr Melissa Petrakis*, 11 May 2020, para. 17; RCVMHS, *Warragul Community Consultation—May 2019*.

88 *Joint Witness Statement of 'Mary Corbett' and 'Jacob Corbett' (pseudonyms)*, 25 June 2020, para. 33.

89 *Witness Statement of Dr Lynne Coulson Barr OAM*, 4 June 2020, para. 35.

90 *Witness Statement of Matthew Carroll*, para. 14; *Witness Statement of Terry Symonds*, 2 November 2020, para. 201; Austin Health, *Submission to the RCVMHS: SUB.0003.0001.0001*, 2019, p. 3.

91 *Witness Statement of Dr Neil Coventry*, 2020, paras. 72–73.

92 *Witness Statement of Professor Penelope Weller*, para. 56; *Witness Statement of Dr Christopher Maylea*, 30 April 2020, para. 22; Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, 2019, p. 13.

93 *Witness Statement of Professor Lisa Brophy*, para. 47; *Witness Statement of Professor Penelope Weller*, para. 56; Victorian Mental Illness Awareness Council, *Submission to the RCVMHS: SUB.0002.0028.0645*, p. 9.

94 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 174; *Witness Statement of Dr Neil Coventry*, 2020, para. 413; Dr Anna Arstein-Kerslake, *Submission to the RCVMHS: SUB.0002.0017.0022*, 2019, p. 13.

95 *Witness Statement of 'Lucy Barker' (pseudonym)*, para. 85.

96 Anonymous, *Brief Comments to the RCVMHS: SUB.0001.0025.0005*, 2019, p. 5.

97 *Witness Statement of 'Anna Wilson' (pseudonym)*, 3 August 2020, paras. 9, 11 and 13.

98 *Witness Statement of Matthew Carroll*, para. 15; *Witness Statement of Dr Christopher Ryan*, 21 May 2020, paras. 26–27; Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, p. 20.

99 *Witness Statement of Emeritus Professor Terry Carney AO*, 17 July 2020, para. 32; Department of Health and Human Services, *Victoria's Mental Health Services Annual Report 2018–19*, 2019, p. 87; *Witness Statement of Associate Professor Ruth Vine*, 2020, para. 37.

100 *Witness Statement of Dr Christopher Maylea*, para. 80; Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, pp. 14–16; Mental Health Legal Centre, p. 34.

101 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 207; Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, p. 8.

102 *Witness Statement of Matthew Carroll*, para. 25.

103 Parliament of Victoria, *The Mental Health Act Statement of Compatibility*, 2014.

104 *Witness Statement of Dr Neil Coventry*, 2020, para. 403; *Witness Statement of Associate Professor Ruth Vine*, 2020, para. 30; *Witness Statement of Dr Christopher Ryan*, para. 34.

105 *Witness Statement of Cath Roper*, para. 69; Scottish Recovery Network; Tina Minkowitz, 'Why Mental Health Laws Contravene the CRPD—An Application of Article 14 with Implications for the Obligations of States Parties', *SSRN Electronic Journal*, (2011), 1–9 (p. 2); Wilson, p. 657.

106 United Nations, *Convention on the Rights of Persons with Disabilities*, Article 25(d).

107 United Nations, *Convention on the Rights of Persons with Disabilities: General Comment No.1 (2014), Eleventh Session*, p. 6.

108 United Nations Treaty Collection, Chapter IV: Human Rights. 15. Convention on the Rights of Persons with Disabilities, New York, 13 December 2006, <treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4>, [accessed 5 May 2020]; Bernadette McSherry, 'Mental Health Laws: where to from here?, *Monash University Law Review,* 40.1 (2014), 175–197 (p. 180).

109 United Nations Treaty Collection.

110 Neeraj S Gill, 'Human Rights Framework: An Ethical Imperative for Psychiatry', *Australian and New Zealand Journal of Psychiatry*, 53.1 (2019), 8–10 (p. 9); George Szmukler, 'Involuntary Detention and Treatment: Are We Edging Toward a "Paradigm Shift"?', *Schizophrenia Bulletin*, 46.2 (2020), 231–235 (p. 233); Sascha Mira Callaghan and Christopher Ryan, 'Is There a Future for Involuntary Treatment in Rights-Based Mental Health Law?', *Psychiatry, Psychology and Law*, 21.5 (2014), 747–766 (p. 747); Wilson, p. 686.

111 Callaghan and Ryan, p. 747; Szmukler, 'Compulsion and "Coercion" in Mental Health Care', p. 260; Bernadette McSherry and Kay Wilson, 'The concept of capacity in Australian mental health law reform: Going in to wrong direction?', *International Journal of Law and Psychiatry, 40* (2015), 60–70, (p. 61).

112 John Dawson, 'A Realistic Approach to Assessing Mental Health Laws' Compliance with the UNCRPD', *International Journal of Law and Psychiatry*, 40 (2015), 70–79 (p. 70); Callaghan and Ryan, p. 748; Szmukler, 'Compulsion and "Coercion" in Mental Health Care', p. 260.

113 *Witness Statement of Professor Neil Rees*, paras. 33–34; Victoria Legal Aid, *Correspondence to the RCVMHS: CSP.0001.0001.0151, Paving the Roads to Recovery: Building a Better System for People Experiencing Mental Health Issues in Victoria*, p. 22; *Witness Statement of Professor Penelope Weller*, para. 60.

114 *Witness Statement of Julie Anderson*, para. 50; *Witness Statement of Erandathie Jayakody*, paras. 113–115; Mental Health Legal Centre, p. 4.

115 Victorian Mental Illness Awareness Council, *Submission to the RCVMHS: SUB.0002.0028.0645*, p. 9.

116 *Witness Statement of Professor Penelope Weller*, para. 40.

117 *Medical Treatment Planning Decisions Act 2016* (Vic), sec. 12(1).

118 *Medical Treatment Planning Decisions Act 2016* (Vic), secs. 1(a) and 1(b).

119 *Medical Treatment Planning Decisions Act 2016* (Vic), sec. 61(1).

120 *Medical Treatment Planning Decisions Act 2016* (Vic), sec. 61(2).

121 *Guardianship and Administration Act 2019* (Vic), sec. 8(1)(b).

122 *Guardianship and Administration Act 2019* (Vic), sec. 9(1)(e).

123 *Guardianship and Administration Act 2019* (Vic), sec. 7.

124 *Mental Health Act 2014* (Vic), sec. 19.

125 *Mental Health Act 2014* (Vic), sec. 23.

126 *Mental Health Act 2014* (Vic), secs. 46 and 55.

127 *Witness Statement of The Hon. Robert Knowles AO*, 16 July 2019, para. 18; *Witness Statement of Andrew Greaves*, 19 July 2019, paras. 31–35; Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 105.

128 *Mental Health Act 2014* (Vic), sec. 117.

129 *Mental Health Act 2014* (Vic), sec. 11(2).

130 Mental Health Complaints Commissioner, *Annual Report 2018–19*, 2019, p. 40.

131 Mental Health Tribunal, Victoria, *Correspondence to the RCVMHS: CSP.0001.0001.0122*, 2020, pp. 10–11.

132 *Witness Statement of Dr Ravi Bhat*, 4 July 2019, para. 23(b).

133 *Personal Story of Julian O'Donnell, Collected by Victoria Legal Aid*, 2020.

134 Victoria Legal Aid, *Correspondence to the RCVMHS: CSP.0001.0001.0151, Paving the Roads to Recovery: Building a Better System for People Experiencing Mental Health Issues in Victoria*, p. 25; *Witness Statement of Indigo Daya*, para. 67; Peninsula Health, *Submission to the RCVMHS: SUB.0002.0028.0109*, 2019, p. 7.

135 *Witness Statement of Professor Richard Newton*, 7 May 2020, paras. 53–54.

136 Bendigo Health, *Submission to the RCVMHS: SUB.0002.0030.0051*, 2019, p. 4.

137 *Witness Statement of Dr Paul Denborough*, 2020, para. 88; Victorian Mental Health Tribunal, p. 28; Arstein-Kerslake, p. 11; Monash Health, *Submission to the RCVMHS: SUB.7000.0003.0001*, 2019, p. 10.

138 Office of Chief Psychiatrist, Department of Health, Tasmania, *Mental Health Act 2013: Review of the Act's Operation Outcomes Report*, 2020, p. 154.

139 *Mental Health Act 2014* (WA), sec. 10(2).

140 *Mental Health Act 2014* (WA), sec. 320.

141 *Carers Recognition Act 2012* (Vic), sec. 12(1).

142 *Disability Act 2006* (Vic), secs. 37–38.

143 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 106; *Witness Statement of Dan Nicholson*, paras 112–114; Victorian Mental Illness Awareness Council, *Submission to the RCVMHS: SUB.0002.0028.0645*, p. 4.

144 *Witness Statement of Dr Christopher Maylea*, para. 38.

145 *Witness Statement of 'Lucy Barker' (pseudonym)*, para. 41; *Witness Statement of Robyn Kruk AO*, 4 May 2020, para. 36; *Witness Statement of Mary O'Hagan*, paras. 49 and 56.

146 *Witness Statement of Cath Roper*, para. 69; Victorian Mental Illness Awareness Council, *Submission to the RCVMHS: SUB.0002.0028.0645*, p. 8.

147 *Witness Statement of Cath Roper*, para. 69; *Witness Statement of Dr Christopher Maylea*, para. 27; Office of the Public Advocate, pp. 11–12.

148 *Witness Statement of Indigo Daya*, para. 68(c); Victorian Equal Opportunity and Human Rights Commission, *Submission to the RCVMHS: SUB.1000.0001.5259*, 2019, pp. 26–27.

149 *Witness Statement of Dr Margaret Leggatt AM*, 11 July 2019, paras. 39–40; *Witness Statement of Marie Piu*, 17 July 2019, para. 25; Tandem, p. 8.

150 *Witness Statement of Professor David Castle*, 29 May 2020, para. 71; *Witness Statement of Professor David Copolov AO*, 7 July 2020, para. 252; RCVMHS, *Compulsory Treatment Roundtable: Record of Proceedings*; Mental Health Legal Centre, p. 11.

151 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 387.

152 McSherry and Weller, p. 395; *Witness Statement of Kym Peake*, 4 October 2020, paras. 341–343; Office of the Public Advocate, pp. 11–12.

153 Belinda Bennett, 'Law, Global Health, and Sustainable Development: The Lancet Commission on the Legal Determinants of Health', *Journal Law and Medicine*, 27 (2020), 505–512 (p. 505); Lawrence O Gostin and others, 'The Legal Determinants of Health: Harnessing the Power of Law for Global Health and Sustainable Development', *The Lancet*, 393.10183 2019, pp. 1857–1910 (p. 1859).

154 Gostin and others, p. 1889.

155 Gostin and others, pp. 1857–1858.

156 *Witness Statement of Erandathie Jayakody*, para. 145.

157 Bernadette McSherry, 'Mental Health and Human Rights: The Role of the Law in Developing a Right to Enjoy the Highest Attainable Standard of Mental Health in Australia', *Journal of Law and Medicine*, 15.5 (2008), 773–781 (pp. 773–774); *Witness Statement of Dr Piers Gooding*, 25 June 2020, para. 53.

158 *Witness Statement of Professor Neil Rees*, 15 June 2020, para. 17; Jennifer Brown, 'The Changing Purpose of Mental Health Law: From Medicalism to Legalism to New Legalism', *International Journal of Law and Psychiatry*, 47 (2016), 1–9 (p. 1); *Rethinking Rights-Based Mental Health Laws*, ed. by Bernadette McSherry and Penelope Weller (Oxford and Portland, Oregon: Hart Publishing, 2010), p. 132.

159 *Mental Health Act 1959* (Vic), sec. 42(7).

160 *Witness Statement of the Honourable Professor Kevin Bell AM QC*, 26 August 2020, para. 32; *Witness Statement of Professor Penelope Weller*, 27 August 2020, paras 23–25; Victorian Mental Illness Awareness Council, *Submission to the RCVMHS: SUB.0002.0028.0645*, 2019, p. 9.

161 *Interpretation of Legislation Act 1984* (Vic), sec. 35(a); PBU and NJE v Mental Health Tribunal, 2018, para. 256.

162 *Charter of Human Rights and Responsibilities Act 2006* (Vic), Preamble.

163 United Nations, *Convention on the Rights of Persons with Disabilities*, 6 December 2006, articles 3 and 25; Office of the High Commissioner for Human Rights, *CESCR General Comment No.14: The Right to the Highest Attainable Standard of Health (Art. 12)*, 2000, pp. 4–5.

164 *Carers Recognition Act 2012* (Vic), secs. 7–9.

165 *Guardianship and Administration Act 2019* (Vic), secs. 8–9.

166 *Public Health and Wellbeing Act 2008* (Vic), secs. 5–11A.

167 Victorian Mental Health Tribunal, pp. 10–11; *Witness Statement of Dr Neil Coventry*, 2019, paras. 65 and 69; *Witness Statement of Dr Lynne Coulson Barr OAM*, paras. 24, 34 and 73.

168 *PBU and NJE v Mental Health Tribunal*, para. 101; *Supreme Court of Victoria, AA v Secretary to the Department of Health and Human Services and Ors* [2020] VSC 400 (First Revision 3 July 2020) [2 July 2020], 2020, para. 178.

169 *PBU and NJE v Mental Health Tribunal*, para. 67.

170 Mental Health Tribunal, Victoria, Guidelines for ECT Hearings and Orders, 2019; Victoria Legal Aid, *Correspondence to the RCVMHS: CSP.0001.0001.0151, Paving the Roads to Recovery: Building a Better System for People*

Experiencing Mental Health Issues in Victoria, p. 20; Law Institute Victoria, *Submission to the RCVMHS: SUB.1000.0001.2134*, 2019, p. 14.

171 Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, pp. 20–21.

172 *PBU and NJE v Mental Health Tribunal*, para. 67.

173 *Witness Statement of Cath Roper*, para. 78; *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 37; *Witness Statement of Dan Nicholson*, para. 103(e); RCVMHS, *Box Hill Community Consultation—May 2019*.

174 *Witness Statement of Dr Christopher Maylea*, para. 22; *Witness Statement of Erandathie Jayakody*, para. 116; *Witness Statement of Dan Nicholson*, para. 112.

175 *Charter of Human Rights and Responsibilities Act 2006* (Vic), sec. 7(2).

176 *Charter of Human Rights and Responsibilities Act 2006* (Vic), sec. 7(2); Supreme Court of Victoria, *Robert Peter De Bruyn v Victorian Institute of Forensic Mental Health* [22 March 2016], 2016, paras. 100–101; Supreme Court of Victoria, *Certain Children v Minister for Families and Children and Ors* (No 2) [2017] VSC 251 [11 May 2017], 2017, para. 234.

177 Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, p. 68; Dr Chris Maylea and others, *Evaluation of the Independent Mental Health Advocacy Service (IMHA)*, 2019, p. 39; RCVMHS, *Compulsory Treatment Roundtable: Record of Proceedings*.

178 Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, p. 8; Victorian Mental Illness Awareness Council, *Submission to the RCVMHS: SUB.0002.0028.0645*, p. 9.

179 *Witness Statement of Dan Nicholson*, paras. 112–113; *Witness Statement of Erandathie Jayakody*, para. 116; Victorian Equal Opportunity and Human Rights Commission, p. 26.

180 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 114; *Witness Statement of Cath Roper*, paras 92–95; Barwon Health, *Submission to the RCVMHS: SUB.0002.0029.0222*, 2019, p. 7.

181 *Public Health and Wellbeing Act 2008* (Vic), sec. 8(1).

182 *Gender Equality Act 2020* (Vic), sec. 7.

183 *Witness Statement of Indigo Daya*, paras. 105–113; United Nations, *Convention on the Rights of Persons with Disabilities*, Article 4.

184 Department of the Prime Minister and Cabinet, *Implementation of Programme and Policy Initiatives*, 2006, pp. 3–4; *Witness Statement of Kym Peake*, 2019, paras. 147–161; *Witness Statement of Professor Penelope Weller*, para. 56.

185 *Witness Statement of the Honourable Professor Kevin Bell AM QC*, para. 28.

186 Neil Rees, 'Learning from the Past, Looking to the Future: Is Victorian Mental Health Law Ripe for Reform?', *Psychiatry, Psychology and Law*, 16.1 (2009), 69–89 (pp. 71–72).

187 Victorian Government, *Submission to the RCVMHS: SUB.5000.0001.0001*, 2019, p. 12.

188 Parliament of Victoria, Mental Health Bill 2014, Legislative Assembly Second Reading Speech.

189 *Witness Statement of Professor Neil Rees*, para. 24.

190 *Witness Statement of Dr Tricia Szirom*, 12 May 2020, para. 18; *Witness Statement of Robyn Kruk AO*, para. 29; Consumers Health Forum of Australia, *Submission to the RCVMHS: SUB.0002.0026.0069*, 2019, p. 14.

191 Anonymous 229, *Submission to the RCVMHS: SUB.1000.0001.1443*, 2019, p. 10.

192 *Witness Statement of Dr Piers Gooding*, para. 53.

193 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 50.

Chapter 27

Effective leadership and accountability for the mental health and wellbeing system—new system-level governance

Recommendation 44:

A new Mental Health and Wellbeing Commission

The Royal Commission recommends that the Victorian Government:

1. establish an independent statutory authority, the Mental Health and Wellbeing Commission, to:
    - **a.** hold government to account for the performance and quality and safety of the mental health and wellbeing system;
    - **b.** support people living with mental illness or psychological distress, families, carers and supporters to lead and partner in the improvement of the system;
    - **c.** monitor the Victorian Government's progress in implementing the Royal Commission's recommendations; and
    - **d.** address stigma related to mental health.
2. ensure the Mental Health and Wellbeing Commission:
    - **a.** is led by a Chair Commissioner and who is supported by a small group of Commissioners, all of whom are appointed by the Governor-in-Council; and
    - **b.** includes at least one Commissioner with lived experience of mental illness or psychological distress and one Commissioner with lived experience as a family member or carer.
3. enable the Mental Health and Wellbeing Commission to:
    - **a.** obtain data and information about mental health and wellbeing service delivery, system performance and outcomes, and other relevant information, from all government agencies;
    - **b.** work with and share data and information with the Department of Health and other relevant entities (for example, the Collaborative Centre for Mental Health and Wellbeing and Safer Care Victoria);
    - **c.** initiate its own inquiries into matters that support its objectives;
    - **d.** handle and investigate complaints about mental health and wellbeing service delivery;
    - **e.** make recommendations to the Premier, any minister and the heads of public service bodies; and
    - **f.** publish reports on the performance and quality and safety of the mental health and wellbeing system.

Recommendation 45:

Effective leadership of and accountability for the mental health and wellbeing system

The Royal Commission recommends that the Victorian Government:

1. establish in legislation the role of Chief Officer for Mental Health and Wellbeing to lead the Mental Health and Wellbeing Division in the Department of Health, and set out in that legislation that this Chief Officer is:

   a. delegated the functions and powers conferred on the Secretary of the Department of Health under the new Mental Health and Wellbeing Act (refer to recommendation 42);
   b. appointed by and reports to the Secretary; and
   c. at the level of a Deputy Secretary.

2. empower the Chief Officer to take responsibility for the implementation of the Royal Commission's recommendations, unless otherwise stated in these recommendations.
3. transfer the functions of Mental Health Reform Victoria (which was established pursuant to the interim report's recommendation 9) to the division by mid-2021.
4. ensure that the division employs people with lived experience of mental illness or psychological distress and people with lived experience of caring for someone living with mental illness in multiple, substantive positions, including leadership positions.

Recommendation 46:

Facilitating government-wide efforts

The Royal Commission recommends that the Victorian Government:

1. establish governance structures to:
   - **a.** facilitate government-wide and community-wide approaches to improving mental health and wellbeing; and
   - **b.** oversee the implementation of the Royal Commission's recommendations.
2. ensure these governance structures comprise:
   - **a.** a Mental Health and Wellbeing Cabinet Subcommittee, chaired by the Premier for at least two years;
   - **b.** a Mental Health and Wellbeing Secretaries' Board, chaired by the Department of Premier and Cabinet and comprising: the Secretaries of the Department of Health, the Department of Families, Fairness and Housing, the Department of Education and Training, the Department of Justice and Community Safety and the Department of Treasury and Finance, as well as the Chief Officer for Mental Health and Wellbeing;
   - **c.** a Suicide Prevention and Response Secretaries' Board Subcommittee, co-chaired by the Department of Premier and Cabinet and the Department of Health, attended and supported by the State Suicide Prevention and Response Adviser (refer to recommendation 26(1)) and comprising all state government departments and relevant agencies, with Deputy Secretary and Secretary-level membership; and
   - **d.** an Interdepartmental Committee on Mental Health and Wellbeing Promotion, co-chaired by the Department of Premier and Cabinet and the Department of Health, attended and supported by the Mental Health and Wellbeing Promotion Adviser (refer to recommendation 2(1)) and comprising all state government departments and relevant agencies, with Deputy Secretary level membership.

27.1 The governance of Victoria's future mental health and wellbeing system

The effective governance of Victoria's mental health and wellbeing system will be fundamental to realising the Commission's aspirations for a reimagined system. Ultimately, the Commission will impart responsibility for its reforms to bodies that oversee the governance of mental health and wellbeing services.

Good governance strengthens the community's confidence in government—ensuring the public trusts that mental health and wellbeing services will meet the expectations of people living with mental illness or psychological distress, families, carers and supporters now and into the future. This will require strong leadership that sets the direction, stays true to the Commission's reforms, inspires and effects system-wide cultural change, and works in accountable and transparent ways.

The World Health Organization identifies governance and leadership as one of the 'six building blocks' of an effective health system, defining it as: 'ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system-design and accountability'.[1]

The Commission was also guided by the following definition of good governance as outlined in an independent review of the Australian public service:

> **Good governance endures in the face of change—it delivers clear processes, decision rights and unambiguous accountabilities. Governance systems and structures need to be supported by effective leadership and the right organisational culture. Good governance allows leaders to focus on the priorities of an organisation and continually deliver—no matter how these priorities evolve in a rapidly changing external context.**[2]

Similarly, the Victorian Public Sector Commission describes good governance as encompassing 'the processes by which public entities are directed, controlled and held to account. It enables public entities to perform efficiently and effectively and to respond strategically to changing demands'.[3]

The governance of mental health services that are funded by the Victorian Government involves two main levels of authority: system-level governance and service-level governance.[4] This chapter focuses on system-level governance: the state bodies responsible for leading the mental health and wellbeing system and holding to account the agencies, particularly service providers, involved in supporting good mental health and wellbeing outcomes. In turn, this chapter also focuses on arrangements to ensure the Victorian Government is better held to account for governing the system, including the policy and funding decisions it makes.

At a system level, good governance ensures that services are responsive, appropriate, effective, connected, safe, accessible and sustainable. This is particularly important when dealing with a complex system involving various service providers, settings and funders, as well as multiple interactions with other service systems, such as health, education and justice.

Mr Terry Symonds, then Deputy Secretary, Health and Wellbeing Division, of the former Department of Health and Human Services, explained the importance of the department's commissioning role in achieving this:

> I believe that, done well, commissioning can set a clear direction for the system, require consistency where appropriate, and ensure strong oversight of quality, safety and equity. Importantly, at the same time it can increase local flexibility, responsiveness and innovation in the planning and delivery of care.[5]

The perspectives of people with lived experience of mental illness or psychological distress, families, carers and supporters, to lead and shape the design, commissioning and delivery of services, are central to the governance of a system. People who use the system provide great insight into challenges and opportunities, and should lead and contribute to decision making. Ms Indigo Daya, Consumer Academic, Centre for Psychiatric Nursing, University of Melbourne, giving evidence in a personal capacity, told the Commission about the importance of the contribution of consumers to decision-making processes:

> Throughout my career, I have noticed myself, and other consumer/survivor workers, open up fresh perspectives on old issues for the mental health sector. When we read documents, hear about issues or reflect on opportunities, our lens is often different to the status quo. Having been in services, and having a lived experience of distress and recovery, means that we are constantly finding ways to shift mental health services to better meet the will and preferences of the people using services.[6]

System-level governance depends on two important factors: strong leadership and accountability. These are critical in realising the Commission's aspirations of a transformed mental health and wellbeing system:

- Effective leadership is required to set the strategic direction for the system, maintain the focus on that direction, inspire and equip the system to meet that direction, and hold services to account for delivering the outcomes they are funded to achieve. Associate Professor Simon Stafrace, Chief Adviser, Mental Health Reform Victoria, giving evidence in a personal capacity, highlighted to the Commission the importance of leadership in reforming the system:

> Leadership is necessary for the transformation of Victoria's mental health system, through its capacity to foster change and innovation in individuals, teams, organisations and systems. Left unchallenged, organisations become static and dysfunctional in the face of continued external change. Leaders are required to communicate a vision of a better future, and to inspire and empower others to challenge the status quo in a form of co-creation.[7]

- Government and its funded agencies must also be held to account for system-wide objectives. It is only through accountability that Victorians can be confident that government is providing a mental health and wellbeing system that improves people's experiences and outcomes and adapts to the needs and expectations of the Victorian community.

Collectively, these factors also support making mental health and wellbeing a priority in government decision making. Effective leadership and transparent outcomes ensure mental health and wellbeing is a primary matter of concern for decision makers, leading to more comparable investment in line with other service systems and priorities.

This chapter sets out the need for a new Mental Health and Wellbeing Commission. The new Commission will assist to reinvigorate system leadership, provide independent oversight of government's actions and support a continuing focus on improving mental health and wellbeing outcomes. The new Commission will be a centrepiece of the future mental health and wellbeing system, with a focus on monitoring progress in improving mental health and wellbeing among Victorians and increasing lived experience leadership.

This chapter also sets out the material changes required to ensure that the Department of Health is equipped to take operational responsibility of the new mental health and wellbeing system: this is referred to as 'system management'.

The recommendations in this chapter consider the context of the COVID-19 pandemic and the importance of designing governance arrangements that can withstand and respond to unexpected challenges. To generate community confidence, government institutions must operate transparently, be held to account, and engage citizens in decision making.

27.2 Victoria's current system management arrangements

On 30 November 2020, the Premier of Victoria announced that the Department of Health and Human Services will be separated into the Department of Health and the Department of Families, Fairness and Housing.[8] The Department of Health will be responsible for health, ambulance services, mental health, alcohol and other drugs and ageing; and the Department of Families, Fairness and Housing will be responsible for child protection, prevention of family violence, housing and disability.[9] These changes come into effect from 1 February 2021.[10] It is expected that the Secretary of the Department of Health will continue the system management functions related to mental health previously undertaken by the Secretary of the Department of Health and Human Services.

The role and functions of the Secretary of the Department of Health as the system manager of mental health services funded by the Victorian Government, are set out under the *Mental Health Act 2014* (Vic) and the *Health Services Act 1988* (Vic). Mr Symonds described the goal of the system manager:

> that all Victorians experience their best possible health, including mental health. In doing so, we focus on people who are disadvantaged and vulnerable, and ensure that people living with mental illness get the same respect and opportunities as everyone else.[11]

Under the Mental Health Act, the Secretary's role is 'to plan, develop, fund, provide and enable the provision of a comprehensive range of mental health services that are consistent with, and promote the objectives of, [the] Act and the mental health principles'.[12] The Secretary's legislated mental health functions under the Act include developing and implementing strategies; planning and developing services; promoting continuous improvement; collecting and analysing data; monitoring the performance of service providers; promoting awareness in relation to mental health; undertaking and funding research; developing and supporting the workforce; promoting coordination between service providers; and submitting an annual report.[13]

Since deinstitutionalisation, when stand-alone psychiatric hospitals were replaced with inpatient and community-based mental health services in the early 1990s, there have been various ministerial and departmental arrangements relating to responsibility for mental health. Until 2006, mental health was part of the Minister for Health's portfolio and was integrated with the health functions in the department.[14] In 2006, the government appointed a dedicated Minister for Mental Health and established a separate mental health division in the department.[15] In 2016, it reintegrated mental health functions with wider health functions, and the Mental Health Branch became part of the Health and Wellbeing Division.[16] Ms Kym Peake, former Secretary, Department of Health and Human Services, described the benefits of this reintegration:

> This has supported a renewed emphasis on the intersections between health and other social services in targeting interventions and sustaining support for people with enduring complex needs.[17]

As of December 2020, responsibility for mental health was primarily split across two branches in the Health and Wellbeing Division within the former Department of Health and Human Services. The Mental Health and Alcohol and Drugs Branch was responsible for policy, planning and strategy, and the Policy, Planning and Monitoring Branch was responsible for commissioning mental health services. At that point, both branches reported to their own respective executive directors, who in turn reported to the Deputy Secretary, Health and Wellbeing. There was still a separate Minister for Mental Health.

On 23 December 2020, changes were announced to the way mental health would be governed within the department, with the establishment of a Mental Health Division, led by a Deputy Secretary. These changes took effect from 11 January 2021.

Additionally, as recommended in the interim report, Mental Health Reform Victoria was established in January 2020 to start implementing the Commission's recommendations. Mental Health Reform Victoria is an administrative office of the Department of Health.

The Secretary oversees public health services, but they are not run by the department. Public health services are established as separate statutory bodies under the Health Services Act. They are governed by public health service boards, whose members are appointed by the Governor-in-Council, on the recommendation of the Minister for Health, under the Health Services Act.[18] Public health service boards provide operational and clinical governance for public specialist mental health services, and coordinate service delivery at a local level.[19] Although there are various powers in the Health Services Act, the main mechanism used by the department to set expectations and monitor the performance of public health services is through issuing an annual *Statement of Priorities*.[20] These measures reflect principles of 'devolution'. Mr Shane Solomon, Partner of Caligo Health, giving evidence in a personal capacity, described to the Commission the benefits:

> **the most effective health services are the ones where you devolve accountability and authority to the lowest competent level (the principle of 'subsidiarity'). This frees the service to respond to the needs of their communities and to innovate. With this comes clear accountability for achieving what the community expects of a service. Victoria has opted to make the devolved model work through strong Boards, with accountability to Government through the annual Statement of Priorities, and various step in authorities if a service is not meeting the requirements of the Statement of Priorities.**[21]

Integrated community health services are subject to similar governance arrangements, including the use of *Statements of Priorities*. Conversely, registered community health services operate independently. Their key accountability mechanism is contractual: a service funding agreement between the provider and the department.[22]

The department also oversees Forensicare, the statewide provider of forensic mental health services in Victoria. Forensicare is established under the Mental Health Act and is accountable to the Minister for Mental Health.[23] Forensicare is governed in a similar way to public health services. It too has a board of directors and a *Statement of Priorities*.[24]

The department must have regard to two other types of services. The first is wellbeing supports (or psychosocial supports), which focus on supporting the recovery of people living with mental illness, such as assisting people to participate in the community, engage in work or study, find housing, manage daily tasks and connect with families and friends.[25]

These supports are mainly provided by non-government organisations through the National Disability Insurance Scheme (NDIS). For the purposes of providing these supports, these organisations are registered and regulated under the *National Disability Insurance Act 2013* (Cth) and the NDIS rules.[26] The Victorian Government retains responsibility for the provision of wellbeing supports for people who are ineligible for the NDIS. These are managed in accordance with the department's *Policy and Funding Guidelines*, which represent the terms and conditions for government-funded healthcare organisations, and service agreements, which represent the terms for the delivery of services in the community on behalf of the department. The Commonwealth also retains some responsibility for the delivery of these services for people who are ineligible for the NDIS, with these services commissioned through Primary Health Networks.

The second is private psychiatric hospitals, which provide treatment, care and support to people living with mental illness. The safety and quality standards that Victoria's private hospitals must meet are set out in the Health Services Act and the *Health Services* (*Health Services Establishment) Regulations 2013* (Vic).[27] The department regulates private hospitals under the Health Services Act using the *Risk Based Regulatory Framework: Private Hospitals 2017*.[28]

The department also works collaboratively with Commonwealth Government agencies. The Commonwealth is responsible for funding primary care services delivered by GPs and other health professionals under the Medicare Benefits Schedule and the Better Access initiative.[29] It also funds Primary Health Networks to plan and commission health and mental health services.[30] The Commonwealth and state governments also jointly fund mental health services governed by a series of agreements, with the *National Health Reform Agreement* being the most significant. Ms Robyn Kruk AO, Interim Chair, Mental Health Australia, giving evidence in a personal capacity, told the Commission:

> **The [mental] health system manager also has responsibility to ensure effective interaction with the Commonwealth health funders through [Council of Australian Governments] structures and provide input into broader national policy and planning and health workforce matters through national health plans and partnership agreements.**[31]

Other Australian states and territories have similar arrangements to Victoria. Their health departments also perform system management for their respective mental health systems. Mental health policy is part of broader health divisions in most states and territories, with the exception of the Australian Capital Territory and South Australia, which both have offices dedicated to mental health and wellbeing.

Over the past 10 years, New South Wales, Queensland, South Australia[32] and Western Australia have established mental health commissions. Broadly, the mental health commissions in New South Wales and Queensland have strategic and advocacy functions, such as developing and monitoring plans, promoting mental health and wellbeing, and undertaking and commissioning research.[33] The Western Australian model is different—there, the Mental Health Commission purchases mental health services on behalf of the state, while the Western Australian Department of Health provides leadership, oversight, policy setting and planning for the state health system, including mental health.[34] Australia also has a National Mental Health Commission, with three main roles: 'monitoring and reporting on Australia's mental health and suicide prevention systems; providing independent advice to government and the community; and acting as a catalyst for change'.[35]

27.3 Limitations with the former Department of Health and Human Services' system management

While the funding of Victoria's mental health services has increased in recent years, past investment in mental health services has been insufficient to provide enough treatment, care and support to meet the needs and expectations of people living with mental illness or psychological distress, families, carers and supporters.[36] The system has also been increasingly unable to meet its stated objectives for access and effectiveness—which means many people living with mental illness or psychological distress, families, carers and supporters have poor experiences of it.[37]

Mr David Martine PSM, Secretary, Department of Treasury and Finance, told the Commission that there are many competing demands for government resources:[38]

> The funding allocated to deliver services to the Victorian community reflects decisions that are made by Government, generally as part of the annual budget process, to implement the government of the day's objectives and priorities.[39]

As section 27.3.1 highlights, contextual factors such as stigma and competing advocacy have contributed to the lack of priority given to mental health in government decision making, with funding outcomes influenced by community interests and perceptions.

Structural challenges that have emerged over several decades have also compromised effective system-level governance, including limited accountability, leadership and system planning. Institutional structures across the Victorian Government during this period have exacerbated the problems. This section examines how these contextual factors and structural challenges have compromised effective leadership within, and accountability for, the mental health system.

27.3.1 The role of stigma

In 2019, the Commission heard evidence suggesting that the community's attitudes regarding people living with mental illness or psychological distress deterred government investment in mental health.

Dr Chris Groot, Lecturer, Melbourne School of Psychological Sciences, University of Melbourne, told the Commission that the distribution of government funding across the Australian and Victorian mental health systems was a result of 'unintentional structural stigma'.[40] Dr Michelle Blanchard, Deputy CEO, SANE Australia and Founding Director, the Anne Deveson Research Centre, referred to structural stigma as the 'societal level conditions, cultural norms, and institutional practices that constrain the opportunities, resources and wellbeing for stigmatised populations'.[41]

While funding decisions are not based on community attitudes, the Hon. Robert Knowles AO, a former Victorian Minister, whose responsibilities included the health and aged care portfolios, including mental health, noted that 'politics is influenced by public perception'.[42] As Dr Gerry Naughtin, a leader across the mental health and community sectors, told the Commission:

> There are not as many votes in mental health reform as there are in reforms in areas such as cancer and heart disease and mental health at times struggles against other competing demands for government resources.[43]

Awareness of mental health and wellbeing, however, is increasing. This is demonstrated by the Victorian and Commonwealth governments' increased focus on mental health and wellbeing in response to both the devastating 2019–20 bushfires and the COVID-19 pandemic. Both governments have publicly committed to the importance of mental health and wellbeing, including significant investment and the establishment of a *National Mental Health and Wellbeing Pandemic Response Plan*. This has also occurred in the context of the Commonwealth's release of the Productivity Commission's *Mental Health Inquiry Report* and the initial findings of the National Suicide Prevention Adviser to the Prime Minister in November 2020. The Productivity Commission has underscored the economic impact of poor mental health and suicide to the national economy, estimated to be up to $70 billion per year.[44] This aligns with the Commission's estimate in the interim report that the economic cost of poor mental health to Victoria is $14.2 billion a year.[45]

The Commission is optimistic that alongside its reforms, community and government interest will continue to drive an increased and enduring focus on mental health and wellbeing. With the importance of mental health and wellbeing highlighted so starkly, communities and governments must maintain the focus.

27.3.2 The role of advocacy

As outlined in the interim report, strong advocacy is important to generate and propel reform, and to ensure it is sustained. Examples of effective advocacy can be observed in other sectors, such as the disability sector, which has seen significant change in recent years through the introduction of the National Disability Insurance Scheme. This reform and its underlying principles represent a major step towards greater participation and inclusion for people living with disability. It was spurred on in part by the *Every Australian Counts* grassroots campaign, involving people living with disability, families, carers and those who work to support them.[46]

The Commission was told, however, that similarly strong examples of advocacy are not so apparent in the mental health sector. For example, the Hon. Andrew Robb AO, former Federal Member of Parliament, told the Commission about weak public advocacy for mental health:

> Mental health has not received the attention it needs. For example, from 2004-2016, during my time as a parliamentarian with a local constituency in Melbourne of 150,000 people, every 3 or 4 weeks I would get a representation from some health groups who were justifiably making their case for more public money, for example for cancer research or diabetes research. For the first 7 years I did not get one representation for mental health.[47]

Mental health professionals have also struggled to achieve unified activism and sustained pressure on government for a well-defined reform direction.[48] The mental health sector in Victoria has had high-profile and effective leaders, but, from the Commission's perspective, professional groups have at times advocated for strategies that appear contradictory. As the Hon. Julia Gillard AC, Chair, Beyond Blue, has noted: 'decision-makers get let off the hook if advocates compete and criticise, rather than cohere'.[49]

Advocacy at times advances seemingly false dichotomies—for example, arguing for prioritising investment in prevention and early intervention, at the expense of investment in services, or vice versa.

27.3.3 Limited accountability

While these external factors have diminished the status of mental health as a priority issue for government, structural challenges have also weakened accountability.

Currently, there is no single independent body that holds government to account for meeting objectives across the mental health system or improving mental health and wellbeing outcomes. This is necessary both for the Department of Health—in its role as system manager—and across government. As the Commission states throughout this report, responsibility for mental health and wellbeing extends beyond the mental health system, requiring a government-wide response. There must be oversight of how various government agencies work together—for example, across the health, education, social services and justice portfolios—to collectively improve mental health and wellbeing outcomes for Victorians.

In comparison, the mental health commissions set up in New South Wales and Queensland, and at the national level, provide an additional check on their respective mental health systems. Mrs Lucinda Brogden AM, Chair, National Mental Health Commission, reported that the National Mental Health Commission is able to provide independent advice to governments and the community on mental health outcomes and reform.[50]

Another example is New Zealand's Mental Health and Wellbeing Commission, which is expected to commence work in early 2021.[51] That Commission will provide independent scrutiny of the New Zealand Government's progress in improving people's mental health and wellbeing, and monitor the progress of the government's response to *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*.[52] While the permanent Commission is being established, an initial Commission is undertaking some of the Commission's permanent functions.[53] The Hon. Dr David Clark, former New Zealand Health Minister, said the initial Commission:

> will be looking at the wider range of factors that contribute to people's overall mental wellbeing. That includes looking across social welfare, housing, education and justice as well as talking to those with experience of mental health and addiction ...[54]

Mr Symonds told the Commission that there is merit in establishing 'independent external scrutiny and oversight into the system design' to ensure the department transparently meets its outcomes and objectives.[55] He pointed to the New Zealand Commission as a relevant example of an effective oversight body.[56] The Productivity Commission's *Mental Health Inquiry Report* recommended that all states and territories establish a mental health commission to foster 'genuine accountability for mental health reform'.[57]

Other service systems also have independent bodies that assist to strengthen system accountability and leadership. For example, the Commission for Children and Young People in Victoria is an independent statutory body that provides scrutiny and oversight of services for children and young people, advocates for improvements in policy and service responses, and promotes the views and experiences of children and young people.[58]

Without this level of scrutiny, there is a continuing risk that government will not meet its objectives, leading to poorer experiences and outcomes for people living with mental illness or psychological distress, families, carers and supporters. Clear accountability is also important to assist in rebuilding the community's trust in government. As outlined in section 27.4, the Commission considers that there must be an independent body to hold government to account: a new Mental Health and Wellbeing Commission.

Service-level accountability and performance monitoring is explored in Chapter 28: *Commissioning for responsive services*.

27.3.4 Limited system leadership and stewardship

The former Department of Health and Human Services has failed to consistently provide strong and focused leadership to direct and improve the mental health system. This is in the face of calls to improve system leadership over several decades, and not just in Victoria.

The Victorian Mental Illness Awareness Council submitted that there is currently no approach to system leadership providing a vision or strategy across the mental health system.[59] Similarly, in the context of mental health services for children and young people, Mr Andrew Greaves, Auditor-General, Victorian Auditor-General's Office, told the Commission that the department had not provided the leadership necessary to set clear direction and service expectations to meet the needs of young people.[60]

Ms Peake acknowledged these limitations, telling the Commission:

> The Department is cognisant of the need to continue improvement of our system leadership and stewardship functions such as policy development, system oversight and commissioning and performance management of services.[61]

Mr Christopher Gibbs, CEO, Mental Health Professionals' Network, submitted to the Commission that:

> there has been no consistent, authoritative voice from the Department that leads to a coherent overall plan to improve the state of mental health services in Victoria.[62]

The former Department of Health and Human Services, however, was progressing work on its responsibilities, and foreshadowed structural and resourcing changes to improve its system leadership, which are expected to continue in the new Department of Health. These include improvements to performance monitoring and commissioning.[63]

The former Department of Health and Human Services has also historically struggled to move from the role of a funder of services to a commissioner of services to achieve joined-up and purposeful outcomes.[64] As the system steward, the department needs to understand how the values and objectives of the system, as reflected in policy settings, are understood and implemented throughout the system.[65]

Reviews since 2005 point to a longstanding debate about the department's role in the context of a devolved system, including whether it has struck the right balance between autonomy and oversight of local decision makers.[66]

Mr Greave's conclusion was that the findings of past reviews speak to:

> an ingrained culture, developed and reinforced over two decades, of not fulfilling the responsibilities that properly pertain to a system manager—either understood and accepted but not acted upon, or there remains debate and uncertainty as to what is the proper role of the department vis a vis health services.[67]

The Commission considers that the mental health system has struggled with the balance between system-level and service-level governance.

27.3.5 Inadequate system planning

System planning to prepare the mental health and wellbeing system for future challenges, such as changing and growing demand, is also a critical function of the department. As set out below, however, the former Department of Health and Human Services struggled to provide consistent, integrated and sophisticated service and infrastructure planning. These issues are described in detail in Chapter 28: *Commissioning for responsive services*.

In March 2019, the Victorian Auditor-General, in a report to Parliament, found that there had been a lack of appropriate system-level planning for the mental health system over many years.[68] The challenges the department faced in trying to perform this role related to limitations in its ability to forecast demand, and to geographic service boundaries inhibiting statewide planning.

In respect of demand forecasting, Mr Greaves reported that 'the department does not adequately capture the extent of mental illness in the population and the true unmet demand'.[69] The Auditor-General's 2019 report on access to mental health services concluded that the department lacked critical information to understand unmet demand, including information about people who contact mental health triage services, but are not accepted for service provision.[70]

The wider health system has effective demand-forecasting mechanisms in place. Without these, the mental health system has lacked the capacity to demonstrate unmet demand, and indeed, it does not have system performance indicators which have political traction, such as elective surgery waiting lists in the health system.

The department's planning capability is further constrained by geographic boundaries known as 'catchments' that see public specialist mental health services provided in a defined area. The boundaries of these catchments are not aligned with other Victorian health and human service areas, local government area boundaries, or Primary Health Networks.[71] In the metropolitan area, there are different catchments for adult, aged, and child and youth mental health services. This makes it difficult for the department to plan 'whole-of-life' integrated services across the state.

Without effective system planning, it is unclear where investment is most needed. This compromises funding outcomes across the system, including in services, the workforce and infrastructure. Further information on planning and the Commission's recommended approach is outlined in Chapter 28: *Commissioning for responsive services*.

27.3.6 The impact of the former Department of Health and Human Services' internal structures

The former Department of Health and Human Services' internal structures have also contributed to the lack of priority given to mental health in government decision making. The fact that the department had a large range of responsibilities across health and social services, and such a broad agenda, possibly resulted in mental health becoming less of a priority. The Mental Health and Alcohol and Drugs Branch, while progressing important work and maintaining positive relationships with much of the sector, could become subsumed among the varied priorities of the department and government.

Mr Solomon told the Commission that the 'relative lack of status of the Mental Health Branch' needed to be raised so it has a 'stronger presence at the decision-making table'.[72] Associate Professor Stafrace spoke of the importance of rethinking the current approach: '[a]fter the final report of the Royal Commission is submitted in February 2021, it is imperative in my opinion that mental health is governed differently within [the former Department of Health and Human Services] than is the case at present.'[73]

The Premier's announcement in November 2020 to split the department into the Department of Health and the Department of Families, Fairness and Housing as of 1 February 2021, along with the announcement on 23 December 2020 that a Mental Health Division will be established in the Department of Health, will support narrowing the focus on such a broad range of portfolios and elevating the status of mental health and wellbeing.

To ensure mental health and wellbeing is not lost among the Department of Health's wide scope of responsibilities, structures must be put in place to elevate and sustain its influence over the long term.

Personal story:

Janet Meagher AM

Janet has been able to use her lived experience of mental illness to promote the consumer voice and has advocated for people with lived experience of mental illness to be leaders across all levels of the mental health system. Janet advocated for many years to have a national representative organisation for mental health consumers and for the need for continual reform of mental health services with consumer leadership.

In 1996 Janet published a book as part of her research findings: *Partnership or Pretence: a handbook of empowerment and self-advocacy for consumers of psychiatric services and those who provide or plan those services*. Her goal for the book was to ensure those who have used services 'have input regarding all aspects of service delivery, policymaking and any issues that affect their quality of life'.

> People using services need to learn to work in partnership with mental health bureaucrats, professionals and service providers through an empowerment and self-advocacy process. *Partnership or Pretence* advocates for genuine partnership in all undertakings, and aims to equip people with the tools to make a genuine partnership a reality.

Janet has provided a lived experience voice in many roles, including government decision making and planning, such as when she was a National Mental Health Commissioner. She describes the need for active participation of consumers in the mental health system.

> A new service framework and strategy must overtly move beyond focusing on beds, acute care and clinical services and move on to include non-government/ community services across all sectors, including peer and family workers.

Janet reflected that a turning point in her work was in 1993, when the Human Rights and Equal Opportunity Commission released the *Report of the National Inquiry into the Human Rights of People with Mental Illness*.

> this was the first time people who'd been through a service, through an experience, actually got to articulate it and have it heard.
>
> it helped empower the consumer and was the start of the consumer movement in Australia; to have that report produced and mental health service reform commenced on the back of that. We now have the *National Mental Health Strategy*, for instance, which came out of that process, and our lived experience voices started to be, not only valued and heard, but there was a demand that we could now have that there couldn't be nothing about us without us.

With her work continuing over many decades Janet was recognised in 2017 with the Australian Mental Health Prize. Before this, in 1996, she was awarded Member of the Order of Australia (AM) 'for service as an advocate for people with mental illness and psychiatric disability'. Janet said the consumer movement is active and making an impact, but more change is needed.

> We are not passive. We will no longer receive. We participate, and you can't take us back 40 years to when we were passive. There is no passivity anymore or into the future, and I think this is where the problem with mental health services lies at the present, that they expect us to be passive, they expect us to have a docile view … They do not expect us to be intelligent participants in their own service or planning for service, and I think that has to change …

Janet reflected that the lived experience workforce has transformed mental health services and is vital to the system.

> we've now developed ways of service provision that includes people whose lived experience is an important and integral part of their role, and I've been very proud to be part of the blooming of that type of service provision, and I say that peer work is probably the most revolutionary thing that's happening in mental health at the present time.

Janet has been an important part of the reform over the past few decades as a consumer leader and advocate and is a role model to many.

> I have become a person who now lives a full and rewarding life. I am now able to contribute at the highest levels of government and to state, national and international mental health movements with enthusiasm and vigour. In this work I have lobbied for enhanced recognition and respect for those people across the world who live with mental health issues or emotional distress.

Source: *Witness Statement of Janet Meagher*, 1 July 2019; *Evidence of Janet Meagher*, 3 July 2019.

27.3.7 Limited representation of people with lived experience of mental illness or psychological distress, and families, carers and supporters

People with lived experience of mental illness or psychological distress and people with lived experience of caring for someone living with mental illness should be central to government decision-making processes. Those who are affected by the outcomes of government decisions offer valuable insights into how those decisions should be made and implemented. This is reflected in the personal story of Janet Meagher AM, an advocate for people with lived experience of mental illness.

Importantly, people with lived experience of mental illness or psychological distress and families, carers and supporters must be recognised as two distinct groups with different perspectives and experiences. Engagement methods must be designed to account for varied perspectives and experiences—both in respecting different ideas and in creating opportunities for groups to come together.

It is expected that the Department of Health will continue to fund organisations, including consumer and family and carer peak bodies, the Victorian Mental Illness Awareness Council and Tandem, to fulfil a number of functions. These include advocacy and participation in engagement activities run by government agencies.

There have been different lived experience advisory groups over the years, but many have not continued or have had varied success. This is due to a range of reasons, including engagement after decisions have been made, individuals in advisory structures being expected to represent the views of all people with lived experience, insufficient remuneration and limited career pathways.[74]

Ms Peake said of lived experience advisory groups:

> In the case of people with a lived experience of mental illness, much of this engagement has centred around work already underway, meaning we have missed opportunities to support genuine co-production with consumers and carers.[75]

In addition to taking advice from people with lived experience, the Department of Health should employ people with lived experience of mental illness or psychological distress and people with lived experience of caring for someone living with mental illness in substantive roles, so that they can shape decisions from the outset. Ms Peake acknowledged that greater efforts are required to integrate the experiences of people with lived experience.[76]

Omitting people with lived experience from government decision making impedes cultural change. Ms Cath Roper, Consumer Academic, Centre for Psychiatric Nursing, University of Melbourne, told the Commission:

> Lack of consumer representation at governance level is problematic. If the consumer perspective is not present at the top level, then it will keep getting lost everywhere else and a critical mass needed to change culture will not occur.[77]

27.4 Recommended approach to new system leadership and oversight: a Mental Health and Wellbeing Commission

Transforming Victoria's mental health and wellbeing system requires strong system leadership and accountability, including the leadership of people with lived experience. The reforms put forward by the Commission demand new ways of working, a cultural shift and reinvigorated leadership. Victorians need to be confident that government will stay true to the Commission's aspirations of a reimagined mental health and wellbeing system.

To reset the current approach to the governance of the system, material changes must be made. A new and impartial body will keep government on track and ensure the mental health and wellbeing system continues to meet the expectations of people with lived experience of mental illness or psychological distress, families, carers and supporters. There must be strong leadership and direction to inspire and motivate the system to improve its performance so people experience better outcomes;[78] and to support the workforce to deliver better services.

As stated in section 27.3.3, Victoria does not currently have an independent body providing statewide leadership and oversight in relation to the mental health system. In comparison, New South Wales and Queensland have independent mental health commissions which review, evaluate, report and advise on mental health services in those states.[79] In New Zealand, system oversight is among the functions of the new national Mental Health and Wellbeing Commission, including a function requiring it to assess whether government entities are performing well as a system.[80]

The Commission received evidence from many sources recommending the establishment of a new and independent body to improve system oversight and leadership and to increase the focus on mental health and wellbeing. While broadly consistent, these sources proposed different functions and objectives of a new body. Mr Angus Clelland, CEO of Mental Health Victoria, told the Commission that a new body 'can act as the capstone of system governance and provide oversight, support the development of new service models, support innovation and snap at the heels of politicians, government departments and service providers'.[81]

Similarly, Dr Peggy Brown AO, a psychiatrist who has held a number of leadership roles in the mental health sector, told the Commission that a new body could assist in the assignment of priority to mental health and wellbeing within government and strengthen accountability:

> **A Commission should be a 'thorn in the side' of the Minister and First Minister regarding whether progress is occurring quickly enough. They can and should act as a conduit to relay community experience. It is essential that Commissions have sufficient power to make them effective and sufficient independence to enable them to be courageous.**[82]

The Victorian Mental Illness Awareness Council also supported establishing a new body to provide sector-wide governance, and to ensure the mental health and wellbeing system is 'visionary and accountable'.[83] Similarly, the Australian Psychological Society proposed a statewide body 'to provide leadership, accountability, and cross-sector oversight to the reform process'.[84] Mental Health Victoria and the Victorian Association of Healthcare recommended an independent body with oversight, advocacy, sector integration, data collection and health promotion functions.[85]

Contributions to the Commission noted that the design of a new body, including the relevant powers, will be important to ensure it has independence and authority. Professor David Copolov AO, Professor of Psychiatry, Monash University and Pro Vice Chancellor Major Campuses and Student Engagement, Monash University, said that a new commission would need 'unusual powers in comparison to other Mental Health Commissions to place effective pressure on the government of the day to ensure that its obligations toward the mental health system were being met.'[86]

Mr Solomon told the Commission that while mental health commissions may appear to afford a higher status to mental health, separate structures can 'marginalise and sideline mental health from the mainstream power of the general health system'.[87]

The Commission considers there is a need to establish a new body to strengthen system leadership and accountability, and that the risks highlighted can be mitigated through proper design of the new body's purpose, functions and powers.

Based on the foundational challenges that Victoria currently faces, a new independent, statutory authority is required—a Mental Health and Wellbeing Commission. It must have bold objectives and appropriate powers to be effective.

This new Commission will be a critical feature of the future mental health and wellbeing system—elevating the status of mental health and wellbeing; holding government to account; and exemplifying and enabling lived experience leadership.

As shown in Figure 27.1, the fundamental purpose of the new Commission will be to:

- hold the government to account for the overall performance and quality and safety of the mental health and wellbeing system, including public health and prevention
- elevate and sustain mental health and wellbeing as a priority in government decision making
- elevate the leadership of people with lived experience of mental illness or psychological distress across the mental health and wellbeing system
- promote the role, value and inclusion of families, carers and supporters across the mental health and wellbeing system
- monitor the Victorian Government's progress in implementing the Royal Commission's recommendations (section 27.6)
- facilitate action on mental health and wellbeing across government, business and the community
- lead actions that challenge stigma relating to mental health.

To achieve these objectives, the new Commission will have the power to:

- obtain data and information about mental health and wellbeing service delivery, system performance and outcomes, and other relevant information from all government agencies
- work with and share data and information with the Department of Health and other relevant entities (for example, the Collaborative Centre for Mental Health and Wellbeing and Safer Care Victoria)
- initiate its own inquiries into matters that support its objectives
- handle and investigate complaints about mental health and wellbeing service delivery
- make recommendations to the Premier, any minister and heads of public service bodies
- publish reports regarding the performance and quality and safety of the mental health and wellbeing system and progress towards improving mental health and wellbeing outcomes for Victorians.

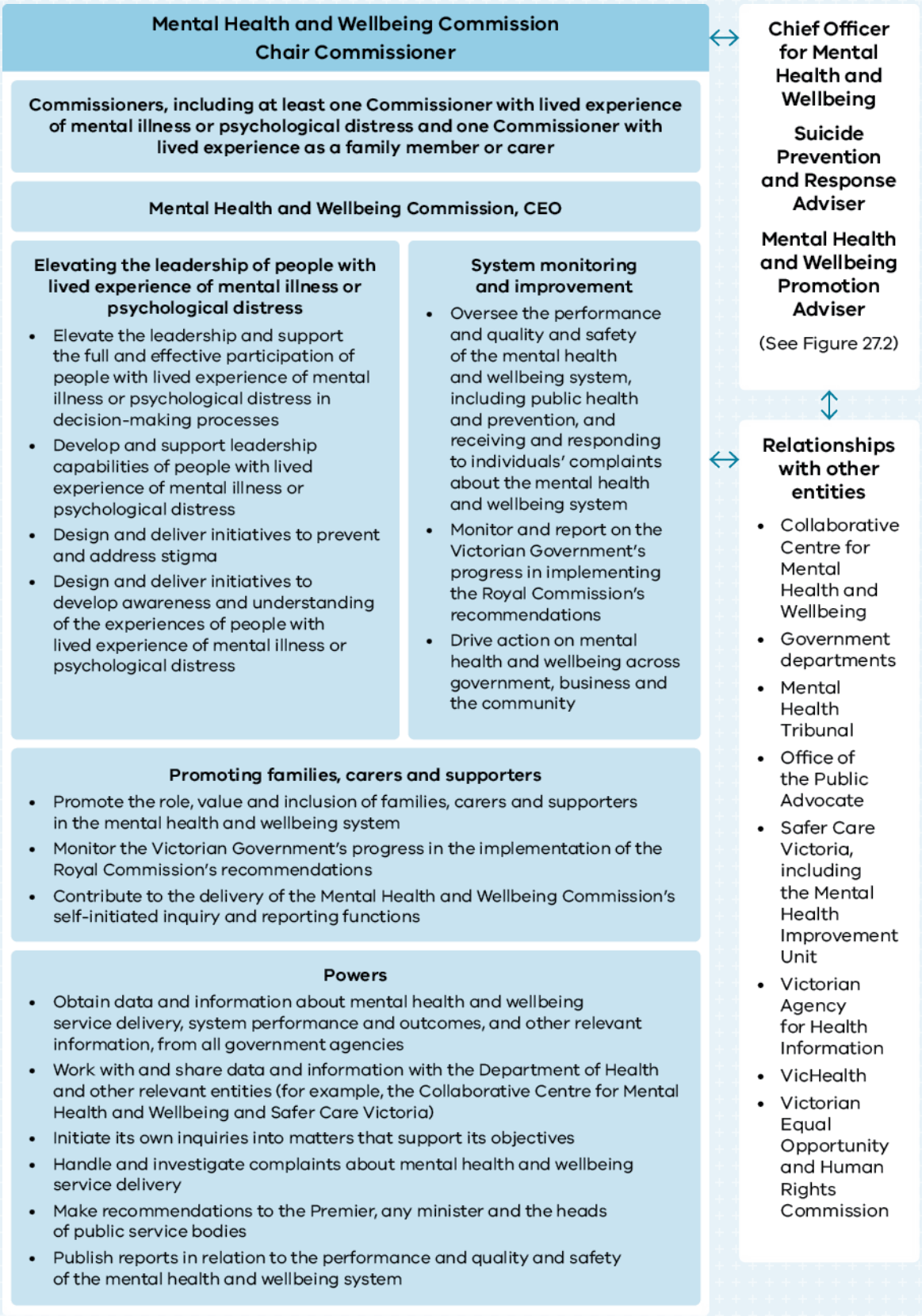
To demonstrate how it is meeting its objectives, the new Commission must submit an annual report to the relevant minister which will be tabled in Parliament.

The new Commission will be led by a Chair Commissioner supported by a small group of Commissioners, including at least one Commissioner with lived experience of mental illness or psychological distress and one Commissioner with lived experience as a family member or carer, all appointed by the Governor-in-Council. The new Commission will be a statutory authority established by legislation. This will ensure its independence and that it is has the appropriate powers to perform its functions and hold others to account. While each Commissioner will bring different experiences to the new Commission, it is expected they will work together to support its overarching objectives.

At least one Commissioner with lived experience of mental illness or psychological distress will be critical to achieving the Royal Commission's aspiration that people with lived experience are active leaders and contributors to the mental health and wellbeing system. As discussed in Chapter 18: *The leadership of people with lived experience of mental illness or psychological distress*, the Commission will promote the leadership and the full and effective participation of people with lived experience of mental illness or psychological distress in decision-making processes. This will require confronting the power dynamics in the current system, where people with lived experience are often marginalised. It will also require the redress of historic challenges such as rare opportunities for lived experience leaders and limited and tokenistic engagement with people with lived experience of mental illness or psychological distress.

In this regard, careful consideration should be given to how many Commissioners are appointed in order to overcome these challenges and to ensure effective and influential lived experience leadership. At least one Commissioner with lived experience of mental illness or psychological distress will likely be required to effect such transformational change and the redistribution of power. There should also be an assumption that any reasonable adjustments will be made when filling all roles within the new Commission.

Figure 27.1: Recommended Mental Health and Wellbeing Commission



The core functions of the Mental Health and Wellbeing Commission are detailed in separate chapters. Table 27.1 outlines where they are discussed.

Table 27.1: Purpose of the new Mental Health and Wellbeing Commission and corresponding chapter references

Focus	Purpose	Chapter
System monitoring and improvement	Independent oversight of the mental health and wellbeing system to ensure it is meeting its objectives	Chapter 3: *A system focused on outcomes*
Quality and safety	Monitoring and reporting on system-wide safety and quality Receiving and responding to individuals' complaints about the mental health and wellbeing system	Chapter 30: *Overseeing the safety and quality of services*
Monitoring reform	Monitoring the Victorian Government's progress in implementing the Royal Commission's reforms	This chapter, section 27.6
The leadership of people with lived experience of mental illness or psychological distress	Promoting the leadership and the full and effective participation of people with lived experience of mental illness or psychological distress in decision making about policies and programs, including those directly concerning them	Chapter 18: *The leadership of people with lived experience of mental illness or psychological distress*
Family, carer and supporter inclusion	Promoting the role, value and inclusion of families, carers and supporters in the mental health and wellbeing system	Chapter 19: *Valuing and supporting families, carers and supporters*
Public health	Overseeing government's approach, led by the Mental Health and Wellbeing Promotion Office in the Department of Health, to promote good mental health and wellbeing and the prevention of mental illness	Chapter 4: *Working together to support good mental health and wellbeing*
Stigma	Confronting stigma regarding mental illness and driving action to reduce stigma	Chapter 25: *Addressing stigma and discrimination* Chapter 18: *The leadership of people with lived experience of mental illness or psychological distress*

As the Department of Health and the new Mental Health and Wellbeing Commission will share much of the responsibility for the future mental health and wellbeing system, it is vital that their respective roles and responsibilities are clear and that they work together collaboratively.

The Royal Commission expects that a Memorandum of Understanding and the new Commission's Ministerial Statement of Expectations will set out the way in which the Department of Health and the new Commission will work together. A Statement of Expectations is developed by the relevant minister and issued to a new agency as part of its establishment process. The Statement sets out the agency's objectives and functions and is periodically updated. The new Commission's enabling legislation should provide that the bodies are to work together collaboratively in accordance with the Statement of Expectations. Details regarding how the new Commission must work with quality and safety bodies, such as the Mental Health Improvement Unit in Safer Care Victoria are outlined in Chapter 30: *Overseeing the safety and quality of services*.

27.5 Recommended approach to new system management arrangements

Along with the establishment of an independent Mental Health and Wellbeing Commission, further changes are required to the structure and functions within the Department of Health. This will ensure mental health and wellbeing becomes an enduring priority in government decision making. It will also enable people with lived experience to lead and take part in the governance of the system in a meaningful way, strengthen system leadership and accountability, and create the right conditions for systemic reform.

27.5.1 Substantive structural changes proposed for the Department of Health

As discussed in section 27.3, numerous factors have contributed to the lack of priority given to mental health in government decision making. These relate to contextual challenges, such as the role of stigma and competing advocacy, and structural challenges, such as limited accountability, leadership and system planning, and departmental structures. To help confront these barriers, this section sets out reforms to departmental arrangements.

Keeping mental health and wellbeing in the Department of Health

The Commission recognises that the former Department of Health and Human Services' system management was constrained by the structural challenges discussed in section 27.3. However, given its experience in policy, implementation and budget processes, the Department of Health, which will continue to perform these functions, is best placed to continue the system management role. The Commission considers, however, that material changes to the role are required.

The Department of Health will receive significant funding in the annual budget cycles. As a result, it has a critical role in advising the government of the day on its investment decisions. Separating mental health from the Department of Health's direct responsibility risks the mental health portfolio being neglected in funding decisions, compromising the ability of the portfolio to secure funding.

In considering an alternative entity to perform the system management role, the Commission was cautioned that it would likely result in missed opportunities to 'pool funding, to work together to manage demand, and to share resources, lessons and evidence'.[88] Further, if system management arrangements were separated, this would risk 'disconnecting the mental health portfolio from the incidental intelligence and collaboration that occurs through participating in whole-of-government decision-making forums on strategic priorities and directions'.[89]

Keeping system management responsibilities within the Department of Health also maintains the links between mental health, alcohol and other drugs, physical health and ageing. These links are important: people living with mental illness or psychological distress, families, carers and supporters often use services across multiple systems, requiring careful management to integrate and coordinate these services where possible. For example, Mr Symonds told the Commission about the importance of maintaining links between mental health and physical health. He reported that separating out the governance of mental health from that of physical health would act as a barrier to achieving good outcomes for people across these areas.[90]

Associate Professor Steven Moylan, Clinical Director for Mental Health, Drug and Alcohol Services at Barwon Health, told the Commission that it would be 'stigmatising' to separate the governance of mental health from other health services.[91] Similarly, Professor Suresh Sundram, Head of Department of Psychiatry, School of Clinical Sciences, Monash University and Director of Research, Monash Health Mental Health Program, giving evidence in a personal capacity, said that separate governance would lead to mental health being 'orphaned from and ignored by the whole [health] system'.[92]

Given the significant link between mental health and wellbeing services and substance use and addiction services, the Department of Health should consider integrating system-level governance arrangements within the new Mental Health and Wellbeing Division. Co-occurring experiences of mental illness and substance use are common, and the Commission has been told that governance should be combined to establish integrated and coordinated services for consumers.[93] The Commission's approach to improving outcomes for people living with mental illness and substance use or addiction is set out in Chapter 22: *Integrated approach to treatment, care and support for people living with mental illness and substance use or addiction*.

The Commission also expects that the new Department of Health and the new Department of Families, Fairness and Housing will work closely together to ensure the links between mental health and social services are maintained to achieve positive outcomes for people using multiple service systems.

Elevating the status of mental health and wellbeing within the Department of Health

The Commission has examined the challenges of the current approach to system management (refer to section 27.3). It considers these challenges can be addressed by making real changes to the way mental health and wellbeing is governed, resourced and led, and by establishing the new Mental Health and Wellbeing Commission (refer to section 27.4).

The Department of Health will also be supported by the Commission's clear reform directions, stronger approaches to commissioning, clearer accountability through the *Mental Health and Wellbeing Outcomes Framework*, and the leadership of people with lived experience. The mental health levy recommended in the interim report will also assist by ensuring substantially increased investment in the mental health and wellbeing system. The Commission was told that setting ambitious reform targets, ensuring sufficient dedicated funding and elevating the experiences of consumers would 'do a lot to raise the prominence of mental health' on the government's agenda.[94]

On 23 December 2020, the establishment of a new Mental Health Division in the Department of Health, to be led by a Deputy Secretary, was announced. Ahead of this announcement, the Commission had drawn the same conclusion. To elevate the status of mental health and wellbeing, a well-resourced and dedicated division is required. Given that the Commission's reform agenda looks beyond the system and recognises the impact of other social services and the places people work, learn, live and connect on people's mental health and wellbeing, it is recommended that the new division is called the Mental Health and Wellbeing Division.

In addition, to strengthen system leadership, the new division will be led by a Chief Officer for Mental Health and Wellbeing. The Chief Officer position will be a statutory office at a Deputy Secretary level. Relevant legislation must establish the position and provide that it reports directly to the Secretary of the Department of Health. The Chief Officer will perform the functions of the Secretary as specified in the new Mental Health and Wellbeing Act and will be delegated those functions legislatively. In some instances, the Secretary's functions will be delegated to other people, such as the CEO of Safer Care Victoria who will undertake some quality and safety functions, as described in Chapter 30: *Overseeing the safety and quality of services*.

The statutory appointment and legislated status of the Chief Officer at a Deputy Secretary level, reporting to the Secretary, is a fundamental component of the Commission's reforms ensuring the Department of Health gives priority to mental health and wellbeing. The Commission is aware that over the years, responsibility for the mental health system has moved incrementally lower in the departmental hierarchy. While not discounting the commitment of individual leaders, reporting lines which are not direct to the Secretary can affect the status of mental health, as well as diminish outside perceptions of authority and influence in decision making.

Ms Jennifer Williams AM, Chair, Northern Health, said the situation in the former Department of Health and Human Services, where the Director of Mental Health reported to an executive with other responsibilities, affected the priority given to mental health within the department.[95]

Associate Professor Stafrace also described the importance of senior reporting lines:

> **The establishment of [Mental Health Reform Victoria] as an administrative office has demonstrated to my mind the value of this structure in elevating mental health issues as a priority within [the department]. The reporting of the Chief Executive Officer directly to the Minister for Mental Health and the Secretary of the Department allows for far greater accountability for mental health reform. It also ensures that mental health is increasingly incorporated as a key consideration in the core work undertaken in response to a host of priorities.**[96]

Enshrining the Chief Officer's role and status in legislation ensures that system management functions remain prominent, safeguards the Chief Officer's direct reporting line to the Secretary, and assists to ensure the position endures over time. It is particularly important that these functions are assigned to a senior-level officer. This ensures the Chief Officer has the required authority within, and outside, the department. The Chief Officer must accordingly have extensive leadership expertise and experience in social policy, project delivery and change management.

The functions of the Chief Officer for Mental Health and Wellbeing

The Chief Officer for Mental Health and Wellbeing will perform the role and functions conferred to the Secretary of the Department of Health under the new Mental Health and Wellbeing Act, the features of which are outlined in Chapter 26: *Rebalancing mental health laws—a new Mental Health and Wellbeing Act*. Before the new Act is enabled, in principle, it is expected that the Chief Officer will perform the functions set out in this section.

Broadly, as set out in Figure 27.2, these functions include responsibility for mental health and wellbeing strategy, policy, planning and commissioning; monitoring the performance of funded mental health and wellbeing service providers; and developing the mental health and wellbeing workforce.

The new division will include the:

- Suicide Prevention and Response Office, with the State Suicide Prevention and Response Adviser reporting to the Chief Officer, whose role is described in Chapter 17: *Collaboration for suicide prevention and response*
- Mental Health and Wellbeing Promotion Office, with the Mental Health and Wellbeing Promotion Adviser reporting to the Chief Officer, as described in Chapter 4: *Working together to support good mental health and wellbeing*
- team, with senior executive leadership, responsible for leading and coordinating an approach to support mental health and wellbeing outcomes for diverse communities, discussed further in Chapter 21: *Responding to the mental health and wellbeing needs of a diverse population*.

The Chief Officer will also be required to undertake a strong stewardship role in supporting the new Regional Mental Health and Wellbeing Boards to successfully perform their functions. In Chapter 5: *A responsive and integrated system*, the Commission has recommended the phased introduction of eight Regional Boards, as part of new regional governance structures that seek to support a more responsive approach to the planning and organisation of mental health and wellbeing services. In particular, the Chief Officer will need to set clear expectations about the standards to which Regional Boards must commission services, and ensure that integrated services and outcomes are a priority.

In monitoring the performance of providers, the Chief Officer must use a 'responsive regulation' approach, whereby providers are held to account under agreed mechanisms and, where there is underperformance, the Department of Health and Regional Boards intervene.

The Chief Officer will also be responsible for implementing the Commission's recommendations. As Mental Health Reform Victoria is currently implementing the Commission's interim report recommendations, its functions must transfer to the new division by mid-2021, as discussed in section 27.6.

The Chief Officer's functions are largely consistent with those set out in section 118 of the current Mental Health Act, except where highlighted in bold in Figure 27.2. These changes are set out here:

- Functions (b), (c) and (j) have been amended to include references to promoting and protecting human rights to ensure that mental health and wellbeing services are operating in ways that recognise human rights obligations.
- Function (b) has been amended to ensure that the Chief Officer has a legislated obligation to *commission* services across the continuum of care, from early intervention to responsive services, and to plan services, at a *state level*, to ensure they are coordinated across the state. The commissioning function will evolve over time as new Regional Boards are established and take on a commissioning role.
- Function (b) has also been amended to include *suicide prevention and response*. This accounts for the fact that the Suicide Prevention and Response Office will be positioned in the new division and for the substantive reform work the Commission has recommended in this area.
- Functions (b) and (d) have been amended to include *Victoria's diverse communities*, to plan, build and sustain a service offering that is transparent, accountable and responsive to diverse communities.
- Function (j) has been added to ensure that the Chief Officer is responsible for developing a sustainable and responsive service offering that meets the expectations of consumers, families, carers and supporters.
- Function (l) has been added to strengthen the Chief Officer's accountability in meeting its legislated functions.

The Commission expects that the new division will be adequately resourced to perform its functions. This includes employing people from outside the public service to ensure the division has the mix of skills needed to implement complex reform.

Figure 27.2 also shows the entities with which the Chief Officer is expected to build relationships and work collaboratively with to improve mental health and wellbeing outcomes. The Commission has recommended establishing some of these bodies, including the Mental Health Improvement Unit in Safer Care Victoria, described in Chapter 30: *Overseeing the safety and quality of services,* and the Mental Health and Wellbeing Commission (refer to section 27.3). Establishment of the Collaborative Centre for Mental Health and Wellbeing was recommended by the Commission in its interim report to bring together a range of people with lived experience of mental illness, researchers and mental health professionals to improve service delivery and research. Additionally, the Chief Officer will be required to work with the Chief Psychiatrist, whose role is explored in Chapter 30: *Overseeing the safety and quality of services*.

Working with the Commonwealth

A critical role of the Chief Officer must be to work with the Commonwealth Government to ensure mental health and wellbeing services are coordinated and integrated. In its interim report, the Commission noted that the mental health system is complex and fragmented, and that a contributor to this fragmentation is shared Commonwealth and Victorian Government responsibility for funding and oversight.[97]

This complexity is compounded by poorly defined roles and responsibilities,[98] leading to large service gaps and a lack of service coordination and integration. These challenges contribute to the 'missing middle': people whose mental health needs are too complex and enduring for primary care services alone, but whose mental illness is not considered 'severe' enough to meet the high threshold to receive treatment from current public specialist mental health services.[99]

Consequently, effective leadership at the state and national level is a crucial element in the success of the Commission's recommendations. Leaders must work cooperatively and collaboratively to ensure mental health and wellbeing services are complementary and that no person 'falls through the gaps'.

State and Commonwealth engagement and recommendations for improvements are explored in Chapter 29: *Encouraging partnerships*.

Government-wide structures

As discussed throughout this report, the Commission considers that mental health and wellbeing is a shared responsibility across the community and across government. The future mental health and wellbeing system must appropriately engage with areas that are beyond the responsibility of the Department of Health. There are many government agencies that have a role to play in Victoria's future mental health and wellbeing system, such as education, justice and community services, with access to these services reflecting the varied aspects of a person's life and some of the factors that can contribute to the attainment of good mental health and wellbeing. The collective and coordinated effort across government portfolios needed to improve mental health and wellbeing is referred to as a whole-of-government approach.

To support government-wide and community-wide approaches to improving mental health and wellbeing, governance structures must be established that comprise all relevant government departments. This includes a Mental Health and Wellbeing Cabinet Subcommittee, chaired by the Premier for at least two years. Further a Mental Health and Wellbeing Secretaries' Board, chaired by the Department of Premier and Cabinet, and comprising the Chief Officer for Mental Health and Wellbeing and the Secretaries of the Department of Health, the Department of Education and Training, the Department of Families, Fairness and Housing, the Department of Justice and Community Safety and the Department of Treasury and Finance will be established. To uphold senior leadership and the prioritisation of mental health and wellbeing, the membership of, and participation in, the Secretaries' Board should not be delegated down.

The Cabinet Subcommittee and Secretaries' Board will oversee the implementation of the Commission's recommendations as described in section 27.5.

The Premier's role in the Mental Health and Wellbeing Cabinet Subcommittee is critical to ensuring mental health and wellbeing is made a priority in government decision making. Political and cross-party leadership at the highest levels of government is vital if Victoria wants to continue to tackle past underinvestment and low interest in mental health and wellbeing.

Additionally, a Suicide Prevention and Response Secretaries' Board Subcommittee, comprising Secretary and Deputy Secretary membership from all government departments, the Coroners Court of Victoria, Victoria Police and WorkSafe will oversee the suicide prevention and response system, noting the important role these agencies play in suicide prevention and response as set out in Chapter 17: *Collaboration for suicide prevention and response*. As recommended in Chapter 4: *Working together to support good mental health and wellbeing*, an Interdepartmental Committee on Mental Health and Wellbeing Promotion will also be established and report to the Secretary of the Department of Health. Given the shared membership and responsibilities across the Secretaries' Board, Secretaries' Subcommittee and Interdepartmental Committee, it is important they establish clear priorities and ways of working together and sharing information to ensure work programs are coordinated.

27.5.2 The leadership and representation of people with lived experience of mental illness or psychological distress, and families, carers and supporters

The Commission's reforms are based on a future mental health and wellbeing system where people with lived experience of mental illness or psychological distress, families, carers and supporters are central to the planning and delivery of treatment, care and support.[100] Specifically, to support the leadership of people with lived experience of mental illness or psychological distress and lived experience of caring for someone living with mental illness or psychological distress, the new Mental Health and Wellbeing Commission will have appointed Commissioners with lived experience.

The Department of Health must also lead by example, with people with lived experience of mental illness or psychological distress, families, carers and supporters being employed in senior leadership positions and central to decision-making processes.

As noted earlier in this chapter, some current efforts to engage with people with lived experience of mental illness or psychological distress, families, carers and supporters can be regarded as piecemeal and not meaningful. In relation to consumer leadership, Ms Roper told the Commission:

> After 25 years of policy stating that consumers should be involved at all levels of service development, delivery and review, Victoria has few to no consumer leadership roles in service governance or executive level, the consumer workforce is still riddled with part-time roles, there are few to no consumer leadership roles in government with genuine influence, none within statutory bodies, no policy leaders and no roles in service monitoring. The few roles that do exist tend to be advisory only or specific to engaging other consumers. Yet there are examples of consumers in leading roles in other jurisdictions.[101]

The benefits, however, of enabling the meaningful leadership of people with lived experience of mental illness or psychological distress in government decision making are substantial. Professor Bruce Bonyhady AM, Executive Chair of the Melbourne Disability Institute, University of Melbourne, giving evidence in a personal capacity, described to the Commission the importance of lived experience representation:

> **In successful businesses, consumer feedback is an essential touchstone driving change and continuous improvement, but in government the processes for co-production or co-design are often poorly developed or a box to be ticked, rather than being integral to the process. This needs to change, because without the contribution of people with lived experience to the development of government policy, practice and research, services will not be reflective of the needs and aspirations of citizens, and governments will fail in their duty to serve.**[102]

Ms Honor Eastly, witness, spoke of the need to 'invest in consumer leadership in an effort to rebalance power, to ensure that the system is reformed by the people who use it'.[103]

Mr Graham Panther, witness, told the Commission that the system manager can be a leader in this area and employ people with lived experience in prominent positions of real influence, where they can make decisions regarding policy and budget.[104]

The Commission recommends that the new Mental Health and Wellbeing Division employs people with lived experience of mental illness or psychological distress and people with lived experience of caring for someone living with mental illness or psychological distress in multiple and substantive leadership positions and throughout its internal structures.

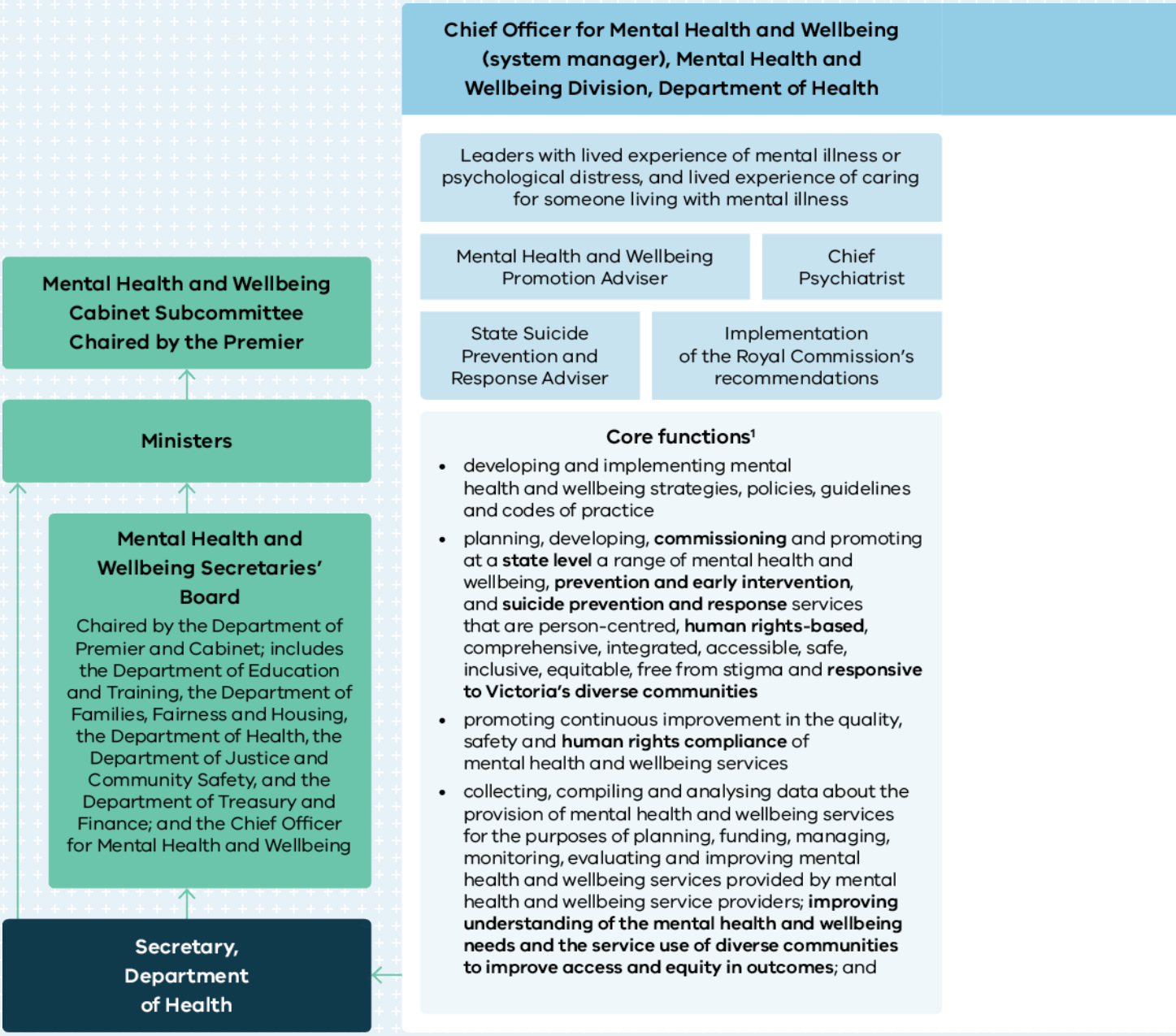
Taking account of the distinct perspectives of these two groups, people employed in these leadership positions are to lead engagement with people with lived experience of mental illness or psychological distress, families, carers and supporters. They must also be involved in decision-making processes regarding:

- the implementation of the Commission's recommendations
- policy decisions relating to mental health and wellbeing across the Department of Health.

To ensure that people with lived experience of mental illness or psychological distress, families, carers and supporters have an enduring role in government decision making and that there is an evolving group of lived experience leaders, the new division must support people with lived experience through training and mentorship programs, with a focus on leadership, policy making and government processes. The new division may partner with other related entities, including the Mental Health and Wellbeing Commission, to grow, develop and support the leadership capabilities of lived experience leaders.

People with lived experience of mental illness or psychological distress, families, carers and supporters must be central to the decision-making processes to ensure that the mental health and wellbeing system is designed by the people who access it, and so that services continue to be improved based on people's experiences.

Figure 27.2: Recommended approach to the Department of Health's system management arrangements



Note: [1] Functions as currently stipulated in the *Mental Health Act (Vic)* 2014, except where **text is highlighted in bold**

conducting research into mental illness, mental health and wellbeing, and related fields

- monitoring and evaluating the performance, standards and outcomes of mental health and wellbeing service providers and the quality and safety of the mental health and wellbeing services they provide
- promoting awareness and understanding among health professionals and within the wider community in relation to mental illness and mental health and wellbeing
- commissioning and facilitating research and evaluation into mental illness, mental health and wellbeing and related fields, including **consumer-led research and evaluation**
- developing, supporting and promoting the capacity of the mental health and wellbeing service workforce to provide mental health and wellbeing services in accordance with the objectives and principles of mental health and wellbeing laws and other relevant laws
- promoting coordination between mental health and wellbeing service providers and providers of other health, disability and community support services
- **overseeing and developing mental health and wellbeing service providers, and intervening as necessary, to build and sustain service offerings that are flexible and responsive to consumer, family, carer and supporter expectations and that protect human rights**
- advising the minister about mental health and wellbeing services and the operation of related mental health and wellbeing laws and regulations
- as soon as practicable after the end of each financial year but no later than the following 31 October, submitting to the minister an annual report containing: a review of the services provided by mental health and wellbeing service providers during the financial year; **details about how the department is meeting its functions**; and any other information the minister has requested in writing
- **implementation of the Royal Commission's recommendations.**

Mental Health and Wellbeing Commission
(See Figure 27.1)

Relationships with other entities

- Collaborative Centre for Mental Health and Wellbeing
- Government departments
- Mental Health Tribunal
- Office of the Public Advocate
- Safer Care Victoria, including the Mental Health Improvement Unit
- Victorian Agency for Health Information
- VicHealth
- Victorian Equal Opportunity and Human Rights Commission

Consistent accountability framework across diverse provider landscape
Regional Mental Health and Wellbeing Boards

Health and mental health and wellbeing services

Community health services

Non-government organisations

Forensicare

27.6 Implementation of the Commission's recommendations

It can be argued that the most important work of the Commission begins when the report is submitted to government and implementation commences.[105] The quality of implementation will have a direct impact on whether the Commission's aspirations for a future mental health and wellbeing system are realised.[106]

As noted in the interim report, many strategies, plans, reports and inquiries into different parts of the system have tried to improve the experiences of consumers, families, carers and supporters.[107] Successfully implementing mental health reform has been a continuing challenge throughout Australia. Independent inquiries into mental health have consistently concluded that reform efforts have failed to meet expectations—that is, they have not transformed services and the outcomes people experience as anticipated.[108]

The implementation challenge is not unique to mental health. Timely and effective implementation of service reforms has proved challenging in Victoria[109] and elsewhere in Australia.[110] Even when reforms have been well designed, broadly supported and ultimately considered successful, implementation is rarely straightforward.[111]

Mental health reform, however, comes with the added complexities of stigma and lack of parity with physical health,[112] as well as competing views and expectations within and beyond the sector.[113] Implementation of the Commission's reforms will also have to take place in the context of the COVID-19 pandemic, which has created a constrained fiscal environment.

The Commission considered two main proposals regarding implementation: placing implementation functions within the Department of Health or creating a new, separate entity.

Mr Gibbs told the Commission that an independent entity was required to attract 'high-quality individuals who have the leadership skills' to make reform happen, saying that:

> The new structure will require the authority to drive the necessary strategies at the relevant interfaces with housing, family support, justice and corrections and employment. Implementation across these fronts is too important to be left to trickle down bureaucratic actions and relevant Departmental responses. Without such a structure the recommendations from the Royal Commission, despite the best intentions, will fall on fallow ground.[114]

This view is consistent with some research, which indicates that creating a new entity to lead reform and promote culture change can be more powerful than adding to old structures that might lack the capacity to deliver[115] or be constrained by established ways of doing things.[116]

Conversely, Ms Peake stressed the difficulties arising when new institutions are tasked with leading reform, and the opportunities afforded by making use of the capabilities in existing organisations to implement reform:

> It can be difficult for new institutions to form and lead transformational change. For this reason, if a logical institution does not exist, it can be appropriate to consider whether a discrete section of an existing organisation can be repurposed or given an elevated role in owning or driving the delivery of new service models and pathways.[117]

Professor Ian Hickie AM, Co-Director, Health and Policy at the Brain and Mind Centre, University of Sydney, giving evidence in a personal capacity, told the Commission that the division of implementation and system management functions are not always logical:

> **In my view, the dichotomy sometimes drawn between system management functions and functions related to the implementation of reforms is a false one. In so far as any entity is responsible for high level systems planning and modelling, this would only require a relatively limited amount of expertise in relation to the technical aspects of reform implementation.**[118]

The Commission considers that it is necessary to locate implementation functions and system management functions, such as policy and commissioning, in the same entity to enable a collective focus and culture of reform. Transformational change is more likely to take hold if the implementation entity is involved in the delivery of the reform and has its own interest in making reform 'stick'.[119] This counters the risk that implementation is only focused on 'ticking off' individual recommendations, rather than aiming for system-wide reform and continuous improvement.

The Commission recommends that the Chief Officer for Mental Health and Wellbeing is responsible for implementing the Commission's recommendations, unless otherwise stated in this report.

The functions of Mental Health Reform Victoria must be transferred to the new division by mid-2021, with the Chief Officer to take over implementation of the interim report's recommendations. As set out in the interim report, Mental Health Reform Victoria was to be established for two years while the Commission designed the final governance arrangements,[120] and as noted in this chapter, the new division is the best entity to take on Mental Health Reform Victoria's functions.

Victorians can be confident that efforts to reform the mental health and wellbeing system will be successful and enduring. The Chief Officer has a substantial task ahead in performing this role, and as a statutory, senior appointment, is well placed to champion reform and lead cultural change.

The Chief Officer must also establish the necessary resources, structures and processes to create the confidence, commitment and momentum needed to transform the mental health and wellbeing system. It is expected that implementation of the Commission's recommendations will start immediately, noting the extensive consultation and system design work the Commission has completed to develop this report.

As stated earlier, whole-of-government oversight of the implementation of the Commission's recommendations will be achieved through a Mental Health and Wellbeing Secretaries' Board, chaired by the Department of Premier and Cabinet, and a Mental Health and Wellbeing Cabinet Subcommittee, chaired by the Premier for at least two years.

The complexity of the mental health and wellbeing system means that reform will take time—this requires strong, committed leadership and support from all political parties.[121]

27.7 Monitoring the implementation of the Commission's recommendations

This Commission has developed a set of recommendations which support a fundamental redesign of Victoria's mental health system.[122] It is critical that the Victorian Government is held accountable to the public for implementing these recommendations.

Oversight of government's progress in implementing the Commission's reforms must be conducted independently and transparently. Professor Patrick McGorry AO, Professor of Youth Mental Health, The University of Melbourne and Executive Director of Orygen, who gave evidence in a personal capacity, said:

> **A standing commission on mental health with independent powers to monitor the implementation of reforms, to safeguard and continue further reform and growth into the future, will be essential if these goals are to be met.**[123]

The Commission believes that as a statutory authority, the new Mental Health and Wellbeing Commission is well placed to independently examine and oversee the implementation of the Commission's reforms across the system. This includes annual public reporting to the Victorian Parliament for the duration of the implementation of the Commission's recommendations.

In this role, the Mental Health and Wellbeing Commission will not be required to monitor itself, as the Royal Commission's recommendation relates to its establishment only. The new Commission will be accountable to the minister for achieving its objectives, including through the tabling of its annual public report in the Victorian Parliament.

As with the Family Violence Reform Implementation Monitor,[124] the new Commission must provide observations which improve the effectiveness of the reform implementation and alert government, the sector and community to any emerging risks and problems.

Transforming Victoria's mental health and wellbeing system will take time, and Victorians should have confidence that government will implement the Commission's reforms in line with its aspirations.

1 World Health Organization, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes, WHO's Framework for Action*, 2007, p. vi.

2 Commonwealth of Australia, *Our Public Service, Our Future. Independent Review of the Australian Public Service*, 2019, p. 278.

3 Victorian Public Sector Commission, Governance, <vpsc.vic.gov.au/governance/>, [accessed 28 September 2020].

4 *Witness Statement of Associate Professor Simon Stafrace*, 14 August 2020, paras. 117–122.

5 *Witness Statement of Terry Symonds*, 2 November 2020, para. 42.

6 W*itness Statement of Indigo Daya*, 12 May 2020, para. 101.

7 *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 41.

8 The Honourable Daniel Andrews MP, Premier of Victoria, Media Release: New Departments To Deliver A Healthier, Fairer Victoria, 30 November 2020, <www.premier.vic.gov.au/new-departments-deliver-healthier-fairer-victoria>, [accessed 1 December 2020].

9 The Honourable Daniel Andrews MP, Premier of Victoria.

10 The Honourable Daniel Andrews MP, Premier of Victoria.

11 *Witness Statement of Terry Symonds*, para. 24.

12 *Mental Health Act 2014* (Vic), sec. 117(a).

13 *Mental Health Act 2014* (Vic), sec. 118(1).

14 *Witness Statement of Kym Peake*, 24 July 2019, para. 31.

15 *Witness Statement of Kym Peake*, 2019, para. 37.

16 *Witness Statement of Kym Peake*, 2019, para. 327.

17 *Witness Statement of Kym Peake*, 2019, para. 49.

18 *Health Services Act 1988* (Vic), sec. 65T(1).

19 *Witness Statement of Kym Peake*, 2019, paras. 340–341 and 354.

20 *Health Services Act 1988* (Vic), sec. 40G.

21 *Witness Statement of Shane Solomon*, 22 May 2020, para. 95.

22 Community Health Taskforce, *Community Health Taskforce: Report to Government*, 2019, p. 15; Victorian Auditor-General's Office, *Community Health Program*, 2018, p. 51.

23 Note: Forensicare also reports to the Minister of Corrections due to contractual relations for prison services. *Mental Health Act 2014* (Vic), sec. 328.

24 *Mental Health Act 2014* (Vic), secs. 332 and 344.

25 South Eastern Melbourne Primary Health Network, Psychosocial Supports, <www.semphn.org.au/commissioning/mental-health/psychosocial-supports.html>, [accessed 14 December 2020].

26 *National Disability Insurance Scheme Act 2013* (Cth), sec. 73B; *National Disability Insurance Scheme (Registered Providers of Supports) Rules 2013*, 2013, p. 3.

27 health.vic, Private Hospitals, <www2.health.vic.gov.au/hospitals-and-health-services/private-health-service-establishments/private-hospitals>, [accessed 16 October 2020].

28 Department of Health and Human Services, *Risk Based Regulatory Framework: Private Hospitals 2017*, 2017, pp. 6–8.

29 Victorian Government, *Submission to the RCVMHS: SUB.5000.0001.0001*, 2019, p. 5.

30 Commonwealth Department of Health, *Correspondence to the RCVMHS: CSP.0001.0001.0093*, 2020, p. 3.

31 *Witness Statement of Robyn Kruk AO*, 4 May 2020, para. 20.

32 Note the South Australian Mental Health Commission was subsumed into Wellbeing South Australia in January 2020, which comprises three Directorates: Prevention and Population Health; Integrated Care System; and Mental Health and Wellbeing.

33 *Mental Health Commission Act 2012* (NSW), sec. 12; *Queensland Mental Health Commission Act 2013* (Qld), sec. 11.

34 Office of the Auditor General, Western Australia, *Access to State-Managed Adult Mental Health Services: Report 4: 2019–20*, 2019, p. 7.

35 National Mental Health Commission, *Submission to the RCVMHS: SUB.0002.0029.0106*, 2019, p. 2.

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

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

38 *Evidence of David Martine PSM*, 26 July 2019, p. 1817.

39 *Witness Statement of David Martine PSM*, 28 June 2019, para. 9.

40 *Witness Statement of Dr Chris Groot*, 4 September 2019, para. 16.

41 *Witness Statement of Dr Michelle Blanchard*, 27 June 2019, para. 46.

42 *Witness Statement of The Hon. Robert Knowles AO*, 16 July 2019, para. 48.

43 *Witness Statement of Dr Gerard Naughtin*, 24 July 2019, para. 15.

44 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, 2020, p. 149.

45 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 361.

46 Mike Steketee, How a Forty-Year-Old Proposal Became a Movement for Change, *Inside Story*, 22 October 2013, pp. 1–8.

47 *Witness Statement of The Hon. Andrew Robb AO*, 26 June 2019, para. 37.

48 Jennifer Doggett, The Personal and the Political, *Inside Story*, 15 June 2019, p. 3.

49 Beyond Blue, Beyond Blue Chair The Hon. Julia Gillard AC Delivers the 2019 Diego De Leo Address, 23 July 2019, <www.beyondblue.org.au/media/news/news/2019/07/22/beyond-blue-chair-the-hon-julia-gillard-ac-delivers-the-2019-diego-de-leo-address>, [accessed 26 September 2019].

50 *Witness Statement of Lucinda Brogden AM*, 11 May 2020, para. 18.

51 Ministry of Health, New Zealand, Mental Health and Wellbeing Commission, <www.health.govt.nz/our-work/mental-health-and-addictions/government-inquiry-mental-health-and-addiction/mental-health-and-wellbeing-commission>, [accessed 25 November 2020].

52 Ministry of Health, New Zealand, *Terms of Reference for the Initial Mental Health and Wellbeing Commission*, 2019, p. 1.

53 Ministry of Health, New Zealand, Mental Health and Wellbeing Commission, para. 9.

54 New Zealand Government, Media Release: Initial Mental Health and Wellbeing Commission Appointed, 12 September 2020, <www.beehive.govt.nz/release/initial-mental-health-and-wellbeing-commission-appointed>, [accessed 25 November 2020].

55 *Witness Statement of Terry Symonds*, paras. 168–169.

56 *Witness Statement of Terry Symonds*, para. 169.

57 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, 2020, p. 1078.

58 Commission for Children and Young People, *Annual Report 2018–19*, 2019, p. 14.

59 Victorian Mental Illness Awareness Council, *Correspondence to the RCVMHS: Governance in Mental Health*, 2020, p. 10.

60 *Witness Statement of Andrew Greaves*, 19 July 2019, para. 31.

61 *Witness Statement of Kym Peake*, 2019, para. 374.

62 Christopher Gibbs, *Submission to the RCVMHS: SUB.0002.0028.0183*, 2019, p. 3.

63 *Witness Statement of Terry Symonds*, paras. 30–37; *Witness Statement of Kym Peake*, 2019, paras. 228–229 and 290.

64 *Witness Statement of Terry Symonds*, para. 29.

65 Evidence of Kym Peake, 25 July 2019, p. 1763.

66 *Evidence of Andrew Greaves*, 25 July 2019, pp. 1701–1702.

67 *Witness Statement of Andrew Greaves*, para. 39.

68 Victorian Auditor-General's Office, *Access to Mental Health Services*, 2019, p. 8.

69 *Evidence of Andrew Greaves*, p. 1700.

70 Victorian Auditor-General's Office, *Access to Mental Health Services*, p. 12.

71 Victorian Auditor-General's Office, *Access to Mental Health Services*, p. 51.

72 *Witness Statement of Shane Solomon*, paras. 98 and 101.

73 *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 121.

74 *Witness Statement of Vrinda Edan*, 10 July 2019, para. 19; Ingrid Ozols, *Submission to the RCVMHS: SUB.0002.0019.0021*, 2019, p. 3; *Witness Statement of 'Rachel Bateman' (pseudonym)*, 16 June 2020, paras. 91 and 168; *Witness Statement of Erandathie Jayakody*, 4 June 2020, para. 66.

75 *Witness Statement of Kym Peake*, 2019, para. 92.

76 *Witness Statement of Kym Peake*, 2019, para. 93.

77 *Witness Statement of Cath Roper*, 2 June 2020, para. 39.

78 Victorian Mental Illness Awareness Council, pp. 2–3.

79 *Mental Health Commission Act 2012* (NSW), sec. 12(1)(c); *Queensland Mental Health Commission Act 2013* (Qld), sec. 11(1)(d).

80 Ministry of Health, New Zealand, *Establishing a New Independent Mental Health and Wellbeing Commission*, 2019, p. 4.

81 *Witness Statement of Angus Clelland*, 5 June 2020, para. 39.

82 *Witness Statement of Dr Peggy Brown AO*, 22 July 2019, para. 8.

83 Victorian Mental Illness Awareness Council, p. 14.

84 Australian Psychological Society, *Submission to the RCVMHS: SUB.0002.0029.0349*, 2019, p. 9.

85 Mental Health Victoria and Victorian Healthcare Association, *Submission to the RCVMHS: SUB.0002.0029.0005*, 2019, p. 54.

86 *Witness Statement of Professor David Copolov AO*, 7 July 2020, para. 193.

87 *Witness Statement of Shane Solomon*, para. 102.

88 *Witness Statement of Kym Peake*, 4 October 2020, para. 88.

89 *Witness Statement of Kym Peake*, 2020, para. 87.

90 *Witness Statement of Terry Symonds*, para. 72.

91 *Witness Statement of Associate Professor Steven Moylan*, 29 May 2020, para. 97.

92 *Witness Statement of Professor Suresh Sundram*, 19 May 2020, para. 108.

93 *Evidence of Dr John Reilly*, 18 June 2020, pp. 37–38; *Witness Statement of Professor Dan Lubman*, 28 May 2020, para. 42.

94 *Witness Statement of Kym Peake*, 2020, para. 85.

95 *Witness Statement of Jennifer Williams AM*, 22 July 2019, para. 51(d).

96 *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 121.

97 *Witness Statement of Dr Peggy Brown AO*, para. 12.

98 *Witness Statement of Bill Buckingham*, 7 July 2020, para. 22.

99 Victorian Government, p. 23; *Witness Statement of Associate Professor Simon Stafrace*, 7 July 2019, para. 85(b).

100 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 13.

101 *Witness Statement of Cath Roper*, para. 17.

102 *Witness Statement of Professor Bruce Bonyhady AM*, 16 June 2020, para. 52.

103 *Witness Statement of Honor Eastly*, 14 September 2020, para. 41(b)(2).

104 *Witness Statement of Graham Panther*, 6 July 2020, para. 137.

105 Emma Norris and Marcus Shepheard, *How Public Inquiries Can Lead to Change*, 2017, p. 27.

106 Parenting Research Centre, *Implementation Best Practice: A Rapid Evidence Assessment*, 2016, p. 13.

107 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 568.

108 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 568.

109 See for example: Family Violence Reform Implementation Monitor, *Report of the Family Violence Reform Implementation Monitor as at 1 November 2018*, 2018, p. iv.

110 Parenting Research Centre, *Implementation of Recommendations Arising from Previous Inquiries of Relevance to the Royal Commission into Institutional Responses to Child Sexual Abuse Final Report*, 2015, p. 153.

111 Joannah Luetjens, Michael Mintrom and Paul 't Hart, *Successful Public Policy: Lessons from Australia and New Zealand* (Australia & New Zealand School of Government, 2019), p. 19.

112 *Witness Statement of Kym Peake*, 2019, para. 76.

113 *Witness Statement of Associate Professor Ruth Vine*, 27 June 2019, para. 111.2; *Witness Statement of Dr Gerard Naughtin*, para. 15.

114 Gibbs, p. 3.

115 Eric M. Patashnik, Chapter 9. Conclusions: The Patterns and Paradoxes of Policy Reform, in *Reforms at Risk: What Happens After Major Policy Changes Are Enacted* (Princeton: Princeton University Press, 2009), pp. 155–180 (pp. 163–167).

116 Janine O'Flynn and others, 'You Win Some, You Lose Some: Experiments with Joined-Up Government', *International Journal of Public Administration*, 34.4 (2011), 244–254 (p. 249).

117 *Witness Statement of Kym Peake*, 2019, paras. 179–180.

118 *Witness Statement of Professor Ian Hickie AM*, 11 August 2020, paras. 147–148.

119 *Witness Statement of Kym Peake*, 2019, para. 176.

120 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 567.

121 *Witness Statement of Associate Professor Ruth Vine*, 2019, para. 97.

122 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 2.

123 *Witness Statement of Professor Patrick McGorry AO*, 2 July 2019, para. 74.

124 Family Violence Reform Implementation Monitor, p. 41.

Chapter 28

Commissioning for responsive services

Recommendation 47:

Planning the new mental health and wellbeing system

The Royal Commission recommends that the Victorian Government:

1. establish 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*.
2. develop and publish a statewide mental health and wellbeing service and capital plan and eight regional mental health and wellbeing service and capital plans, with the first plans to be endorsed by the Mental Health and Wellbeing Secretaries' Board (refer to recommendation 46(2)(b)) by the end of 2022, with the remainder approved by the end of 2023.
3. update the statewide mental health and wellbeing service and capital plan every three years.
4. by no later than the end of 2026, empower Regional Mental Health and Wellbeing Boards (refer to recommendation 4(2)) to update regional mental health and wellbeing service and capital plans every three years.

Recommendation 48:

Selecting providers and resourcing services

The Royal Commission recommends that the Victorian Government:

1. build on the interim report's recommendation 8 regarding a new approach to mental health investment and use, and empower Regional Mental Health and Wellbeing Boards (refer to recommendation 4(2)) to use, new service standards developed by the Royal Commission to select providers of mental health and wellbeing services, including new providers and provider partnerships.
2. support the further development of new and existing providers to meet the long-term ambition of the service standards.
3. develop new ways of funding providers that encourage the provision of mental health and wellbeing services that consumers, families, carers and supporters value and result in an equitable allocation of resources through:

    a. trialling then implementing an activity-based funding model for both bed-based and community-based mental health and wellbeing services;

    b. working with the Collaborative Centre for Mental Health and Wellbeing to develop and implement an approach to bundling funding into one price for an evidence-informed pathway that is linked to improving outcomes; and

    c. developing and trialling a capitation funding model that provides a tailored package for consumers, families, carers and supporters.

Recommendation 49:

Monitoring and improving mental health and wellbeing service provision

The Royal Commission recommends that the Victorian Government:

1. establish a new performance monitoring and accountability framework to:

    a. hold, and empower Regional Mental Health and Wellbeing Boards (refer to recommendation 4(2)) to hold, mental health and wellbeing service providers to account and improve performance over time;

    b. improve the outcomes and experiences of consumers, families, carers and supporters; and

    c. measure the effectiveness of mental health and wellbeing services from the perspectives of consumers, families, carers and supporters.

28.1 A fundamentally redesigned system for consumers, families, carers and supporters

The Commission's highest priority has been to listen to the perspectives and expertise of those who have sought or accessed treatment, care or support from Victoria's mental health system to understand their experiences and to hear their ideas for change and improvement.

The Commission described in its interim report some of the positive accounts and experiences people have shared, including of empathetic workers who have listened and provided support, and of services that have helped them recover.[1] As one person said, 'I was lucky to find the treating doctor that I have. She's saved my life dozens of times through compassionate, evidence-based care.'[2]

Yet, despite the best endeavours of the mental health workforce and service providers, these reports have been few and far between. Wide-reaching failures have left the system in disrepair. As Ms Lynda Watts, a witness before the Commission, expressed, 'I cannot emphasise this enough, that there are wonderful, skilled, kind workers everywhere, but they are as much caught up in the system and the dysfunction as are consumers and carers.'[3]

As explored throughout this chapter, structural challenges, including marked underinvestment over many years, unclear roles and responsibilities across the entities that operate in Victoria's mental health system, and inconsistent and ineffective planning, have contributed to a mental health system that is plagued by large service gaps and poorly coordinated services. It is a system in which people living with mental illness or psychological distress, families, carers and supporters struggle and sometimes fail to get the treatment, care and support they seek.[4]

Ms Brooke Collins shared her experience with the Commission:

> Whilst I was a patient, I attempted to access care on many occasions and was often turned away for either difficulty understanding my unique situation or due to lack of resources. This led to risk-taking [behaviour] including suicide attempts and self-harm as a way of getting the attention and care that I required. I was often shuttled between a different doctor and care team each day who had not read my file or communicated with each other and would thus provide the wrong care or confuse me with conflicting diagnoses.[5]

For many, access to mental health services is only available during a crisis and for an insufficient amount of time to meet their needs.[6] One person shared their experience of struggling to find services in a system that focused on responding to and managing risk:

> 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.[7]

Others have shared how inadequate treatment, care and support have resulted in a 'revolving door effect', where people are discharged from services, only to return shortly thereafter. As Mr Kiba Reeves, a witness, told the Commission:

> My experience with the hospitals in the adult mental health system was that it was a revolving door and that their focus was not on helping me recover. … 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.[8]

The Commission was told that as a result of an inadequately resourced system, people were 'patched up' and sent home too early. As this person shared:

> My mother was an alcoholic, had [an] eating disorder and had anxiety, which meant most [of the] time she was unable to leave her house. She would have panic attacks if she left the house. She was constantly in and out of hospital even though the hospital always seemed to lose files and never really [knew] what was going on. She was basically in hospital until she was patched up [and] sent home for two to three months until she would be back.[9]

Inadequate, limited and poorly connected mental health services have meant many people have not been supported to receive the treatment, care and support that best meets their individual needs. One person explained, '[s]ervices manage to both ignore the circumstances that make one apparently 'unwell' and contribute to those negative circumstances. They have never made a connection between my situation and my experiences of distress.'[10]

The way mental health services are planned, funded and monitored, referred to as commissioning,[11] has a considerable impact on the experiences of individuals, as well as the ability of the workforce to respond to the needs and preferences of consumers, families, carers and supporters. These experiences have been front of mind for the Commission when considering a new approach to commissioning mental health and wellbeing services.

28.1.1 A new approach to commissioning mental health and wellbeing services

The Commission envisages a future mental health and wellbeing system in which people living with mental illness or psychological distress, families, carers and supporters receive treatment, care and support when and where it makes the most difference. It is a system that respects the needs and preferences of individuals and supports them to choose the services they need to live their life.

Achieving these aspirations will require the Victorian Government to commission innovative and responsive mental health and wellbeing services using a new approach. It will require collaboration between services that are funded by the Victorian Government, the Commonwealth Government and funded privately.

While there is no single agreed definition of commissioning, it can be understood as the continual process of planning, funding and monitoring services. A new approach to commissioning that considers each of these aspects will help create a reformed mental health and wellbeing system that is well funded, adaptive and accountable to the people it seeks to support.

The reforms detailed in this chapter will build on the Commission's interim report, which recommended a new revenue mechanism and capital fund to secure dedicated and enduring investment in Victoria's future mental health and wellbeing system.[12]

The Victorian Government, notably the Department of Health, will continue to be accountable for delivering mental health and wellbeing services. However, the Commission has recommended a more localised approach to commissioning these services.

As described in Chapter 5: *A responsive and integrated system*, Regional Mental Health and Wellbeing Boards will, by no later than the end of 2026, be responsible for planning, funding and monitoring Victorian Government–funded mental health and wellbeing services delivered in their region. The Department of Health will be responsible for system stewardship, resourcing and monitoring Regional Boards, and for commissioning statewide services.

In the interim, the department will commission all Victorian Government–funded mental health and wellbeing services. The department will be supported by interim regional bodies, that will have an important role in assisting with assessing the needs of their populations, and in planning mental health and wellbeing services.

The new approach to commissioning will be achieved through:

- evidence-informed service and capital planning, ensuring that investment in mental health and wellbeing services is enduring and directed towards the areas of greatest need (refer to section 28.3)
- a set of service standards, which will develop the capabilities of new and existing providers, and support them to work together (refer to sections 28.4.1 to 28.4.3)
- a new approach to funding services that delivers more value for Victorians by distributing resources in a more equitable way and encouraging providers to respond to the needs and preferences of individuals (refer to sections 28.4.4 to 28.4.5)
- strengthened performance monitoring, which will hold service providers accountable for the outcomes and experiences that matter to consumers, families, carers and supporters, and support providers to continue to improve (refer to section 28.5).

Together, these reforms will provide important foundations for a future system in which people have equitable and dependable access to mental health and wellbeing services, experience services as one system (rather than a series of disconnected services), and have improved outcomes and experiences.

28.2 The system foundations in need of reform

Victoria's mental health and wellbeing system must be supported by solid foundations—effective planning, enduring investment and strong performance monitoring—if it is to function well and keep pace with the changing needs and expectations of people living with mental illness or psychological distress, and of families, carers and supporters. But there are major structural problems, including inadequate planning and investment, ineffective stewardship and diminished accountability, that have prevented the mental health system from achieving these objectives.

28.2.1 Inadequate system planning

Effective system planning is critical to understanding and anticipating the mental health needs of individuals and to make sure investment is directed where it is most needed.

The mental health system has not benefited from consistent, integrated and sophisticated planning. This includes limited demand forecasting, fragmented service and infrastructure planning, and patchy approaches to investment and reform. This has contributed to services that are not always available, or have significant waiting lists.

One person with lived experience of mental illness told the Commission that the service capacity of the mental health system is insufficient:

> Unfortunately, the system is completely burdened and in such high demand that people can't access resources when they need [to]. Having waiting lists of a minimum of six weeks isn't good enough.[13]

Similarly, another person with lived experience of mental illness explained how the system is greatly overloaded:

> the most affected ... are left to navigate an overburdened and essentially dysfunctional system. ... I feel like the public system is battling to not fall apart itself, that its crisis reflects on us.[14]

Planning of mental health services has been limited by the former Department of Health and Human Services' systems and tools to forecast demand. Mr Andrew Greaves, Victoria's Auditor-General, reported that the department does not sufficiently take into account the extent of mental illness and unmet demand among Victorians.[15] Mr Terry Symonds, then Deputy Secretary, Health and Wellbeing in the Department of Health and Human Services, also told the Commission that '[t]he department does not have adequate systems in place to capture data about current service system capacity, demand and delivery.'[16]

More than a decade ago, the Victorian Government acknowledged that there was no systematic approach to planning mental health services, 'Victoria does not systematically apply a planning model that links service responses to the prevalence of mental health problems across defined areas.'[17]

Since then, the Victorian Government has released *Victoria's 10-Year Mental Health Plan* and the *Statewide Design, Service and Infrastructure Plan for Victoria's Health System 2017–2037*.

The 10-year plan was released in 2015 and established a set of outcomes to guide 'efforts to create the best conditions for Victorians' mental health'.[18] In March 2019, the Victorian Auditor-General, in a report to parliament, found that 'the 10-year plan outlines few actions that demonstrate how [the department] will address the demand challenge'.[19]

The *Statewide Design, Service and Infrastructure Plan for Victoria's Health System 2017–2037* was released in 2017 and was intended to guide health and mental health service and infrastructure investment in Victoria over the subsequent 20 years.[20] But the plan only lists infrastructure projects for the first five-year period,[21] and only six projects specifically relate to mental health.[22]

Individual providers such as public health services also undertake service and capital planning for their local communities.[23] The Commission has been told that this approach to planning often does not take a wide enough view that considers the needs of the population more broadly.[24] It is also important to consider the availability of other services when planning because services beyond the mental health system have a significant impact on the attainment of good mental health and wellbeing.[25]

There has also been an absence of long-term planning to direct investment to the areas of greatest need. In a submission to the Commission, Monash Health said '[t]he current Victorian Mental Health System has little by way of strategic planning, measurement of outcomes relative to purpose, or coordination with federal funding initiatives' and that this had 'resulted in a poverty of action to develop and implement better care or adequately plan for population growth and associated infrastructure'.[26]

The Commission has also received evidence that inadequate planning has contributed to underinvestment in the physical infrastructure of public mental health services.[27] Few facilities have welcoming, safe and therapeutic features. Much of the system's physical infrastructure is old, operating beyond its useful life, and no longer supporting evidence-informed models of treatment, care and support.[28]

While there are some recently developed and very well-regarded mental health facilities built to new design standards,[29] such as Mercy Mental Health's Clare Moore inpatient unit, many facilities were designed some decades ago and are no longer fit for purpose.

The department also does not routinely involve consumers, families, carers and supporters in planning processes. This is despite the valuable insight and expertise they bring to understanding the quality, effectiveness, accessibility and appropriateness of services.

Where connection does occur, some consumers are unsure whether policymakers have genuinely sought their views and perspectives, or just 'ticked boxes'.[30] As Ms Cath Roper, Consumer Academic in the Centre for Psychiatric Nursing at the University of Melbourne, stated, 'consumers need to be involved in setting the agenda, or in the early stages of planning and thinking through the scope of and rationale for a project'.[31]

To realise the Commission's vision, a new approach is required to understand the need for mental health and wellbeing services and to clearly plan how to increase the capacity of the system to respond to these needs.

28.2.2 Limited system stewardship

System stewardship is essential to a responsive and coordinated mental health and wellbeing system. It involves a range of responsibilities including strong oversight, leading system-wide change, encouraging learning and improvement, and managing funding and data systems.[32] The system steward's role is to give purpose and direction and to ensure there are structures that encourage coordinated efforts to deliver the best outcomes.[33] For Victorian Government–funded mental health services, these responsibilities rest with the Department of Health.

A critical component of the department's role in system stewardship is 'market stewardship'. Market stewardship specifically entails monitoring, evaluating and overseeing service providers, and where necessary, intervening to grow the range and quality of providers to ensure they respond to consumers' needs and preferences.[34] Interventions might include increasing the price paid for services in rural and regional areas or encouraging services to work together to exchange knowledge and resources. The Productivity Commission has suggested it requires governments to 'step in and take over an underperforming or failing provider, or set up arrangements for a "provider of last resort"'.[35]

Ms Kym Peake, then Secretary of the Department of Health and Human Services, accepted that planning, resourcing and performance monitoring are part of the department's responsibilities and critical to its role.[36] Yet the Commission has been told that the department struggles to move beyond the role of a purchaser or funder of services in a payer–provider relationship to the responsibilities required of a system steward. As Mr Symonds said:

> **While the department has measured needs, set policy directions, developed service models, measured outcomes and so on, we have not done so in a joined-up way or used our funding as purposefully and precisely as we could to achieve outcomes. In that sense, I would say that the department has operated more as a funder than a commissioner for health and mental health services.[37]**

Evidence before the Commission suggests that the department has found it difficult to achieve an effective balance between undertaking the role of system steward and operating in a system of 'devolved governance'.[38]

Victoria's public health services and public hospitals currently operate under a devolved governance model where public health service and public hospital boards are appointed by the Victorian Minister for Health and are given responsibility for overseeing health services, including specialist mental health services, in their area. These boards operate at arm's length from the department, rather than being directly managed by the department.[39]

Devolved governance cuts back on micro-level management, creating a system of 'earned autonomy' where high-performing service providers are given greater freedoms.[40] As research from the University of Melbourne has suggested, '[w]ith an increasing trend in contracting out services to external parties, the role of the public sector in Australia has evolved from, 'doing' to more of an 'enabling' role'.[41]

While this offers some benefit, such as greater freedom to innovate, there are concerns that the department's approach is too devolved and overly reliant on local decision-makers.[42] Further consideration must be given to the role of the department as an enabler of system improvement and to how it can strike the right balance between autonomy and direct influence.

Mr Greaves suggested that the department either does not fully understand or has failed to act on its role,[43] advising that:

> it is incumbent on the system manager to understand what is happening … so as to be able to fully advise government and to inform investment decisions that meet government and legislated objectives.[44]

The *2016 Targeting Zero* review into avoidable harm in Victorian hospitals foreshadowed a greater role for the department in system leadership and oversight, suggesting that, 'while devolved governance has emphasised local initiative, it has not adequately addressed accountability and leadership'.[45] Similarly, an independent review of Victoria's governance model for health services stated:

> Without destroying the benefits of the Victorian values of 'earned autonomy' and devolved governance, there is a case for the department to become more involved in clinical service planning, rather than just being a funder which provides advice and feedback.[46]

The Commission has considered opportunities to get the balance right by ensuring the department gives service providers the flexibility to innovate, while providing the required information, performance monitoring and support structures that will foster collaboration and joint problem solving so the system continues to improve.[47]

28.2.3 Underinvestment and poorly allocated funding

Past investment in the mental health system has failed to fund enough safe and effective mental health services to meet the needs of people living with mental illness or psychological distress, families, carers and supporters.

This challenge has been known for at least 10 years. In a mental health strategy for 2009 to 2019, the Victorian Government acknowledged that, '[d]emand pressures on specialist public mental health services are considerable … [and] the rate of involuntary admissions, bed occupancy levels and emergency department waits remain a cause for concern'.[48]

Since then, successive reviews have clearly identified funding gaps.[49] Ms Peake said that while considerable growth funding had been allocated to mental health services in the *2017–18 State Budget* and subsequent budgets, this followed a period of zero growth funding over the preceding three years.[50]

In addition to being significantly under-resourced for successive years, available resources have not been used in a way that encourages services to value and respond to individuals' needs and preferences.

The Commission was told that current funding, which has been mostly allocated on an historical basis, is poorly distributed and does not '[a]djust for wide disparities in the needs and complexity of clients'.[51] Barwon Health observed, '[t]he funding is capped and insufficient to meet demand in areas such as Geelong, which has experienced significant population growth.'[52] Similarly, Associate Professor Ruth Vine, former Executive Director of NorthWestern Mental Health, said that '[o]ver the past decade, the population [supported by NorthWestern Mental Health] has increased substantially such that, on a per capita basis, our funding, bed stock and equivalent full-time positions have declined.'[53]

Current funding models do not encourage providers to deliver a diverse range of services or allow them the flexibility to adapt their services to respond to the needs and preferences of consumers. As Dr Tricia Szirom, CEO of the Victorian Mental Illness Awareness Council at the time of providing evidence, shared:

> **There should be community-based alternatives that are affordable, available, flexible in choice of supports and located throughout Victoria that respect the self-determination of people with mental health challenges, emotional distress or neurodiversity.**[54]

While the model for funding mental health services in Victoria has remained essentially unchanged since the 1990s,[55] the former Department of Health and Human Services, now the Department of Health, has been working to reform these arrangements.[56] The department has developed an activity-based funding model for public specialist mental health services[57] whereby providers receive funding for each individual consumer they support, with the amount based on each consumer's needs.[58] Based on the information available to the Commission, implementation would initially focus on adult community-based services.[59]

Multiple organisations have recommended that the Commission consider funding reforms that deal with these problems, including tackling underinvestment in mental health and wellbeing services and distributing funding in a way that better reflects needs.[60]

28.2.4 Weaknesses in performance monitoring and accountability

The department carries out its monitoring role at two levels. The first is at the system level, through the annual budget process, which involves reporting against quality, quantity, timeliness and cost measures and targets[61] and annual monitoring and reporting on the outcomes and related indicators contained in the *Mental Health Outcomes Framework*.[62] The second is at the service provider level, through the performance improvement process outlined in the *Health Services Act 1988* (Vic), *Mental Health Act 2014* (Vic), and the *Victorian Health Services Performance Monitoring Framework*.[63]

The focus of this chapter is on service provider–level performance monitoring; the Commission's preferred approach to system-wide outcomes monitoring is detailed in Chapter 3: *A system focused on outcomes*.

Under the Mental Health Act, a core function of the Secretary of the Department of Health is to 'monitor and evaluate the performance, standards and outcomes of mental health service providers'.[64]

There are different performance monitoring and accountability arrangements across the range of providers that operate in Victoria's mental health system, leading to different levels of understanding of how services are meeting people's needs, and different approaches to performance improvement.

Public health services, public hospitals and integrated community health services[65] are held to account by the Statement of Priorities. This is an annual accountability agreement signed by the Minister for Health (in consultation with the Minister for Mental Health)[66] and the Board Chair of each health service or hospital and contains budget information, key performance indicators and agreed local actions on strategic priorities.[67]

Registered community health services are held to account via a service agreement between the service provider and the Department of Health.[68] The department has fewer ways to intervene and improve performance under a service agreement compared with under the Statement of Priorities.[69]

In practice it is unclear how extensively the department is monitoring mental health service delivery in community health services. Some community health services also report that different performance monitoring and accountability arrangements are contributing to their administrative workload and duplicating reporting requirements and that this may be preventing services from working together.[70]

The Commission has been told that public specialist mental health services are not the priority when the department monitors the performance of public health services and public hospitals.[71] For example, Mr Angus Clelland, CEO of Mental Health Victoria, reflected on the challenges of getting mental health prioritised in performance discussions between the department and public health services:

> I hear repeatedly from clinical service directors that it is very difficult to get mental health onto the table in their discussions with senior executives because mental health has traditionally been a secondary issue to all of the other pressures that hospitals face. We need to raise the importance of mental health in the hospital system.[72]

This may be partly explained by the limited focus on mental health within the Statement of Priorities. In 2019–20, of the roughly 50 key performance indicators it outlines, fewer than 10 specifically relate to mental health.[73] Ms Felicity Topp, CEO of Peninsula Health, made the following observations:

> [The department] can require Peninsula Health to prioritise mental health by including mental health-related goals, strategies and deliverables in Peninsula Health's [Statement of Priorities] but, to my knowledge, [the department] has not done so until this coming year's [Statement of Priorities]. In its [Statement of Priorities] guidelines for 2019/20, [the department] specifically referred to improving access to mental health treatment as a priority in Part A of the [Statement of Priorities]. The performance targets in the [Statement of Priorities] have, however, remained unchanged from previous years.[74]

Ms Topp also stated that the key performance indicators included within the Statement of Priorities 'do not provide any meaningful information in respect of deliverables, quality of care and patient outcomes'.[75]

More recently, the former Department of Health and Human Services took steps to improve performance monitoring of health services, with plans to increase the number and type of mental health key performance indicators in the Statement of Priorities.[76]

The Commission has observed that a lack of oversight and prioritisation of the performance of public specialist mental health services has led to diminished accountability.[77] For example, where a person spends more than 24 hours in an emergency department, this is considered a 'breach' that requires immediate notification to the department to undertake remedial action.[78] But the Commission was told that a person with mental health–related needs who spends more than 24 hours in an emergency department does not necessitate the same kind of response as a person who is there for other health reasons.

As Dr Ainslie Senz, Director of the Department of Emergency Medicine at Footscray Hospital, Western Health, described:

> We don't breach 24 hours [for other health conditions], it creates a very significant investigation, including the management of the hospital need to report to the Department of Health to explain what happened. That doesn't happen in the breach of a mental health — let me say, it's not as rigorous, there's not as much fear around a 24-hour breach in the mental health scenario.[79]

Alongside diminished accountability, evidence before the Commission suggests that mental health performance monitoring focuses more heavily on service 'outputs', such as activity, processes and program expenditure rather than on service performance relevant to the community—that is, whether people can get the right services at the right time in line with their own preferences and needs.[80]

In Victoria, a range of tools with different measurement scales are used for collecting this information. For example, for many years, Victoria has collected data on clinical outcomes for consumers of public specialist mental health services using the Health of the Nation Outcome Scales.[81] This is an internationally accepted tool used by clinicians to measure and assess the outcomes of mental health services delivered.[82]

While it is important for planning purposes, it does not capture outcomes from the perspective of consumers, families, carers and supporters. Professor David Copolov AO, Professor of Psychiatry and Pro Vice Chancellor of Major Campuses and Student Engagement at Monash University, said that while the Health of the Nation Outcome Scales is useful for providing insight into consumers' clinical outcomes, 'more holistic and comprehensive outcome measures' are required.[83]

Some have likened the Health of the Nation Outcome Scales to 'asking the hotel managers to rate the guests'[84] because it does not collect information from the perspective of those who use services. It is the view of Ms Indigo Daya, Consumer Academic in the Centre for Psychiatric Nursing at the University of Melbourne, who provided evidence in a personal capacity, that a focus on clinical outcome measures has hindered the implementation of recovery-oriented practice.[85]

The Commission notes that there are tools to collect data from the perspectives of individuals across mental health services. The Your Experience of Service Survey, for example, is used to collect data from consumers about their experiences in specialist mental health services and selected community-based settings.[86] A similar survey, the Mental Health Carer Experience Survey, has also recently been developed to capture the experiences of families, carers and supporters. The Victorian Government started using this survey in 2020.[87]

But the Your Experience of Service Survey is limited; response rates are low and not all data are made publicly available. This makes information difficult for individuals to find because access to data at the service provider level depends on individual providers making the data available.[88] In a personal story, Mr Douglas Holmes OAM, a witness before the Commission, explained the importance of understanding and embedding the views of consumers in mental health performance monitoring to improve service delivery.

The usefulness of current performance monitoring is further diminished by the fact that there is little benchmarking between mental health services.[89] The Commission was told that while other health services have access to benchmarked data across a range of measures, this type of data is limited for mental health services.[90]

As explored in Chapter 30: *Overseeing the safety and quality of service*s, the Commission has observed unwarranted variation in approaches to service delivery across mental health services.[91] The capacity of service providers to identify and respond to unwarranted variation may be affected in part by a lack of access to appropriate targets and data to benchmark aspects of service delivery.

To help, the Victorian Agency for Health Information developed the *Inspire: Mental Health* report. The report benchmarks the performance of designated mental health services across a rotating set of key performance indicators related to quality and safety. It is distributed every six months on a confidential basis to service providers and clinical leaders.[92]

Benchmarked data provide a greater understanding of the performance of service providers in comparison with their peers, encourage service improvement and, in some cases, can also promote collaboration between providers.[93] For benchmarking to be successful it must be founded on the principles of transparency and accountability—that is, a willingness to share information and a commitment to learn and take action to improve performance.[94]

Overall, the Commission considers that current service performance measures could be improved to more effectively capture the outcomes that are meaningful to people.[95] This information is vital to ensuring services are meeting the needs of consumers, families, carers and supporters while evolving to meet changing needs and expectations.

28.3 A new way to anticipate and plan for the needs of consumers, families, carers and supporters

A reformed approach to needs assessment and service and capital planning will help the Victorian Government deal with current under-resourcing and system deficiencies. It will build on the interim report's recommendation, supporting the Victorian Government to develop a new revenue mechanism and a dedicated capital investment fund for mental health and wellbeing services, and help the Department of Health and Regional Boards target investment to areas of greatest need.

A new method of assessing and monitoring demand for mental health and wellbeing services that is well supported and understood will achieve this. Publicly released service and capital plans that are developed with input from a range of stakeholders, including consumers, families, carers and supporters, and service providers, will encourage an ongoing focus on understanding and responding to needs.

Box 28.1 lists the key terms used in this section.

Box 28.1: Key terms for planning mental health and wellbeing services

Planning

Planning is 'the translation of clear goals and objectives into meaningful strategies for implementation. It mandates leadership and decision making about priorities, timeframes, resources, and an ongoing commitment to monitoring progress and driving achievement'.[96]

Service and capital plan

A service and capital plan, or service and infrastructure plan, 'identifies present and, as best as possible, future demand for services' and is intended to 'guide the future allocation of resources'.[97]

Personal story:

Douglas Holmes OAM

Douglas has over 24 years' experience in the consumer workforce. He has held a variety of positions, including Consumer Participation Officer at St Vincent's Hospital in Sydney, member of the New South Wales Consumer Advisory Group Mental Health Inc (now known as Being), and board director of Neami National.

He is the co-founder and General Manager of MH-worX, a consultancy that aims to 'transform recovery practices in the mental health sector'.

Over the course of his career, Douglas has participated in many landmark projects, with a view to further embedding the views and perspectives of consumers across the mental health system. In 2001, Douglas co-led a partnership between the NSW Consumer Advisory Group and the Centre for Mental Health, Ministry of Health (NSW).

> The aim of the project was to identify or develop a measure and process to collect, collate, report and respond to consumers' views of mental health services.

As part of the project, a tool was developed to measure and collect data from consumers on their experiences and perceptions of mental health services, with a view to drive quality improvement across services in New South Wales.

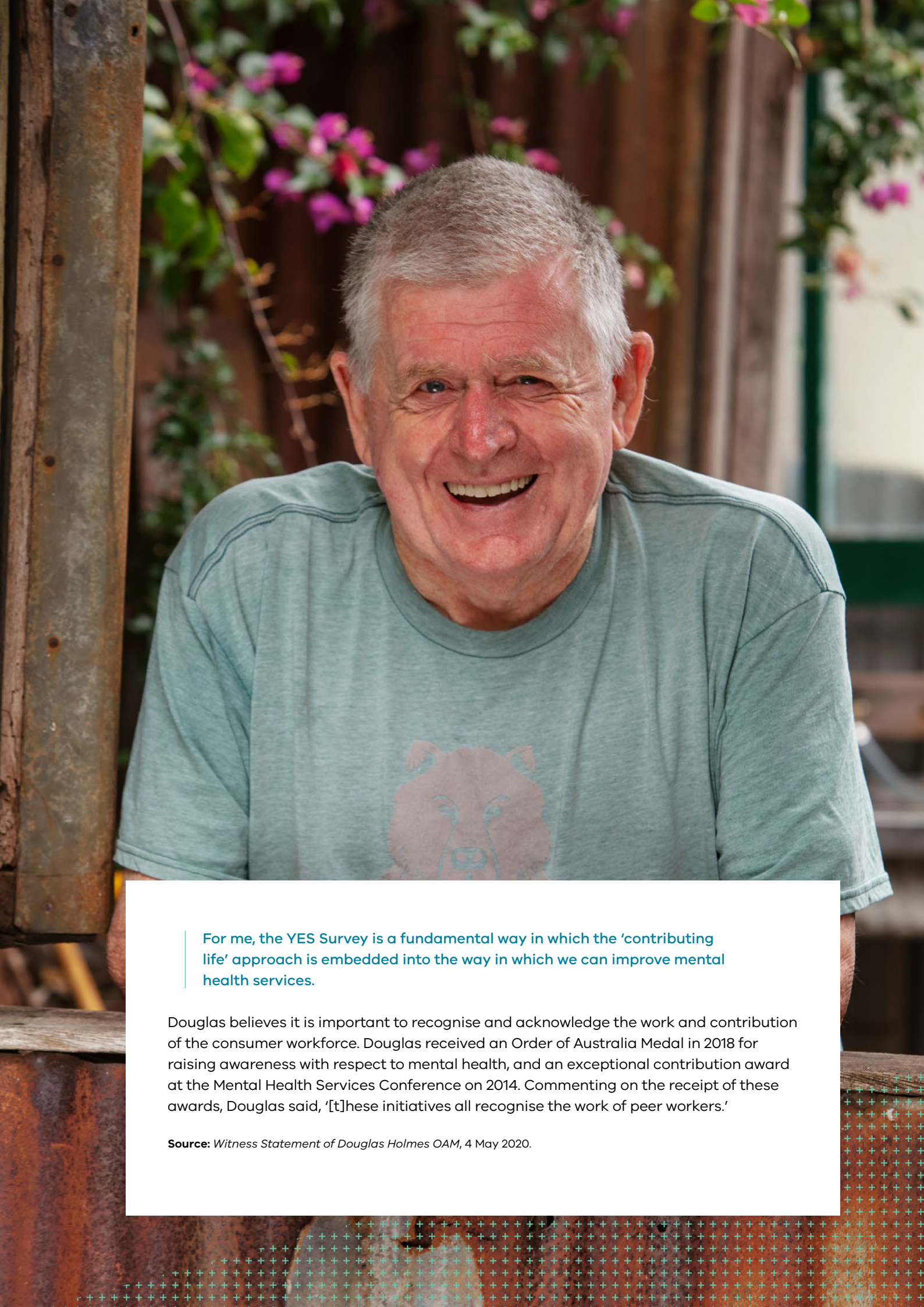
Douglas explained there were initial concerns from mental health professionals that the tool could be used as a 'witch hunt', where one consumer may complete multiple surveys to 'make it seem like there was a bigger problem than there was'.

Douglas noted that following the involvement of mental health professionals in the process of distributing the survey and the associated controls, these concerns were alleviated and the results of the survey were used to improve service delivery.

> We held statewide days where services would come in and demonstrate what they were doing, and I found that the Mental Health Directors became serious about the results and setting goals—they would establish their [key performance indicators] based on what the survey results said.

Following this, a national survey called the Your Experience of Service Survey (YES Survey) was developed to gather feedback from consumers of mental health services around Australia.

> The YES Survey is designed to gather information from consumers about their experiences of care, and aims to help mental health services and consumers to work together to build better services.



> For me, the YES Survey is a fundamental way in which the 'contributing life' approach is embedded into the way in which we can improve mental health services.

Douglas believes it is important to recognise and acknowledge the work and contribution of the consumer workforce. Douglas received an Order of Australia Medal in 2018 for raising awareness with respect to mental health, and an exceptional contribution award at the Mental Health Services Conference on 2014. Commenting on the receipt of these awards, Douglas said, '[t]hese initiatives all recognise the work of peer workers.'

Source: *Witness Statement of Douglas Holmes OAM*, 4 May 2020.

28.3.1 Understanding current and future service need

A lack of understanding of the need for mental health services across the Victorian population has contributed to service gaps and people missing out on the treatment, care and support they seek.

One person described how service gaps had made it difficult for them to receive support:

> I personally have asked for help from all the promoted channels and been turned away as I was not suicidal enough … . Surely if someone has the courage to ask for help, Australia has the resources to help.[98]

A family member of someone receiving mental health services also told the Commission how stretched existing services are:

> There are some good supports for my son and carers … but their case loads are so big they simply cannot effectively support everyone. As a result of the overloaded and under-resourced workforce, clinicians often give up and discharge consumers from their service before even giving them the chance to build rapport.[99]

To deal with these gaps, a robust and continuous process of assessing and understanding the Victorian population's need for mental health and wellbeing services is required. This will support the Department of Health and Regional Boards to anticipate, plan and respond to people's needs and preferences ensuring there is increased investment in mental health and wellbeing and funding that is directed to where it is most needed.

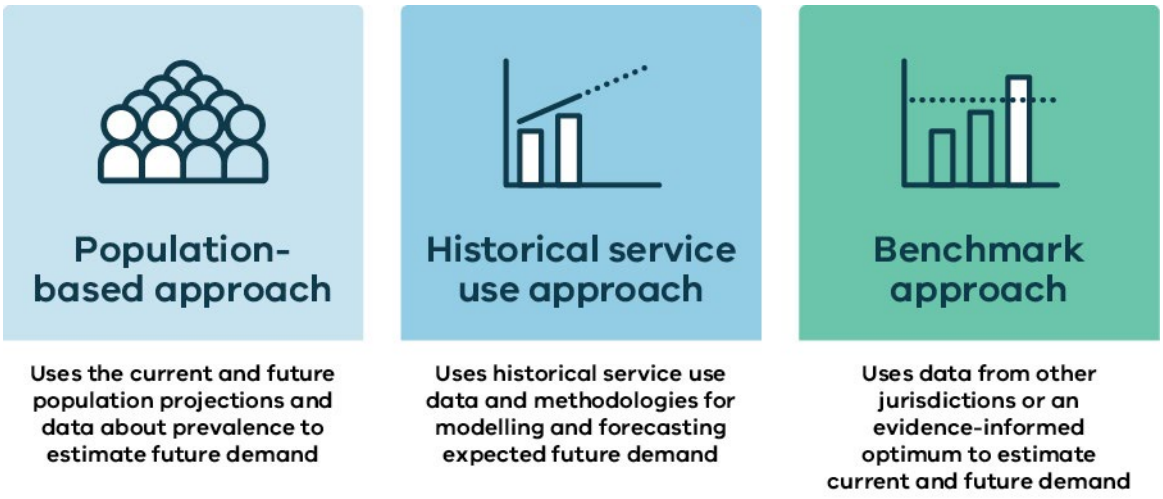
In developing a process to assess and understand need, the Commission has sought to ensure the recommended approach considers the Commission's system design features and policy settings.

While the primary focus will be on understanding the need for mental health and wellbeing services that are directly funded by the Victorian Government, there should be an understanding of the need for all mental health and wellbeing services. This includes services that receive funding from the Commonwealth Government, Primary Health Networks, the National Disability Insurance Agency and from individuals directly.

The Commission has considered three approaches to demand modelling: a population-based approach, a historical service use approach and a benchmarking approach (refer to Figure 28.1). Demand modelling methodologies may combine different approaches. For example, a methodology may use expected population growth to estimate the number of people requiring services as well as some benchmarking to estimate the level of service each person may need.

The former Department of Health and Human Services, now the Department of Health, uses a historical service use approach to model demand for other health services.[100] The problem with this approach is that it assumes there is close alignment of supply of services and demand for services. As the Commission identified in its interim report, there continues to be a significant gap between the need for mental health services and the level of services currently available.[101]

Figure 28.1: Approaches to demand modelling



A historical service use approach may be an effective approach to demand modelling where there is information available about who receives treatment and how long they wait, for example, for elective surgery or for responses to people who present at emergency departments. However, information about the number of people who seek but do not get mental health services has not been readily available.[102]

The department recently improved its approach to modelling demand for mental health services. The revised approach considers future population growth and includes some benchmarking. It anticipates an increase in the volume of services that each person will receive, in recognition that available mental health services have been insufficient for some consumers in the past.[103] But the approach does not account for the experiences of people described in the Commission's interim report who are currently turned away or unable to find services.[104]

To support the system to understand demand, including people who are unable to get mental health services, the *National Mental Health Service Planning Framework* will be used as a starting point. Importantly, this framework is founded on estimates of prevalence of mental illness and psychological distress rather than historical data on service use.[105] Starting with the number of people who require mental health and wellbeing services will help to redress the gap between the number of people who seek, and the number of people who receive, services.

The Commission considers the framework more suitable than the department's current approach and will support the Commission's reforms without causing lengthy delay. The framework covers a diverse range of mental health and wellbeing services, including those funded by the Commonwealth Government and specific services delivered by lived-experience workforces.

The framework is not too prescriptive about the types of organisations that deliver particular services.[106] This fits with the Commission's aspirations for a future system that includes, for example, more consumer-led mental health and wellbeing services.

Using this framework also supports joint planning and a more collaborative approach to investment between the Victorian and Commonwealth governments. The Productivity Commission's *Mental Health Inquiry Report* recommended that the framework be used by the Commonwealth Government, state and territory governments and Primary Health Networks to complete a gap analysis for each region, and for each state and territory.[107]

The Commission has been told about the limitations of the framework. These include that it does not adjust for some risk factors, it may not have the balance right between hospital-based and community-based mental health services, and it does not consider the availability of services outside the mental health system.[108]

While the framework is a good starting point, as with any tool, adaptation will be required. Changes to the framework and associated processes must involve service providers to give an operational perspective, and the Department of Treasury and Finance to ensure there is central agency endorsement for the planning process and subsequent requests for additional investment that flow from these processes.

The changes that will be required include:

- updating the data on the prevalence of mental illness and prevalence of psychological distress, including updated prevalence estimates from national and international literature and population surveys, and consideration of social factors influencing mental health and wellbeing
- aligning the *National Mental Health Service Planning Framework's* service models with the Commission's recommended core functions for future community-based mental health and wellbeing services, and other service features recommended by the Commission
- broadening the needs assessment and demand modelling from a focus on clinical services delivered in hospitals to a more balanced assessment of people's mental health and wellbeing needs
- modelling demand for:
  - highly specialised services (for example, Aboriginal-led services and statewide services including neuropsychiatric services)
  - services not part of the framework, including forensic mental health services and alcohol and other drug services
  - supported housing for adults and young people living with mental illness, and contributing to Victorian Government demand modelling for housing supports more generally
- considering the challenges of delivering services in rural and regional areas, and the impact of changes in digital technology on service delivery or demand and the opportunities these changes present.

Demand modelling and needs assessment is an ongoing process. As the quality of the data collections improve and more information becomes available, the modelling will be reviewed and revised.

The Department of Health's modelled demand estimates, developed with support from interim regional bodies and then Regional Boards, will help inform government budget decisions and how funding is allocated to different regions and providers. This will be central to service and capital planning. The initial modelling, alongside the assumptions that inform it, will be presented to the Mental Health and Wellbeing Secretaries' Board jointly by the Department of Health and the Department of Treasury and Finance. It will be regularly updated by the Department of Health and Regional Boards and used to direct funding to the areas of greatest need. The modelling will provide an estimate of demand for different types of mental health and wellbeing services in different areas, as well as overall demand.

28.3.2 Service and capital planning

The Department of Health and interim regional bodies will develop a statewide plan and a service and capital plan for each region. The Mental Health and Wellbeing Secretaries' Board will endorse the first of these plans by the end of 2022, with all plans to be approved by the end of 2023.

The department will be responsible for delivering the statewide plan and each interim regional body will be involved in developing the first plans for their respective regions (through consultation led by the department). Regional plans will be reviewed and updated by newly formed Regional Boards by no later than the end of 2026. Statewide and regional service and capital plans will be updated every three years.

Mr Frank Quinlan, former CEO of Mental Health Australia, told the Commission in his personal capacity about the importance of service planning and the details included in service plans:

> **there needs to be more detail in what plans are going to achieve, what roles different individuals and organisations will have in achieving the intended outcomes and the amount of funding that will be provided to the program. Expectations need to be tied to budget allocations directly.**[109]

It is vital that the statewide and regional plans contain enough detail and clarity. To ensure this, statewide and regional mental health and wellbeing plans will:

- measure current and future demand, including long-term estimates up to 20 years into the future, for services using the adapted demand modelling and needs assessment approach
- identify all currently available mental health and wellbeing services and infrastructure funded by the Victorian Government—including, for example, mental health and wellbeing services delivered in schools and prisons—Commonwealth Government, Primary Health Networks, the National Disability Insurance Agency and private organisations and individuals
- describe current and emerging service and infrastructure gaps
- detail what resources will be required and what actions will be taken in the short, medium and long term to fill the gaps
- be published publicly and updated every three years.

Importantly, service and capital planning will include the experiences, perspectives and expertise of consumers, families, carers and supporters. As a witness before the Commission Ms Rachel Bateman, said:

> **If people with lived experience are involved in the development of policy, practice and research, then the services that result from that work will become more reflective of what consumers think and need.**[110]

Regional planning is required to understand what is needed in each region—the mental health and wellbeing service needs and the actions required to fill any service gaps. Historically, service planning in Victoria has centred on the needs of individual service providers rather than the needs and available services in a region. This was supported by Mr Symonds, who told the Commission that service and infrastructure planning has generally been led by individual public health services.[111] Mr Symonds also advised that the department has been trying to move 'towards a region and locality-based planning approach' enabling a more 'coordinated approach to address[ing] [service] gaps'.[112]

A statewide plan is also required to provide the system with a framework to guide investment and innovation over the long term. As Mr Quinlan said, '[t]he most fundamental barrier that we face in the mental health system is the short-termism of public policy and the consequential short-termism of public funding.'[113] Associate Professor Jo-An Atkinson, Head of Systems Modelling and Simulation with the Brain and Mind Centre at the University of Sydney, told the Commission in a personal capacity that planning approaches can 'lack focus' and may just be a 'range of poorly targeted and poorly coordinated programs and services'.[114] Ms Peake also observed that the mental health system needs 'a robust planning framework to guide service, workforce and infrastructure investment over the long [term]'.[115]

Future investment decisions will be grounded in a planning process that considers the current and future demand for mental health and wellbeing services, and the availability of existing services, including those funded by the Commonwealth or funded privately. As Ms Christine Morgan, CEO of the National Mental Health Commission, asserted, '[a]n integrated policy and planning approach is required across sectors and levels of government to address the gaps in the system.'[116] A joint submission from Victoria's rural and regional area mental health services stated that planning should also consider co-locating mental health and wellbeing services with other key agencies, including housing, employment, alcohol and other drug services and family violence services.[117]

Mental health and wellbeing service and infrastructure planning will include a commitment to therapeutic design principles to ensure services, and the infrastructure they occupy, directly contribute to better outcomes for consumers. Therapeutic design creates spaces that meet the mental health and wellbeing needs of consumers, families, carers and supporters, and promote healing and recovery. It includes architectural design features, such as physical planning, layout, size, shape and accessibility for people with different auditory, visual and physical abilities;[118] interior design features, such as the use of furnishings, colour and artwork;[119] and ambient design features, such as lighting, access to natural light, sound, air quality and ventilation.[120]

The Commission has been told about the importance of outdoor and green space when planning mental health infrastructure. Ms Roper said '[t]he principles of good design … [include] a good mix of communal and private spaces and accessible garden areas.'[121] Ms Karyn Cook, Executive Director of Mental Health Services at South West Healthcare, Warrnambool Community Health, also stated the benefits of the outdoor spaces at South West Healthcare:

> **The [prevention and recovery care service] is designed to be a home-like environment, and is intended to feel welcoming. The welcoming, calm environment inside and outside in the garden demonstrates to consumers (known as guests) that they are valued and enables a recovery oriented model of care in partnership with the guest to occur.**[122]

A commitment to therapeutic design principles will support safe and positive experiences for all consumers, families, carers and supporters, and the workforce. These principles will be part of infrastructure maintenance and renewal processes, and the planning and design of new buildings. While space and resource constraints can make this challenging, therapeutic design principles need to be given priority in planning. The objective will always be to ensure the safety of individuals and workers, and providing consumers, families, carers and supporters with therapeutic experiences.

To promote public confidence and trust, the department and Regional Boards will publish their estimates of demand for, and existing supply of, mental health and wellbeing services. A recent review of the Australian public service found that only 30 per cent of Australians trusted government services.[123] This may be partly explained by the fact that governments often make decisions behind closed doors or beyond the general population's reach.[124] A research paper prepared for the review of the Australian public service concluded that improved transparency over policy making could improve trust in governments.[125]

Planning, including the relevant tools, will be regularly reviewed and updated to ensure the latest evidence and information is used. Ms Peake advised that planning needs to be updated to capture 'new evidence and emerging models of practice'.[126] It will also be regularly reviewed to update demand estimates.[127]

Requiring the department and Regional Boards to update and publish plans at least every three years, as part of the same coordinated planning cycle, will align with other capital planning approaches, including Infrastructure Victoria's obligation to update its infrastructure plan every three to five years.[128]

28.3.3 Planning for service streams

As part of its planning function, the Department of Health will specifically consider service planning for consumers across all stages of life, with individual statewide plans developed for:

- statewide services, beginning with statewide services for people living with a dual disability
- people with mental health needs generally related to ageing
- young people (aged 12–25 years)
- infants and children (ages 0–11 years).

As described in Chapter 5: *A responsive and integrated system*, there has been limited planning for statewide services. A lack of planning and understanding of demand has resulted in underinvestment in statewide services, which has led to capacity constraints,[129] long wait times, service gaps[130] and poor connections with area mental health services.[131]

To confront these issues, the department will develop a plan for each statewide service. This will include, but will not be limited to, a plan for dual disability services, dual diagnosis services, forensic mental health services and trauma services. The department will develop plans for statewide services following the release of the first statewide plan, which is due to be completed by the end of 2023.

By way of example, the department should start planning for statewide services by developing a dual disability services plan. Dual disability is 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).[132]

A dual disability services plan is required for a number of reasons. First, there is a need to understand how the National Disability Insurance Scheme has affected access to services for people living with a dual disability, including mental health and wellbeing services and disability-related supports. A plan will support the expansion of services for people with a dual disability in a way that considers these impacts, including any existing or emerging service gaps.

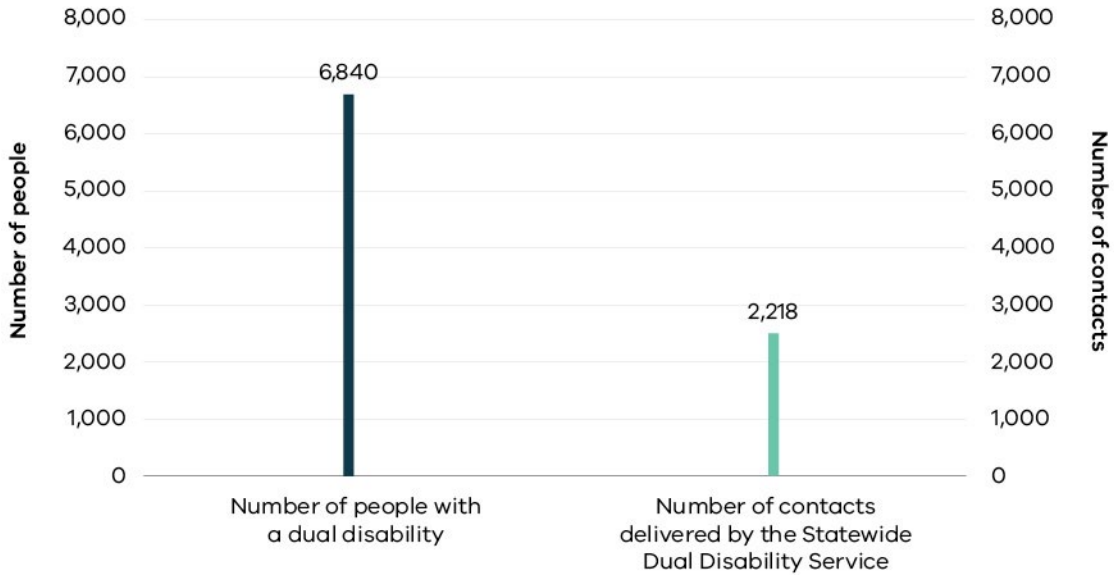
Second, it provides an opportunity to understand and respond to the need for specialist services for dual disability. As one person shared, '[m]any public services refuse treatment to people with a "dual disability", referring them instead (if they're lucky) to a dual disability or specialist service, which have very limited capacity.'[133]

In its technical paper on intellectual disability, the Victorian Government advised that '[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.'[134]

Analysis undertaken by the Commission (refer to Figure 28.2) suggests that only a proportion of consumers living with a dual disability in Victoria's specialist public mental health services currently receive services from the statewide Victorian Dual Disability Service at St Vincent's Hospital, Melbourne. The Commission notes that other area mental health services deliver services to people living with a dual disability and not every individual needs a specialist service.

Third, a plan is also required to expand the capabilities of the workforce with evidence suggesting there are opportunities to improve specialist knowledge and training to better meet the needs of people living with a dual disability.[135] The Commission understands that, at present, the workforce only has access to the secondary referral services at the Victorian Dual Disability Service at St Vincent's Hospital, Melbourne and the Centre for Developmental Disability Health at Monash Health.[136] The Commission notes there are a small number of other area mental health services with dual disability services, for example Alfred Health also runs a mental health and intellectual disability service for young people.[137]

Figure 28.2: The number of people living with a dual disability receiving public specialist mental health services and the number of contacts delivered by the statewide Victorian Dual Disability Service, St Vincent's Hospital Melbourne, 2019–20



Source: Department of Health and Human Services, Client Management Interface/Operational Data Store 2019–20.

Notes: The number of people with a dual disability includes those who were a consumer of public specialist mental health services in 2019–20 and had ever received a diagnosis of acquired or neurodevelopmental disability (such as an intellectual disability, autism spectrum disorder, attention-deficit/hyperactivity disorder or a communication disorder). The following ICD codes, and previous codes for the same diagnosis, were included: F7 (any prefix), F8 (any prefix), F06.8, F06.9, G93.1, G93.8, G93.9, G94.8, P11.2, Q04.8 and Q04.9.

All contacts delivered by St Vincent's statewide dual disability service are captured including direct client contacts and secondary consultation with another service.

The dual disability services plan will detail how future investment will better support the assessment and understanding of people's needs, increase the availability of specialist dual disability services, and improve the workforce's ability to provide responsive and tailored treatment, care and support. Planning the expansion of statewide dual disability services will consider the availability of all government services that people with a dual disability may use. This might include other health services, other social services including child and family services and housing and homelessness services, and disability-related supports funded under the National Disability Insurance Scheme.

Age-based service and capital plans are required to support the Commission's proposed approach to streaming within the new mental health and wellbeing system.

The Commission considers that a plan is also required for older Victorians living with mental illness or psychological distress. As identified in Chapter 14: *Supporting the mental health and wellbeing of older people*, the Commission is concerned that over the past decade, little attention has been given to the mental health needs of older Victorians.

A plan will elevate the needs and experiences of older Victorians within the mental health and wellbeing system and ensure they remain a priority in policy development and planning. Similar to the *NSW Older People's Mental Health Services Service Plan (2017–2027)*, the plan will outline elements of relevant services, evidence-informed models of service delivery, and strategic priorities for the development, delivery and improvement of services.[138] In line with the statewide and regional plans, a plan for older Victorians will also consider the availability of and policy settings for Commonwealth Government–funded services including aged care services.

This plan will also clarify the role of Victoria's mental health and wellbeing services and the role of the aged care system in supporting people with complex signs and symptoms of dementia. The need for clarity is discussed further in Chapter 14: *Supporting the mental health and wellbeing of older people*.

The Commission also acknowledges the lack of a strategic direction for mental health services for infants, children and young people. A 2019 Victorian Auditor-General's report on child and youth mental health services noted that '[Victoria's] 10-Year [mental health] plan does not provide a strategic framework for child and youth mental health.'[139]

To continue the design and development of the mental health and wellbeing system beyond the Commission's reforms, the planning process will include a focus on infants and children, and on young people, noting these two distinct groups have different needs and require tailored approaches to planning.

Plans for the infant, child and family health and wellbeing service stream and the youth mental health and wellbeing service stream will estimate future demand for services, plan expanded investment in services, clearly define the roles of Local Mental Health and Wellbeing Services, Area Mental Health and Wellbeing Services and statewide services, and identify evidence-informed practice approaches that involve families, carers and supporters.

28.4 Funding a greater variety and diversity of services

The Commission has been encouraged to create a future system with greater variety and diversity of services, so people can receive the mental health and wellbeing services that best meet their needs and preferences.

Ms Janet Meagher AM, an advocate for people with lived experience of mental illness, suggested that services need to help people gain or regain their purpose in life. For this to happen, services need to 'move beyond focusing on beds, acute care and clinical services and move on to include non-government [and] community services across all sectors, including peer and family workers'.[140]

Similarly, the Victorian Mental Illness Awareness Council's declaration emphasised the need for more options in the kinds of supports available, the places and services consumers get support from, and how they access those supports.[141]

Ms Mary O'Hagan MNZM, the Manager of Mental Wellbeing at Te Hiringa Hauora in New Zealand, providing evidence in a personal capacity, advocated for a shift towards a 'Big Community' system, with a broad range of comprehensive community-based services that extend beyond the health system.[142]

While new services are essential in an expanded, diversified system, so are services offered by those providers who already work tirelessly to support their communities. Many existing service providers have asked for more resources.[143] They have also asked for stronger direction. They do not want to be micromanaged, but they do seek clearer leadership from government.

Associate Professor Steven Moylan, Clinical Director for Mental Health, Drug and Alcohol Services at Barwon Health, suggested:

> **Rather than being prescriptive as to the precise services that are to be provided and how, what is needed is clear articulation of the role and scope of services to be provided within each region and then it is important that each local service system has the opportunity to explore the most appropriate arrangements for their local area based upon local factors. Support to develop appropriate system leadership is key to this, as it is through this leadership that partnerships and other shared arrangements are facilitated.[144]**

A well-planned, funded and monitored system can support providers to deliver a diverse and responsive service offering, spanning all core functions for community-based mental health and wellbeing services and the system features recommended by the Commission. This will include supporting new providers, such as those that are consumer-led, and encouraging provider partnerships that bring together providers with complementary strengths so they can offer innovative services.

Adopting a structured approach to developing and cultivating a diverse service offering will help achieve the Commission's aspirations for a contemporary mental health and wellbeing system. Ensuring this approach is enduring and evolving will mean the system can adapt to changing needs and preferences, and to emerging research about what works.

28.4.1 Service standards for selecting and funding providers

In a future mental health and wellbeing system, the Department of Health and Regional Boards will make decisions about funding distribution. The Commission has developed service standards to help the department and Regional Boards to select providers, including new providers such as consumer-led providers, and provider partnerships.

While the department and Regional Boards will lead the commissioning of mental health and wellbeing services, they will continue to work towards advancing Aboriginal self-determination by progressively supporting Aboriginal organisations and communities to lead decisions on Aboriginal social and emotional wellbeing services.

As established in the Commission's interim report and by Aboriginal experts, Aboriginal organisations and communities need time and support to ensure they are equipped and well positioned to take on this role.[145] Over time, responsibility for assessing Aboriginal community-controlled health organisations' readiness to implement social and emotional wellbeing services, allocating funds and monitoring the performance of services should be transferred to the Victorian Aboriginal community.

The service standards (refer to Table 28.1) have been designed to support the commissioning process. The standards are divided into minimum service standards that providers will be first required to meet, and additional service standards that providers will meet at 'maturity'—where providers are operating at their full potential to fulfil the Commission's aspirations for the future system. The standards are modelled on an approach based in Ontario, Canada.[146]

Table 28.1: Service standards

Domains	Minimum service standards	Additional service standards at full maturity
Consumer, family, carer and supporter outcomes and experiences	• Delivers care that is safe, inclusive, responsive, trauma-informed and accessible • Offers timely access to treatment, care and support 24 hours, 7 days (area providers) or extended hours (local providers) whether directly, virtually or via formal pathways • Supports seamless care, planned around the all-inclusive needs of consumers, families, carers and supporters • Strives towards measuring, and responding to, diverse consumer, family, carer and supporter needs, outcomes and experiences • Offers welcoming, home-like environments including in consumers' homes augmented by digital platforms	• Collects, analyses and shares data on consumer-completed measures and family-carer-and-supporter-completed measures to understand, and respond to, diverse needs, outcomes and experiences of consumers, families, carers and supporters • Offers all-inclusive access to care with seamless transitions • Offers consumers easy access to their own health information • Offers families, carers and supporters information to support their caring role

Domains	Minimum service standards	Additional service standards at full maturity
Consumer, family, carer and supporter partnerships and community engagement	• Practices supported decision-making • Involves consumers, families, carers and supporters in: – treatment, care and support – service planning, design, delivery and evaluation • Supports community involvement and the principles of co-production	• Partners with consumers, families, carers and supporters, including through opportunities for co-production and other collaborative activities including co-planning, co-design, co-delivery and co-evaluation • Partners with diverse consumers, families, carers and supporters (including the organisations that represent them), supporting them to lead and participate
Defined population and provider scope	• Understands the diverse needs of the target population • Coordinates services within its organisation (e.g. hospital, community, home care) and across organisations (e.g. public and private) • Works with other providers (e.g. joint planning, information sharing, partnership projects, joint learning and development) • Delivers coordinated services spanning more than one setting, organised around the needs of diverse populations	• Is responsible for the outcomes of a population within a geographic area, with a service mix matched to the size and characteristics of the population (with networked referral to more specialised services) • Uses data modelling and forecasting to actively plan and invest in services based on the needs of the population • Works collaboratively and not competitively to support integrated care across a full continuum for a population, for all ages
Leadership, accountability, governance	• Meets expectations in relevant legislation, regulations and standards including: – rights set out in the *Victorian Charter of Human Rights and Responsibilities Act 2006* (Vic) – corporate governance (e.g. culture, vision, leadership and accountability towards excellence, innovation, creativity, collaboration) – clinical governance (e.g. leadership and culture, quality and safety systems, clinical effectiveness and risk management, promoting safe environments, engaging consumer, carer and clinical leaders) – consumer, family, carer and supporter partnerships (see domains earlier) – technology (see domain later)	• Operates in accordance with a single, shared accountability framework • Has strong governance, a unifying vision and strategy, and a culture of: – consumer, family, carer and supporter involvement and partnering – safety and quality improvement – integrated, collaborative care – data- and evidence-driven decisions – performance monitoring and evaluation – learning and innovation

Domains	Minimum service standards	Additional service standards at full maturity
Performance measurement and improvement	• Committed to collecting and transparently reporting accurate, timely performance data covering: – performance domains such as appropriate, effective, connected, safe, accessible, value and equity • Ensures continuous quality improvement • Makes decisions in accordance with clinical standards, evidence-based guidelines and protocols and addresses unwarranted variation • Monitors, evaluates and improves implementation and delivers change management	• Measures and improves performance against consumer, family, carer and supporter outcomes and population health outcomes; consumer, family, carer and supporter experience; provider experience; and value • Tailors performance monitoring and service improvement to local, diverse needs within a consistent, system framework • Initiates and engages in service improvement processes, including capacity building
Financial	• Demonstrates financial sustainability and capability in line with: – funding policies and guidelines – procurement and contracting policies and guidelines • Has appropriate fee-for-service rates (with means-tested billing for those who cannot pay)	• Operates via a shared accountability framework that may include sharing financial risk (e.g. pooled funding or bundled payments across more than one provider)
Technology	• Has the infrastructure and information management capacity to collect and share information, support decisions and maintain privacy/security • Aligns with relevant standards regarding digital health delivery • Invests in new digital infrastructure for greater standardisation and interoperability and new forms of virtual care	• Has digital service delivery solutions that are: – consistent with all functionalities specified in guidelines, standards and directions – aligned with relevant privacy, security, and quality standards – fully integrated and interoperable, delivering seamless connectivity between consumers, families, carers and supporters, their care teams, other professionals and other providers
Workforce	• Strives to attract, recruit and support the diverse workforce needed to meet service standards • Strives to monitor and improve workforce capacity, culture, safety and wellbeing • Offers continued workforce learning and development in defined priority capability areas	• Operates in accordance with evidence-based guidelines and protocols to recruit and support a diverse workforce • Commits to share workforce flexibility across providers to meet demand • Implements high-quality workforce wellbeing supports • Embeds priority capabilities (knowledge, skills and attributes) across the workforce

Selected service standards directly link to legislation, regulations and standards that have an important bearing on mental health and wellbeing providers. For example:

- the *Charter of Human Rights and Responsibilities Act 2006* (Vic), which requires all public authorities to consider and act with respect for human rights
- mental health legislation, which promotes supported decision-making and recovery-oriented practice for people accessing state-funded mental health and wellbeing services
- the *Health Services Act 1988* (Vic), which requires public health service and public hospital boards of directors to have effective risk management systems to monitor and improve the quality, safety and effectiveness of services, and to manage any problems.

The standards will provide a clear process for the department, existing providers and provider partnerships to achieve the Commission's expectations of the future system. The standards will also provide minimum expectations and conditions for new providers to be able to receive funding. The standards do not replicate or replace professional or quality standards or regulatory processes. However, where possible, they are aligned to reduce administrative burden.

The department will maintain the service standards, which will be reviewed annually to remain up to date and reflect any changes to associated legislation, regulations or standards. However, the Commission's intent and level of ambition will not be lost through this process. While the service standards apply statewide, Regional Boards may choose to apply additional standards in their region.

The standards will be used to guide investment decisions and support provider development. They will allow the department and Regional Boards to target funding to providers who can demonstrate essential capabilities. Standards will apply to Victorian Government–funded mental health and wellbeing services, including bed-based and community-based services, Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services, as well as statewide services.

Providers and provider partnerships, both existing and new, will need to demonstrate they can meet, or are undertaking actions to meet, the standards. Regional Boards may invest in tailored supports for providers still in development so they can progress towards the minimum standards.

Not all providers will reach maturity at the same time. Some providers may already be meeting some of the more ambitious standards. Others will need time and support to reach these standards. The department will aim for providers to meet all standards in line with broader timelines for the Commission's reform agenda. Service standards will, at first, be non-mandatory, with an emphasis on encouraging development. As the system matures, the standards will be more closely tied to funding decisions.

Over time, all providers and provider partnerships will be supported to progress towards more ambitious service standards that reflect the Commission's expectations of providers at full maturity. Importantly, they will be encouraged to respond to the preferences of consumers, families, carers and supporters.

28.4.2 Growing, developing and diversifying services

To fulfil its role as system steward of the mental health and wellbeing system, the Department of Health needs to expand its focus from simply funding services. This will involve commitment to the development of new and existing providers and provider partnerships to meet the long-term ambition of the service standards.

To successfully carry out this role, the department needs to partner with consumers, families, carers and supporters to develop a self-assessment tool that can be used to assess providers against the standards.

Stewardship of the mental health and wellbeing system is an important function of the department. It will enable the recommended commissioning reforms and, more broadly, will help realise the ambition the Commission holds for the future mental health and wellbeing system.

The Productivity Commission noted that there are 'sound efficiency and equity reasons' for governments to be heavily involved in the funding and provision of human services because 'left to their own devices [the provider market] would not deliver the appropriate level, or distribution, of human services across the community'. There is, therefore, an enduring role for system stewards to be responsible for what 'services should be made available and the effectiveness of those services'.[147]

Echoing this sentiment, research from the School of Social Sciences at the University of NSW suggested, '[i]t is not enough to undertake a needs analysis—a commissioning approach demands that policymakers and planners also understand the supply side and accept some responsibility for its ongoing performance.'[148]

Stewardship is also essential for protecting the interests and safety of individuals, and for ensuring they are not excluded. Professor Bruce Bonyhady AM, Executive Chair of the Melbourne Disability Institute at the University of Melbourne, providing evidence in his personal capacity, stated 'careful stewardship [is required] to avoid exploitation of disadvantaged people, avoid market failure and ensure there are appropriate services for the most complex and vulnerable people'.[149]

As part of its stewardship function, the department and Regional Boards will be responsible for identifying providers that are in development, based on their assessment against the selection criteria. For those providers, the department and Regional Boards will support the further development of providers and their workforces, through additional tools, resources and supports that are co-designed with consumers, families, carers and supporters.

The tools, resources and supports that could be made available, drawing on other parts of the Commission's reform package, include:

- data and analytics to improve understanding of performance, population and financial data
- digital health supports to improve access to, and measurement and sharing of, information with individuals and providers
- collaborative and participatory learning platforms to share knowledge and experiences; integrate evaluation and practice translation; and coordinate professional development opportunities in areas such as corporate and clinical governance, implementation, and consumer involvement (including through the Collaborative Centre for Mental Health and Wellbeing)
- funding incentives to increase health service capacity, quality and performance
- legislation, regulation and policy to ensure the regulatory environment is designed to support and not impede performance.

As this chapter has touched on, the Commission has received evidence about the insufficiency and inequity of past investment. Service standards could be used to direct new investments to where they are most needed. This includes investing in and developing community-based mental health and wellbeing services and consumer-led providers.

In parallel and as described in Chapter 18: *The leadership of people with lived experience of mental illness or psychological distress*, the Victorian Government will establish a new agency to provide dedicated supports for the growth and development of organisations and services that are led by people with lived experience of mental illness or psychological distress. This new agency will help providers to develop capacity and capability to meet the service standards. Importantly, this will include developing strong clinical and corporate governance and protocols for delivering evidence-informed, high-quality services. The Commission anticipates a staged expansion of services led by people with lived experience of mental illness or psychological distress, given the sector will need time and dedicated investment to develop.

Separately, the commissioning process may be contained to one or more providers, where the services required are more specialised, and need specific workforces and infrastructure such as: culturally appropriate services; low-volume, high-complexity services that support consumers with less common conditions; LGBTIQ+ services; or forensic services. This targeted approach will encourage expertise, leadership and specialisation in these fields.

The commissioning process may be tailored for selected providers who face unique challenges in their area. For example, in rural areas (where the workforce is limited), in areas where the proportion of consumers experiencing social disadvantage is greater or where consumers are dispersed over large geographical areas, there would be flexibility in applying the service standards, with an emphasis on encouraging provider partnerships.

This approach recognises that fixing the supply gap requires more than just increasing funding for existing providers. It also requires efforts to encourage new providers to deliver services, and to support all providers to continually develop.

As Professor Suresh Sundram, the Head of Department of Psychiatry in the School of Clinical Sciences at Monash University and Director of Research, Monash Health Mental Health Program, told the Commission in a personal capacity:

> Increasing funding is only a partial solution to reducing the gap between the supply and demand for community mental health services. Doing more of the same, even with additional funds, will not address the problem.[150]

Professor Sundram called for the reconfiguration and restructure of community mental health services to better use a range of community-based service providers.[151]

Through this approach, with support from the department and Regional Boards, providers will be supported to grow and develop. This approach will also encourage new providers to realise their potential to deliver safe, high-quality mental health and wellbeing services. It is only through this active process of identifying and developing the strengths of providers that the department can fix the gaps in the mental health and wellbeing system.

28.4.3 Encouraging provider partnerships

While having a range of providers is important to support the different preferences and needs of consumers, families, carers and supporters, it may also cause them difficulty and confusion when trying to navigate the system. For example, there are many helplines that all do similar things but vary in size and reach. Lifeline alone receives more calls than the largest of the other helplines combined.[152]

Partnerships between providers are key to supporting integrated service delivery from a range of mental health and wellbeing services. As the Commission was told by Dr Margaret Grigg, CEO of Forensicare, multiple organisations will have a role to play, and they will all jointly contribute in a future reformed system.[153]

This is clearly demonstrated in the Commission's recommendation for forming service partnerships between a public health service or public hospital, and a non-government organisation that provides wellbeing supports for the delivery of Area Mental Health and Wellbeing Services, as established in Chapter 5: *A responsive and integrated system*. The nature of each partnership will vary according to the partners and the strengths they each bring. Some partnerships may support a broader service offering, such as in rural communities where services cannot be sustained locally. Other partnerships may support culturally safe services, such as in communities with higher numbers of people from culturally diverse backgrounds.

Several effective partnerships already exist. Alfred Health currently partners with headspace National Youth Mental Health Foundation and the South Eastern Melbourne Primary Health Network. The benefit of this partnership is that both the state-funded child and youth mental health services and the Commonwealth-funded headspace Youth Early Psychosis Program can be closely integrated.[154] The Commission has expressed a preference for these arrangements to be more commonplace, as described in Chapter 13: *Supporting the mental health and wellbeing of young people*.

System stewardship is essential to strike the right balance between a range of providers that can support diverse preferences and needs, and a system that is easy to navigate. Encouraging partnerships can help to achieve this balance. The service standards can be used to encourage an individual provider to join with one or more complementary providers to form a provider partnership to meet the standards.[155]

Mr Graham Panther, a witness before the Commission, described a New Zealand example of contracting that brought two organisations together:

> No single bid met the criteria, so they asked two leading bidders to join bids. One was a well-known, relatively conservative clinical service, and the other was an organisation with significant peer leadership at the highest levels. It seemed an unlikely pairing to all involved at the outset, but the partnership was a fruitful one, bringing the best of both worlds. … [T]he peer expertise in that partnership had its own home, its own organisation with its own equal standing.[156]

The COVID-19 pandemic has placed unprecedented pressure on service providers and the mental health system. This common threat has helped to unite individual organisations, exposing them to shared challenges that they cannot tackle in isolation. It has helped forge new partnerships to deliver services and reforms that have previously been deemed difficult to achieve. As Mr Clelland shared:

> COVID-19 has provided an opportunity for individual service providers to think of themselves as part of a bigger system. … the COVID-19 crisis has forced people to come together in unprecedented ways and to think about what happens outside the boundaries of their own organisation, be it a hospital, a community health organisation or some other form of service provider. This change in how service providers perceive themselves will be useful as the reform process gets underway.[157]

Similarly, Mr Gary Croton, Clinical Nurse Consultant in the Hume Border Victorian Dual Diagnosis Initiative at Albury Wodonga Health, told the Commission:

> The past several months have brought extraordinarily rapid service development to allow people, who previously would have been treated in acute inpatient units, to be treated with intensive mental health community care. … This change has involved:
> … A greater focus on working in partnerships with consumers and their significant others, peer workers, GPs, [alcohol and drug] services and relevant [non-government organisations] and [National Disability Insurance Scheme] providers to create a recovery plan for intensive mental health community care.[158]

Associate Professor Moylan suggested the COVID-19 pandemic has enabled change, creating an '"all bets are off" environment' that has given services greater freedom to implement new service models. Associate Professor Moylan recognised the impermanence of these arrangements, stating that 'unless community centred care is culturally reinforced in the system, it is likely that the system will revert back after the pandemic'.[159]

Cultivating a diverse service offering will help fulfil the Commission's aspirations for a modern mental health and wellbeing system. But deliberate efforts are needed to ensure the system does not remain overly complex and difficult for people to navigate. System stewardship can encourage providers to come together to overcome this complexity. The Department of Health will need to build on those productive partnerships that have already been developed.

28.4.4 Rethinking the way mental health and wellbeing service funding is distributed

The Commission has been told that current funding arrangements do not adequately cover demand and the distribution of resources is inequitable and does not reflect need.[160] These deficiencies mean providers have not been encouraged to respond to the diverse needs and preferences of consumers, families, carers and supporters.[161]

Current funding arrangements must shift from focusing on 'inputs' to focusing on 'value'. 'Value-based health care' is a term increasingly used when discussing funding arrangements. Dr Alice Andrews, Director of Education at the Value Institute for Health and Care and Assistant Professor in the Department of Medical Education, Dell Medical School at the University of Texas, explained, '[t]he 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.'[162]

Funding models need to encourage providers to achieve greater value for Victorians by responding to the individual needs of consumers. As one person told the Commission, '[t]he government expects people to fit into a box, but we don't we are all [u]nique. We all have different needs and experiences.'[163]

Box 28.2 provides an overview of the different options for funding mental health and wellbeing services.

Box 28.2: Options for funding mental health and wellbeing services

Block funding

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.[164] The 'block' of funding might be calculated based on 'inputs' such as, in the case of mental health services in Victoria, the number of beds available or the number of community mental health service hours that are available.[165]

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.[166]

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.[167]

Bundled funding

Bundled funding provides a single price to cover all of a person's treatment, care and support over a defined period spanning multiple episodes and settings.[168] While similar to an activity-based funding model, bundled funding provides funding for services delivered over a longer period across multiple settings. For example, bundled funding may provide a single bundle of funding that covers all services delivered in a hospital and then all services delivered once that person is discharged back into the community.

Capitation funding

Under a capitation funding model, providers receive a fixed amount of funding for each person who registers with them for a specified period, usually a year.[169] Capitation funding is similar to block funding, but the funding is based on the number and mix of people who are registered with the service and their individual needs.

While it is not the end goal, the shift from inputs to value begins with implementing an activity-based funding model. The Department of Health will trial and then implement an activity-based funding model for both bed-based and community-based mental health and wellbeing services to begin this shift.

Activity-based funding encourages providers to respond to the diverse needs and preferences of individuals, including offering a range of mental health and wellbeing services.[170] Activity-based funding reimburses service providers for the volume and mix of people they support. Unlike block funding, which goes directly to a provider, regardless of how many people they see,[171] under an activity-based funding model, funding follows the person.[172]

Since 1993, other health services in Victoria have been funded using activity-based funding, using a model based on 'diagnosis-related groups'.[173] The same approach to funding other health services on an activity basis has been used nationally for inpatient mental health services since reforms introduced under the 2011 *National Health Reform Agreement*.[174] The model used nationally has not been implemented in Victoria, and the Commission has been told that it is not appropriate for mental health services.[175] An effort to implement an activity-based funding model for mental health services was also made in the 1990s, but it was unsuccessful due to the unavailability of data.[176]

There has been recent work to develop an activity-based funding model for mental health services that shows promise. The Independent Hospital Pricing Authority has been developing an alternative classification for an activity-based funding model for mental health services since 2013,[177] and has begun trialling that model in the most recent financial year.[178] The Commission understands that the former Department of Health and Human Services intended to trial a model for community-based mental health services in 2020–21 before the COVID-19 pandemic pushed out its timeline.[179] A number of people have told the Commission there is promise in this work.[180]

Based on the evidence before it, the Commission considers that applying an activity-based funding model will shift the emphasis from the inputs and processes of mental health and wellbeing services towards value and, importantly, the outcomes and experiences that consumers consider are important. A major barrier to implementing funding models that encourage a focus on value is the ability to see accurate cost and outcomes data.[181] While cost and outcomes data are available for mental health services in Victoria, the quality of the data is poor.[182] The department's activity-based funding model uses outcomes data,[183] which may encourage providers to improve their data collection.

The main attraction of activity-based funding is that it takes into account a person's needs. Under an activity-based funding model, consumers are essentially allocated a tailored funding package for their mental health and wellbeing services. Activity-based funding considers several factors that influence a person's needs, including complexity, intensity and other factors, such as social factors, that influence people's mental health. Activity-based funding allocates funding to where it is needed most by using data on the costs of delivering services.[184]

Another benefit of activity-based funding is that it will help support the Department of Health and service providers to put forward arguments to central government agencies for increased funding because it provides greater transparency on what is delivered. As Mr Symonds told the Commission, activity-based funding 'provides a clarity on how much has been spent on what in terms that the Department of Treasury and Finance understand, which will strengthen the case for increased investment in mental health by government'.[185]

Despite the benefits of activity-based funding, there is a risk that it introduces some unwanted incentives. According to a 2016 review of commissioning by the King's Fund and the University of Melbourne, activity-based funding leads to a greater number of episodes of treatment, care and support and reduced length of stay.[186] While this may be beneficial for some other health services, it may not be desirable for mental health and wellbeing services. A 2014 systematic review of activity-based funding also noted that it may increase readmissions, leading to increased costs to the health system in the long run.[187]

As Mr Bill Buckingham, Director of Buckingham Consulting, suggested in a personal capacity, '[d]eveloping and implementing an activity-based funding model that promotes community care presents a real challenge.'[188] But only using activity-based funding for bed-based services may encourage increased funding for these services at the expense of community-based services. Under these arrangements, services would be rewarded for providing more bed-based services, but not for providing more community-based services. To respond to this risk, activity-based funding must be used to fund mental health and wellbeing services delivered in the community and in bed-based settings.

The Commission considers that the benefits of introducing activity-based funding outweigh the risks. It will be important that the Department of Health uses strategies to monitor and mitigate any contradictory incentives. This will include making incentive payments to encourage preferred models such as: services that use compulsory treatment as a last resort;[189] services that respond to the needs and preferences of consumers including, for example, supporting group-based activities; meeting performance monitoring requirements; and achieving quality and safety outcomes.

Activity-based funding will also consider costs that might not otherwise be captured by providing additional funding to the price paid, including for consumers living in rural and regional areas. The Independent Hospital Pricing Authority's *Pricing Framework for Australian Public Hospital Services 2020–21* states that where there are 'unavoidable variations in the costs of delivering health care services' an adjustment to the activity-based funding provided is required. The framework also states that 'patient-based characteristics' that influence cost—for example, where a consumer or patient lives—should be considered for an adjustment to ensure funding follows 'the patient wherever possible'.[190]

The Commission was told that providers delivering services in rural and regional areas have additional costs that are not currently recognised. South West Healthcare suggests that 'current funding for clinical bed-based services [only] covers around 70 [per cent]'[191] of the costs of providing services. Similarly, Latrobe Regional Hospital said that funding reform needs 'to address the rural and regional context of service delivery and support innovation to provide access to those hard to reach populations who are not receiving service[s]'.[192]

Providing additional funding, or a loading to the price paid, is consistent with other approaches taken to recognise additional costs. The Independent Hospital Pricing Authority recognises additional costs of providing services to people living in 'regional, remote or very remote' areas by paying a higher price for those people.[193]

The department has a similar model to recognise the additional costs of providing other health services to Aboriginal Victorians, where a 30 per cent loading is applied to the price.[194] It is expected that the department would also apply this loading to the price paid for mental health and wellbeing services.

The Commission considers that a loading should be applied for rural and regional Victorians in the first instance, with additional loadings considered and applied as the model is developed and implemented.

There are some providers and services that cannot be funded using activity-based funding, or that would benefit from an alternative approach. For these services, block funding and fee-for-service funding will be used to complement activity-based funding.

Like activity-based funding, fee-for-service funding also effectively follows the person, encouraging providers to be more responsive. The Productivity Commission's *Mental Health Inquiry Report* said that a fee-for-service funding model could encourage services 'to devote more time to consumer-related activities'.[195]

There are a number of problems with fee-for-service funding that the department will have to consider. First, providers receive more funding the more services they deliver, regardless of whether the services contribute to better outcomes.[196] The Grattan Institute's 2016 report *Chronic Failure in Primary Care* also noted that Australia's Medicare Benefits Scheme, a fee-for-service funding model, encourages 'reactive rather than systematic care' and inhibits multidisciplinary planning and care coordination between GPs and specialists.[197]

Block funding can give providers certainty and stability, and allow flexibility to innovate. The former Department of Health and Human Services recognised that some services should be funded through a specified grant to make sure there is enough scale and scope to deliver services where there is low demand or high costs.[198]

If using block funding, the Department of Health will have to consider the matters that have already been documented in this chapter. These matters include that block funding can contribute to a gap between funding and demand for services and may lead to an inequitable distribution of resources.[199]

Statewide services that deliver highly specialised services to a small number of consumers will be more appropriately funded using a mix of block funding and fee-for-service funding. The flexibility that comes with block funding will support statewide service providers and the Collaborative Centre for Mental Health and Wellbeing to take on a leadership and coordination role, helping to translate knowledge and research into practice, supporting consumers from across the state to receive treatment, care and support in the community, and supporting providers of Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services to build their capabilities.

There are also some smaller local providers—for example, small regional community health service providers—that cannot be funded based on activity in the short term. Where there is an absence of economies of scale for mental health and wellbeing service providers, often experienced when a provider is small and cannot increase in size to reduce their average costs, the Independent Hospital Pricing Authority recommends block funding rather than activity-based funding.[200]

These new approaches to funding mental health and wellbeing services will help make sure there is enough funding to cover demand and that resources are distributed more equitably.

28.4.5 Other funding reforms that achieve better outcomes and deliver greater value

Other funding reforms must be pursued in parallel with implementing activity-based funding. Without implementing activity-based funding alongside other funding reform, funding approaches for mental health and wellbeing risk being left behind as new ways of commissioning public services are implemented. In a mature system, funding based on value and outcomes (rather than activity) will encourage providers to adopt new ways of working.

Funding will, first and foremost, be driven by the outcomes that individuals value. To enable this, funding decisions will support progress towards the outcomes in the *Mental Health and Wellbeing Outcomes Framework*, recommended in Chapter 3: *A system focused on outcomes*.

To promote the delivery of mental health and wellbeing services that consumers, families, carers and supporters value, the department will work with the Collaborative Centre for Mental Health and Wellbeing to develop an approach to bundling funding for a whole pathway of treatment, care and support.

First, this will involve developing and trialling an evidence-informed mental health and wellbeing service pathway. The pathway will be co-designed with consumers, families, carers and supporters and will recognise the importance of supported decision-making principles and practices whereby a person is enabled to make and communicate decisions with respect to personal or legal matters.[201] Second, the department and the Collaborative Centre for Mental Health and Wellbeing will develop and trial a funding model that bundles all funding into one price for the services delivered as part of that pathway. These payments will be linked to improvements in outcomes and allow providers flexibility to tailor mental health and wellbeing services based on individual needs and preferences.

Providing funding across a whole pathway encourages providers to think about service delivery beyond an isolated hospital admission or a community mental health and wellbeing service appointment and to consider people's overall experience of their treatment, care and support. According to a Harvard Business School report by Michael Porter and Robert Kaplan, who have led research on value-based health care, bundled payments most closely align the interests of payers, providers and consumers because they 'reward the value of the care delivered', not the volume of services provided.[202] A recent review of the literature from the Australian Healthcare and Hospitals Association suggested that bundled payments may decrease costs and improve service quality.[203]

One of the preconditions to implementing bundled funding is developing a defined pathway. The Victorian Government has previously worked with stakeholders to develop 'optimal care pathways' for different types of cancers.[204] Optimal pathways, as defined in relation to cancer care, provide a clear and consistent standard of care that all consumers can expect when they are diagnosed with a particular cancer.[205]

Pathways for mental health services are a feature of service delivery in England, following the 2016 report from the Independent Mental Health Taskforce to the National Health Service.[206] Since this report the National Health Service has published a series of pathways including one for perinatal mental health services.[207]

In Chapter 10: *Adult bed-based services and alternatives*, the Commission recommends implementing a new extended rehabilitation pathway. This pathway is modelled on the pathway recommended by the United Kingdom Joint Commission Panel for Mental Health.[208]

As well as developing a bundled funding model, the department will develop and trial a capitation funding model. Under a capitation funding model, providers will receive a fixed amount of funding for each consumer they provide with mental health and wellbeing services.[209]

Under this model, consumers could choose to register with a service provider, who would be paid a package of funding to deliver mental health and wellbeing services to that person for the whole financial year. The payments would allow flexibility for consumers, families, carers and supporters to work with providers to design a package that meets their needs and preferences. Capitation payments can also be designed to include existing informal supports such as family supports.

An example of a capitation funding model is Victoria's HealthLinks. Under this funding model, providers convert some of their existing activity-based funding to a more flexible 'capitation grant', which can be used to support consumers with a chronic disease without having to deliver a certain level of activity. The size of a provider's grant is determined by the number of people enrolled with the health service. The capitation grant is intended to cover the chronic condition–related healthcare costs of all enrolled people across the year.[210]

There is emerging evidence that suggests capitation funding could improve the coordination of care. The Productivity Commission's *Mental Health Inquiry Report* concluded that a well-administered capitation payment could 'incentivise providers to minimise the costs of achieving good clinical and functional outcomes for consumers, usually by better coordinating care and shifting care to lower cost settings'.[211] A review of a capitation funding model for people with diabetes in the Netherlands indicated that the payment 'improved the organization and coordination of care and led to better collaboration among healthcare providers'.[212]

In time, a capitation funding model could be used to support integrated commissioning, as described in Chapter 29: *Encouraging partnerships*. While an integrated contract will encourage service providers to come together to deliver integrated treatment, care and support, a capitation funding model could further ensure providers have the necessary funding flexibility to tailor services to individuals' needs.

Despite the benefits of bundled and capitation funding approaches, there are some barriers to implementing these models for mental health and wellbeing services. These approaches rely on collecting accurate cost and outcome data,[213] which is currently not well captured in Victoria.[214] Bundled and capitation funding also require accurate data on, and an understanding of, the factors that influence a person's needs.[215] As previously noted, implementing an activity-based funding model for mental health and wellbeing services may help improve data collection.

Another barrier to implementing these funding reforms is understanding and acceptance among service providers. A literature review undertaken by the King's Fund and the University of Melbourne on health service commissioning noted the importance of providers and the workforce having the capabilities and expertise to take on capitation funding.[216] Given the limited experience of bundled and capitation funding in Victoria, this may be a challenge in the short term.

However, the Commission is aware that the Victorian Government and service providers are already exploring new and innovative approaches to funding. Mr David Martine PSM, Secretary of the Department of Treasury and Finance, told the Commission about one example, the Partnerships Addressing Disadvantage program, which is:

> an outcomes-based funding model in which government makes payments upon the achievement of measurable social outcomes, such as a reduction in hospital admissions for program participants … . This program provides a new way for Government funding arrangements to be used to incentivise demonstrably better outcomes for Victorians facing social challenges.[217]

These reforms will support continued efforts to align funding with the Commission's vision for the future mental health and wellbeing system, including progressing towards the outcomes detailed in the *Mental Health and Wellbeing Outcomes Framework* and encouraging providers to respond to the diverse needs and preferences of consumers, families, carers and supporters.

28.5 Performance monitoring and accountability centred on consumer, family, carer and supporter outcomes and experiences

Performance monitoring is important to ensure mental health and wellbeing services are delivering improved experiences and outcomes for consumers, families, carers and supporters. It also provides clarity between the Department of Health and service providers about service delivery expectations, and supports continuous improvement.

Ms Meagher described her ambitions for performance monitoring and accountability from the perspective of those who access services:

> There is more to people's lives than the services they use; they are, of course important, but we must look not just at the number of services, but also their range, availability, accessibility and quality. We must agree and report on a number of meaningful indicators and ambitious, but achievable targets. These need to concentrate and link up effort in all the areas that help people to live contributing lives: having a home, having something meaningful to do, improving opportunities, attaining good personal health, having healthy relationships and having adequate mental health and social supports.[218]

What constitutes 'meaningful accountability' for consumers, families, carers and supporters, differs from the views of providers, the Victorian Government and the broader community. An article published in *The Journal of Mental Health Policy and Economics* noted the multiple objectives of performance monitoring:

> Consumers and families want to know what services and treatments work. Funders want information in relation to cost effectiveness and value for money … . Health care providers want to know about the impact of the care they have provided to their patients. The general community want to know if they have a mental health system on which they can rely.[219]

The Commission envisages a future performance monitoring and accountability approach that can deliver on these divergent, but nonetheless important, objectives while ensuring that service providers are held to account for the outcomes that they are resourced to achieve.

A new approach to performance monitoring will enhance accountability of providers across the system and will ensure the views and perspectives of consumers, families, carers and supporters are central. As Professor Bonyhady stated:

> A key aspect of performance monitoring is ensuring that the metrics that are tracked are those that matter to citizens, rather than those that are considered to be most important to governments or bureaucrats. In order to identify what matters most to people, you need to ask them.[220]

This section describes a new approach to performance monitoring and accountability for Victorian Government–funded providers of mental health and wellbeing services. While this chapter focuses on mental health and wellbeing service delivery, it is one part of the Commission's broader ambitions to achieve improved mental health and wellbeing outcomes for Victoria, as described in Chapter 3: *A system focused on outcomes*.

Box 28.3 outlines the key terms used in this section.

Box 28.3: Key terms for performance monitoring of mental health and wellbeing services

Performance domains

Performance domains group related outcomes or key performance indicators. In the context of performance monitoring, performance domains can encourage consideration of the broader social, economic and environmental factors that may influence outcomes.[221]

Key performance indicators

Key performance indicators, also referred to as key performance measures or outcome indicators, help measure and track progress and performance.[222] In mental health, key performance indicators cover different aspects of services and can help consumers, families, carers, supporters, service providers and funders to understand service performance.[223]

Consumer-completed measures and family-carer-and-supporter-completed measures

Consumer-completed measures and family-carer-and-supporter-completed 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 person. This information can be collected using a range of tools including questionnaires or standardised surveys.[224] There are two distinct but related types of measures:

- experience measures that collect information about a person's experience accessing treatment, care and support—for example, measures related to communication and timeliness
- outcome measures that assess the impact of treatment, care and support across a range of outcomes—for example, participation in the community.[225]

28.5.1 A new performance monitoring and accountability approach

A reimagined mental health and wellbeing system will include a broader service offering, delivering new types of treatment, care and support to meet the individual and evolving needs of consumers, families, carers and supporters.

A greater diversity of mental health and wellbeing services, supported by a mix of service providers, means the usual tools at the disposal of the Victorian Government to monitor performance and hold providers to account will not be available across all service providers.

The Commission acknowledges recent work led by the former Department of Health and Human Services to improve performance monitoring and accountability arrangements for mental health services. While this work provides a strong foundation for future advancements, its limited focus on clinical mental health services means it will need to be adapted to reflect the Commission's aspirations for a broader suite of mental health and wellbeing services.[226]

A new approach to performance monitoring and accountability, designed for use by the Department of Health and Regional Boards, will hold all providers of Victorian Government–funded mental health and wellbeing services to account.

A new performance monitoring and accountability framework for mental health and wellbeing services will comprise:

- a consistent set of performance domains to group related outcomes or key performance indicators
- tailored key performance indicators and consumer-completed measures and family-carer-and-supporter-completed measures to measure and track progress
- a performance improvement process that identifies performance concerns and supports implementation of a performance improvement plan.

These features are consistent with effective performance monitoring and accountability arrangements in Victoria, Australia and other jurisdictions[227] and will be supported in part by collecting, analysing and disseminating meaningful data. These features are described in more detail in the following sections.

28.5.2 Performance domains

A new performance monitoring and accountability framework comprising a uniform set of performance domains will embed a level of consistent expectations across all providers about what constitutes strong performance. It will also minimise inequities in both the access to and quality of mental health and wellbeing services.

The department and Regional Boards, once they have been established and have taken on commissioning functions for their region, will monitor Victorian Government–funded mental health and wellbeing service providers against a common set of performance domains that group related outcomes. As described in section 28.5.3, there will be some variation and tailoring of key performance indicators, depending on the types of services provided.

The Commission has been told it is important to monitor and hold to account all service providers in a consistent way. Peninsula Health described how a consistent approach increases the ability of providers to compare or benchmark themselves against other providers:

> in order for its Board to properly oversee and monitor the performance, quality and safety of its mental health service, the [department] needs to implement a degree of consistency within mental health models of care, such as consistent definitions, assessment tools and quality outcome measures. Transparency and accountability will be enhanced by meaningful performance, quality and safety indicators that are benchmarked across the state of Victoria and, eventually Australia.[228]

A review by the Victorian Auditor-General's Office also highlighted the importance of a standardised approach to performance monitoring across community health service providers, noting there are different arrangements to performance monitoring for integrated community health providers and registered community health providers.[229]

It has also been suggested that current disparate performance monitoring arrangements do not focus on the experiences of consumers, nor do they measure alignment across the range of services that people need to support their mental health and wellbeing. Anglicare Victoria explained:

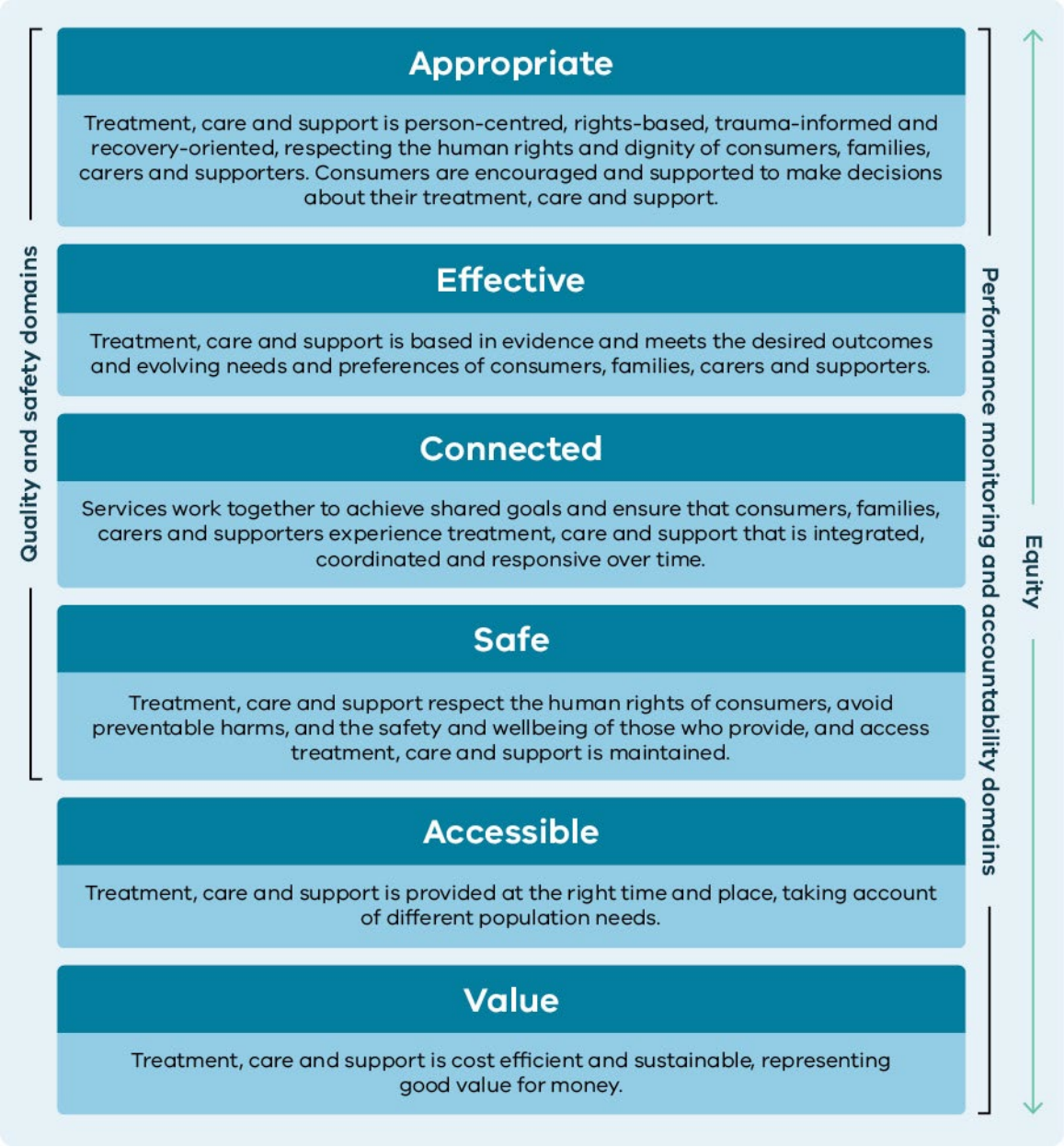
> Accountability and performance monitoring for funded services continues to focus on the delivery of particular services by particular branches of government and often focuses on the volume of service delivered. Anglicare Victoria is not aware of any effective accountability mechanism that addresses the whole client journey, or measures coordination and alignment across these service streams.[230]

The importance of a shared vision to support integration and continuous service improvement has also been raised. As Associate Professor Simon Stafrace, Chief Adviser, Mental Health Reform Victoria, acknowledged in a personal capacity:

> For health services to be able to deliver and commit to continuous improvement, they need alignment throughout the organisation of what their improvement direction is (a clear shared goal) … . At the level of the mental health care system, there is need for [a] mindset shift that embeds continuous improvement of service delivery with a focus on improved outcomes as an accountability measure for health services.[231]

The Commission recommends that performance domains in the new performance monitoring and accountability framework align with those identified in the *National Mental Health Performance Framework 2020*, based on the *Australian Health Performance Framework* (Figure 28.3).[232]

Figure 28.3: Performance domains of a new performance monitoring and accountability framework



Source: Adapted by the Commission based on the domains identified in the Australian Institute of Health and Welfare, *National Mental Health Performance Framework 2020*.

As the *National Mental Health Performance Framework* continues to adapt and evolve over time, the domains of Victoria's new performance monitoring and accountability framework will be updated and remain aligned. This approach is recommended to ensure that services that may be funded from different sources remain aligned and that providers are encouraged to work in partnership towards shared outcomes.

To embed a level of consistency across a redesigned mental health and wellbeing system, four of the proposed performance domains are included in the Commission's recommended vision to support high-quality and safe treatment, care and support detailed in Chapter 30: *Overseeing the safety and quality of services*. The new performance monitoring and accountability framework includes two added domains—accessibility and value—to capture all aspects of service provider performance.

The Commission's preferred approach to system monitoring is detailed in Chapter 3: *A system focused on outcomes*, and will see development of a *Mental Health and Wellbeing Outcomes Framework* to drive collective responsibility for system-wide transformation. A system-wide approach to monitoring will take a broader view, with a focus on measuring outcomes at the individual and population levels. Data collected via the new performance monitoring and accountability framework for Victorian Government–funded service providers will form an important component of the system-wide approach. Acknowledging these intersections, the Department of Health should develop both frameworks in tandem.

Respecting the human rights and dignity of consumers, including ensuring consumers are supported to make decisions about their treatment, care and support, will be a central feature of performance domains, in particular those related to 'appropriate' and 'safe'.

'Equity' will be considered an overarching concept that influences all aspects of the new framework. The *Australian Health Performance Framework* explicitly recognises the need to monitor equity across all domains.[233] As Mr Symonds explained:

> **performance monitoring should be structured to take equity into account across all levels and domains of activity—that is, the minimisation of avoidable differences in health and mental health outcomes between groups or individuals.[234]**

This will be achieved by collecting data across different population groups, including Aboriginal people and culturally diverse people, and into different geographic areas, including rural and regional areas, as well as data that measures the different needs of consumers.

A uniform set of performance domains will embed a level of consistent expectations across the range of providers expected to operate in a redesigned mental health and wellbeing system and will encourage continuous service improvement.

28.5.3 Performance measurement

Key performance indicators, both new and existing, will measure provider performance. Service providers will be assessed against each performance domain, towards an absolute target or a stepped target that demonstrates year-on-year improvement.[235]

The Department of Health should lead a consultation process to develop new and existing key performance indicators with a range of partners, including engaging with the new agency led by people with lived experience of mental illness or psychological distress, recommended in Chapter 18: *The leadership of people with lived experience of mental illness or psychological distress*.

Measures will include a mix of efficiency and outcome measures, including measures that collect information from the perspective of those who use services. These measures are discussed more in the following section. Ms Robyn Kruk AO, Interim Chair of Mental Health Australia, reflected in a personal capacity on the importance of outcome measures in embedding transparency and oversight:

> **In Victoria, as is the case in most administrations, the performance agreements for local health districts are traditionally heavily weighted to health system procedures rather than specific mental health system outcomes. There is less transparency and oversight about the system's ability to assess whether mental health services are provided in the most equitable, cost effective and impactful manner.**[236]

Key performance indicators will align to the range of functions delivered by service providers, including the core functions recommended as part of future community mental health and wellbeing services. Measures will continue to evolve as people's needs and preferences change, data collection improves and new evidence emerges. It is expected that new key performance indicators related to integrated alcohol and other drug services, and measures related to community connection and social wellbeing, will be developed.

Key performance indicators must be relevant and tailored to the types of services provided to ensure service providers are accountable for the outcomes and outputs that are within their remit. Some key performance indicators, however, will be measured across all service providers. For example, the Commission considers that key performance indicators related to supported decision-making practices must be collected across all service providers.

Where possible, it will be essential for the new performance monitoring and accountability framework to embed the same expectations and targets for consumers of mental health and wellbeing services as for other health services, for example length of stay in an emergency department. This will ensure mental health and wellbeing continues to be a priority in decision-making processes.

Refreshed key performance indicators will provide rich information and insight to ensure providers are continually adapting and improving their performance to better meet people's needs.

28.5.4 Consumer-completed measures and family-carer-and-supporter-completed measures

Alongside development of key performance indicators, a new approach is also required to understand the outcomes and experiences from the perspective of those who use services. This information is vital to achieving considerable and sustained improvements in mental health and wellbeing services and for making sure that treatment, care and support reflects evolving needs and expectations.

Ms Roper told the Commission that current approaches do not always measure the outcomes that are important to consumers, including their sense of power over their own lives:

> the things that are important to consumers are not always measured. There's such a difference if you did measure things like how a person's sense of agency, or their sense of hope was affected by their use of a service.[237]

Ms O'Hagan reflected on how approaches to performance monitoring would be different if measures were designed by those who used services. Including for example a broader focus on wellbeing, social connection and a contributing life.[238]

One way of measuring and collecting data from the perspectives of those who use services is through consumer-completed measures and family-carer-and-supporter-completed measures. In other health services, these are sometimes referred to as 'patient-reported measures'.

There are two distinct but related types of measures:

- experience measures that collect information about a person's experience while they are accessing treatment, care and support—for example, measures related to communication and timeliness
- outcome measures—that assess the impact of treatment, care and support across a range of outcomes—for example, quality of life and daily functioning.

Common across these measures is the fact that information is collected directly from the people who use these services rather than from the mental health workforce.[239] This information can be collected using a range of tools such as questionnaires or standardised surveys.[240]

While there are some existing tools with which to collect this information across Victorian Government–funded mental health services, they are limited in their application and are not yet widely used. The Behavior and Symptom Identification Scale, a measure that assesses changes in consumer self-reported symptoms over the course of treatment within inpatient and community-based settings,[241] does not appear to be routinely used. The Commission notes that in 2019–20, across all Victorian public specialist mental health services, the Behavior and Symptom Identification Scale only captured information from 7 per cent of all community cases.[242]

Calls for a strengthened approach to collection of measures from the perspectives of consumers, families, carers and supporters are shared by workers and service providers across Victoria's mental health system. As Dr Paul Denborough, Clinical Director of Alfred Child and Youth Mental Health Service, providing evidence in his personal capacity, suggested:

> A system that allowed for the collection and measurement of patient outcomes as measured by patients themselves would lead to greater accountability for services.[243]

Similarly, Ms Peake told the Commission that ensuring consumers, families, carers and supporters are treated as partners in the new system would be supported by:

> greater accountability across the system for lived experience engagement, such as co-designing performance indicators that cover the collection and use of experience of care feedback, lived experience workforce measures, and leadership support for lived experience structures.[244]

Dr Sarah Pollock, Executive Director in Research and Advocacy at Mind Australia, described the importance of collecting data that is valuable to consumers, families, carers and supporters:

> to be able to understand and optimise opportunities and developments over the long term, we need an approach to data that centres on the outcomes that are meaningful to people … . Unless we have outcomes data that is truly person-centric, the data we have available to us will not be sufficient to understand what creates value for mental health consumers and carers.[245]

Similarly, the Centre for Psychiatric Nursing recommended more measures to capture the outcomes and experiences of consumers, families, carers and supporters:

> We need a measure of mental health, capturing an outcome of service use that is meaningful for consumers. There are several recovery measures worth reviewing; the decisions should be consumer expertise endorsed. Better use might be made of the existing 'your experience of service' tool as a [key performance indicator] at a higher level, and perhaps a family carer equivalent.[246]

Measures designed by consumers, families, carers and supporters will result in a deeper and more-nuanced understanding of the experiences and outcomes that matter to people. This could include new measures related to wellbeing, recovery and social connection.

To this end, as part of the performance monitoring and accountability framework, the Department of Health will establish a phased approach to the development, collection and reporting of consumer-completed measures and family-carer-and-supporter-completed measures. This new approach will be developed in co-production with consumers, families, carers and supporters and will outline a process for how measures will be developed and for which cohorts of people. Over the long term, it is envisaged that the use of these measures will be greatly expanded across all Victorian Government–funded mental health and wellbeing service providers.

Consumers, families, carers and supporters will participate and lead across all aspects of the new approach to data collection from the outset, including co-planning, co-designing and co-delivering, right through to co-evaluating. Power dynamics will be acknowledged and addressed to ensure decision making is shared. Proactive efforts will be made to support and build the capabilities of individuals to lead and participate.[247] It should be noted that measures designed by consumers may differ from those designed by families, carers and supporters, reflecting the different needs and perspectives of these two groups.

In developing these measures, the department will also partner with the agency led by people with lived experience of mental illness or psychological distress recommended in Chapter 18: *The leadership of people with lived experience of mental illness or psychological distress,* to take advantage of its expertise and the Victorian Agency for Health Information, an administrative office of the Department of Health, to build on work that is already underway.

In establishing a new approach, the department should align with and take advantage of current initiatives in Victoria and Australia. This includes considering opportunities to adapt and use existing measures in other settings and to better analyse data and link existing data sets with the performance improvement process. This proposition was supported by Mr Symonds, who suggested that the Your Experience of Service Survey could be expanded to include children over 12 years old and older adults over 65 years old.[248] Noting that adaptations should be made to ensure measures are fit for purpose and meet the needs and preferences of people.

As new measures are developed, the new performance monitoring and accountability framework will be updated to reflect new approaches to data collection and measurement. The department and Regional Boards will support service providers to implement and report against the new measures.

A new approach to collecting performance measures from the perspective of those who use services will ensure the future mental health and wellbeing system is grounded in the outcomes and experiences that matter to consumers, families, carers and supporters.

28.5.5 A performance improvement process

A new performance monitoring and accountability framework for mental health and wellbeing services will also outline a performance improvement process. The process will identify emerging or actual performance concerns; evaluate performance risks; and determine appropriate supports and interventions that are tailored and proportionate to the a service provider's level of underperformance and the associated risk.

The performance improvement process will enable performance problems to be identified early and help in the implementing of a performance improvement plan. The Department of Health, and then Regional Boards, will determine the appropriate level and types of supports or interventions, proportionate to the level of risk.

This could include, but would not be limited to, the department and then Regional Boards:

- directing the provider to develop a strategy to tackle the problem
- linking the provider with an appropriate, complementary service to learn from their experiences and implement strategies to improve performance
- having more direct intervention, such as engaging an independent expert to review policies and practices.[249]

These arrangements are premised on the idea of 'responsive regulation', meaning providers will be held to account in ways that have been agreed with the department or Regional Boards. Where performance falls short, the department and then Regional Boards will intervene to improve performance.[250]

Dr Andrews referred to this as the concept of 'loose-tight', meaning high-performing providers are given greater freedoms to innovate:

> **This means focussing on outcomes and results rather than micro-managing costs for each process. Where a health service is 'loose' on the process and 'tight' on the results, health workers are given more autonomy to do what is best for patients with certain limits in place. The results, and the overall expenses involved in achieving results are still monitored, assuring accountability.** [251]

New arrangements for performance monitoring and accountability will be facilitated through legislation and reflected in policy and funding decisions, and there will be clear accountabilities for the department to hold Regional Boards to account. Similar to existing arrangements for public health service boards, where stronger intervention is required, the relevant minister will have the powers they need to appoint delegates to the Regional Boards and to remove directors and replace them with an administrator.[252]

To ensure continuous improvement, a strategy will be in place to review the recommended performance monitoring and accountability framework each year, including key performance indicators, consumer-completed measures and family-carer-and-supporter-completed measures. The Commission notes that the Victorian Agency for Health Information is responsible for monitoring and reporting on public and private services, including reporting, creating and recommending indicators against which to measure performance.[253]

The annual review strategy will be complementary. It will be led by the department, in consultation with Regional Boards, and should involve consumers, families, carers and supporters. This process will ensure the performance and accountability approach is appropriate and continues to evolve in line with contemporary practice, emerging evidence and the preferences of consumers, families, carers and supporters. As arrangements continue to evolve, the department and Regional Boards will support service providers to adapt their approach to performance monitoring, data collection and measurement.

28.5.6 Data as a key enabler

The success of the performance monitoring and accountability framework depends on collecting, analysing and disseminating meaningful data. Benchmarked data comparing similar providers play an important role in informing consumer choice, driving innovation and encouraging better practice. It also will enable the department and Regional Boards to manage poor provider performance.

Benchmarking data is often misunderstood as a passive process that involves comparing data against a standard, then publishing the results. In practice, benchmarking must be a dynamic process that involves continuous learning and improvement.

As the National Mental Health Performance Subcommittee, a part of the former Australian Health Ministers' Advisory Council structure, described:

> benchmarking is an active process of participation and learning that involves bridging the gap between evidence and practice. This requires the engagement of participants in reflective practice, in measuring performance … and receiving feedback in a way that allows learning through comparisons.[254]

The Mental Health Legal Centre noted the importance of data collection and benchmarking in providing accountability:

> Appropriate data collection is vital for monitoring the effectiveness and safety and quality of our mental health system. Public reporting of data is essential to providing accountability and helps to drive service improvement through transparent benchmarking of services.[255]

A new performance monitoring and accountability framework will improve data collection and analysis across a core set of performance domains. Where appropriate and subject to relevant privacy considerations, data will also be made public to encourage continuous improvement and to provide consumers, families, carers and supporters with the information they need to make informed choices about their treatment, care and support. This will include transparent public reporting on efforts to reduce the use of seclusion[256] and restraint,[257] as well as compulsory treatment.[258]

To inform consumer choice and decision making, data must be both accessible and meaningful, as Professor Bonyhady explained:

> Transparency is another essential element of performance monitoring. Performance metrics not only need to be based on what matters most to people, they also need to be couched in language that is accessible and meaningful to people.[259]

Alongside benchmarking, information and data sharing between the department, Regional Boards and other quality, safety and oversight bodies will be important to ensure high-quality and safe services are provided and that there is a culture of continuous service improvement. This flow of information will be supported by information-sharing protocols outlining clear roles and responsibilities for sharing information.

28.6 Commissioning as a collective activity

Commissioning is increasingly being defined as a collective activity that focuses on a local system or population rather than an individual contract with a single provider.[260] It requires multiple organisations with various commissioning and regulating functions to work with people and providers to effectively plan and develop services that are in line with the latest evidence.

As Mr Symonds told the Commission:

> [it] is my belief that we must build the future system in partnership with consumers and their families, Aboriginal communities and our broader communities. It is easy to focus on the nuts and bolts of system design and commissioning structures, and it is important to get these things right, but we must never forget to hardwire in the aspirations of the people we serve through everything we do.[261]

The Commission has recommended creating new entities—including the Mental Health and Wellbeing Commission, Regional Boards, the Mental Health Improvement Unit and the Victorian Collaborative Centre for Mental Health and Wellbeing—established in the Commission's interim report. There are also existing entities that support current government operations such as the Victorian Agency for Health Information and Safer Care Victoria.

These entities each offer expertise and specialisation in their fields. The new Mental Health and Wellbeing Commission will ensure mental health and wellbeing is prioritised, will hold government to account, and will exemplify and enable lived experience leadership. The new Mental Health Improvement Unit within Safer Care Victoria will provide a contemporary and multidisciplinary approach to quality improvement in mental health and wellbeing service delivery, working with service providers to embed evidence-based approaches to quality improvement. The Victorian Collaborative Centre for Mental Health and Wellbeing will focus on education and knowledge translation, leading new research, delivering evidence-informed services and supporting workforce development. Regional Boards will have a deep understanding of their local communities and strong technical skills in commissioning, encouraging providers in their regions to work together and share information and resources.

The Department of Health will continue to manage and steward the mental health and wellbeing system and will ultimately be accountable for the system's performance and the outcomes and experiences of Victorians. The department will oversee Regional Boards and will directly commission statewide services. Regional Boards will, by the end of 2026, become responsible for planning, funding and monitoring mental health and wellbeing services within their region.

For the department to embrace a more contemporary way of commissioning services, it will need to recognise and draw on the dedicated and specialised functions of new and existing entities, and not duplicate them. This will require shared agreement on what each entity does.

To realise the potential of reforms and the benefits they can deliver to people and communities, the department must consider the expertise within these entities in all commissioning decisions.

1 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, pp. 226–227.

2 Anonymous 236, *Submission to the RCVMHS: SUB.0002.0021.0007*, 2019, p. 5.

3 *Witness Statement of Lynda Watts*, 1 July 2020, para. 54.

4 *Witness Statement of Felicity Topp*, 23 July 2019, para. 15; *Witness Statement of Jennifer Williams AM*, 22 July 2019, para. 52; *Witness Statement of Associate Professor Simon Stafrace*, 7 July 2019, para. 77; *Witness Statement of 'Aaron Robinson' and 'Kristy Robinson' (pseudonyms)*, 12 June 2020, para. 28; Anonymous, *Brief Comments to the RCVMHS: SUB.0001.0032.0028*, 2019, p. 4.

5 Brooke Collins, *Brief Comments to the RCVMHS: SUB.0001.0031.0194*, 2019, p. 4.

6 Victorian Auditor-General's Office, *Access to Mental Health Services*, 2019, p. 41; Eastern Health, *Submission to the RCVMHS: SUB.0002.0028.0585*, 2019, p. 7; Harriet Hiscock, Rachel Neely, Shaoke Lei and Gary Freed, 'Paediatric Mental and Physical Health Presentations to Emergency Departments, Victoria, 2008-15', *Medical Journal of Australia*, 208.8 (2018), 334–348 (p. 334); Anonymous 240, *Submission to the RCVMHS: SUB.0002.0023.0047*, 2019, p. 5; Emily Reints, *Submission to the RCVMHS: SUB.0002.0032.0158*, 2019, p. 4.

7 *Personal Story of Imogen Gandolfo, Collected by Victoria Legal Aid*, 2020.

8 *Witness Statement of Kiba Reeves*, 29 May 2020, paras. 13–15.

9 Anonymous, *Brief Comments to the RCVMHS: SUB.0001.0031.0126*, 2019, p. 5.

10 *Personal Story Number 9, Collected by Victoria Legal Aid*, 2020.

11 The Commission acknowledges that there is no single agreed definition of commissioning, refer to: Karen Gardner, G. Powell Davies, Karen Edwards, Julie McDonald, Terry Findlay, Rachael Kearns, Chandni Josh and Mark Harris, 'A Rapid Review of the Impact of Commissioning on Service Use, Quality, Outcomes and Value for Money: Implications for Australian Policy', *Australian Journal of Primary Health*, 22.1 (2016), 40–49 (p. 40).

12 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 560.

13 Anonymous 419, *Submission to the RCVMHS: SUB.0002.0013.0002*, 2019, p. 5.

14 Anonymous 221, *Submission to the RCVMHS: SUB:0002.0028.0395*, 2019, p. 1.

15 *Evidence of Andrew Greaves*, 25 July 2019, p. 1700.

16 *Witness Statement of Terry Symonds*, 2 November 2020, para. 105.

17 Department of Human Services, *Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009–2019*, 2009, p. 35.

18 Department of Health and Human Services, *Victoria's 10–Year Mental Health Plan*, 2015, p. 1.

19 Victorian Auditor-General's Office, *Access to Mental Health Services*, p. 8.

20 *Witness Statement of Robert Fiske*, 15 October 2020, para. 85.

21 *Witness Statement of Robert Fiske*, para. 88.

22 Department of Health and Human Services, *Statewide Design, Service and Infrastructure Plan for Victoria's Health System 2017–2037*, 2017, pp. 14–15.

23 *Witness Statement of Adjunct Professor David Plunkett*, 24 July 2019, para. 51.

24 *Witness Statement of Terry Symonds*, para. 116.

25 Department of Health and Human Services, *Victoria's 10–Year Mental Health Plan*, pp. 10–11.

26 Monash Health, *Submission to the RCVMHS: SUB.7000.0003.0001*, 2019, pp. 5–6.

27 *Witness Statement of Jennifer Williams AM*, para. 58; Bendigo Health, *Submission to the RCVMHS: SUB.0002.0030.0051*, 2019, p. 4; Mercy Mental Health, *Submission to the RCVMHS: SUB.0002.0029.0267*, 2019, p. 16; Victorian Auditor-General's Office, *Access to Mental Health Services*, p. 8.

28 NorthWestern Mental Health (A Division of Melbourne Health), *Submission to the RCVMHS: SUB.0002.0030.0061*, 2019, p. 28; *Evidence of Al Gabb*, 15 July 2019, pp. 949–950.

29 Australasian Health Infrastructure Alliance, *Australasian Health Planning Guidelines: Part B—Health Facility Briefing and Planning: 134—Adult Acute Mental Health Inpatient Unit*, 2019, p. 3.

30 *Witness Statement of Indigo Daya*, 12 May 2020, para. 113.

31 *Witness Statement of Cath Roper*, 2 June 2020, para. 9.

32 New Zealand Productivity Commission, *More Effective Social Services*, 2015, p. 10.

33 *Evidence of Kym Peake*, 25 July 2019, p. 1763.

34 National Disability Insurance Scheme, *Market Enablement Framework*, 2018, p. 4.

35 Productivity Commission, *Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform—Preliminary Findings Report*, 2016, p. 44.

36 *Witness Statement of Kym Peake*, 24 July 2019, paras. 230 and 235.

37 *Witness Statement of Terry Symonds*, para. 29.

38 *Witness Statement of Dr Neil Coventry*, 29 July 2020, paras. 364–365; *Witness Statement of Tim Marney*, 11 June 2020, para. 62; Chris Ham and Nicholas Timmins, *Managing Health Services Through Devolved Governance. A Perspective from Victoria, Australia*, 2015, p. 45.

39 Ham and Timmins, pp. 6 and 8.

40 Ham and Timmins, p. 21.

41 Wilma Gallet, Janine O'Flynn, Helen Dickinson and Siobhan O'Sullivan, 'The Promises and Pitfalls of Prime Provider Models in Service Delivery: The Next Phase of Reform in Australia?', *Australian Journal of Public Administration*, 74.2 (2015), 1–10, (p. 2).

42 Department of Health and Human Services, *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality of Care, Report of the Review of Hospital Safety and Quality Assurance in Victoria*, 2016, pp. 68–69; Ham and Timmins, pp. 45–47.

43 *Witness Statement of Andrew Greaves*, 19 July 2019, para. 39.

44 *Witness Statement of Andrew Greaves*, para. 40.

45 Department of Health and Human Services, *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality of Care, Report of the Review of Hospital Safety and Quality Assurance in Victoria*, 2016, p. 68.

46 Ham and Timmins, p. 47.

47 *Evidence of Andrew Greaves*, p. 1791.

48 Department of Human Services, p. 35.

49 Victorian Auditor-General's Office, *Access to Mental Health Services*, p. 40.

50 *Witness Statement of Kym Peake*, 2019, para. 79.

51 Victorian Government, *Submission to the RCVMHS: SUB.5000.0001.0001*, 2019, p. 27.

52 Barwon Health, *Submission to the RCVMHS: SUB.0002.0029.0222*, 2019, p. 4.

53 *Witness Statement of Associate Professor Ruth Vine*, 27 June 2019, para. 44.

54 *Witness Statement of Dr Tricia Szirom*, 12 May 2020, para. 16.

55 *Witness Statement of Kym Peake*, 2019, para. 264.

56 Victorian Auditor-General's Office, *Access to Mental Health Services*, pp. 41–42.

57 *Witness Statement of Terry Symonds*, para. 129.

58 Department of Health and Human Services, *Clinical Mental Health Funding Reform: Building a Stronger Foundation for Funding Adequacy, Growth and Fairness*, 2020, p. 3.

59 Department of Health and Human Services, *Clinical Mental Health Funding Reform: Building a Stronger Foundation for Funding Adequacy, Growth and Fairness*, p. 14.

60 Monash Health, p. 8; NorthWestern Mental Health (A Division of Melbourne Health), p. 4; Mercy Mental Health, p. 18; Bupa, *Submission to the RCVMHS: SUB.1000.0001.0712 (Appendix)*, 2019, p. 5; Latrobe Regional Hospital, *Submission to the RCVMHS: SUB.0002.0028.0034*, 2019, p. 5; CoHealth, *Submission to the RCVMHS: SUB.0002.0029.0410*, 2019, pp. 31–32.

61 Victorian Government, *Victorian Budget 2019–20: Service Delivery: Budget Paper No. 3*, 2019, pp. 241–242.

62 *Witness Statement of Kym Peake*, 2019, paras. 98–99.

63 *Witness Statement of Terry Symonds*, paras. 152–154.

64 *Mental Health Act 2014* (Vic), sec. 118(1)(e).

65 Integrated community health services refer to community health services that are operated by public health services described in the *Health Services Act 1988* (Vic)

66 The Minister for Mental Health signs the Statement of Priorities for Forensicare instead of the Minister for Health.

67 *Witness Statement of Kym Peake*, 2019, para. 281.

68 Community Health Taskforce, *Community Health Taskforce: Report to Government*, 2019, p. 15; Victorian Auditor-General's Office, *Community Health Program*, 2018, p. 51; *Health Services Act 1988* (Vic), secs. 65ZFA and 40G. Pursuant to section 65ZFA of the *Health Services Act 1988* (Vic), the Statement of Priorities is prepared annually by a board of a health service in consultation with the Secretary to the Department of Health and Human Services. It is approved by the Minister for Health.

69 Pursuant to sections 65V, 65ZAA and 271 of the *Health Services Act*, where a more interventionalist role is required the Minister can sanction providers, via appointing delegates to the board and removing directors from the board and replacing with an administrator.

70 *Witness Statement of Tass Mousaferiadis and Kent Burgess*, 20 May 2020, paras. 62 and 64–65; *Witness Statement of Nicole Bartholomeusz*, 9 June 2020, paras. 81 and 83.

71 Victorian Auditor-General's Office, *Child and Youth Mental Health*, 2019, pp. 55–58; *Witness Statement of Associate Professor Ruth Vine*, 29 April 2020, para. 131; *Witness Statement of Professor George Braitberg AM*, 19 May 2020, para. 100; *Witness Statement of Felicity Topp*, paras. 28 and 30.

72 *Witness Statement of Angus Clelland*, 5 June 2020, paras. 135–136.

73 *Witness Statement of Kym Peake*, 2019, paras. 283–284.

74 *Witness Statement of Felicity Topp*, para. 26.

75 *Witness Statement of Felicity Topp*, para. 29.

76 *Witness Statement of Terry Symonds*, para. 163; Department of Health and Human Services, *Mental Health Performance and Accountability Framework*, 2020, pp. 29–31.

77 *Witness Statement of Professor David Copolov AO*, 7 July 2020, para. 185; *Witness Statement of Associate Professor Simon Stafrace*, 14 August 2020, para. 119; Peninsula Health, *Submission to the RCVMHS: SUB.0002.0028.0109*, 2019, pp. 5 and 7.

78 *Witness Statement of Kym Peake*, 2019, para. 299; Department of Health and Human Services, *Victorian Health Services Performance Monitoring Framework 2019–20*, 2019, p. 26.

79 *Evidence of Dr Ainslie Senz*, 11 July 2019, p. 702.

80 *Evidence of Andrew Greaves*, pp. 1699 and 1705–1706; Victorian Auditor-General's Office, *Community Health Program*, p. 39; *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 119.

81 Jane Pirkis, Philip Burgess, Tim Coombs, Adam Clarke, David Jones-Ellis and Rosemary Dickson, 'Routine Measurement of Outcomes in Australia's Public Sector Mental Health Services', *Australia and New Zealand Health Policy*, 2.8 (2005), 1–7 (p. 3).

82 Mick James, Jon Painter, Bill Buckingham and Malcolm Stewart, 'A Review and Update of the Health of the Nation Outcome Scales (HoNOS)', *BJPsych Bulletin*, 42 (2018), 63–68 (p. 63).

83 *Witness Statement of Professor David Copolov AO*, paras. 169–170.

84 Sebastian Rosenberg and Luis Salvador-Carulla, 'Accountability for Mental Health: The Australian Experience', *The Journal of Mental Health Policy and Economics*, 20.1 (2017), 37–54 (p. 44).

85 *Witness Statement of Indigo Daya*, para. 36.

86 Australian Mental Health Outcomes and Classification Network, Your Experience of Service Surveys, <www.amhocn.org/your-experience-service-surveys>, [accessed 18 October 2019]; Department of Health and Human Services, *Policy and Funding Guidelines 2019–20: Policy Guide*, 2019, p. 133.

87 health.vic, Consumer and Carer Experience Surveys, <www2.health.vic.gov.au/mental-health/working-with-consumers-and-carers/consumer-and-carer-experience-surveys>, [accessed 7 December 2020].

88 *Witness Statement of Dr Neil Coventry*, 28 June 2019, para. 252; *Witness Statement of Dr Neil Coventry*, 2020, paras. 98–99.

89 *Witness Statement of Felicity Topp*, para. 42; *Witness Statement of Erandathie Jayakody*, 4 June 2020, para. 117.

90 *Witness Statement of Felicity Topp*, para. 87.

91 *Witness Statement of Dr Neil Coventry*, 2020, para. 100(d).

92 *Witness Statement of Dr Neil Coventry*, 2020, para. 125; Better Safer Care, Special Mental Health Issue of Inspire Released, <www.bettersafercare.vic.gov.au/mentalhealthInspire>, [accessed 12 October 2020]; Department of Health and Human Services, *Policy and Funding Guidelines 2019–20: Policy Guide*, p. 140.

93 National Mental Health Performance Subcommittee, *National Mental Health Benchmarking Project Evaluation Report*, 2009, p. 8.

94 National Mental Health Performance Subcommittee, p. 15.

95 *Evidence of Georgie Harman*, 4 July 2019, p. 186; *Witness Statement of Mary O'Hagan*, 16 June 2020, paras. 63–64; *Witness Statement of Dr Paul Denborough*, 11 May 2020, para. 108.

96 Department of Health and Human Services, *Strategic Planning Guidelines for Victorian Health Services*, 2017, p. 5.

97 Douglas G Travis, *Travis Review: Increasing the Capacity of the Victorian Public Hospital System for Better Patient Outcomes*, 2015, p. 1.

98 Anonymous, *Brief Comments to the RCVMHS: SUB.0001.0032.0028*, p. 4.

99 Anonymous 346, *Submission to the RCVMHS: SUB.0002.0026.0090*, 2019, p. 3.

100 Department of Treasury and Finance and PricewaterhouseCoopers, *Background Review on Demand Forecasting*, 2018, p. 29.

101 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 178.

102 *Witness Statement of Terry Symonds*, para. 105.

103 Aspex Consulting, *Statewide Mental Health Demand Model Report Briefing*, 2019, p. 3.

104 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 162–164.

105 National Mental Health Service Planning Framework, *Introduction to the NMHSPF*, 2019, p. 7.

106 National Mental Health Service Planning Framework, pp. 7–14.

107 Productivity Commission, *Mental Health Inquiry Report Volume 3*, 2020, p. 1229.

108 *Witness Statement of Kym Peake,* 2019, para. 242; *Witness Statement of Terry Symonds,* para. 108; *Witness Statement of Professor Graham Meadows*, 26 June 2020, para. 65; *Witness Statement of Professor David Copolov AO*, para. 162; *Witness Statement of Dr John Reilly*, 29 May 2020, para. 78; *Witness Statement of Dr Peggy Brown AO*, 22 July 2019, para. 22.

109 *Witness Statement of Frank Quinlan*, 25 May 2020, para. 37.

110 *Witness Statement of 'Rachel Bateman' (pseudonym)*, 16 June 2020, para. 165.

111 *Witness Statement of Terry Symonds*, para. 114.

112 *Witness Statement of Terry Symonds*, paras. 118–119.

113 *Witness Statement of Frank Quinlan*, para. 13.

114 *Witness Statement of Associate Professor Jo-An Atkinson*, 29 April 2020, para. 28.

115 *Witness Statement of Kym Peake*, 4 October 2020, para. 254(b).

116 *Witness Statement of Christine Morgan*, 11 May 2020, para. 32.

117 Regional and Rural Area Mental Health Services, *Submission to the RCVMHS: SUB.0002.0029.0415*, 2019, p. 7.

118 Bradley E. Karlin and Robert A. Zeiss, 'Environmental and Therapeutic Issues in Psychiatric Hospital Design: Toward Best Practices', *Psychiatric Services*, 57.10 (2006), 1376–1378 (pp. 1377–1378).

119 Karlin and Zeiss, pp. 1376–1378.

120 Karlin and Zeiss, p. 1376.

121 *Witness Statement of Cath Roper*, para. 96.

122 *Witness Statement of Karyn Cook*, 21 May 2020, para. 195.

123 Commonwealth Government, *Our Public Service, Our Future. Independent Review of the Australian Public Service*, 2019, p. 21.

124 Monash Sustainable Development Institute, Monash University, *Correspondence to the RCVMHS: CSP.0001.0103.0001, A Primer Paper: Forces Shaping Victoria's Mental Health System*, 2020, p. 18.

125 Nikolas Kirby and Simone Webbe, *Being a Trusted and Respected Partner: The APS Integrity Framework: An ANZSOG Research Paper for the Australian Public Service Review Panel*, 2019, p. 25.

126 *Witness Statement of Kym Peake*, 2019, para. 239.

127 Victorian Auditor-General's Office, *Prison Capacity Planning*, 2012, pp. 22 and 28.

128 Infrastructure Victoria, *Victoria's 30–Year Infrastructure Strategy*, 2016, p. 3.

129 Monash Health, p. 74.

130 RCVMHS, *St Kilda Community Consultation—May 2019*.

131 Eating Disorders Victoria, *Submission to the RCVMHS: SUB.0002.0025.0056*, 2019, p. 5.

132 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 42.

133 Anonymous 67, *Submission to the RCVMHS: SUB.0002.0014.0040*, 2019, pp. 4–5.

134 Department of Health and Human Services, *Intellectual Disability: 10–Year Mental Health Plan Technical Paper*, 2015, p. 3.

135 Dr Danny H Sullivan, Micahel Daffern, Stuart Thomas and Terri Robertson, *Senior Practitioner—Disability: Building Capacity to Assist Adult Dual Disability Clients Access Effective Mental Health Services*, 2013, p. 7.

136 Sullivan, Daffern, Thomas and Robertson, pp. 10–11.

137 *Witness Statement of Dr Paul Denborough*, 9 July 2019, para. 14.5.

138 New South Wales Health, *NSW Older People's Mental Health Services: Service Plan 2017–2027 Guideline*, 2017, p. iv.

139 Victorian Auditor-General's Office, *Child and Youth Mental Health*, p. 25.

140 *Witness Statement of Janet Meagher AM*, 1 July 2019, para. 37(e).

141 Victorian Mental Illness Awareness Council, The VMIAC Declaration, <www.vmiac.org.au/declaration/>, [accessed 6 November 2019].

142 *Witness Statement of Mary O'Hagan*, para. 53.

143 St Vincent's Hospital Melbourne, *Submission to the RCVMHS: SUB.0002.0030.0106*, 2019, p. 4; Alfred Health, *Submission to the RCVMHS: SUB.0002.0028.0156*, 2019, p. 9; Eastern Health, p. 3; StarHealth, *Submission to the RCVMHS: SUB.0002.0028.0582*, 2019, p. 12; Peninsula Health, p. 6; South West Healthcare, *Submission to the RCVMHS: SUB.0002.0029.0138*, 2019, pp. 13–14; NorthWestern Mental Health (A Division of Melbourne Health), p. 50; Monash Health, pp. 5–7.

144 *Witness Statement of Associate Professor Steven Moylan*, 29 May 2020, para. 78.

145 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 480; *Evidence of Andrew Jackomos PSM*, 16 July 2019, p. 1084; *Witness Statement of Andrew Jackomos PSM*, 11 July 2019, paras. 94–96.

146 Ministry of Health, Ontario, *Ontario Health Teams: Guidance for Health Care Providers and Organizations*, pp. 2–3.

147 Productivity Commission, *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services, Inquiry Report*, 2017, pp. 7–8.

148 Gary Sturgess, 'Public Service Commissioning: Origins, Influences, and Characteristics', *Policy Design and Practice*, 1.3 (2018), 155–168 (p. 163).

149 *Witness Statement of Professor Bruce Bonyhady AM*, 16 June 2020, para. 36.

150 *Witness Statement of Professor Suresh Sundram*, 19 May 2020, para. 45.

151 *Witness Statement of Professor Suresh Sundram*, para. 46.

152 *Witness Statement of John Brogden AM*, 7 July 2020, para. 53.

153 *Witness Statement of Dr Margaret Grigg*, 28 May 2020, para. 48.

154 Alfred Health, pp. 27–28.

155 Ministry of Health, Ontario, p. 11.

156 *Witness Statement of Graham Panther*, 6 July 2020, paras. 188–189.

157 *Witness Statement of Angus Clelland*, para. 14.

158 *Witness Statement of Gary Croton*, 21 May 2020, paras. 129 and 130.

159 *Witness Statement of Associate Professor Steven Moylan*, para. 106.

160 Orygen, The National Centre of Excellence in Youth Mental Health, *Submission to the RCVMHS: SUB.2000.0001.0741*, 2019, p. 4.

161 Michael E Porter and Robert S Kaplan, *How Should We Pay for Health Care?* 2015, pp. 4–5.

162 *Witness Statement of Alice Andrews*, 7 July 2020, para. 8.

163 Anonymous, *Brief Comments to the RCVMHS: SUB.0001.0031.0126*, p. 5.

164 Austin Health, *Submission to the RCVMHS: SUB.0003.0001.0001*, 2019, p. 5.

165 Department of Health and Human Services, *Policy and Funding Guidelines 2019–20: Policy Guide*, p. 17.

166 Porter and Kaplan, p. 2.

167 Department of Health and Human Services, *Clinical Mental Health Funding Reform: Building a Stronger Foundation for Funding Adequacy, Growth and Fairness*, p. 5.

168 Kylie Woolcock, *Value Based Health Care: Setting the Scene for Australia*, 2019, p. 28.

169 Porter and Kaplan, p. 3.

170 *Witness Statement of Peter Kelly*, 29 May 2020, para. 55; Alfred Health, p. 27.

171 Porter and Kaplan, pp. 4–5.

172 Karen S. Palmer, Thomas Agoritsas, Danielle Martin, Taryn Scott, Sohail Mulla, Ashley Miller, Arnav Agarwal, Andrew Bresnahan, Afeez Abiola Hazzan, Rebecca Jeffery, Arnaud Merglen, Ahmed Negm, Reed Siemieniuk, Neera Bhatnagar, Irfan Dhalla, John Lavis, John You, Stephen Duckett and Gordan Guyatt, 'Activity-Based Funding of Hospitals and Its Impact on Mortality, Readmission, Discharge Destination, Severity of Illness, and Volume of Care: A Systematic Review and Meta-Analysis', *PLoS ONE*, 9.10 (2014), 1–14 (p. 1).

173 Healthcare Financial Management Association, *Victorian Health Services Funding Models*, 2017, pp. 9 and 12.

174 *Witness Statement of Bill Buckingham*, 7 July 2020, para. 141.

175 *Witness Statement of Bill Buckingham*, para. 141.

176 *Witness Statement of Bill Buckingham*, para. 143; Commonwealth Department of Health, 4.2 Further Development of a Mental Health Casemix Classification, <www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-infopri2-toc~mental-pubs-n-infopri2-pt4~mental-pubs-n-infopri2-pt4-2>, [accessed 13 November 2020].

177 Tim Coombs, *Mental Health Phase of Care: Inter-Rater Reliability Study Final Report*, 2017, p. 5.

178 Independent Hospital Pricing Authority, *Pricing Framework for Australian Public Hospital Services 2020-21*, 2019, p. 16.

179 Department of Health and Human Services, *Clinical Mental Health Funding Reform: Building a Stronger Foundation for Funding Adequacy, Growth and Fairness*, p. 18.

180 *Witness Statement of Professor Graham Meadows*, para. 68; *Witness Statement of Peter Kelly*, para. 55.

181 Porter and Kaplan, pp. 14–15.

182 For example, only 7 per cent of self-related outcome measures were completed in 2019–20, and Victoria did not provide cost data to support development of the Australian Mental Health Care Classification. Victorian Agency for Health Information, *Adult Mental Health Quarterly Report: April–June 2020*, 2020, p. 9; Independent Hospital Pricing Authority, *Australian Mental Health Care Classification Pricing Feasibility Report 2020–21*, 2020, pp. 9–10.

183 Department of Health and Human Services, *Clinical Mental Health Funding Reform: Building a Stronger Foundation for Funding Adequacy, Growth and Fairness*, p. 2.

184 health.vic, Activity Based Funding, <www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/activity-based-funding>, [accessed 3 April 2020].

185 *Witness Statement of Terry Symonds*, para. 131.

186 The King's Fund, London and The University of Melbourne, *Challenges and Lessons for Good Practice: Review of the History and Development of Health Service Commissioning*, 2016, p. 17.

187 Palmer and others, p. 5.

188 *Witness Statement of Bill Buckingham*, para. 139.

189 Compulsory treatment refers to the treatment of a person for their mental illness subject to an order under the *Mental Health Act 2014* (Vic).

190 Independent Hospital Pricing Authority, *Pricing Framework for Australian Public Hospital Services 2020–21*, p. 19.

191 South West Healthcare, p. 23.

192 Latrobe Regional Hospital, p. 5.

193 Independent Hospital Pricing Authority, *National Efficient Price Determination 2020–21*, 2020, pp. 13–14.

194 Department of Health and Human Services, *Policy and Funding Guidelines 2019–20: Policy Guide*, p. 26.

195 Productivity Commission, *Mental Health Inquiry Report Volume 3*, pp. 1168–1169.

196 Porter and Kaplan, p. 2.

197 Hal Swerissen, Stephen Duckett and Jo Wright, *Chronic Failure in Primary Care*, 2016, p. 15.

198 Department of Health and Human Services, Funding Policy Options, p. 1.

199 Orygen, The National Centre of Excellence in Youth Mental Health, p. 4; *Witness Statement of Kym Peake*, 2019, para. 267.

200 Independent Hospital Pricing Authority, *National Efficient Cost Determination 2020–21*, 2020, p. 7.

201 M. B. Simmons and P. M. Gooding, 'Spot the Difference: Shared Decision-Making and Supported Decision-Making in Mental Health', *Irish Journal of Psychological Medicine*, 34.4 (2017), 1–12 (p. 5); United Nations General Assembly, *Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary-General,* p. 15.

202 Porter and Kaplan, p. 12.

203 Adjunct Associate Professor Paresh Dawda, *Bundled Payments: Their Role in Australian Primary Health Care,* 2015, p. 5.

204 *Witness Statement of Professor Robert Thomas OAM*, 12 May 2020, para. 44.

205 *Witness Statement of Professor Robert Thomas OAM*, para. 45.

206 Mental Health Taskforce to the NHS in England, *The Five Year Forward View for Mental Health*, 2016, p. 33.

207 National Collaborating Centre for Mental Health, *The Perinatal Mental Health Care Pathways: Full Implementation Guidance*, 2018, p. 10.

208 Joint Commissioning Panel for Mental Health, *Guidance for Commissioners of Rehabilitation Services for People with Complex Mental Health Needs*, 2016, p. 8.

209 Porter and Kaplan, p. 3.

210 Department of Health and Human Services, *HealthLinks Chronic Care Evaluation: Summary of Implementation and Outcomes for 2016–17*, 2019, pp. 8–9.

211 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1171.

212 Dinny H. de Bakker, Jeroen Struijs, Caroline Baan, Joop Raams, Jan-Erik de Wildt, Hubertus Vrijhoef and Frederik Schut, 'Early Results From Adoption Of Bundled Payment For Diabetes Care In The Netherlands Show Improvement In Care Coordination', *Health Affairs*, 31.2 (2012), 426–433 (p. 426).

213 Porter and Kaplan, p. 13.

214 For example, only 7 per cent of self-related outcome measures were completed in 2019–20, and Victoria did not provide cost data to support development of the Australian Mental Health Care Classification. Independent Hospital Pricing Authority, *Australian Mental Health Care Classification Pricing Feasibility Report 2020–21*, p. 9; Victorian Agency for Health Information, pp. 9–10.

215 Porter and Kaplan, p. 3.

216 The King's Fund, London and The University of Melbourne, pp. 18–19.

217 *Witness Statement of David Martine PSM*, 28 June 2019, paras. 121–122.

218 *Witness Statement of Janet Meagher AM*, para. 37(e).

219 Rosenberg and Salvador-Carulla, p. 38.

220 *Witness Statement of Professor Bruce Bonyhady AM*, para. 49.

221 Victorian Government, *Outcomes Reform in Victoria*, 2019, p. 5.

222 Victorian Government, *Outcomes Reform in Victoria*, p. 5; Department of Health and Human Services, *Key Performance Measures and Underlying Risk Factors 2019–20*, 2019, p. 6.

223 Australian Institute of Health and Welfare, Mental Health Services in Australia: Key Performance Indicators for Australian Public Mental Health Services, <www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-indicators/key-performance-indicators-for-australian-public-mental-health-services>, [accessed 20 November 2020].

224 Kathryn Williams, Janet Sansoni, Darcy Morris, Pam Grootemaat and Cristina Thompson, *Patient-Reported Outcome Measures: Literature Review,* 2016, pp. 1 and 18.

225 Charlotte Kingsley and Sanjiv Patel, 'Patient-Reported Outcome Measures and Patient-Reported Experience Measures', *BJA Education*, 17.4 (2017), 137–144 (pp. 137–138); Cristina Thompson, Jan Sansoni, Darcy Morris, Jacquelin Capell and Kate Williams, *Patient-Reported Outcome Measures: An Environmental Scan of the Australian Healthcare Sector*, 2016, pp. 4–5.

226 Department of Health and Human Services, *Mental Health Performance and Accountability Framework*, 2020, p. 6.

227 Department of Health and Human Services, *Victorian Health Services: Performance Monitoring Framework 2019–20*, pp. 9 and 12–22; Australian Institute of Health and Welfare, National Mental Health Performance Framework 2020, <meteor.aihw.gov.au/content/index.phtml/itemId/721188>, [accessed 18 December 2019]; Queensland Health, *Delivering a High Performing Health System for Queenslanders: Performance Framework*, 2019, pp. 16–28; New South Wales Ministry of Health, *NSW Health Performance Framework*, 2017, pp. 5–8.

228 Peninsula Health, p. 7.

229 Victorian Auditor-General's Office, *Community Health Program*, pp. 40, 51 and 60.

230 Anglicare Victoria, *Submission to the RCVMHS: SUB.0002.0028.0718*, 2019, p. 35.

231 *Witness Statement of Associate Professor Simon Stafrace*, 2020, paras. 140–141.

232 Australian Institute of Health and Welfare, National Mental Health Performance Framework 2020.

233 The National Health Information and Performance Principal Committee, *The Australian Health Performance Framework*, 2017, p. 5.

234 *Witness Statement of Terry Symonds*, para. 159.

235 See for example, Department of Health and Human Services, *Victorian Health Services: Performance Monitoring Framework: Indicators Business Rules 2017–18*, 2017, p. 75.

236 *Witness Statement of Robyn Kruk AO*, 4 May 2020, para. 22.

237 *Witness Statement of Cath Roper*, para. 92.

238 *Witness Statement of Mary O'Hagan*, para. 64.

239 Kingsley and Patel, pp. 137–138; Thompson, Sansoni, Morris, Capell and Williams, pp. 4–5.

240 Williams, Sansoni, Morris, Grootemaat and Thompson, pp. 1 and 20.

241 McLean Hospital, Belmont, USA, BASIS-32®—Measuring Patient Self Reported Outcomes, <www.ebasis.org/basis32>, [accessed 27 May 2020].

242 A case is a term currently used in the collection of mental health services data in the Client Management Interface/Operational Data Store. It is used to represent a period of case management by a mental health service with a clear beginning and end date, noting that practices may vary. Victorian Agency for Health Information, pp. 7–8 and 12.

243 *Witness Statement of Dr Paul Denborough*, 2020, para. 108.

244 *Witness Statement of Kym Peake*, 2020, para. 145(b).

245 *Witness Statement of Dr Sarah Pollock*, 14 May 2020, para. 118.

246 The Centre for Psychiatric Nursing, *Submission to the RCVMHS: SUB.0002.0028.0284*, 2019, p. 7.

247 Cath Roper, Flick Grey and Emma Cadogan, *Co-Production: Putting Principles into Practice in Mental Health Contexts*, 2018, pp. 2 and 6.

248 *Witness Statement of Terry Symonds*, para. 177.

249 Department of Health and Human Services, *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality of Care, Report of the Review of Hospital Safety and Quality Assurance in Victoria*, 2016, pp. 88–89; Department of Health and Human Services, *Victorian Health Services Performance Monitoring Framework 2019–20*, p. 20.

250 Department of Health, *The Victorian Health Services Governance Handbook: A Resource for Victorian Health Services and Their Boards*, 2012, p. 6.

251 *Witness Statement of Alice Andrews*, para. 21.

252 *Health Services Act 1988* (Vic), secs. 65V, 65ZAA and 271.

253 The Hon. Jill Hennessy MP, Letter to Dr Diane Watson Re: Statement of Expectations (SoE) for the Victorian Agency for Health Information (VAHI), pp. 1–2.

254 National Mental Health Performance Subcommittee, p. 2.

255 Mental Health Legal Centre, *Submission to the RCVMHS: SUB.0002.0032.0106 (Submission 1)*, 2019, p. 36.

256 Seclusion means 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.

257 Restraint refers to a form of physical, mechanical or chemical restraint that prevents a person having free movement of their limbs.

258 Compulsory treatment refers to the treatment of a person for their mental illness subject to an order under the *Mental Health Act 2014* (Vic)

259 *Witness Statement of Professor Bruce Bonyhady AM*, para. 50.

260 Ruth Robertson and Leo Ewbank, *Thinking Differently About Commissioning: Learning from New Approaches to Local Planning*, 2020, p. 58.

261 *Witness Statement of Terry Symonds*, para. 341.

Chapter 29

Encouraging partnerships

Recommendation 50:

Encouraging national partnerships

The Royal Commission recommends that the Victorian Government:

1. work with the Commonwealth Government and the National Cabinet Reform Committee to:

   a. delineate the responsibilities of governments in providing a structured, coordinated, long-term approach to planning, investment and reform through the new National Mental Health and Suicide Prevention Agreement;

   b. raise the profile of:

   - mental health and wellbeing, and suicide prevention and response services;
   - associated supports such as housing and homelessness services; and
   - lived experience leadership.

   c. ensure a strong focus on the implementation of mental health and wellbeing strategies.

Recommendation 51:

Commissioning for integration

The Royal Commission recommends that the Victorian Government:

1. build on new ways of resourcing and monitoring mental health and wellbeing services (refer to recommendations 48 and 49) and empower Regional Mental Health and Wellbeing Boards (refer to recommendation 4(2)) to:

    a. commission one demonstration project in each region (refer to recommendation 3(3)) in which a provider or providers deliver multiple services to people living with mental illness who require ongoing intensive treatment, care and support;

    b. commission demonstration projects in each region in which a provider or providers deliver multiple services to people living with mental illness who require short-term treatment, care or support and who are in the 'missing middle';

    c. evaluate demonstration projects to inform decisions on scaling approaches and expanding to new providers or provider partnerships that are tailored to the needs of communities and span the full age spectrum; and

    d. monitor provider partnerships using a common set of indicators with an emphasis on improving mental health and wellbeing outcomes.

2. in collaboration with Regional Mental Health and Wellbeing Boards (refer to recommendation 4(2)), work with the Commonwealth and Primary Health Networks to establish a co-commissioning approach for Commonwealth and state-funded mental health and wellbeing services that:

    a. builds on joint Commonwealth–state planning approaches to mental health and wellbeing service delivery; and

    b. leverages existing commitments including in the Addendum to the *National Health Reform Agreement* 2020–2025.

29.1 Joining into one system

There is a growing number of complex problems facing the mental health system that require coordinated action from governments across multiple sectors.[1] Individuals with mental health needs seek more personalised and integrated services that span more than one organisation. Yet, individual organisations each operate with a level of independence. Government decisions and policy settings do not bring these organisations together; rather, they often drive them further apart, at a time when the need for collaboration has never been clearer.

The impacts of these failures to integrate are felt most acutely by consumers, families, carers and supporters. In their contributions to the Commission, several people expressed frustration at a system that is fragmented, duplicative and complex.

For example, witness Ms Nina Edwards said:

> The Victorian mental health system is not working, partly because of the disconnect between services. It is very difficult to navigate the system; in my experience, both workers and consumers in the sector find this difficult. The mental health services operate in silos and consumers are not given the tools to navigate the system.[2]

Another person spoke about their frustration and distress in trying to find the right services:

> I am an intelligent and educated person but I have absolutely no idea how and am not well enough to find, negotiate and access mental health support services and I have no idea how any of it links.[3]

Regarding the need for services to consider the broader needs of individuals, one person said, '[w]e need to think about all of the elements that make up a person's life.'[4]

Mr Michael Silva, a carer for his brother Alan, told of how the system did not come together to support his brother's dual diagnosis:

> we were once trying to give an explanation of Alan's dual diagnosis … Their response was, 'We're not concerned about what the cause is. We just deal with the symptoms.' … In general, there were some people who said, 'No, this is clinical mental health. We're not worried about anything else.' When we heard that, we felt helpless.[5]

Professor Karen Fisher, Professor at the Social Policy Research Centre at the University of New South Wales, told the Commission how a disconnect between mental health and housing policy created a 'catch-22', where 'people with unsupported mental health needs are excluded from social housing or the private market when they do not receive the additional support for their mental health that they require to sustain stable housing'. At the extreme end, this means they end up in hospitals, in prisons or homeless.[6]

The Commission has also been told that, because the system is so disjointed, individuals are required to repeatedly retell their story to different service providers and practitioners. And yet, despite the efforts they take to share their stories, the Commission was told that people still struggle to feel heard:

> medical professionals do not come to understand you, forcing you to start from the beginning over and over again. There is a loss of continuity as a result of the chopping and changing of medical professionals.[7]

> [Mental health services] never ask me what I want or need. Instead, I am bent out of shape to fit what they need. It's like the train is so busy trying to be on schedule, that it's leaving all of the passengers behind.[8]

The Commission envisages a more integrated mental health and wellbeing system, where individuals, workforces, service providers and governments are encouraged to be more proactive, collaborative and coordinated in approaches to planning and delivering services. At the system level, individual contributions from different levels of government will be brought together through strong leadership—underpinned by a united vision and clear accountability—that elevates the needs and values of consumers, families, carers and supporters. At the service level, providers will be supported to work together, using new and innovative ways to overcome traditional barriers to collaboration.

29.1.1 With challenge comes opportunity

The challenges with achieving collaborative and coordinated approaches, particularly between governments, are not unique to the mental health system. In 2020, large-scale natural and human disasters have cast a shadow over the nation's sense of safety and security. While these events have driven new approaches to collaboration, they have also exposed the vulnerabilities of Australia's federated system in which there are separate Commonwealth and state and territory governments, each with separate constitutions.

The final report of the Royal Commission into National Natural Disaster Arrangements, established in response to the extreme bushfire season of 2019–20, identified an important role for all levels of government to work collaboratively, with national leadership from the Commonwealth Government. The report recognised that 'disaster management in Australia has benefited from the collective efforts of Australian, state and territory government agencies working together'.[9]

The report noted that both Commonwealth and state governments funded initiatives specific to the mental health needs of bushfire-affected communities.[10] At this Royal Commission's roundtable held in East Gippsland, there was an encouraging discussion about how partnerships within the region had enabled a rapid response to the bushfires:

> We've established some really good partnerships across the region with the idea of working collaboratively in the best interests of the community. And these partnerships have really enabled us to enact a very quick response when the bushfires hit at the end of last year and we ended up being able to get a clinician on the ground in Mallacoota by the 8th of January.[11]

However, the Royal Commission into National Natural Disaster Arrangements also uncovered a 'tension of interests between national outcomes and state or territory objectives [which] will become more challenging to manage in the midst of compound disasters'.[12]

Shortly after the bushfires, the COVID-19 pandemic caused more extraordinary upheaval. To urgently respond to the economic, health and social fallout from the pandemic, Commonwealth–state relations were reformed. They transitioned from the slow-moving, over-managed Council of Australian Governments into the new, more agile National Cabinet.[13] Mr Frank Quinlan, former CEO of Mental Health Australia, giving evidence in a personal capacity, told the Commission:

> The COVID-19 crisis has shown that governments have been able to make collaborative commitments to do things differently in a matter of days. We need to reflect on this before we return to cycles of governance following the crisis where it can take six or 12 months for minute changes to be agreed in arrangements between the government and service providers.[14]

While these arrangements have proven successful in the context of the pandemic, they are yet to show whether they can withstand long-term pressures and challenges that extend beyond the crisis stage. Unless coupled with broader structural reform, governments and agencies will continue to battle against the tide of a system that is misaligned, inflexible and that ultimately does not encourage collaboration.[15]

The Royal Commission believes it is time for both levels of government to work together to overcome system challenges so services can be more integrated across settings and sectors. The Commission was encouraged to see this message strongly carried in the Productivity Commission's *Mental Health Inquiry Report*. The report recommended a focus:

> beyond healthcare, improving the provision of a range of services that can make a difference to the experience of people with mental ill-health, including psychosocial services, housing and homelessness services, as well as first responders, police and the justice system ...[16]

This is something that is recognised and supported by the Hon. Daniel Andrews MP, Premier of Victoria. Regarding the mental health risks of the COVID-19 pandemic, the Premier stated:

> We've got lots of partnerships and we're very pleased to work with so many different people, ... indeed the federal government through some of the things that they've announced, [and] GPs. ... [W]e've all got to work really hard to support every single person who needs that mental health care.[17]

The Commission has been further encouraged to hear these sentiments echoed by the Commonwealth Government. At the launch of the Productivity Commission's *Mental Health Inquiry Report*, the Hon. Scott Morrison MP, Prime Minister of Australia, said:

> the mental health system needs to look beyond the symptoms to work out what help a person needs to recover and remain well. Because multiple factors—biological, environmental and social—affect mental health and wellbeing ... we all need to play a role at various levels. We need to go beyond Government. We need to go far beyond the health system, and we need a whole of economy approach, whole of community approach, partnerships between all levels of Government, sectors, organisations. All of us are involved in this.[18]

29.2 A complex and fragmented system

The complexity and fragmentation of the mental health system is not a new problem; it has been discussed in many other inquiries, reports, plans, policies and strategies on mental health.[19]

As established in the Commission's interim report, a major contributor to the system's complexity is the fact that no one entity has complete oversight or control of the mental health system. While numerous agencies deliver mental health services, such as public and private health services and non-government organisations, responsibility for funding and oversight is primarily shared between the Commonwealth and Victorian governments (refer to Box 29.1).

Box 29.1: The Australian system of government

Australia formed a federation when separate colonies joined together into a single country. The Australian Constitution formalised these arrangements.

The Federal (or Commonwealth) Parliament was created to make laws about national matters, but this parliament alone does not make all laws across the nation. In addition to the Federal Parliament in Canberra, there are state and territory parliaments in each state and territory capital city, and local councils across Australia.[20]

While parliaments and councils make laws, it is governments that put these laws into action. Three levels of government work together to provide Australians with the services they need:

- The federal (or Commonwealth) government is responsible for issues that affect all Australians (national issues), such as trade and defence.
- State and territory governments are responsible for issues that affect people in that state or territory, such as schools and hospitals.
- Local councils are responsible for issues that affect local communities, such as rubbish collection and recycling.[21]

Intergovernmental architecture supports government collaboration and helps federal and state governments to fulfil individual and shared responsibilities. This architecture includes government decision-making forums—for example, National Cabinet—and written agreements—for example, the National Health Reform Agreement.

Governments share responsibility for health and mental health. Intergovernmental architecture is particularly important for supporting interactions and decision making on mental health system and service-level matters that are relevant to both tiers of government.

The existence of multiple commissioning bodies that are not well connected (for example, the Victorian and Commonwealth governments and Primary Health Networks), and the subsequent risk of parallel and disjointed commissioning approaches for the same type of services, results in complex navigation pathways, duplication of services and service gaps. It also leads to variation in relation to the involvement of consumers, families, carers and supporters and the quality of care they receive.

Further adding to this complexity, there are competing views and expectations within and beyond the sector about what needs to be done to improve the system. As one witness stated:

> there are diverse views about priorities for change and Governments at times find the politics of change difficult to manage. The stakeholder groups can present different and at times competing priorities to Governments at national and Victorian levels.[22]

The consequences of this complexity negatively affect consumers, families, carers and supporters, namely through service gaps and poorly coordinated services.

29.2.1 Poorly defined roles and responsibilities

Traditionally, the Victorian Government has been responsible for overseeing mental health services for Victorians experiencing high and often continuing levels of need.[23] It has been described as the 'steward of the "specialist mental health system"'.[24] The Commonwealth Government is responsible for services that cover a broad section of the population, typically catering for people with lower levels of need (refer to Box 29.2). The Commonwealth Government is also responsible for administering the National Disability Insurance Scheme (NDIS), which provides supports for people living with disability, including psychosocial support services (also called 'wellbeing supports', as described in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*).

The historical roles and responsibilities between the Commonwealth and Victorian governments have evolved and changed over time, with growing areas of overlap such as suicide prevention and response efforts as well as preventative mental health programs. While the Commonwealth has traditionally been responsible for strategic policy direction at the national level rather than delivering specialist services, its role has expanded—for example, the Commonwealth's recent investment in new mental health HeadtoHelp clinics in Victoria.

As the roles and responsibilities of governments have changed, this has unintentionally led to distorted lines of responsibility and accountability.[25] As Dr Peggy Brown AO, a psychiatrist who has held several leadership roles in the mental health sector, told the Commission:

> the mental health system is unnecessarily complicated by the fact that the differentiation between the respective responsibilities of the Commonwealth and the States has become increasingly blurred and, partially as a result of that, the system has become even more fragmented and possibly less accountable.[26]

Box 29.2: Funding of mental health services

Some parts of the mental health system are funded entirely by one level of government; for example, the Commonwealth Government is solely responsible for the Medicare Benefits Schedule, which subsidises medical services, and the Pharmaceutical Benefits Scheme, which subsidises prescription medications.

More commonly, however, the Commonwealth and state governments jointly fund mental health services. This cooperation is governed by a series of agreements. The *National Health Reform Agreement* is the most significant agreement for mental health funding. As described by Mr David Martine PSM, Secretary of the Department of Treasury and Finance, this 'enshrines that Commonwealth, State and Territory Governments are jointly responsible for funding public hospital services (including mental health services)'.[27]

Funding for psychosocial support services does not have a comparable overarching approach; it is shaped by a range of different agreements and projects delivered at each level of government, primarily through non-government organisations. There are multiple funders of psychosocial support services in Victoria, including Primary Health Networks and health services. Each commissions services differently, and there is a lack of coordination and consistency across the state.[28] On top of this, the introduction of the NDIS has added further complexity and barriers to accessing psychosocial supports.[29]

Commonwealth investments are unevenly spread across the state and are not reaching the right people. In particular, people who experience greater disadvantage and who live outside of major cities are less likely to access Commonwealth-funded mental health treatment, care and support.[30] There is evidence to suggest that state investments are also inequitably distributed and poorly targeted.[31]

There are service gaps for people with the highest level of needs, who are traditionally supported by the state-funded public mental health system.[32] Due to sustained underinvestment, the capacity of the state-funded system has been severely constrained, which has further raised the threshold for access to mental health services. Facing rising demand, health services have had no choice but to 'move away from continuing care to an episodic care model'[33]—that is, a model that only meets immediate needs and does not provide ongoing support.

This evidence suggests that insufficient investment by both levels of government has failed to cover the full spectrum of mental health treatment, care and support.[34]

This causes difficulties for service providers and the workforce, as well as consumers, carers, families and supporters. The separation of primary and specialist mental health services, and of Commonwealth- and state-funded initiatives (refer to Box 29.3), generates barriers to integrated care, creates inefficiencies in practice[35] and 'causes tremendous frustration' for people in terms of being 'bounced around' the system.[36] Eastern Health suggested that the complexity of the mental health system makes it difficult for both the workforce and consumers to know what services there are and how to connect with them.[37] Barwon Health also supported this notion.[38]

Box 29.3: How funding exacerbates fragmentation

Because of the Commonwealth's greater revenue-raising capacity, the states rely heavily on the Commonwealth to fund their activities. This imbalance between the revenue-raising capacity and spending responsibilities of governments within a federation—known as the vertical fiscal imbalance—is greater in Australia than many other countries.[39]

Vertical fiscal imbalance has seen the Commonwealth emerge from having no mental health responsibilities to playing a dominant role in this area. This fiscal dominance sometimes encourages the Commonwealth to try to achieve its policy objectives without state involvement.[40] It also means it can be difficult for lower levels of government to provide services adapted to local conditions—a concept known as 'subsidiarity'.[41]

Mr Bill Buckingham, Director of Buckingham Consulting, gave evidence in a personal capacity, telling the Commission that the blurring of traditional boundaries has led to a 'spaghetti bowl of complexity and confusion about who does what'.[42] Mr Buckingham added:

> merging of roles, between the Commonwealth and state governments is not being done in a deliberate way and is relatively uncoordinated. There are many areas of mental health service delivery where it is essentially a toss of the coin whether a project is funded by the Commonwealth or a state/territory government. Generally, the answer to that question will depend on where you live.[43]

Mr Tim Marney, Principal of Nous Group and former Mental Health Commissioner in Western Australia, also told the Commission in a personal capacity:

> you have too many people playing in the same sandpit. Boundaries between Commonwealth, State and [non-government organisations'] responsibilities are fluid in the mental health space, in many instances targeting [the] same cohort of individuals and largely to deliver the same intended outcomes.[44]

While national intergovernmental structures aim to coordinate action, it has been suggested that 'governments can, and often do, make decisions without proper consideration of the flow-on effects on other levels of government'.[45] This is evident between levels of government, and also within government, and between the government and the broader public.[46]

However, governments have shown a willingness to work more closely to integrate mental health services. Regarding the Commonwealth's recent investment in 15 new mental health HeadtoHelp clinics in Victoria, Ms Kym Peake, then Secretary of the Department of Health and Human Services, explained, '[w]hile temporary, the clinics are a welcome investment, and could provide a platform on which to build further joint efforts, including co-commissioning opportunities for similar approaches, into the future.'[47]

Unclear roles and responsibilities and blurred lines of accountability create an ongoing challenge for the mental health system. While there are promising developments, more can be done to support governments to better understand their own roles and to identify opportunities to work collaboratively to ensure investments are well targeted and respond to the needs of consumers, families, carers and supporters.

29.2.2 Emergence of the 'missing middle'

The lack of clarity in roles and responsibilities, coupled with the lack of effective leadership, has led to large service gaps. These gaps have been particularly felt by people whose mental health needs are too complex and enduring for primary care services alone but whose mental illness is not considered severe enough to meet the high threshold to receive treatment from current public specialist clinical mental health services.[48] These people are often referred to as falling into the 'missing middle'.

Professor Patrick McGorry AO, Executive Director of Orygen and Professor of Youth Mental Health at the University of Melbourne, says the missing middle is 'a huge blindspot'.[49] Giving evidence in a personal capacity, he told the Commission there are many Victorians who fall into this category:

> This group of people … is characterised by the nearly two million Australians and several hundred thousand Victorians, both young people and older adults, whose illnesses are too complex, too severe and/or too enduring for primary care alone to be sufficient.[50]

In her 2019 witness statement to the Commission, Ms Peake confirmed that there are 'few options' for some people living with mental illness or psychological distress:

> For people whose illnesses (or episodes of illness) are too complex or enduring to be treated in primary care—but who are not considered severe enough to meet the high threshold for specialist mental health services—there are few options for accessing support. This can often mean that they are left without help until their illness gets worse.[51]

The Productivity Commission's *Mental Health Inquiry Report* also found that the split in responsibilities between governments contributes to the missing middle.[52] The Royal Commission shares the views of the Productivity Commission that this divide between governments can be overcome at the local level.[53] However, the Commission does not share the Productivity Commission's preference for placing all commissioning responsibilities for psychosocial support services with a single government. In this case, the Productivity Commission recommended reassigning Primary Health Network funding for psychosocial support services to state governments.[54]

Primary Health Networks commission mental health services and psychosocial support services for several different populations including bushfire- and drought-affected communities and people in residential aged care.[55] The Productivity Commission's recommendation would remove funding from Primary Health Networks, disrupting established relationships and funding arrangements for priority communities, on top of the changes associated with the introduction of the NDIS.

As is the case with health and hospital funding, it is important for both levels of government to have 'skin in the game'.[56] By placing all funding with a single government, there would be less accountability and less incentive for both governments to sufficiently fund, and coordinate seamless access to, psychosocial supports and other services. Rather than move funding around to overcome barriers, the Commission strongly advocates for all levels of government to work together to plan and deliver services.

29.2.3 Lack of service coordination and integration

A range of providers work to support the mental health needs of individuals. In community settings alone, mental health services are provided by general practice, Primary Health Networks (refer to Box 29.4), community health organisations, public hospitals, headspace, the NDIS and private providers.[57]

Box 29.4: Primary Health Networks

Primary Health Networks 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.[58]

Primary Health Networks seek to understand and contract services to meet the specific needs of local populations, particularly those who are disadvantaged.[59] The networks have skills in needs analysis and planning, and, because of their regional focus, are well positioned to understand and support the needs of their local communities.[60] Dr Stephen Duckett, Health Program Director at Grattan Institute and Chair of Eastern Melbourne Primary Health Network, suggested in a co-authored paper in 2015:

> By performing a needs analysis of the local area, [Primary Health Networks] will better understand regional issues and particularities. Armed with local knowledge, a [Primary Health Network] can do that which state and federal governments generally cannot; that is, to craft and implement locally-tailored solutions to the problems of primary health care. [Primary Health Networks] have a unique power to innovate and reform the system.[61]

In addition, Primary Health Networks are well placed to encourage local integration.[62] Mr Matt Jones, Chair of the Victorian and Tasmanian Primary Health Network Alliance and CEO of Murray Primary Health Network, suggested, in a personal capacity, that Primary Health Networks approach their role with a strong focus on collaboration and partnership, '[w]e are not funding individual services into individual communities, rather we are developing regional models.'[63]

There are positive examples of Victorian Primary Health Networks partnering with other local providers to develop integrated service responses co-designed with consumers such as the Connecting2community program supported by Western Victorian Primary Health Network.[64]

During recent crises, Primary Health Networks have played an important role in providing support to primary care providers such as GPs. During the 2019–20 bushfires, networks: facilitated the sharing of information, the coordination of primary care volunteers and the assessment of local healthcare needs; provided governments with local reports; and assisted with the distribution of medical supplies.[65] The Commission understands that they also played a similar role during the COVID-19 pandemic.

There is evidence, however, of shortcomings in the operation of Primary Health Networks that are both within and outside of their control.[66] Primary Health Networks have only been operating for five years. This means they may not yet have reached their potential and that their role is not always recognised and included in system planning and response.[67] Further, Primary Health Networks have not had consistent support and guidance from the Commonwealth, which has led to variation in approaches taken by each network.[68]

Professor McGorry believes that competitive tendering[69] by Primary Health Networks has 'inevitably fragmented a very poorly funded system even further into smaller inefficient pieces, [which] is very bad for patient care'.[70] Furthermore, Monash Health has suggested that Primary Health Networks lack structure and experience and do not operate in an integrated way with Victoria's mental health system.[71]

The Productivity Commission stated in its *Mental Health Inquiry Report* that Primary Health Networks 'receive neither the support they need nor the flexibility to commission the mental health services that best meet the needs of their region'.[72]

Primary Health Networks, along with primary care providers, play a vital role in alleviating pressure on hospitals by providing early treatment, care and support. The Productivity Commission has noted:

> **Partnerships between [Primary Health Networks] and [health services] are currently rare in Australia, a consequence of relatively weak financial incentives, and underdeveloped governance arrangements for their universal adoption and (based on feedback from stakeholders) the likelihood that there is insufficient funding of [Primary Health Networks] for them to achieve their goals ...**[73]

There is further potential for Primary Health Networks and primary care providers to work more closely with state-funded providers.

Improved mental health outcomes depend on all parts of the system working well together. A person experiencing psychological distress might seek treatment, care and support from state-funded crisis and emergency services, Commonwealth-funded primary care services and Commonwealth- and state-funded supports in the community.[74] They may seek further support from a range of other services such as housing, education and employment supports.

As recognised in the Commission's interim report, dispersed funding arrangements and unclear roles and responsibilities can contribute to a poorly coordinated service system. In a submission to the Commission, a group of mental health clinicians said that a lack of coordination between the Commonwealth and Victorian governments has contributed to an increasingly fragmented system.[75]

Current arrangements do not encourage collaboration or integration between different parts of the system.[76] As South West Healthcare told the Commission:

> Within the mental health sector there is prevailing confusion amongst consumers and service providers about the role and interface between State funded clinical health services and federally funded mental health packages. It is not always clear who services are targeted to, which leads to difficulty in navigating the mental health stepped care model.[77]

The lack of coordination and integration was further articulated as such:

> The delivery of mental health care in Victoria is a hotchpotch of numerous services, poorly co-ordinated and not staffed adequately. There are numerous services provided by the various Area Mental Health Services as well as a myriad of Non-Government Organisations providing support roles … There is no or poor defining of roles and responsibilities in the care of an individual patient. There is enormous waste of scarce resources caused by this lack of organisation.[78]

This is particularly challenging for people whose needs span more than one sector. For example, people living with dual disability—that is, a co-occurring mental illness and acquired or neurodevelopmental disability (such as autism spectrum disorder or traumatic brain injury)—struggle to connect with services from two divergent systems.[79] While the introduction of the NDIS has benefited some, it has also created further complexity and led to some individuals losing vital mental health and wellbeing supports.[80]

One person told the Commission:

> The people working in the disability sector are reluctant to work with someone who has a mental health issue as the needs are too complex. The people in the mental health sector are reluctant to work with people with a disability as the behaviour is seen as stemming from the intellectual disability, not the mental health issue. Therefore no one wants to work with these people and the police end up dealing with the issue. NDIS seems to have made this increasingly difficult as service providers are more able to choose which clients they are going to work with.[81]

Individuals with high levels of need face an 'increasingly thin market'; that is, they find it difficult to connect with an NDIS provider or worker with not only the skills but also the willingness to engage with them.[82] Tragically, this has led to some people being held in custody or becoming homeless.[83]

These system-level issues have deep and personal consequences for people living with mental illness or experiencing psychological distress, families, carers and supporters who seek dependable access to treatment, care and support regardless of where the funding is coming from.

29.2.4 Complexities for service providers

As outlined in the Commission's interim report, having multiple layers of government involved in stewardship and funding of the mental health system has created a complex environment for service providers. Bendigo Health described the challenges in coordinating a service response across multiple service partners that are each configured differently.[84] Barwon Health explained that when consumers and referrers struggle to navigate the complex system, consumers ultimately end up seeking help from the emergency system, stating that an average of 12 consumers seek mental health support through University Hospital Geelong's emergency department each day.[85]

It was put to the Commission that a further complexity for service providers is navigating the different ways the Commonwealth and Victorian governments fund mental health services.[86] Associate Professor Ruth Vine, the then Executive Director of NorthWestern Mental Health, told the Commission, '[t]here is a Commonwealth and State divide in relation to funding … These two do not sit easily together, especially when both are under pressure, such that funding is rationed to some extent.'[87]

Existing Commonwealth–state funding arrangements and payment models (such as fee-for-service and activity-based funding) can act as barriers to collaboration and innovation.[88] These models, funded on the basis of activity, can encourage a focus on episodic treatment above long-term care and prevention. They can also discourage providers from coordinating care across settings.[89] Ms Peake believes that future funding arrangements under existing health agreements could provide 'more explicit detail on processes and mechanisms to deliver greater flexibility in the application of … funding for mental health care delivered through public health services'.[90]

This complex environment for service providers is made all the more difficult by the lack of clarity of roles between governments and the lack of agreement in how they work together. Inevitably, responsibilities fall to other parts of the system. For example, a report by Grattan Institute found:

> there is no clear systems manager for primary care, who can be held accountable for gaps in services. In the absence of such a manager, the coordination burden falls on: public hospitals, which rarely have good links with primary care; GPs, who rarely have the resources to develop effective programs to reduce hospital demand; and nascent Primary Health Networks, which have a broad remit but limited authority.[91]

Through evidence presented to the Commission, and through multiple previous reviews, it is clear that more effort is required of governments to overcome system challenges that can reinforce this complexity and inhibit productive partnerships.

29.2.5 National leadership challenges

As first stated by the Commission in its interim report, effective national leadership will be a crucial element in the success of the Commission's recommendations. Ultimately, the next generation of leaders will be progressing a reformed mental health—they will be central to the promotion and understanding of the need for change and renewal.

Overseeing the implementation of complex and enduring reforms that span sectors and systems is challenging. It requires the involvement of all levels of government, of wide-ranging public, private and non-government organisations, and of individuals and communities. New strategies and governance structures will not be enough to bring together all relevant parties to deliver on reforms.

In its *Mental Health Inquiry Report*, the Productivity Commission stated:

> **Effective leadership will be essential if the national mental health strategy is to significantly improve outcomes for people with mental ill-health and their carers … While this is generally true for policy reform, it is especially true for mental health, where complex policy issues require cross-portfolio solutions …**[92]

Mr John Menadue AO, former Secretary of the Department of Prime Minister and Cabinet, has stated that the politics of 'what's in it for me' has discouraged the nation from facing some of its biggest challenges.[93] Dealing with this tension between achieving an individual's own mission and supporting the goals of the broader collective[94] requires individuals to look beyond their own personal gain and to seek out collective interests and shared ambitions.

Strong national leadership is required to respond to and resolve the complexities and challenges of reform. There needs to be regular consultation and negotiation, and clearly defined accountability. Professor Peter Shergold AC, former Secretary of the Department of the Prime Minister and Cabinet and current Chancellor of Western Sydney University, recognises that there are often 'competing interests' and 'different perspectives' that can only be understood and attended to through a process of 'interaction and negotiation'.[95]

Collaborative leadership must include all relevant organisations and individuals, and all must be on equal footing. Critical to this is recognising the experiences, expertise and perspectives held by consumers, families, carers and supporters, and supporting them to participate in decisions, including national decisions.

Consumers, families, carers and supporters have frequently expressed how they have struggled to feel heard and to have influence over decisions related to reform. Part of the reason for this is an 'epistemic injustice', which treats the accounts of consumers as less valuable or reliable than those of non-consumers.[96] People living with mental illness or psychological distress are particularly vulnerable to epistemic injustices.[97]

The Commission has been advised that consumer leaders struggle to influence decisions at the system level. The Victorian Mental Illness Awareness Council explained how consumer leaders are challenged to collaborate at this level while also maintaining a connection to their community:

> **On the one hand, [consumer leaders] may sit 'inside the tent', with the necessary legal machinery and power, but be compromised by contrary clinical, carer and bureaucratic objectives, and in so doing lose the faith of their own community. On the other hand, they choose independence 'outside the tent', maintaining their integrity, as well as their irrelevance.**[98]

It has been impressed upon the Commission that there needs to be commitment and leadership from government to a new approach that is centred on trust and openness and a willingness to distribute power.[99] Dr Shergold spoke of the need for leadership behaviour where agendas are not imposed, but negotiated.[100]

29.3 Commonwealth and state roles, responsibilities and partnerships

So far, this chapter has highlighted how unclear leadership across governments, coupled with disjointed and disorganised structural and policy settings, has fragmented the current system.

To meet the challenges facing the mental health system, several structural reforms are needed to allow genuine collaboration between both levels of government that fund and regulate mental health and wellbeing services.

29.3.1 National Cabinet and mental health governance

Since 1992, collaborative governance between the Commonwealth and states has occurred through the Council of Australian Governments (COAG). COAG was established to manage matters of national significance or matters that need coordinated action by all Australian governments.[101] A range of COAG Councils and Ministerial Forums report to COAG, including the Mental Health Principal Committee and the National Mental Health Consumer and Carer Forum.

As stated earlier in the chapter, since the COVID-19 pandemic, intergovernmental collaboration and decision making—including in relation to mental health—now occurs through National Cabinet. National Cabinet is made up of the Prime Minister and state and territory premiers and chief ministers.

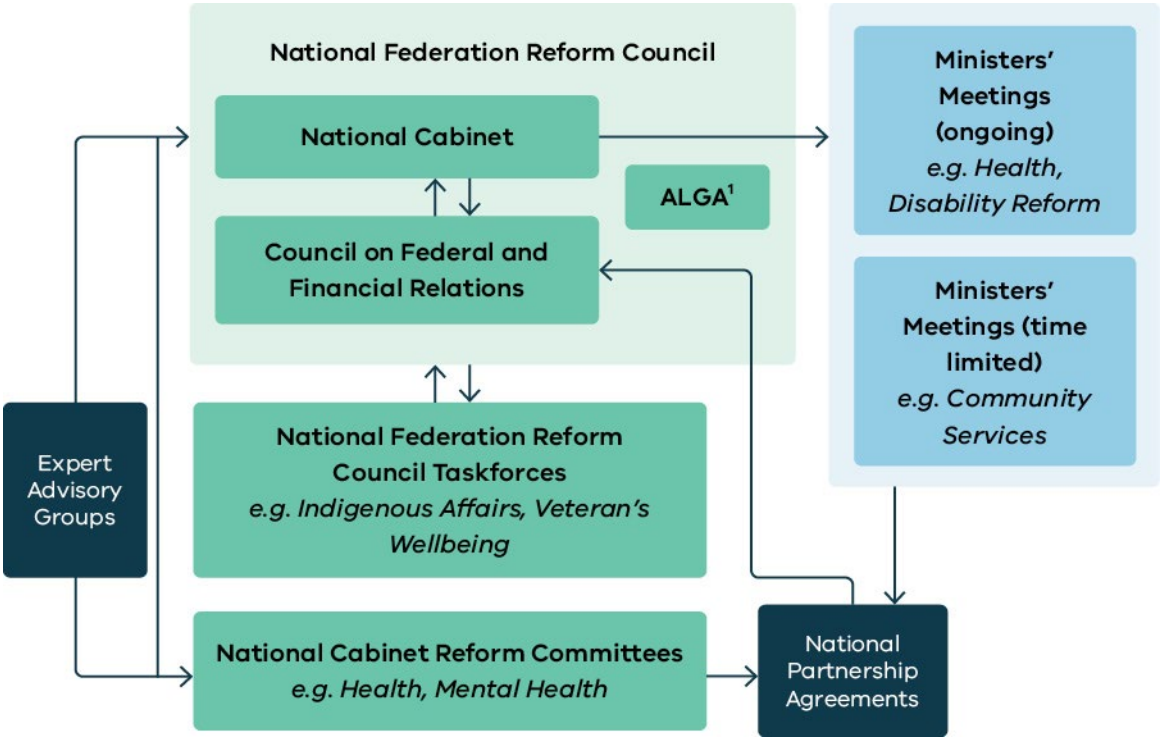
The Council on Federal Financial Relations, comprising federal and state treasurers, reports to National Cabinet. The council is responsible for all funding agreements[102] including negotiating funding elements of new national agreements in consultation with relevant ministers.[103]

Newly formed National Cabinet Reform Committees will report to the Council of Federal Financial Relations. These committees will be driven by leaders of National Cabinet and tasked to progress a rapid jobs agenda[104] (refer to Figure 29.1).

National Cabinet has agreed to a National Cabinet Reform Committee for mental health.[105] The committee will be led by the Federal Minister for Health and include relevant ministers from the Commonwealth and states.[106] A small strategic advisory group comprising professionals, Australians with lived experience of mental health and the business sector will support this committee. It is not known if the committee will be supported by advice from other related portfolio ministers or sector leaders.

There are some emerging advantages to the new structure. During a hearing of the Royal Commission into National Natural Disaster Arrangements, Professor Brendan Murphy, Secretary of the Commonwealth Department of Health, told the Royal Commission that the establishment of National Cabinet and streamlined reporting lines during the pandemic had been 'an incredibly powerful and responsive mechanism' and 'a highly effective way to deal with [the COVID-19] crisis'.[107]

Figure 29.1: National Federation Reform Council



Source: Peter Conran AM, Review of COAG Councils and Ministerial Forums, 2020.

Note: Selected Ministers' Meetings have been disbanded, for example housing and homelessness.
1. Australian Local Government Association

Further, creating a dedicated mental health committee under National Cabinet, supported by a new national agreement (discussed later in this chapter), will support federal and state governments to work together on mental health reform. In this regard, the Commission was encouraged by recent statements made by the Prime Minister in which he acknowledged the 'grey area' of responsibilities that exist between governments and expressed commitment to greater partnering between governments to tackle this challenge.[108]

There are also some possible disadvantages and uncertainties regarding these arrangements. While they have proven successful in the context of the pandemic, this has been while there is a 'common threat to rally around'.[109] Beyond the pandemic, the Commission has concerns that the arrangements may reduce the ability of states to shape the mental health agenda and escalate matters that cannot be resolved unilaterally. This relates to the mental health portfolio and also associated portfolios such as housing and homelessness. Further, the arrangements may reduce accountability and the transparency of decisions.[110]

A recent review, endorsed by National Cabinet, has determined that the former COAG Councils and Ministerial Forums will be rationalised. Some forums will be disbanded, while others will be made time-limited.[111] Some of the forums that will be disbanded are relevant to mental health, such as the Housing and Homelessness Ministers' Meeting. The Commission has concerns that this reduces the avenues available for the Commonwealth and state to discuss matters of national importance and progress joint reform in areas such as housing and homelessness.

The Commission also has concerns that the remaining Ministerial Forums will not report directly to National Cabinet. Therefore, matters that require escalating must first be raised with the relevant first minister of a jurisdiction through their own Cabinet. The first minister can then request National Cabinet consideration.[112] The consolidation of national forums, and changes to reporting lines, therefore reduces the avenues available to state governments to raise and escalate issues.

For example, the former Disability Reform Council, comprising disability ministers reporting to COAG, oversaw the Applied Principles and Tables of Support.[113] The Applied Principles outline the roles and responsibilities of different sectors (including mental health services) and the role of the NDIS in delivering supports to people living with disability.[114] The Applied Principles allowed for matters to be escalated to the Disability Reform Council and COAG.[115] Now, matters that cannot be resolved must first be raised by individual ministers with their first minister,[116] so there is no guarantee that a matter will progress to the National Cabinet agenda.

More promisingly, the same review acknowledges that aged care issues, previously handled by the Health Ministers' Meeting, could be elevated to a new body to support interjurisdictional efforts to improve the aged care system.[117] The Commission supports the establishment of a dedicated aged care body—this would provide an avenue to deal with findings arising from the Royal Commission into Aged Care Quality and Safety, which are anticipated to include a focus on integrating aged care with other services, including mental health services.[118]

The Prime Minister has stated that improving the mental health and wellbeing of Australians requires the coordinated effort of multiple agencies, extending beyond the health system.[119] This was also echoed by the Productivity Commission:

> **Housing, employment services and services that help a person engage with and integrate back into the community, can be as, or more, important than healthcare in supporting a person's recovery. Clinical and community services should be coordinated to create a system of care that promotes recovery, with care coordinators to help people with complex needs.[120]**

The Commission is encouraged by—and very supportive of—national collaborative leadership for mental health that is based on a broad, inclusive approach. The Commission is concerned, however, that the current membership of the National Cabinet Reform Committee for mental health may be too narrow. Given that issues regarding the pandemic recovery, mental health and housing and homelessness are deeply entwined, the Victorian Government should advocate for the National Cabinet Reform Committee for mental health to include representation from related social policy portfolios such as housing. The Commission hopes the small strategic advisory group that will report to this committee will have broad enough representation to represent a range of views that extend beyond the mental health portfolio. It should also be enduring.

The Commission is also concerned that the new mental health arrangements may not sufficiently prioritise consumer and carer leadership. The Commission supports the Productivity Commission's call for greater consumer and carer leadership at the national level.[121]

Consumers and carers must be a part of the national decision-making process for mental health. Consumer and carer leaders bring unique experiences and insights, and these should be recognised. If genuinely collaborative decisions are to be made, consumers and carers need to be able to participate. While National Cabinet substructures are still being finalised, the Commission recommends that the Victorian Government advocates for consumer and carer leadership to be included in the national forum responsible for overseeing national mental health strategies, which are discussed later in this chapter. The Commission believes national-level representation of consumers should be separate from the representation of carers, given the unique experiences and insights each brings.

The National Cabinet Reform Committee for mental health will deliver a new *National Mental Health and Suicide Prevention Agreement* and oversee the implementation of the *National Mental Health and Wellbeing Pandemic Response Plan*.[122] The new *National Mental Health and Suicide Prevention Agreement* is to be finalised by November 2021.[123]

The Commission views the new *National Mental Health and Suicide Prevention Agreement* with great optimism. The Commission hopes that this agreement extends beyond mental health and that it seeks to resolve outstanding issues and funding shortfalls from previous agreements, such as those relating to psychosocial supports. The Commission supports the Productivity Commission's views that the Commonwealth and state governments need to work together to deal with the current funding shortfall for psychosocial supports outside of the NDIS.[124]

As the Agreement is developed, the Commission encourages the Victorian Government to work closely with the Commonwealth to ensure its focus extends beyond the mental health system and also considers the systems that support the social determinants of mental health.

29.3.2 Roles, responsibilities and partnerships

The Commonwealth and state governments are both involved in policy, funding and regulation in mental health. These roles have changed over time, but not in a structured way. The Commonwealth and state governments are each responsible for managing problems that arise from poor coordination of mental health services, yet neither is held solely accountable.[125]

While Victoria has no jurisdiction over Commonwealth investment decisions, the Commission encourages the Victorian Government to partner with the Commonwealth to ensure its reforms are fit for purpose and complement state investments and reform efforts.

The Productivity Commission's *Mental Health Inquiry Report* states:

> the Australian Government and State and Territory Governments share responsibility for clinical mental healthcare and psychosocial supports. The current split in responsibilities contributes to the missing middle, as it does not allow either level of government to be fully held responsible for the problem … The major intergovernmental agreements that lay out responsibilities for healthcare and disability supports do not satisfactorily clarify responsibility for mental healthcare and psychosocial supports.[126]

Intergovernmental agreements present an opportunity to clarify roles and responsibilities to ensure the Commonwealth and the states plan, fund and deliver complementary and coordinated mental health and wellbeing services. Mr Buckingham believes:

> We need a fundamental agreement between the Commonwealth and states about who does what, and who pays for what, in the area of mental health. In my opinion, reaching that agreement is the key to unlocking the future of mental health in Victoria (and indeed across Australia).[127]

As noted earlier, the Commission supports National Cabinet's decision to deliver a new *National Mental Health and Suicide Prevention Agreement*. The Commission recommends that the Victorian Government advocates to the mental health National Cabinet Reform Committee for this agreement to deliver increased investment and provide role clarity between governments.

The new *National Mental Health and Suicide Prevention Agreement* must commit to increased, long-term investment in mental health and wellbeing, suicide prevention and response services to fix current service gaps and funding insufficiencies. The agreement must be enduring so it remains protected from electoral cycles and changes of government.

A view was expressed by Ms Peake, who stated, '[i]t will be important that any future funding arrangements articulated through the [*National Mental Health and Suicide Prevention Agreement*] provide sustained and durable funding for long term mental health reform.' Ms Peake also called for this agreement to be enduring and to offer greater funding flexibility.[128]

Ms Georgie Harman, CEO of Beyond Blue, told the Commission that the national mental health system is challenged by insufficient and poorly directed investment, which is 'exacerbated in times of fiscal constraint and by electoral cycles'.[129] Ms Harman believes:

> most investment continues to be tied up in comparatively expensive, tertiary, clinical services, it is incredibly difficult to 'shift the pendulum' (as the National Mental Health Commission's review recommended in 2014) and rebalance investment over time to resource preventive and early intervention strategies.[130]

This view was supported by Associate Professor Vine, who has found that discrete investments made by each level of government in isolation has made the system even more complex:

> It sometimes seems as if both levels of government are (perhaps inadvertently) making the system more complex and fragmented through 'new initiatives' (for example, suicide prevention initiatives and the Early Psychosis Prevention & Intervention Centre (EPPIC)) rather than system improvement and integration. These new initiatives have separate entry and exit criteria, as well as funding and policy requirements, creating a fragmented system that is hard to manage.[131]

Investment should not only cover service delivery but should also support implementation of new reforms. Service providers have expressed frustration at being asked to implement new initiatives without being provided with the additional resources needed to do so. South West Healthcare told the Commission:

> collaborative projects are a significant impost on [area mental health services] resources, in circumstances where no funding is provided to the [area mental health services] for project management roles, or roles required to execute the project.[132]

While the Commission recognises that an overall increase in investment is required, there has also been resounding evidence in support of more strategic and coordinated investment. The Commission believes the new national agreement will help deliver the required coordination and direction.

The new agreement must provide clear guidance and better explanation of the roles and responsibilities of governments in funding and delivering mental health and wellbeing, suicide prevention and response services so that all consumers have access to adequate treatment, care and support, including consumers in the missing middle.

This desire for more clarity about government roles is echoed in a number of other reviews. In its 2014 review, the National Mental Health Commission called for clearer roles and responsibilities in mental health, describing a patchy landscape of services that has resulted in gaps including for people in the missing middle:

> While the Commonwealth has parachuted various siloed programmes into the mental health system, the states and territories have been pulling back their community-based mental health services, resulting in a growing gap between what GPs do and what services are provided in hospitals. The 'missing middle' is causing enormous system failure, with people falling through the gap between GPs and primary healthcare on the one hand, and emergency departments and hospitals on the other hand.[133]

The 2018 Senate Inquiry into the Accessibility of Mental Health Services in Rural and Remote Areas heard from a range of organisations that fragmentation of policy advice and funding arrangements was a contributing factor to poor cultural competency of mental health services for Aboriginal people living in rural and remote areas.[134] For example, the inquiry described how a confusing array of funding sources, and insufficient and unstable funding, has a negative impact on the capacity of service providers to improve mental health outcomes for Aboriginal people.[135]

The Productivity Commission's *Mental Health Inquiry Report* also called for clearer roles and responsibilities, stating that '[c]ooperation and coordination between Australian Government's Primary Health Networks and State and Territory Governments' Local Hospital Networks is very patchy, which undermines accountability for delivering improved consumer outcomes.'[136]

The new *National Mental Health and Suicide Prevention Agreement* also presents an opportunity to deliver other system improvements. As described in Chapter 35: *New approaches to information management*, data is a vital source of information on consumer and carer outcomes and experiences and helps governments commission services effectively. Also described in Chapter 35, the effective management and flow of information is a vital component of a well-connected mental health and wellbeing system.

Data reform is not only required at the state level. There also needs to be commitment at the national level for Commonwealth and state governments to deal with data gaps and poor data linkage so that all governments can have a complete understanding of the needs, service use, outcomes and experiences of populations. The Productivity Commission suggested that further high-quality data is required to inform decision making, including decisions to do with national reform.[137] It has called for a commitment to fix critical data and information gaps, including those in relation to data on non-government organisations that provide mental health services.[138] There have also been numerous calls to establish a national minimum dataset for primary care to understand the efficacy and reach of primary care services.[139]

Structural pressures on emerging and future workforces also need to be resolved. This is a universal issue faced by services in the Victorian mental health system. Yet, many of the levers to creating a sufficient workforce pipeline rest with the Commonwealth. This Commission encourages the Victorian Government to advocate for the Commonwealth to take a more active role in developing new supported places and pathways to deal with workforce shortages and to ensure the workforce grows into the future. The new national agreement offers an important avenue for seeking this commitment.

This chapter has touched on a range of challenges in coordinating state and Commonwealth services, meaning that people who have multiple and higher levels of need are not adequately supported. The *Addendum to the National Health Reform Agreement 2020–2025* recognises the challenges regarding the interfaces between the health, primary care, disability and aged care systems,[140] which lead to people experiencing long waits to enter one system when they are based in another. For example, people can wait for extended periods in a hospital bed while trying to get NDIS supports that would enable them to return home. The Addendum commits the Australian Institute of Health and Welfare to work with the Commonwealth and states to develop indicators to monitor equity of access to these systems. The Addendum also commits to governance arrangements that will monitor and resolve system interface issues that arise.[141]

Unfortunately, the arrangements set out in the Addendum do not specifically mention mental health. The Commission received extensive evidence about the system interface challenges faced by individuals, particularly those seeking psychosocial support services funded by the Commonwealth, the state and the NDIS. If these issues will not be dealt with through the Addendum, there must be similar measures agreed in the new *National Mental Health and Suicide Prevention Agreement* so there are clear avenues for dealing with issues of people 'falling through the cracks' and missing out on vital supports when they need to use different services.

29.3.3 National policy

As Figure 29.2 illustrates, there is no shortage of national mental health and suicide prevention strategies, plans and frameworks that either exist, are in development, or are scheduled to be refreshed.

Ms Mary-Ann O'Loughlin AM, the then Deputy Secretary of Skills and Higher Education in the New South Wales Department of Education, suggested in a personal capacity that government efforts to tackle complex problems have been slightly misguided, focusing on elaborate and perpetual plans over tangible action:

> we think the issues are complicated: that we need lots of experts and to develop elaborate plans, which end up being necessarily unevenly and often poorly implemented. When this happens, we say we need more data, more time, more resources, more expertise; we cycle between perpetual reviews and planning.[142]

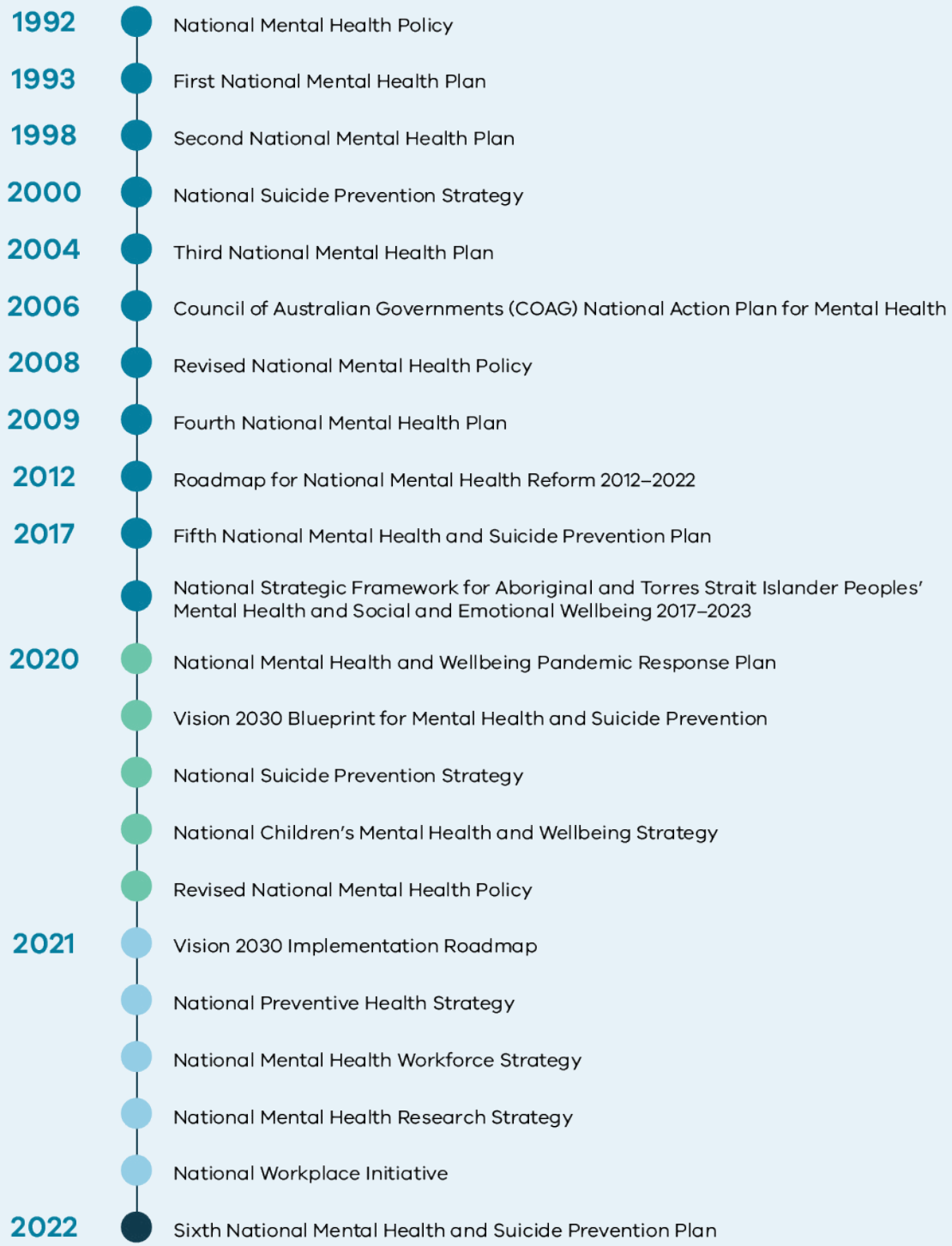
Many policies and plans have been let down in implementation. Mental Health Australia has suggested '[t]he failure to deliver on previous Plans is testimony to the intransigence of governments to invest in change and collaborate effectively under current governance arrangements.'[143]

Ms Harman perceives great willingness that has failed to translate into long-term impact:

> At a macro level—despite bipartisanship and significant political, sector and community attention, goodwill and effort, increased investment and several national strategies and plans—as a nation we have not to date been able to successfully plan, implement and continuously measure a truly balanced mental health system for the long term …[144]

The first priority area under the *Fifth National Mental Health and Suicide Prevention Plan* commits all governments to work with Primary Health Networks and health services to implement integrated planning and service delivery at the regional level. While the National Mental Health Commission finds that actions under this priority area are generally on track, these actions mostly focus on joint engagement and planning.[145]

Figure 29.2: National mental health and suicide prevention strategies, policies and plans



Source: Adapted from the National Mental Health Commission, Vision 2030 for Mental Health and Suicide Prevention, <www.mentalhealthcommission.gov.au/mental-health-reform/vision-2030>, [accessed 28 October 2020]; Commonwealth Department of Health and Ageing, *National Mental Health Report 2013: Tracking Progress of Mental Health Reform in Australia, 1993–2011*, 2013.

The Commission recognises that efforts towards joint engagement and planning are valuable and will form the essential foundations for more ambitious reform such as Commonwealth–state co-commissioning. Once fully realised, joint regional plans will support Primary Health Networks and health services to partner with local communities to make decisions that will fix service gaps, inefficiencies and duplication. They will also support more streamlined care pathways and navigation between Commonwealth- and state-funded services.

However, a shortcoming of the *Fifth National Plan* is its lack of detail regarding implementation and its lack of accountability measures.[146] A further shortcoming is the plan's narrow focus. It fails to recognise contributions from the private and non-government sectors. The Productivity Commission further suggested that the plan has become outdated, given it does not recognise that psychosocial supports outside of the NDIS are commissioned by Primary Health Networks.[147]

Orygen expressed concern that the *Fifth National Plan* places too much expectation on Primary Health Networks and health services to respond to gaps in service provision without stating how Commonwealth and state governments will deal with funding shortfalls. It suggested the *Fifth National Plan* evades action that would directly deal with funding issues.[148]

This has meant implementation of the *Fifth National Plan* has been uneven, with some Primary Health Networks and health services progressing faster than others. Later in this chapter some promising examples of partnership approaches to commissioning are described.

There are similar problems with another national mental health framework, the *National Mental Health and Wellbeing Pandemic Response Plan*, which is designed to reduce the negative impacts of the pandemic on mental health and wellbeing. Like the *Fifth National Plan*, it lacks an implementation or investment plan. 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 that 'there is still so far a complete lack of commitment and action from the Commonwealth to ensure upgrading of familiar, in-person, local and regional mental health services'.[149] Where there have been investments, the Commission was told that both Commonwealth and state governments announced new mental health investments at similar times, towards similar ends, but entirely independent of the other.[150]

While the National Cabinet Reform Committee for mental health will oversee implementation of the *National Mental Health and Wellbeing Pandemic Response Plan*, at the time of finalising this report, it is not yet clear which forum will be responsible for overseeing other national strategies such as the *Fifth National Plan* and *Vision 2030: Blueprint for Mental Health and Suicide Prevention* which, once released, will shape national mental health policy over the next decade.

The Commission recommends that the Victorian Government advocate for national mental health, suicide prevention and response strategies to have a strong focus on implementation. This could be achieved by developing detailed, staged implementation plans for each national strategy, with clear explanations of responsibilities, timelines, costs and evaluation points. The most relevant national forum could be made responsible for tracking the progress of implementation and evaluating outcomes, including determining any action required to deal with failures in implementation or respond to unanticipated developments. This could also include flagging where additional investment is required.

The Commission acknowledges encouraging developments in mental health and suicide prevention policy. In 2019, Ms Christine Morgan, CEO of the National Mental Health Commission, was appointed National Suicide Prevention Adviser to the Prime Minister. Ms Morgan's responsibilities include improving the suicide prevention activities to tackle the complex factors contributing to Australia's suicide rate across governments and portfolios.[151] Her interim advice to inform a whole-of-government approach to suicide prevention was provided to the Prime Minister in August 2020,[152] with final advice due to follow.

Further, the National Mental Health Commission has consulted widely to inform development of both *Vision 2030* and its Implementation Roadmap, which, at the time of finalising this report, were shortly expected to be released. *Vision 2030* is expected to articulate a long-term approach to national mental health reform. It holds great promise for clarifying roles and responsibilities and better focusing and streamlining investment and reform efforts. Of the plan, Ms Morgan stated:

> **Collaboration is recognised as a primary driver to enable change in the implementation of Vision 2030. The [National Mental Health Commission] is working alongside states and territories … to endorse content from the final Vision 2030 products as a national mental health strategy and action plan.[153]**

Pending the outcomes of these strategies, the Commission encourages the Victorian Government to seek to ensure that future national mental health strategies are all-encompassing, spanning governments and sectors (including non-government and private sectors), and that they complement rather than duplicate each other.

29.3.4 System reform

A number of Commonwealth-led reform initiatives, including the mental health inquiry led by the Productivity Commission, afford opportunities for reforming the system to deliver complementary services. However, at the time of finalising this report, the Commonwealth had not yet released its position on the Productivity Commission's findings. The Commission further notes that a new Select Committee on Mental Health and Suicide Prevention is to be established to inquire into the findings of this report, and others, and is not due to issue its own final report until November 2021.[154]

The Victorian Government does not need to await the outcomes of this new inquiry. Presently, the *Addendum to the National Health Reform Agreement 2020–2025* includes a Commonwealth commitment to 'invest in programs designed to minimise the impact of potentially preventable hospital admissions arising from shortcomings in areas within its own direct policy control'.[155] This includes investments and flexible funding models to better support people living with 'severe mental health conditions', consistent with the Commonwealth's 2015 response to the National Mental Health Commission report *Contributing Lives, Thriving Communities*.[156] This commitment seeks to enhance linkages between primary care, health services and the NDIS.

However, since 2015, when this commitment was first made, progress has been slow. The Royal Commission encourages the Victorian Government to work with the Commonwealth, leveraging this commitment to advance reforms outlined in this chapter and other related chapters, most notably Chapter 28: *Commissioning for responsive services*. Such reforms have great potential to deal with system interface challenges common to people living with higher levels of need. For example, reforms could assist people living with mental illness who have the highest needs to get into affordable and safe housing—a critical component of recovery.

The Addendum commits to trial several health system reforms. System reforms of note include:

- funding reform—support to explore value-based funding and payment mechanisms that closely tie to outcomes for consumers[157]
- co-commissioning reform—support for local health organisations such as Primary Health Networks and health services, as well as primary and community health services, to coordinate care through pooled budgets and commissioning arrangements[158]
- prevention investment reform—support for innovative approaches to increase investment in primary prevention.[159]

The Addendum is an important avenue for the Commonwealth and Victoria to trial innovative models of care through bilateral agreement. There is an opportunity for Victoria to play a leading role, demonstrating the potential for the Commonwealth and a state to enter bilateral agreement on an ambitious joint reform that seeks to resolve the problem of disintegrated services and funding.

The Commission encourages the Victorian Government to take advantage of these commitments in the 2020 Addendum to progress Commonwealth–state partnership approaches to system reform to deliver on several of the Commission's recommendations.

29.4 Commissioning integration

Many consumers, families, carers and supporters seek care that is coordinated and streamlined, particularly when more than one type of service is required. People want services to talk to one another and share information so they do not need to retell their story. And people want services to work as one system so they are not passed on or turned away when they reach out for help. This is further described in the personal story of Ms Erin Davies and her son Matthew.

Ms Catherine White, a witness before the Commission, reflected on the range of supports that are required for her to meaningfully recover and to maintain recovery:

> There are a lot of factors to consider. It's not just about 'recovering' in one particular aspect of a person's life. What is the point of getting a person's medication under control and managing their symptoms, if that person ultimately becomes homeless? Recovery requires looking at all aspects, taking a holistic approach of a person's life and putting in place a range of safety nets and supports so that if one falls over, the person can sort of lift themselves up with another.[160]

Victoria Legal Aid's Your Story, Your Say project shared the views of one consumer who called for an integrated system that can provide complete support for all of a person's needs:

> the system needs to be integrated with other services to help solve circumstances (e.g. legal issues, relationships and so on) that arise for people. Unless services can show an understanding of the situation you are in, all they are doing is interfering and doing more harm than good.[161]

There are several ways to achieve greater integration:

- clinical integration, such as through shared guidelines or protocols
- service integration, such as through multidisciplinary teams
- functional integration, such as through electronic medical records
- organisational integration, such as through contracting or provider networks
- normative integration, such as through shared missions, visions, values and culture that enable trust and collaboration
- systemic integration, such as through coherent rules and policies at all organisational levels.[162]

Integration can vary in its intensity from simply linking between existing organisational units (for example, the use of referral tools), to coordinating through existing organisational units (such as sharing clinical information), to full integration (such as pooling funds and creating new organisations).[163]

This reform, centred on organisational integration, is one of several approaches recommended by the Commission to improve service integration. In practice, approaches are often used in combination.[164] The Productivity Commission has suggested that '[m]aking the system more accessible, and improving the links between its individual parts, requires a number of different approaches [that] … come together to create clear pathways for consumers'.[165]

One option to improve integration would be to have services 'co-located' (brought together in a single physical location) such as through community-based services in a local setting. However, one approach on its own may not be enough to deliver integration. Ms Amelia Callaghan, Director of Clinical Service Innovation at Orygen, gave evidence in a personal capacity, telling the Commission:

> There is a need to progress beyond co-location of services to integration. Even in headspace Centres where primary and tertiary services are in the one physical location they are very rarely integrated in their systems or medical records. In practice this means a change of clinician, retelling of their story, having to be discharged from one system to be assessed and registered in another system, all of which can be disruptive to the therapeutic relationship and slow down or stop any therapeutic gains.[166]

Ms Nicole Bartholomeusz, CEO of cohealth, believes:

> In Victoria, we need to think of the common client: there are several service providers in the health care system who are essentially caring for the same person. However, the various service providers care for and treat that person as an individual rather than [as] a common client.[167]

Mr Terry Symonds, formerly the Deputy Secretary of Health and Wellbeing at the Department of Health and Human Services, suggested:

> Provider-led initiatives can also drive collaboration at the local level … Many providers are very sophisticated and can play a key role in developing service offerings. To do this, we need to think about how we can provide direction and support them. This could include … using funding incentives to encourage providers to deliver innovative care or form partnerships to make better use of limited resources.[168]

Organisational integration can bring together a variety of providers to support an individual's needs, including, as Ms Sue Williams, CEO of Cabrini Health Australia and Board Member of Forensicare, suggested, between public and private sectors. Ms Williams, who gave evidence in a personal capacity, advised that principles should be established to guide commissioning processes but with 'flexibility at a local level to enable health services and private providers to identify where the greatest benefit can be realised'.[169]

The focus on different parts of the system has not always been equitable. Mr Tass Mousaferiadis, Chair of the Board of Star Health, and Mr Kent Burgess, Acting CEO of Star Health, emphasised the importance of including community health providers in collaborative approaches:

> governance and consortia arrangements need to give equity to the different partners. In this way, the focus can be on community and on the location of the person's environment ... We need an integrated approach which also gives us integrated governance.[170]

This notion is also supported by Mr Quinlan. He suggested that the way in which non-government organisations are contracted is a barrier to this occurring:

> the most effective arrangements are ones that involve a forum where policy [and] planning, implementation and monitoring and evaluation [are] taking place in a genuinely shared environment. This will not be achieved if [non-government organisations] are operating in short term arrangements and subject to constant tendering processes.[171]

Dr Sarah Pollock, Executive Director of Research and Advocacy at Mind Australia, believes that non-government organisations are now well placed to participate in new collaborative approaches. She stated 'now is an opportune time to consider an expanded role for [non-government organisations], in our own right and through partnerships with clinical services'.[172]

Based on the evidence received, the Commission has been encouraged to consider new ways of commissioning and contracting to achieve more integrated service delivery. While contracting can encourage providers to collaborate, this can be further encouraged through more flexible funding models. New funding approaches are described in Chapter 28: *Commissioning for responsive services*.

29.4.1 Priority cohorts

There is a growing evidence base supporting a targeted approach to integration that first focuses on people with the greatest needs and potential to benefit. In its 2017 Shifting the Dial review, the Productivity Commission suggested that '[r]elatively small groups of people account for a high usage of services.'[173] The review encouraged all actors in the health sector to discover 'the most vulnerable and intensive users of the health system' to 'build services around them to manage their chronic conditions better'.[174] The Productivity Commission added that integration 'should concentrate most on those whose health conditions are critical and for whom the returns will be greatest in terms of better health outcomes and lower health costs'.[175]

With the support of the Victorian Government, Regional Mental Health and Wellbeing Boards (hereafter Regional Boards), which have been recommended by the Commission to support regional decision making, should test, then scale, new ways of commissioning to support integration. The Victorian Government, with Regional Boards, will need to develop new ways of contracting and commissioning providers, using more flexible funding approaches, to help create meaningful integration that lasts. They should begin with selected cohorts that have the greatest potential to benefit from integrating multiple providers.

Personal story:

Erin Davies

Erin* cares for her son Matthew* who is 11 years old. Erin says that as a baby and toddler, Matthew was affectionate and interested in the world. She started to notice changes in Matthew in kindergarten.

> I spoke to my maternal child health nurse, but she assured me it was Matthew adjusting to change.
>
> When Matthew started Prep at school … [h]e became very negative, rude, aggressive, angry. It was heartbreaking.

Erin said that by the time Matthew was in Year 1, both the school and the family accepted that Matthew needed more help. The family went to a psychologist, who treated Matthew for generalised anxiety and social anxiety.

Erin said that by Year 2, things were worse. They tried seeing a speech pathologist and a psychologist. Midway through Year 2, Matthew was diagnosed with autism spectrum disorder. But by this time, he was too old to qualify for Commonwealth Early Intervention Funding.

Erin describes trying a range of strategies over the next few years to support Matthew, but his behaviour and distress continued to worsen. At one point, being left with no option, Erin called Triple Zero for urgent medical help, which led to Matthew being restrained by police and taken to the emergency department, only to be discharged shortly afterward. Following this incident, Erin said she begged the Child and Adolescent Mental Health Service to see him. A psychiatrist tried a range of medications with Matthew and eventually recommended the family stay in a children's inpatient unit at a hospital. Matthew was at the start of Year 5.

> The inpatient unit felt like a horrible place, and its look made me feel terrible.
>
> Matthew became more violent than he'd ever been in the unit … I said to the hospital during our stay, 'Things have never been worse. What's happening?'
>
> when our time was up, the hospital said, 'You've got to go home now'. They sent us home with a safety plan [and] told us to use lavender oil and, if that didn't work, to call Triple Zero … We had rung Triple Zero before and we were not doing that again—ever. I wondered, what sits between lavender oil and Triple Zero?

Erin said that after their stay at the inpatient unit, a range of services were involved. However, this was challenging.

> We found the 'siloed' nature of the mental health system to be unhelpful.

> Through the [National Disability Insurance Scheme] … we received … a number of pre-determined appointments with occupational therapists and speech pathologists. But we had funded those sorts of therapies ourselves for years, and we knew they wouldn't work.
>
> [Matthew's National Disability Insurance Scheme] funding stops at the school gate, because what happens after the school gate is the responsibility of the Department of Education.
>
> I have had meetings where there's been a person from [the Intensive Mobile Youth Outreach Service], a special school worker, a hospital worker, a special education teacher for Matthew (funded by Matthew's severe behaviour funding), an after school care safety officer, the Principal, and Matthew's teacher. I have to organise these meetings and coordinate everyone's diaries.

The effort required to coordinate these services and care for Matthew has taken its toll on Erin and her family.

> it's too much; it's overwhelming … the stress has taken a massive toll on my relationship with my husband … All our energy goes into Matthew's care, and there's nothing left for anything else … If [my husband] and I split up, what would that do for Matthew's mental health? What does that do for all our mental health?

Erin noted that Matthew's needs often seemed to be 'peripheral' to the services, '[t]he services just continued doing their thing, regardless of whether it was helping him.' She believes that for people to have all of their needs recognised and responded to, the system needs to be more accommodating:

> I choose to believe that people are intelligent and well-meaning, but that they are constrained in what they can do when they're operating in a system with rule fidelity and a cookie-cutter model; when it is all about adhering to the guidelines.

Erin observed that there were so many opportunities for their family to be connected with services and supports, but that these opportunities were missed.

> Matthew has [autism spectrum disorder], which is not preventable. However, the mental ill-health that has come from his [autism spectrum disorder], and exacerbates his experience of it, could have been reduced if there had been earlier intervention.
>
> Requiring people to fit themselves into a rigid, fractured system that does not function across the domains of people's lives is damaging and not helpful or healing … It would be great to, instead, have a child-centric approach that can move seamlessly across school grounds, the family home, public health systems and private providers. The child and family should feel that it's about them, not about them fitting into the fractured system.

Source: *Witness Statement of 'Erin Davies' (pseudonym)*, 1 July 2020.

Note: * Names have been changed in accordance with an order made by the Commission.

The Commission was also encouraged by several witnesses to adopt a more focused approach. Giving evidence in a personal capacity, Associate Professor Jo-An Atkinson, Managing Director of Computer Simulation and Advanced Research Technologies and Head of Systems Modelling and Simulation with the Brain and Mind Centre at the University of Sydney, said that investments have tried to deal with too many things at once, which has added further complexity to the system:

> **complex challenges have resulted in a move towards the implementation of comprehensive strategies, with investments in a broad range of different programs and services … [T]his approach may actually undermine the potential impact of investments by spreading available resources too broadly … This, in turn, makes the mental health system even more complex and difficult to navigate for clients.**[176]

Along this same line, Ms O'Loughlin also sees benefit in narrowing the focus rather than trying to do everything at once. Citing work from the British Prime Minister's Delivery Unit on managing complex social policy problems, she suggested the first step is '[p]rioritise: agree a small number of clear priorities. Rather than "everything matters"'.[177]

Associate Professor Simon Stafrace, Chief Adviser of Mental Health Reform Victoria, also supports adopting a targeted approach that can be expanded. He told the Commission in a personal capacity that 'reform can start with small incremental or local initiatives that can and often do lead to system-wide improvements'.[178]

A further benefit of small-scale approaches is that they support experimentation and adaptation, allowing for local action, based on local circumstances.[179] Ms O'Loughlin favours this approach, particularly when trying to solve complex problems. She suggested, 'learn by doing, trial and error, with iteration to improve response. Unique and shifting contexts require experimentation with real time feedback and data about what is working, and then adjustment'.[180]

Through this evidence, the Commission has determined that a targeted approach to reform will support efforts that concentrate on people with the greatest need, and at a scale that can safely support experimentation. The Commission expects that as reforms mature and evidence is generated, they would be further scaled.

The Commission has examined evidence from witnesses, academic literature and available data to consider which cohorts could most benefit from integration through commissioning and contracting reform. Based on analysis, the Commission has identified two priority cohorts: people living with mental illness who need ongoing intensive treatment, care and support, and people who need short-term treatment, care and support but are currently in the missing middle. The evidence to support this finding is described in the next sections.

29.4.2 People who need ongoing intensive treatment, care and support

As described in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*, people living with mental illness who need ongoing intensive treatment, care and support must be able to enter a mental health and wellbeing system that recognises all their needs and preferences. The National Mental Health Commission has defined the 'ideal' mental health system as featuring 'clearly defined pathways between health and mental health … [that] recognise the importance of non-health supports such as housing, justice, employment and education, and emphasise cost-effective, community-based care'.[181]

A 2019 review by the Royal Society for Public Health in the United Kingdom suggested factors that place individuals at higher risk of poor mental health and wellbeing are more common for certain groups of individuals. Such individuals may benefit from 'targeted approaches to prevent widening of inequalities'.[182]

Professor Harriet Hiscock, Paediatrician at the Centre for Community Child Health, and Director of the Health Services Research Unit at the Royal Children's Hospital, also believes there is benefit in targeting approaches to certain groups. Professor Hiscock, who gave evidence in a personal capacity, suggested that '[t]o get the "best bang for buck" bringing health and social services together, we should focus on "at risk" populations who typically cluster in low socioeconomic status (SES) areas.'[183]

Professor Lisa Brophy, Discipline Lead in Social Work and Social Policy in the Department of Occupational Therapy, Social Work and Social Policy at La Trobe University, who also gave evidence in a personal capacity, believes that people with multiple and highly complex needs can benefit from a specific package that is targeted to their needs.[184]

A 2016 study, by Professor Lisa Brophy and her colleagues, suggested that people 'living with severe psychosocial disability' associated with 'severe and persistent mental illness' experience a common set of difficulties. Typically, they have 'more severe illness … and treatment resistant symptoms … cognitive impairments and comorbid mental health problems'. They more often require supported accommodation and have physical health problems. The study also identified emerging evidence that 'childhood trauma and adversity complicate the course of illness'.[185]

Professor Brophy and her colleagues further submitted that people who can get 'psychosocial rehabilitation and recovery support' from non-government organisations report receiving greater assistance with housing, employment and relationships. Yet the study findings also suggested that 'people living with psychoses and severe psychosocial disability' are less likely to receive 'psychosocial rehabilitation' from non-government organisations. The study proposed that the absence of these supports can have detrimental effects on their ability to cope with everyday life.[186]

A 2020 review by the University of Melbourne on behalf of the Commission identified some promising approaches to improve outcomes for people living with 'severe and persistent mental illness', though the results were modest. A 2019 study cited in the review suggested that 'relational continuity'—that is, continuity of care from seeing the same support person over time—can improve the physical health of people living with 'SMI [severe mental illness]' and reduce their need for unplanned hospital care.[187]

Based on these findings, the Commission considers that people living with mental illness who need ongoing intensive treatment, care and support would benefit from an approach designed to bring a range of providers together to assist their multiple needs. This could include, for example, services to support physical health, mental health and wellbeing, stable housing, education and employment.

29.4.3 People in the missing middle

Targeted, integrated care should not only focus on those who are currently disadvantaged but also look to intervene early to support those who may become disadvantaged in the future.[188]

As introduced earlier in this chapter, there is a large service gap for people in the missing middle, whose mental health needs are too complex and enduring for primary care services but not considered severe enough for treatment in public specialist clinical mental health services. Both the Commission's interim report and the Productivity Commission's *Mental Health Inquiry Report* make clear that community services for the missing middle are inadequate.[189] These existing service gaps must be filled so all people, regardless of the complexity or severity of their needs, can connect with the treatment, care and support they seek.

The Victorian Government's submission to the Commission identified that:

> **Gaps in psychosocial service delivery arising from the transition to the NDIS are also contributing to the missing middle.**
>
> **People with unmet needs for treatment and care are often forced to seek assistance elsewhere or are left without help until their illness gets worse. This means that unmet or hidden demand for mental health services may manifest as costs in other government services, such as justice and homelessness services.**[190]

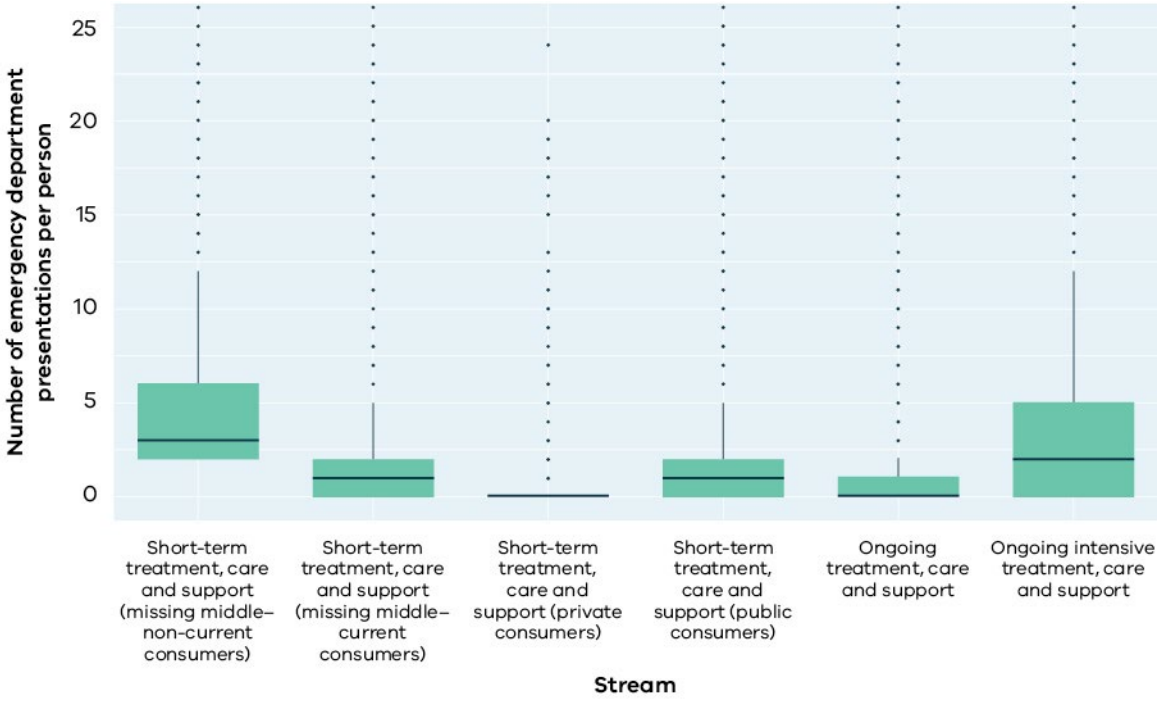
In 2018–19, consumers in the missing middle who were unable to connect with Victorian clinical mental health services presented to emergency departments more frequently than other cohorts (refer to Figure 29.3). It is important to note that these findings are not only due to poor integration, they are also a product of sustained underinvestment in the mental health system.

The needs of people in the missing middle are numerous and varied. Western Sydney Primary Health Network suggests that the missing middle are 'vulnerable populations with combinations of moderate mental illness and complexity; drug and alcohol, comorbid physical conditions and social issues'.[191]

Ms Williams believes that '[c]ommissioning would be the most efficient and co-ordinated process' for supporting people in the missing middle to connect with 'integrated community and hospital services'.[192]

The Commission recognises the importance of focusing on people who require ongoing, intensive treatment, care and support. However, based on the evidence, it has been encouraged to also focus integrated reform on people who need short-term treatment, care and support but are currently in the missing middle. These people often miss out on vital services, which places them at risk of developing more serious and urgent needs.

Figure 29.3: Emergency department presentations per person, by stream based on current service use, Victoria, 2018–19



Sources: Department of Health and Human Services, Integrated Data Resource, Client Management Interface/Operational Data Store, Victorian Emergency Minimum Dataset, Victorian Admitted Episodes Dataset, E-justice, Law Enforcement Assistance Program Extract, Child Protection – case management, Specialist Homelessness Services Collection, Victorian Housing Register, State Alcohol and Drug Treatment Service Utilisation Data Collection, Family Services Data Collection, Family Violence Support Services Data Collection, Sexual Assault Services, Child FIRST Dataset, Community Health Minimum Dataset, Disability – individual support packages, Cradle to Kinder services, Mental Health Community Support Services Data Collection, 2018–19.

Notes: Consumers have been grouped into streams according to their current service use. This does not mean that their needs align with the stream they are in.

Consumers have been grouped to streams as follows:

- *Short-term treatment, care and support (missing middle – non-current consumers)* is defined as consumers who presented to a public hospital emergency department for a mental health–related reason and did not meet the definition of any other stream.
- *Short-term treatment, care and support (missing middle – current consumers)* is defined as consumers who are registered in the Client Management Interface/Operational Data Store and received a community contact from a specialist public mental health service but did not receive any case management (no case was opened). Most of these consumers received a small number of contacts from a triage team or a Crisis Assessment and Treatment team.
- *Short-term treatment, care and support (private consumers)* is defined as consumers who were admitted to a mental health bed in a private hospital and did not meet the definition of the short-term treatment, care and support (public consumers); ongoing treatment, care and support; or ongoing intensive treatment care and support streams.
- *Short-term treatment, care and support (public consumers)* is defined as consumers registered in the Client Management Interface/Operational Data Store who received case management (a case was opened) from a specialist public mental health service but did not meet the definitions for the ongoing treatment, care and support; or ongoing intensive treatment, care and support streams.
- *Ongoing treatment, care and support* is defined as consumers registered in the Client Management Interface/Operational Data Store who received case management from a specialist public mental health service in 2018–19 and either 2017–18 or 2016–17, and did not meet the definition of the ongoing intensive treatment, care and support stream.
- *Ongoing intensive treatment, care and support* is defined as consumers who meet the definition of ongoing treatment, care and support stream and they received services from more than two of the following: alcohol and other drug services, child protection and child and family services, mental health community support services, community health services, justice or youth justice services, disability services, homelessness and housing services, sexual assault services or family violence services.

Professor Ian Hickie AM, Co-Director of Health and Policy at the Brain and Mind Centre at the University of Sydney, gave evidence in a personal capacity, suggesting that 'some of the more forward-thinking' partnerships between health services and Primary Health Networks are examining the needs of people in the missing middle and contracting service providers to meet their needs.[193]

Examples of partnership approaches to commissioning for specific cohorts are further illustrated in Box 29.5.

Box 29.5: Commissioning for selected cohorts

The North Coast Collective in New South Wales began as a partnership between North Coast Primary Health Network and Mid North Coast and Northern New South Wales Local Health Districts for joint planning. It has since expanded to encompass 30 partner organisations, including community-managed organisations, local government, volunteer organisations and people with lived experience of mental health. It is now piloting an approach focused on integrating mental health and alcohol and other drug supports using pooled resources.[194]

The Health Alliance between Brisbane North Primary Health Network and Metro North Hospital and Health Service is trialling approaches to integration for selected cohorts. They have identified three priority cohorts, including people who experience complex physical and mental health issues at the same time as social issues such as insecure housing and social isolation, and who frequently attend emergency departments. The alliance connects with consumers and service providers to reach shared agreement on the challenges and how to tackle them.[195]

Central Coast Local Health District, Hunter New England Central Coast Primary Health Network, the New South Wales Department of Education and The Benevolent Society co-commissioned the Family Referral Service. The service provides family-based assessment and engagement in disadvantaged school communities to link vulnerable children, young people and families with early intervention and support in their local area.[196]

The Adelaide Primary Health Network, the Women's and Children's Hospital Network and the Department of Human Services South Australia have formed a partnership to deliver an evidence-based group therapy program for mothers with borderline personality disorder in the perinatal period. The partnership is designed to provide group-based, specialised services in primary care settings and childcare centres in communities, close to where the consumers live.[197]

29.4.4 Commissioning models

As illustrated in Figure 29.4, three emerging contractual models are encouraging providers to come together to support people with more than one need.

The opportunities and risks of innovative commissioning models are varied and not yet fully understood. It has been suggested that there is a need to assess how different models work in practice by testing and evaluating alternative approaches.[198] While the examples in Figure 29.4 offer some idea of how the models may operate, existing models will need to be adapted and refined. For example, in discussing the Victorian Government HealthLinks: Chronic Care initiative, Mr Symonds remarked:

> **It is important to note that the current model works by incentivising individual providers to rearrange their funds—purchasing non-hospital care in order to reduce the costs of hospital care. The model would need to be carefully re-designed if it is used to create incentive structures across clusters of services in a regional operational commissioning environment.[199]**

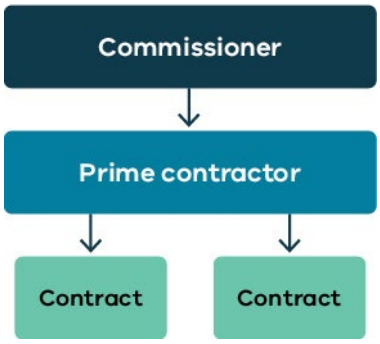
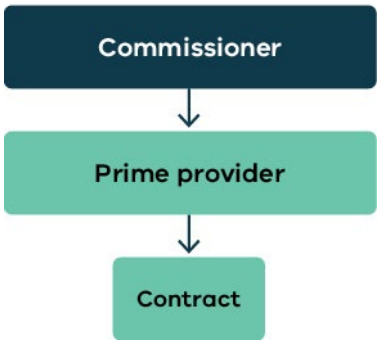
The Commission believes that Regional Boards and relevant providers will need flexibility to determine the contractual model that is most suited to their local circumstances. The Commission recommends the Victorian Government directs Regional Boards to trial new commissioning and contracting to improve integration. Drawing on these contractual models, Regional Boards will bring several funding sources together into a single contract for a 'demonstration' project for a specific cohort. A demonstration project is a way to promote innovation and to capture and disseminate best practice through developing and analysing a project as it progresses. It helps to test and support improvements and build an evidence base.

Initially, projects will be funded by the state only but could progress to include other funding sources, as discussed later in this chapter. A provider or provider partnership will apply to operate a demonstration project. Regional Boards will be responsible for selecting from providers or provider partnerships, using the service standards. Regional Boards could have direct involvement in a demonstration project by leading the contract themselves or by joining in an alliance contract.

In accordance with the service standards, which are described in Chapter 28: *Commissioning for responsive services*, each provider or provider partnership will need to demonstrate their commitment to working with consumers, families, carers, supporters and other providers to deliver coordinated services that span more than one setting. Regional Boards will use contracts to hold providers and provider partnerships accountable for the outcomes and experiences of the target cohort.

Regional Boards will contract one demonstration project in each region focused on people living with mental illness who need ongoing intensive treatment, care and support. They will also contract one demonstration project in each region for people who need short-term treatment, care and support but are currently in the missing middle.

Figure 29.4: Emerging contractual models that can encourage integration

Model	Features
Prime contract model 	Contract with a single organisation (or consortium) The organisation receives a single budget to manage all care specified in the contract The organisation manages the supply chain through individual subcontracts with each provider The organisation takes responsibility for the day-to-day management of other providers, but does not deliver care directly
Prime provider model 	Contract with a single organisation (or consortium) Similar to the prime contract model, but the contracted organisation also delivers services directly—that is, it is the prime 'contractor' and 'provider' The organisation uses the budget to buy additional services (through subcontracts) that it cannot deliver directly
Alliance contract model 	Contract that legally binds a set of organisations or an 'alliance' All organisations within the alliance contract are equal partners who share risk and responsibility for meeting agreed outcomes There are no subcontractual arrangements Members share decisions on delivery of care Alliance members are each accountable to the commissioner, and hold each other accountable to contract terms agreed by the alliance Success is judged by the performance of the alliance overall rather than the performance of single organisations within it

Source: Adapted from Rachael Addicott, Commissioning and Contracting for Integrated Care, 2014, pp. 10, 19, 20, 25–27, 34, 35–36. 1. Productivity Commission, *Mental Health Inquiry Report, Volume 3, 2020*, p. 835; 2. Department of Health and Human Services, *HealthLinks Chronic Care Evaluation: Summary of Implementation and Outcomes for 2016–17, 2019*, pp. 5, 8–9; 3. Ministry of Health, Ontario, *Ontario Health Teams: Guidance for Health Care Providers and Organizations*, pp. 2–3.

Benefits	Risks	Examples
Simple for commissioners to manage Supports a single entity to control the budget for the whole consumer care pathway Shifts clinical accountability onto the prime contractor and providers	Risks relating to funding and relationship management are shifted to the prime contractor Concern over management of co-morbidities and other boundaries Providers may not have sufficient skills in contracting, supply chain management and commissioning	**Primary Health Network commissioning of psychosocial supports[1]** Primary Health Networks commission psychosocial support services via contracts with service providers. They do not deliver services themselves.
Increased direct control over service provision across a pathway Demand risk shifts to provider(s) Enables money to move within the pathway Clear governance arrangements through contractual/subcontractual arrangements	Possible provider monopoly Perverse incentives—may limit consumer choice and promote selection of consumers with less costly or less complex needs Provider organisation may not have sufficient skills in contracting, supply chain management and commissioning	**HealthLinks: Chronic Care, Victoria[2]** A single provider is paid a 'capitated' grant based on the number of 'enrolled' consumers with a chronic illness. The provider can choose to deliver all of the care directly, or can subcontract services to other providers. The provider is held accountable for reducing unplanned hospitalisations.
Strong incentives to collaborate Limits dominance of a single organisation Strengthens relationship between commissioners and providers Retains the active involvement of commissioners	Shared financial and clinical risk, reliant on the performance of other providers More complex for commissioners to manage Requires existing relationships founded on strong trust, which might not be present in all areas Possibility of weak leadership and accountability unless appropriate governance arrangements are established	**Ontario Health Teams, Canada[3]** An Ontario Health Team is a group of service providers who voluntarily partner to deliver coordinated healthcare. They are jointly accountable for the cost and provision of services and associated outcomes for their local population. They commission and also deliver services. Refer to case study for further detail.

Demonstration projects will not be time-limited pilots. Contracts will be structured to ensure enough funding for providers to recruit workforces and invest in infrastructure. Demonstration projects will be evaluated to enable understanding of whether they are improving consumer, family, carer and supporter outcomes, and integration across providers. The outcomes of evaluation will be used to inform decisions on further scaling existing demonstrations, as well as expanding to new providers or provider partnerships.

Regional Boards may choose cohorts to focus on, tailored to the unique characteristics of their populations and involving all age groups. A 2019 review by the Royal Society for Public Health identified several groups of individuals, across all age groups, that are at higher risk of poor mental health and wellbeing and that could most benefit from targeted treatment, care and support. These groups range from young carers and young people who are homeless, to adults in contact with the justice system and older people in residential care.[200] This review provides valuable evidence that could help to inform decisions on selecting cohorts.

As illustrated in Box 29.6, several factors are critical to the success of new models of commissioning and contracting to support integration.

Box 29.6: Factors that are critical to the success of commissioning reform

- Ongoing engagement with providers, consumers, families, carers and supporters and the wider community will ensure there is a shared vision of what the future should look like. This vision then forms the foundation of the model to meet these aspirations.
- Building trusting relationships between providers will ensure any new contractual models are supported through strong local relationships.
- Aligning payment approaches and incentives across providers will ensure the way providers are reimbursed is streamlined. This tackles a primary source of care fragmentation.
- Appropriate governance and organisational models will ensure there are strong processes for decision making, managing risks and holding each provider to account, particularly given that greater risk is shifted onto providers and provider partnerships.
- Commissioners will need to develop a new range of competencies to establish and monitor new contractual models, including holding organisations to account for outcomes, and working with new service providers.[201]

The success of demonstration projects rests on the ability to account for these critical factors, which will take time. Many of these factors are discussed in detail in related chapters.

There will need to be better data on outcomes and experiences, and processes for holding providers or provider partnerships accountable to these outcomes, which is described in Chapter 3: *A system focused on outcomes* and Chapter 28: *Commissioning for responsive services*. There will need to be adequate data on activity and costs, which is described in Chapter 35: *New approaches to information management*, and also suitable funding and pricing models, which is described in Chapter 28: *Commissioning for responsive services*. Community-based and consumer-led providers will need support to develop the capacity and capability to meet the needs of all consumers, also set out in Chapter 28: *Commissioning for responsive services*. Ultimately, there will need to be trusting relationships between providers, governments and the broader community, so that everyone understands, and is working towards, the same aim, as stated in Chapter 37: *Implementation*.

Considering lessons learnt from a recent Commonwealth integrated care trial, Mr Symonds said:

> **it takes time to implement change and build trust—the importance of allowing enough time at the commencement of such initiatives for participating services to be properly prepared and putting the right arrangements in place to support them should not be underestimated.**[202]

In the initial years of the contract, there should be no change in the way money flows to providers, so that providers are not financially penalised. Regional Boards, with support of the Victorian Government, should introduce new financial arrangements as new funding models are developed and tested, and as the quality of information on the usage and cost of services improves.

The Commission has examined several examples of successful partnership approaches to integration. Based on these examples, the Commission believes it is important that Regional Boards should seek to build on, and not create barriers to, existing approaches. Ms Lynda Watts, a witness before the Commission, said, '[i]t's about building up and acknowledging where good work has been done, so more good work can be done.'[203]

Documenting existing arrangements in a formal contract can recognise the contribution of a range of providers, reduce the risk of having a dominant provider and ensure providers are accountable to the same consumer outcomes.[204]

While contracting can encourage providers to collaborate, this can be further encouraged through more flexible funding models. As Box 29.6 highlights, aligning payment incentives across providers will ensure the way providers are reimbursed is streamlined. An example of a flexible funding model to support integrated commissioning is a 'capitation' funding model, which is further described in Chapter 28: *Commissioning for responsive services*.

Under a capitation funding model, consumers could choose to voluntarily 'enrol' with a provider or provider partnership to receive a funding package that supports a range of mental health and wellbeing supports. The payments would allow flexibility for consumers, families, carers and supporters to work with providers to design a package that meets their needs and preferences.

For demonstration projects designed for people living with mental illness who need ongoing intensive treatment, care and support, an integrated contract will encourage services to come together to deliver integrated treatment, care and support. A capitation funding model will ensure funding encourages and does not put up barriers to integrated approaches.

This approach has great potential to overcome the challenges and frustrations faced by so many people. One person shared her and her mother's great efforts to navigate a complex system and plan for the needs of their family member with a mental illness in the absence of sufficient support:

> It gets to the point where my mother has to turn herself into a social worker, a mental health nurse and a case manager to find my sister the appropriate services and care that she needs. She does this because she loves her daughter, and there is no other option. Neither my mother nor I are experts in this field, so to navigate it on our own is time consuming and exhausting, and it makes us both feel disheartened when we think about the future.[205]

29.4.5 Commonwealth–state co-commissioning

As mentioned, the ambiguity of Commonwealth versus state government responsibilities and accountabilities, and the fragmented service that results from this, negatively affects consumers, families, carers and supporters, namely through service gaps and poorly coordinated services. While there should be efforts at the national level to resolve this ambiguity, there should also be efforts at the regional and local levels to encourage providers to come together to support the needs of individuals.

As part of the Commission's vision for a responsive and integrated system, it has recommended creating eight Regional Boards, with boundaries that support collaboration with Primary Health Networks. This creates a future opportunity for Regional Boards to partner with Primary Health Networks to encourage more coordinated approaches spanning Commonwealth and state-funded services, including through pooled budgets and co-commissioning.

Mr Symonds believes:

> Due to the split of funding between state and Commonwealth governments, enhancing the role of Victorian primary care providers in mental health is inextricably tied to the Commonwealth. We should look to partnerships and opportunities to undertake joint or co-commissioning with the Commonwealth through [Primary Health Networks] to close the missing middle ...[206]

Demonstration projects, mentioned earlier in this chapter, could also include Commonwealth-funded services and be designed to support people who are currently in the missing middle. Several witnesses to the Commission suggested that supporting the missing middle should be a joint Commonwealth–state responsibility.

Professor Hickie proposed:

> there should be joint Commonwealth and state responsibility for the missing middle. This could be driven, for example, through organised collaboration between [Primary Health Networks] and [health services], which are funded by the Commonwealth and state governments respectively … the states cannot solve this problem on their own.[207]

Ms Callaghan told the Commission:

> To address the missing middle there is a need for further integration between the state and [C]ommonwealth funded services. This requires a commitment from both state and federally funded services to work together and to use the different funding sources to create a seamless and collaborative service model rather than a fractured service. To achieve this, funding, governance and information technology systems must integrate across all of the parts of the mental health system.[208]

While the *Fifth National Mental Health and Suicide Prevention Plan* commits to better integrate Commonwealth- and state-funded services through greater collaboration, as mentioned earlier in the chapter, efforts have been slow and uneven. The plan includes a further action to examine 'innovative funding models, such as joint commissioning of services and fund pooling for packages of care and support'.[209] However, the action does not extend beyond simply 'examining' models. While there have been some promising collaborative approaches arising from the plan, the Productivity Commission has found that indicators of the progress made so far are mixed.[210]

Achieving the *Fifth National Plan's* ambitious reforms, such as integrated planning and funding, is difficult without sufficient guidance and authorisation. The Productivity Commission supports this notion, stating that there is not enough guidance or monitoring of actions under the plan, that joint planning is not sufficiently mandated, and that there is limited oversight and accountability for plans, which creates a risk that they will be of little substance.[211] Similar views were expressed by participants at the Commission's roundtable on governance and commissioning.[212]

As stated earlier in this chapter, the *Addendum to the National Health Reform Agreement 2020–2025* presents a number of avenues for supporting Commonwealth–state collaboration through commissioning and flexible funding. This agreement could offer the necessary authorisation to develop a co-commissioning approach, if both the Commonwealth and the State of Victoria entered into bilateral agreement to deliver this reform.

At a recent meeting of the National Federation Reform Council, comprising the Prime Minister, premiers, chief ministers, treasurers and President of the Australian Local Government Association, the council agreed that all jurisdictions will 'work together on shared funding arrangements for services … based on key inputs such as: final reports from the Productivity Commission, Victorian Royal Commission, the National Mental Health Commission's Vision 2030, and the National Suicide Prevention Advisor'.[213] This work is to be taken forward by the new Select Committee on Mental Health and Suicide Prevention, but as stated earlier, the final report from this inquiry is not expected until late 2021.[214]

As touched on throughout this chapter, there are challenges and uncertainties that still need to be overcome to deliver collaborative reform. Selected national policies and intergovernmental agreements that could help drive reforms are yet to be successfully implemented or are not finalised. *Vision 2030: Blueprint for Mental Health and Suicide Prevention* and its Implementation Roadmap, which are being developed by the National Mental Health Commission, may hold some promise. However, at the time of finalising this report, these documents were yet to be released.

The Productivity Commission's *Mental Health Inquiry Report* recommends reforms to strengthen cooperation between Primary Health Networks and health services by requiring comprehensive joint regional planning and commissioning of mental health care, suicide prevention and psychosocial supports.[215] Where cooperative efforts are unsuccessful, the Productivity Commission recommends that states establish new Regional Commissioning Authorities, to be given responsibility for commissioning all mental health care, suicide prevention and psychosocial supports.[216] At the time of finalising this report, the Commonwealth is yet to release its position on these recommendations. The Commonwealth is likely to be guided by the Select Committee on Mental Health and Suicide Prevention, which is only expected to release its report 18 months after the Productivity Commission first handed its report to the Commonwealth.[217]

The Commission recommends that the Victorian Government and Regional Boards work with the Commonwealth and Primary Health Networks to establish a co-commissioning approach designed to improve integration between Commonwealth and state-funded services that builds on joint Commonwealth–state planning approaches.

In doing so, it will be important that the Victorian Government seeks to:

- align co-commissioning reforms with directions outlined in national policies and reviews, including the National Mental Health Commission's *Vision 2030: Blueprint for Mental Health and Suicide Prevention*
- support co-commissioning reform by entering into bilateral agreement with the Commonwealth and Primary Health Networks, taking advantage of commitments in the *Addendum to the National Health Reform Agreement 2020–2025*.

The Victorian Government should also align reforms to the Commonwealth's position on the Productivity Commission's *Mental Health Inquiry Report* and any future opportunities arising from the *National Mental Health and Suicide Prevention Agreement.* However, given their likely delays, the Victorian Government should not wait for these to be finalised.

29.4.6 Accountability of partnerships

The Victorian Government primarily focuses on managing the performance of individual organisations and how they each independently care for the needs of individuals. Under the new system, both the Victorian Government and Regional Boards will share accountability for the performance of organisations, with a sharp focus on improving outcomes for—and the experiences of—individuals.

For this to occur, both the Victorian Government and Regional Boards will need to shift their focus to ensure the interventions and behaviours they use to manage performance do not present a barrier to collaboration. The effectiveness of integrated approaches depends on several things, one of which is '[t]he extent to which the incentives and governance arrangements under which they operate are aligned to support shared goals and effective collaboration.'[218]

Mr Symonds suggested:

> there are a number of commissioners—Commonwealth, state and local—who manage interdependent systems to deliver mental health care. By introducing regional operational commissioning arrangements, these commissioners can collaborate to develop shared needs assessments, aligned outcomes, and co-commissioning approaches.[219]

Streamlining performance accountability measures across providers is an important initial step in better integrating services. As set out in Chapter 28: *Commissioning for responsive services*, the Commission has recommended a consistent approach to performance monitoring and accountability for all Victorian-funded provider types. This includes a universal focus on the outcomes and experiences that are important to consumers, families, carers and supporters, as described in Chapter 3: *A system focused on outcomes*.

The Commission further recommends that the new performance monitoring and accountability framework for mental health and wellbeing services includes a dedicated section on monitoring provider partnerships, as recommended in Chapter 28: *Commissioning for responsive services*. It will centre on a common set of indicators that draws on both national and state performance frameworks, with an emphasis on outcomes.

Collaboration involves interdependence, dealing constructively with differences and sharing responsibility for decisions. Collaborative relationships are also fragile, particularly when they are new. This is often a result of the autonomy and competing priorities that each participant brings to the relationship.[220] The Victorian Government will need to carefully manage both individual and collective contractual agreements in such a way as to lessen the risk of competing accountabilities and to ensure performance management processes are streamlined.

This is particularly important for emerging partnerships between Victorian- and Commonwealth-funded agencies. Should Victoria and the Commonwealth reach agreement on co-commissioning reform between Regional Boards and Primary Health Networks, there would need to be an approach developed for monitoring these partnerships. The Productivity Commission has suggested that such an oversight function should have a focus on driving cooperation.[221]

The Commission has recommended that performance monitoring and accountability arrangements for Victorian mental health services largely align with arrangements at the national level by seeking to align the performance domains of both Victorian and national performance monitoring and accountability frameworks. Aligning domains at the state and national levels is important for monitoring joint Commonwealth–state planning efforts, and ultimately in monitoring co-commissioning between state and Commonwealth providers.

If a performance problem is identified with one or more provider in a partnership, the Victorian Government or Regional Board should not approach the provider but should instead approach the entire partnership to fix it. This will ensure each partner organisation is mutually accountable and works as a collective to support the other partners.

A similar approach is taken by the Canterbury District Health Board in New Zealand. Ms Carolyn Gullery, the Health Board's Executive Director of Planning, Funding and Decision Support, described how it encourages multiple providers to work together through an:

> alliance framework that basically indicates a model of collective collaboration—everybody wins or everybody loses. Basically, if you are part of our alliance, then the Canterbury [District Health Board] will work with you to make sure that you are sustainable and successful.[222]

The ability to hold a provider or provider partnership accountable for consumer outcomes is a critical factor determining the success of an integrated commissioning approach. Dr Alice Andrews, Director of Education for the Value Institute for Health and Care and Assistant Professor of the Department of Medical Education, Dell Medical School at the University of Texas, told the Commission:

> 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 …[223]

Another important element of performance monitoring and accountability is encouraging continuous improvement. This requires fostering a culture of openness, a willingness to identify shortcomings and a commitment to reform. As Dr Margaret Grigg, CEO of Forensicare, reflected 'there is no single agent that can be responsible for all the mental health outcomes of a community'.[224] Providers will need to work with each other, and also learn from each other, by sharing both successes and challenges.

Associate Professor Stafrace believes the role of leadership is vital:

> There is an argument that the mental health system operates with historical and ingrained hierarchies that limit capacity for collaborative, system wide reform … Collaborative, engaging and innovative leadership is crucial to promote cultures of continuous quality and safety improvements and to create positive and engaging workplace cultures.[225]

1 John Wanna, Chapter 1: Collaborative Government: Meanings, Dimensions, Drivers and Outcomes, in *Collaborative Governance: A New Era of Public Policy in Australia?* (Canberra: ANU E Press, 2008), pp. 3–12 (p. 9).

2 *Witness Statement of 'Nina Edwards' (pseudonym)*, 26 July 2019, para. 29.

3 Anonymous 599, *Submission to the RCVMHS: SUB.0002.0001.0037*, 2019, p. 5.

4 RCVMHS, *Shepparton Community Consultation—May 2019*.

5 *Witness Statement of 'Michael Silva' (pseudonym)*, 22 June 2020, paras. 31–32.

6 *Witness Statement of Professor Karen Fisher*, 5 May 2020, para. 20.

7 *Personal Story of 'Romana' (pseudonym), Collected by the Mental Health Legal Centre*, 2020.

8 *Personal Story Number 7, Collected by Victoria Legal Aid*, 2020.

9 Royal Commission into National Natural Disaster Arrangements, *Royal Commission into National Natural Disaster Arrangements Report*, 2020, p. 94.

10 Royal Commission into National Natural Disaster Arrangements, *Royal Commission into National Natural Disaster Arrangements Report*, p. 349.

11 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*, 2020.

12 Royal Commission into National Natural Disaster Arrangements, *Royal Commission into National Natural Disaster Arrangements Report*, p. 89.

13 Stephen Duckett, 'Governance Lessons from COVID-19', *Australian Health Review*, 44.3 (2020), 335 (p. 335); Cheryl Saunders, *A New Federalism? The Role and Future of the National Cabinet*, 2020, pp. 4–5.

14 *Witness Statement of Frank Quinlan*, 25 May 2020, para. 16.

15 Jarrod Ball, *Australia's Federation: Post-Pandemic Playbook*, 2020, pp. 7–10.

16 Productivity Commission, *Mental Health Inquiry Report*, *Volume 2*, 2020, p. 166.

17 Interview by The Project, Coronavirus Victoria: Melbourne Roadmap Out of Stage Four Lockdown Detailed by Daniel Andrews, 6 September 2020, <www.news.com.au/world/coronavirus/australia/coronavirus-australia-live-victoria-qld-nsw-covid19/live-coverage/13df46f1482932899e9bb0010316c0d3>, [accessed 24 December 2020].

18 The Honourable Scott Morrison MP, Prime Minister of Australia, Speech—Parkville, 16 November 2020, <www.pm.gov.au/media/speech-parkville>, [accessed 18 November 2020].

19 Mental Health Council of Australia, *Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia,* 2005, pp. 169–171 and 557; National Mental Health Commission, *Contributing Lives, Thriving Communities: Report of the National Review of Mental Health Programmes and Services, Volume 3: What People Told Us—Analysis of Submissions to the Review*, 2014, pp. 39–40, 52, 75–78, 89 and 96–103; Department of Health and Human Services, *Victoria's 10–Year Mental Health Plan*, 2015, p. 14; National Mental Health Commissioner, *Vision 2030: Blueprint for Mental Health and Suicide Prevention*, 2020, p. 9; Victorian Auditor-General's Office, *Child and Youth Mental Health*, 2019, p. 24; Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 661.

20 Parliamentary Education Office, Australian System of Government, <peo.gov.au/understand-our-parliament/how-parliament-works/system-of-government/australian-system-of-government/>, [accessed 26 November 2020].

21 Parliamentary Education Office, The Roles and Responsibilities of the Three Levels of Government, <peo.gov.au/understand-our-parliament/how-parliament-works/three-levels-of-government/the-roles-and-responsibilities-of-the-three-levels-of-government/>, [accessed 26 November 2020].

22 *Witness Statement of Dr Gerard Naughtin*, 24 July 2019, para. 15.

23 Victorian Government, *Submission to the RCVMHS: SUB.5000.0001.0001*, 2019, p. 5.

24 *Witness Statement of David Martine PSM*, 28 June 2019, para. 36.

25 National Mental Health Commission, *Contributing Lives, Thriving Communities: Report of the National Review of Mental Health Programmes and Services, Volume 1: Strategic Directions Practical Solutions 1–2 Years*, 2014, p. 56.

26 *Witness Statement of Dr Peggy Brown AO*, 22 July 2019, para. 12.

27 *Witness Statement of David Martine PSM*, para. 44.

28 *Witness Statement of Angus Clelland*, 5 June 2020, para. 138.

29 *Witness Statement of Associate Professor Ruth Vine*, 27 June 2019, para. 37; *Witness Statement of Douglas Holmes*, 4 May 2020, para. 64; *Joint Witness Statement of Tass Mousaferiadis and Kent Burgess*, 20 May 2020, para. 68; *Witness Statement of Dr Sarah Pollock*, 14 May 2020, paras. 83 and 95; *Witness Statement of Catherine Humphrey*, 30 April 2020, paras. 49–50.

30 *Witness Statement of Professor Graham Meadows*, 26 June 2020, paras. 24–26; Graham N Meadows and others, 'Better Access to Mental Health Care and the Failure of the Medicare Principle of Universality', *Medical Journal of Australia*, 202.4 (2015), 190–194 (pp. 193–194).

31 Victorian Auditor-General's Office, *Child and Youth Mental Health*, p. 42; Victorian Auditor-General's Office, *Access to Mental Health Services*, 2019, pp. 27–28.

32 *Witness Statement of Kym Peake*, 24 July 2019, para. 66.

33 *Witness Statement of Associate Professor Ruth Vine*, 2019, para. 22.

34 *Witness Statement of Kym Peake*, 2019, para. 61.

35 *Witness Statement of Associate Professor Simon Stafrace*, 7 July 2019, para. 96(d).

36 *Witness Statement of Dr Paul Denborough*, 9 July 2019, para. 68.3.

37 Eastern Health, *Submission to the RCVMHS: SUB.0002.0028.0585*, 2019, p. 14.

38 Barwon Health, *Submission to the RCVMHS: SUB.0002.0029.0222*, 2019, p. 3.

39 Dr Anne-marie Boxall, *The Changing Demands on Australia's Health Policymakers: A Case Study on Intergovernmental Relations in Health over 40 Years*, 2016, p. 1; Commonwealth Government, *Re: Think: Tax Discussion Paper: Better Tax System, Better Australia*, 2015, pp. 16 and 153.

40 Ben Rimmer, Cheryl Saunders and Michael Crommelin, *Working Better with Other Jurisdictions*, 2019, p. 12.

41 Rimmer, Saunders and Crommelin, pp. 12 and 24.

42 *Witness Statement of Bill Buckingham*, 7 July 2020, para. 21.

43 *Witness Statement of Bill Buckingham*, para. 22.

44 *Witness Statement of Tim Marney*, 11 June 2020, para. 63.

45 Department of the Prime Minister and Cabinet, *Reform of the Federation Discussion Paper*, 2015, p. 33.

46 Valerie Braithwaite, 'Beyond the Bubble That Is Robodebt: How Governments That Lose Integrity Threaten Democracy', *Australian Journal of Social Issues*, 55.3 (2020), 242–259 (p. 256); Commonwealth Ombudsman, *Centrelink's Automated Debt Raising and Recovery System: A Report About the Department of Human Services' Online Compliance Intervention System for Debt Raising and Recovery, Report No. 02*, 2017, p. 3; David Tune AO PSM, *Review of the National Disability Insurance Scheme Act 2013: Removing Red Tape and Implementing the NDIS Participant Service Guarantee*, 2019, pp. 28 and 37; Board of Inquiry into the COVID-19 Hotel Quarantine Program, *COVID-19 Hotel Quarantine Inquiry: Interim Report and Recommendations*, 2020, p. 29.

47 *Witness Statement of Kym Peake*, 4 October 2020, para. 71.

48 Victorian Government, p. 23; *Witness Statement of Associate Professor Simon Stafrace*, 2019, para. 85(b).

49 Professor Patrick McGorry, Mental Illness Is More Ubiquitous Than Cancer. How Can We Help the "Missing Middle"?, *The Guardian*, 2019, <www.theguardian.com/commentisfree/2019/apr/26/mental-illness-is-more-ubiquitous-than-cancer-how-can-we-help-the-missing-middle>, [accessed 20 August 2019].

50 *Witness Statement of Professor Patrick McGorry AO*, 2 July 2019, para. 49.

51 *Witness Statement of Kym Peake*, 2019, para. 65.

52 Productivity Commission, *Mental Health Inquiry Report: Supporting Material (Appendices B–K)*, 2020, p. 122.

53 Productivity Commission, *Mental Health Inquiry Report: Supporting Material (Appendices B–K)*, p. 127.

54 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, 2020, pp. 1143–1145.

55 Primary Health Networks Cooperative, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, 2020, p. 8.

56 The Honourable Kevin Rudd AC, the then Prime Minister of Australia, Better Health, Better Hospitals: The National Health and Hospitals Network: Speech to the National Press Club, 3 March 2010, <parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpressrel%2FG22W6%22>, [accessed 13 November 2020].

57 Productivity Commission, *Mental Health Inquiry Report: Supporting Material (Appendices B–K)*, p. 124.

58 PHN Eastern Melbourne, Mental Health, AOD and Suicide Prevention, <www.emphn.org.au/what-we-do/mental-health>, [accessed 24 October 2019].

59 EY, *Evaluation of the Primary Health Networks Program Final Report*, 2018, p. 2.

60 *Witness Statement of Dr Elizabeth Deveny*, 8 June 2020, para. 15.

61 Stephen Duckett and others, *Leading Change in Primary Care: Boards of Primary Health Networks Can Help Improve the Australian Health Care System*, 2015, p. 17.

62 Duckett and others, p. 18.

63 *Witness Statement of Matt Jones*, 29 July 2020, para. 37.

64 *Witness Statement of Richard (Rick) Corney*, 3 May 2020, paras. 19–23.

65 Royal Commission into National Natural Disaster Arrangements, *Royal Commission into National Natural Disaster Arrangements Report*, p. 341.

66 EY, pp. 2–3 and 5; PHN Advisory Panel on Mental Health, *Report of the PHN Advisory Panel on Mental Health*, 2018, pp. 4 and 6–11.

67 Royal Commission into National Natural Disaster Arrangements, *Royal Commission into National Natural Disaster Arrangements Report*, p. 341.

68 PHN Advisory Panel on Mental Health, p. 13; EY, p. 5; Productivity Commission, *Mental Health Inquiry Report: Supporting Material (Appendices B–K)*, pp. 116–117.

69 Competitive tendering is the process of selecting a preferred supplier from a range of potential contractors by seeking offers (tenders) and evaluating these on the basis of one or more selection criteria. Industry Commission, *Competitive Tendering and Contracting by Public Sector Agencies Report No. 48*, 1996, p. xix.

70 *Witness Statement of Professor Patrick McGorry AO*, 22 June 2020, para. 49.

71 Monash Health, *Submission to the RCVMHS: SUB.7000.0003.0001*, 2019, p. 6.

72 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1160.

73 Productivity Commission, *Integrated Care: Supporting Paper No.5, 5 Year Productivity Review*, 2017, p. 32.

74 The Boston Consulting Group, *Improving Mental Health Outcomes in Victoria: The Next Wave of Reform*, 2006, p. 18.

75 David Castle and others, *Submission to the RCVMHS: SUB.0002.0002.0118*, 2019, p. 2.

76 *Witness Statement of Dr Caroline Johnson*, 30 June 2019, para. 76; SANE Australia, *Submission to the RCVMHS: SUB.0002.0030.0197*, 2019, p. 19.

77 South West Healthcare, *Submission to the RCVMHS: SUB.0002.0029.0138*, 2019, p. 48.

78 Dr Cameron Martin, *Submission to the RCVMHS: SUB.0002.0028.0508*, 2019, p. 1.

79 Dr Danny Sullivan and others, *Senior Practitioner—Disability: Building Capacity to Assist Adult Dual Disability Clients Access Effective Mental Health Services*, 2013, pp. 6–7; Erin Louise Whittle and others, 'Barriers and Enablers to Accessing Mental Health Services for People With Intellectual Disability: A Scoping Review', *Journal of Mental Health Research in Intellectual Disabilities*, 11.1 (2018), 69–102 (pp. 86–87); Victorian Auditor-General's Office, *Child and Youth Mental Health*, p. 102.

80 Australian Federation of Disability Organisations, Disability Resource Centre, Women with Disabilities Victoria, Women's Mental Health Network Victoria and Disability Justice Australia, *Submission to the RCVMHS: SUB.0002.0028.0223*, 2019, pp. 35–36.

81 Anonymous, *Brief Comments to the RCVMHS: SUB.0001.0003.0007*, 2019, p. 4.

82 Office of the Public Advocate, *Submission to the RCVMHS: SUB.0002.0029.0448 (Submission 1)*, 2019, p. 48.

83 National Legal Aid, Tasmania, *Putting People First: Removing Barriers for People with Disability to Access NDIS Supports. Submission to the Review of the NDIS Act and the New NDIS Participant Service Guarantee*, 2019, pp. 9, 14 and 37; Victorian Ombudsman, *Investigation into the Imprisonment of a Woman Found Unfit to Stand Trial*, 2018, pp. 15, 16, 28, 33 and 42.

84 Bendigo Health, *Submission to the RCVMHS: SUB.0002.0030.0051*, 2019, p. 11.

85 Barwon Health, p. 3.

86 The Boston Consulting Group, p. 18.

87 *Witness Statement of Associate Professor Ruth Vine*, 2019, para. 62.2.

88 *Witness Statement of Kym Peake*, 2020, para. 325(c). Productivity Commission, *Efficiency in Health Research Paper*, 2015, p. 34.

89 Department of the Prime Minister and Cabinet, *Reform of the Federation White Paper: Roles and Responsibilities in Health—Issues Paper 3*, 2014, p. 17.

90 *Witness Statement of Kym Peake*, 2020, para. 55(b).

91 Stephen Duckett and Hal Swerissen, *Building Better Foundations for Primary Care*, 2017, p. 8.

92 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1096.

93 John Menadue, Fairness, Opportunity and Security Policy Series Edited by Michael Keating and John Menadue, <johnmenadue.com/john-menadue-role-of-government-the-importance-of-values/>, [accessed 11 December 2020].

94 Ann Marie Thomson and James L. Perry, 'Collaboration Processes: Inside the Black Box', *Public Administration Review*, 66.s1 (2006), 20–32 (p. 28).

95 Dr Peter Shergold, Chapter 2: Governing Through Collaboration, in *Collaborative Governance: A New Era of Public Policy in Australia?* (Canberra: ANU E Press, 2008), pp. 13–22 (p. 20).

96 Karen Newbigging and Julie Ridley, 'Epistemic Struggles: The Role of Advocacy in Promoting Epistemic Justice and Rights in Mental Health', *Social Science and Medicine*, 219 (2018), 36–44 (p. 37).

97 Newbigging and Ridley, p. 37.

98 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. 32.

99 Monash Sustainable Development Institute, Monash University, *Correspondence to the RCVMHS: CSP.0001.0103.0001, A Primer Paper: Forces Shaping Victoria's Mental Health System*, 2020, p. 21.

100 Shergold, p. 21.

101 Council of Australian Governments, About COAG, <www.coag.gov.au/about-coag>, [accessed 19 October 2020].

102 The Honourable Scott Morrison MP, Prime Minister of Australia, *Transcript of Press Conference: Australian Parliament House, ACT*, 29 May 2020, p. 3.

103 Peter Conran AM, *Review of COAG Councils and Ministerial Forums*, 2020, p. 19.

104 The Honourable Scott Morrison MP, Prime Minister of Australia, Media Statement: Update on Coronavirus Measures, 12 June 2020, <www.pm.gov.au/media/update-coronavirus-measures-12june20>, [accessed 28 October 2020].

105 The Honourable Scott Morrison MP, Prime Minister of Australia, Media Statement: National Cabinet, 23 October 2020, <www.pm.gov.au/media/national-cabinet-1>, [accessed 28 October 2020].

106 The Honourable Scott Morrison MP, Prime Minister of Australia, Speech—Parkville; Conran AM, p. 19.

107 Royal Commission into National Natural Disaster Arrangements, *Transcript of Proceedings, Day 29*, 5 August 2020, p. 2595.

108 The Honourable Scott Morrison MP, Prime Minister of Australia, Speech—Parkville.

109 Conran AM, p. 16.

110 Janina Boughey, 'Executive Power in Emergencies: Where Is the Accountability?', *Alternative Law Journal*, 45.3 (2020), 168–174 (pp. 169–170 and 174).

111 Conran AM, p. 20.

112 Conran AM, p. 18.

113 National Disability Insurance Scheme, NDIA Working with State and Territory Governments, <www.ndis.gov.au/understanding/ndis-and-other-government-services/ndia-working-state-and-territory-governments>, [accessed 30 October 2020].

114 National Disability Insurance Scheme.

115 National Disability Insurance Scheme.

116 Conran AM, p. 18.

117 Conran AM, p. 23.

118 Royal Commission into Aged Care and Quality and Safety, *Interim Report: Neglect, Volume 1*, 2019, p. 190.

119 The Honourable Scott Morrison MP, Prime Minister of Australia, Speech—Parkville.

120 Productivity Commission, *Mental Health Inquiry Report, Volume 1*, 2020, p. 2.

121 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, pp. 1111–1112.

122 The Honourable Scott Morrison MP, Prime Minister of Australia, Media Statement: National Cabinet.

123 The Honourable Scott Morrison MP, Prime Minister of Australia, Media Statement: National Cabinet.

124 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 826.

125 Department of the Prime Minister and Cabinet, *Reform of the Federation White Paper: Roles and Responsibilities in Health—Issues Paper 3*, pp. 40–41.

126 Productivity Commission, *Mental Health Inquiry Report: Supporting Material (Appendices B–K)*, pp. 122–123.

127 *Witness Statement of Bill Buckingham*, para. 40.

128 *Witness Statement of Kym Peake*, 2020, para. 55.

129 *Witness Statement of Georgie Harman*, 1 July 2019, para. 108.

130 *Witness Statement of Georgie Harman*, 2019, para. 108.

131 *Witness Statement of Associate Professor Ruth Vine*, 2019, para. 69.

132 South West Healthcare, p. 28.

133 National Mental Health Commission, *Contributing Lives, Thriving Communities: Report of the National Review of Mental Health Programmes and Services, Volume 1: Strategic Directions Practical Solutions 1–2 Years*, p. 33.

134 The Senate, Community Affairs References Committee, Parliament of Australia, *Accessibility and Quality of Mental Health Services in Rural and Remote Australia*, 2018, p. 129.

135 The Senate, Community Affairs References Committee, Parliament of Australia, pp. 131–132.

136 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1133.

137 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, pp. 1208 and 1214.

138 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1204.

139 Maddy Thorpe and Sharon Sweeney, *Call for the Establishment of a Primary Health Care National Minimum Data Set, Issues Brief No. 29*, 2019, p. 5.

140 Council of Australian Governments, Schedule J—Addendum to the National Health Reform Agreement: Revised Public Hospital Funding and Health Reform Arrangements, <www.federalfinancialrelations.gov.au/content/npa/health/other/NHRA_2020-25_Addendum.pdf>, [accessed 10 July 2020].

141 Council of Australian Governments, Schedule J—Addendum to the National Health Reform Agreement: Revised Public Hospital Funding and Health Reform Arrangements.

142 *Witness Statement of Mary-Ann O'Loughlin AM*, 28 July 2020, para. 56(b).

143 Mental Health Australia, *Submission to the Productivity Commission Inquiry into Mental Health: Intergovernmental Arrangements*, 2019, p. 7.

144 *Witness Statement of Georgie Harman*, 2019, para. 35.

145 National Mental Health Commission, *Fifth National Mental Health and Suicide Prevention Plan 2018 Progress Report*, 2018, pp. 15–20.

146 Productivity Commission, *Mental Health Inquiry Report: Supporting Material (Appendices B–K)*, p. 131.

147 Productivity Commission, *Mental Health Inquiry Report: Supporting Material (Appendices B–K)*, p. 132.

148 Orygen, The National Centre of Excellence in Youth Mental Health, *Response to the Draft Fifth National Mental Health Plan*, 2016, p. 4.

149 *Witness Statement of Professor Alan Rosen AO*, 23 July 2020, para. 290.

150 RCVMHS, *Governance and Commissioning Roundtable: Record of Proceedings*, 2020.

151 Commonwealth Government, *Terms of Reference—National Suicide Prevention Adviser*, 2019, p. 1.

152 National Suicide Prevention Taskforce, *Interim Advice Report: Towards a National Whole-of-Government Approach to Suicide Prevention in Australia*, 2020.

153 *Witness Statement of Christine Morgan*, 11 May 2020, para. 24.

154 House of Representatives, Parliament of Australia, *Votes and Proceedings*, 10 December 2020, pp. 1547–1549.

155 Council of Australian Governments, Schedule J—Addendum to the National Health Reform Agreement: Revised Public Hospital Funding and Health Reform Arrangements.

156 Commonwealth Department of Health, *Australian Government Response to Contributing Lives, Thriving Communities—Review of Mental Health Programmes and Services*, 2015, p. 17.

157 Council of Australian Governments, Schedule J—Addendum to the National Health Reform Agreement: Revised Public Hospital Funding and Health Reform Arrangements.

158 Council of Australian Governments, Schedule J—Addendum to the National Health Reform Agreement: Revised Public Hospital Funding and Health Reform Arrangements.

159 Council of Australian Governments, Schedule J—Addendum to the National Health Reform Agreement: Revised Public Hospital Funding and Health Reform Arrangements.

160 *Witness Statement of Catherine White*, 2 July 2020, para. 39.

161 *Personal Story Number 9, Collected by Victoria Legal Aid*, 2020.

162 Richard Q Lewis and others, *Where Next for Integrated Care Organisations in the English NHS?*, 2010, pp. 11–12.

163 Sara Shaw, Rebecca Rosen and Benedict Rumbold, *What Is Integrated Care?*, 2011, p. 15.

164 Shaw, Rosen and Rumbold, pp. 7–8.

165 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 661.

166 *Witness Statement of Amelia Callaghan*, 5 May 2020, para. 41.

167 *Witness Statement of Nicole Bartholomeusz*, 9 June 2020, para. 31.

168 *Witness Statement of Terry Symonds*, 2 November 2020, paras. 67–67(a).

169 *Witness Statement of Sue Williams*, 7 July 2020, para. 37.

170 *Joint Witness Statement of Tass Mousaferiadis and Kent Burgess*, para. 84.

171 *Witness Statement of Frank Quinlan*, para. 17.

172 *Witness Statement of Dr Sarah Pollock*, para. 102.

173 Productivity Commission, *Integrated Care: Supporting Paper No.5, 5 Year Productivity Review*, p. 31.

174 Productivity Commission, *Integrated Care: Supporting Paper No.5, 5 Year Productivity Review*, p. 31.

175 Productivity Commission, *Integrated Care: Supporting Paper No.5, 5 Year Productivity Review*, p. 9.

176 *Witness Statement of Associate Professor Jo-An Atkinson*, 29 April 2020, para. 28.

177 *Witness Statement of Mary-Ann O'Loughlin AM*, para. 74(a).

178 *Witness Statement of Associate Professor Simon Stafrace*, 14 August 2020, para. 67(d).

179 Jo-An Atkinson and others, 'Bringing New Tools, a Regional Focus, Resource-Sensitivity, Local Engagement and Necessary Discipline to Mental Health Policy and Planning', *BMC Public Health*, 20:814 (2020), 1–10 (p. 1).

180 *Witness Statement of Mary-Ann O'Loughlin AM*, para. 58.

181 National Mental Health Commission, *Contributing Lives, Thriving Communities: Report of the National Review of Mental Health Programmes and Services, Volume 1: Strategic Directions Practical Solutions 1–2 Years*, p. 43.

182 J Campion, *Public Mental Health: Evidence, Practice and Commissioning*, 2019, p. 53.

183 *Witness Statement of Professor Harriet Hiscock*, 1 May 2020, para. 37.

184 *Witness Statement of Professor Lisa Brophy*, 29 April 2020, para. 67.

185 Carol Harvey, Lisa Brophy, Samuel Parsons and others, 'People Living with Psychosocial Disability: Rehabilitation and Recovery-Informed Service Provision within the Second Australian National Survey of Psychosis', *ANZJP*, 2015, p. 535.

186 Harvey, Brophy, Parsons and others, pp. 544–545.

187 Carol Harvey, Lisa Brophy, Justine Fletcher 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, p. 40.

188 Chris Ham and Nicola Walsh, *Making Integrated Care Happen at Scale and Pace*, 2013, p. 5.

189 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 163; Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 529.

190 Victorian Government, p. 24.

191 WentWest, *Submission to the Productivity Commission Inquiry into Mental Health*, 2019, p. 28.

192 *Witness Statement of Sue Williams*, para. 66.

193 *Witness Statement of Professor Ian Hickie AM*, 11 August 2020, para. 65.

194 North Coast Collective, For Better Lives, <nccforbetterlives.com.au/>, [accessed 24 July 2020].

195 The Health Alliance, Metro North Hospital and Health Service and Brisbane North PHN, Our Work, <www.healthalliance.org.au/page/our-work>, [accessed 10 November 2020]; Metro North HHS, Brisbane North PHN, Metro South HHS and Brisbane South PHN, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, 2020, p. 6.

196 Primary Health Networks Cooperative, p. 21.

197 Primary Health Networks Cooperative, p. 15.

198 Ham and Walsh, p. 5.

199 *Witness Statement of Terry Symonds*, para. 140.

200 Campion, pp. 53–57.

201 Rachael Addicott, *Commissioning and Contracting for Integrated Care*, 2014, pp. 4–5 and 47.

202 *Witness Statement of Terry Symonds*, para. 228.

203 *Witness Statement of Lynda Watts*, 1 July 2020, para. 55.

204 Addicott, p. 28.

205 *Personal Story of 'Claire' (pseudonym), Collected by the Mental Health Legal Centre*, 2020.

206 *Witness Statement of Terry Symonds*, para. 213.

207 *Witness Statement of Professor Ian Hickie AM*, para. 62.

208 *Witness Statement of Amelia Callaghan*, para. 62.

209 Commonwealth Department of Health, *The Fifth National Mental Health and Suicide Prevention Plan*, 2017, p. 21.

210 Productivity Commission, *Mental Health Inquiry Report: Supporting Material (Appendices B–K)*, p. 125.

211 Productivity Commission, *Mental Health Inquiry Report: Supporting Material (Appendices B–K)*, pp. 129–132.

212 RCVMHS, *Governance and Commissioning Roundtable: Record of Proceedings*.

213 The Honourable Scott Morrison MP, Prime Minister of Australia, Media Statement: National Federation Reform Council Statement, 11 December 2020, <www.pm.gov.au/media/national-federation-reform-council-statement>, [accessed 14 December 2020].

214 House of Representatives, Parliament of Australia, pp. 1547–1549.

215 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1142.

216 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1149.

217 House of Representatives, Parliament of Australia, p. 1548.

218 Lewis and others, p. 15.

219 *Witness Statement of Terry Symonds*, para. 63.

220 Thomson and Perry, pp. 23 and 29.

221 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1139.

222 *Witness Statement of Carolyn Gullery*, 1 September 2020, para. 10.

223 *Witness Statement of Alice Andrews*, 7 July 2020, para. 10(e).

224 *Witness Statement of Dr Margaret Grigg*, 28 May 2020, para. 48.

225 *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 64.

Chapter 30

Overseeing the safety and quality of services

The Commission recognises the strength of people living with mental illness and those experiencing psychological distress, their families and carers, 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 may contain information that could be distressing. You may want to consider how and when you read this chapter.

If you are upset by any content in this chapter, or if you or a loved one require 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**.
- **For situations that are harmful or life-threatening contact emergency services immediately on Triple Zero (000).**

Recommendation 52:

Improving the quality and safety of mental health and wellbeing services

The Royal Commission recommends that the Victorian Government:

1. by no later than the end of 2021, establish a Mental Health Improvement Unit within Safer Care Victoria to provide a multidisciplinary approach to improving the quality and safety of mental health and wellbeing services.
2. enable the Mental Health Improvement Unit to work with mental health and wellbeing services to:

    a. provide system leadership on quality and safety improvement;

    b. provide professional, clinical and practice leadership for mental health and wellbeing services;

    c. promote awareness and understanding of high-quality service delivery across the mental health and wellbeing system;

    d. co-design quality and safety improvement programs with people with lived experience; and

    e. issue practice guidelines and frameworks.

Recommendation 53:

Strong oversight of the quality and safety of mental health and wellbeing services

The Royal Commission recommends that the Victorian Government:

1. enable the Mental Health and Wellbeing Commission (refer to recommendation 44) to use its full suite of complaints and oversight functions (refer to recommendation 44(3)) to monitor, inquire into and report on system-wide quality and safety.
2. facilitate the Mental Health and Wellbeing Commission to monitor, as matters of priority, the:

    a. use of seclusion and restraint;

    b. use of compulsory treatment;

    c. incidence of gender-based violence in mental health facilities; and

    d. incidence of suicides in healthcare settings.

3. enable the Mental Health and Wellbeing Commission to:

    a. work with the Department of Health and relevant regulators to build a comprehensive understanding of quality and safety issues in mental health and wellbeing services;

    b. ensure on an ongoing basis that complaints-handling and investigation approaches:

    - meet the needs of consumers, families, carers, and supporters and
    - support services to resolve concerns;

    c. advise government on issues of concern and areas for improvement; and

    d. record, report and publish service-level complaints and other relevant data and information.

30.1 Independent oversight, quality improvement and the delivery of high-quality and safe mental health and wellbeing services

High-quality and safe treatment, care and support are central to the Commission's vision for Victoria's mental health and wellbeing services. Consumers, families, carers and supporters can expect a mental health and wellbeing system in which the inherent dignity of people living with mental illness is respected and that the treatment, care and support is holistic, comprehensive and effective.[1]

To achieve this, the mental health and wellbeing system needs a clear vision for high-quality and safe treatment, care and support. The system also needs purposeful roles and functions within a quality and safety architecture to enable this vision. Within this architecture a dedicated approach to quality improvement will be important to achieve higher quality treatment, care and support and better outcomes from mental health service delivery.[2]

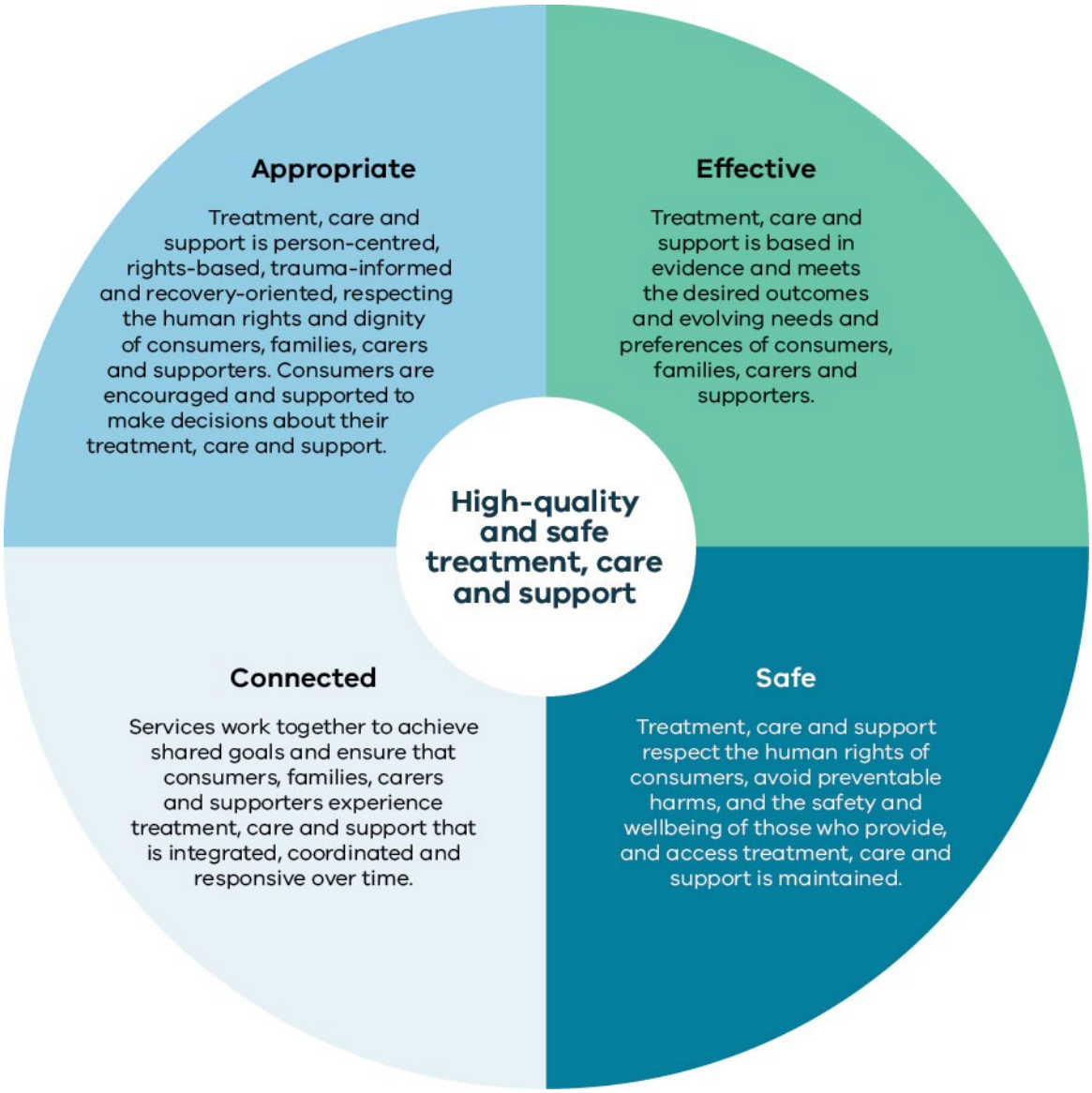
Effective oversight of the quality and safety of mental health and wellbeing treatment, care and support is also essential, particularly in a system that has 'failed to aid those who are most in need of high-quality treatment, care and support'.[3] The Mental Health Legal Centre highlighted the importance of overseeing the quality of mental health service delivery:

> Appropriate oversight of mental health is essential to ensure person centred care, avoid preventable harm, appropriately respond to individual episodes of poor care, drive system improvement and inform long term planning.[4]

30.1.1 The vision for high-quality and safe treatment, care and support

To achieve consistently high-quality treatment, care and support, the mental health and wellbeing system needs a shared understanding of what this means in practice, created through a common objective and clear definition. The Commission's understanding of high-quality and safe treatment, care and support in mental health and wellbeing is outlined in Figure 30.1. In summary, though, it is appropriate, effective, connected and safe.

Figure 30.1: Domains of high-quality and safe mental health and wellbeing treatment, care and support



Victoria's future mental health and wellbeing system will be underpinned by a strong human rights framework where obligations under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) and the United Nations *Convention on the Rights of Persons with Disabilities* will provide a foundation for mental health legislation, policy and service delivery. Legislation will safeguard the rights and dignity of consumers and will promote recovery-oriented practice where consumers are supported to build and maintain a life they define and determine themselves, regardless of whether symptoms of mental illness are present.[5]

These human rights obligations will also provide a foundation across the domains of high-quality treatment, care and support outlined above. For example, to provide appropriate care that responds to the needs of the individual, it is vital to place the consumer at the centre of decision making.

The Commission's independent oversight and quality improvement arrangements are designed to be informed by the human rights obligations of mental health and wellbeing service providers. They are not intended to replace other mechanisms for responding to failures to meet human rights obligations, such as the functions of the Victorian Ombudsman or the Victorian Equal Opportunity and Human Rights Commission.

30.1.2 New arrangements for independent oversight and quality improvement

To achieve the Commission's vision, Victoria's mental health and wellbeing system requires a quality and safety architecture that enables and supports the delivery of high-quality and safe treatment, care and support.

Such an architecture creates quality and safety roles and responsibilities throughout the system. In the future system, everyone from frontline workers to senior leaders within an oversight body will understand what high-quality and safe service delivery looks like and how to make sure it happens.[6]

Consumers and frontline workers will be at the centre of the architecture. Mental health and wellbeing service providers will have quality management systems that support the frontline workforce to deliver high-quality care to every consumer, every time. Quality management systems require first a vision, and then the leadership (including consumer leadership), culture, governance systems and capability to make it a reality.[7]

The Department of Health will support providers by promoting a shared vision and offering improved funding, updated infrastructure and a stronger workforce—all necessary requirements for delivering high-quality and safe treatment, care and support.[8] These arrangements (including the governance of the mental health and wellbeing system) are discussed in Chapter 27: *Effective leadership and accountability of the mental health and wellbeing system—new system-level governance*, and Chapter 28: *Commissioning for responsive services*.

Across the system, regulatory, oversight and quality improvement functions also help ensure consumers receive high-quality and safe treatment, care and support. The Adult Psychiatric Imperative described the roles of these functions:

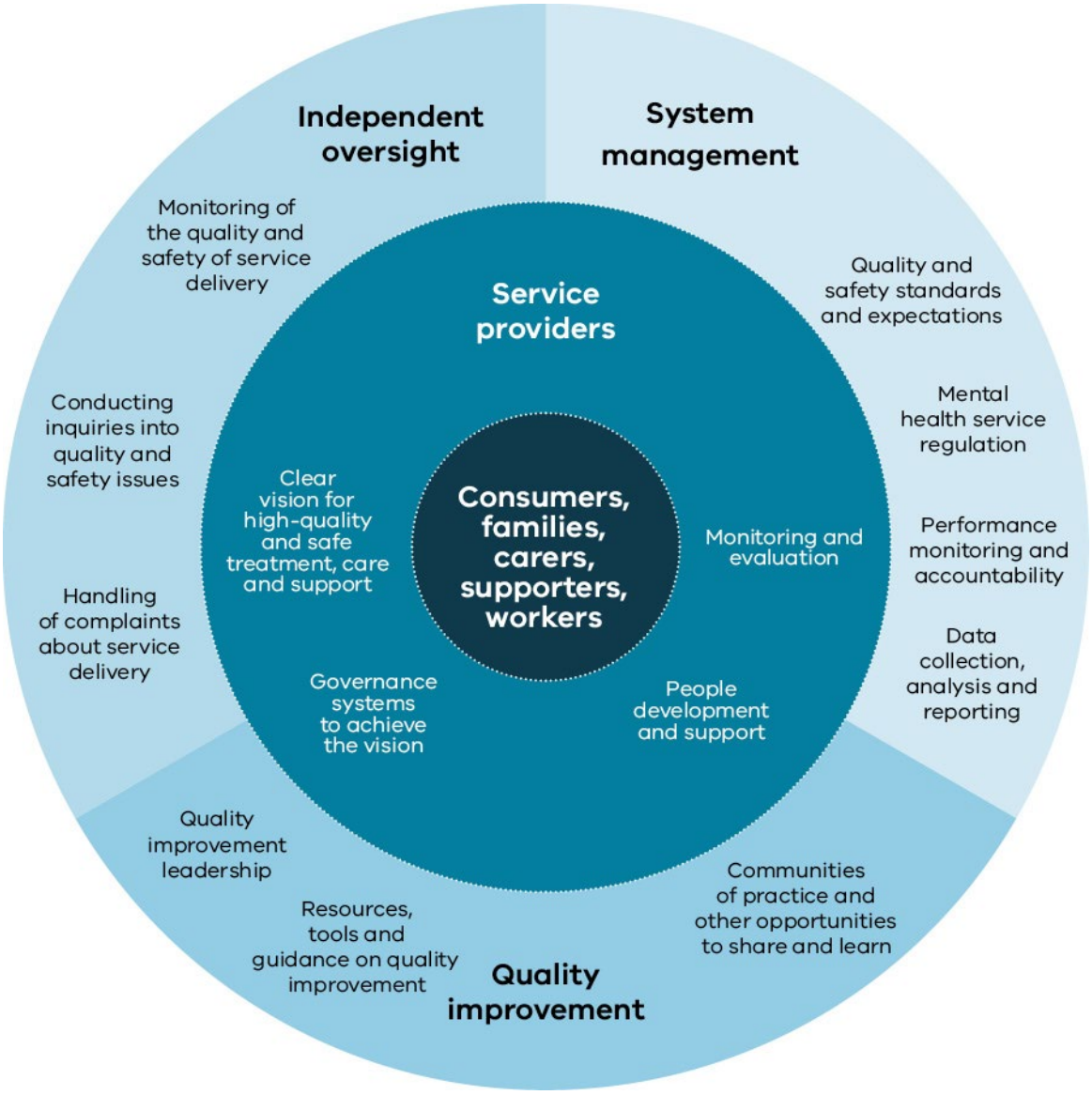
> **The quality and safety [management] function is mainly about improving services by engendering a culture of curiosity and encouraging a range of service improvement initiatives. The regulatory function, on the other hand, focuses on the maintenance of high levels of service standards by ensuring regulatory compliance, especially with the legislative expectations contained within the Mental Health Act.[9]**

High-quality and safe service delivery depends on balancing quality improvement with regulation and oversight. Focusing too heavily on one can risk developing an ineffective culture.[10] For example, focusing on only regulatory and independent oversight can alienate the workforce, direct attention to what is measured (while other aspects of care are ignored) and lead to data manipulation to create the appearance of compliance.[11]

The new Mental Health Improvement Unit, established within Safer Care Victoria, will help services to embed contemporary approaches to quality improvement. The Mental Health and Wellbeing Commission—established to hold government to account for the performance, safety and quality of the mental health and wellbeing system—will provide oversight of the quality and safety of mental health and wellbeing treatment, care and support. The role of the Mental Health Complaints Commissioner will be transferred into the new Commission, which will receive and respond to consumer complaints and work with services to resolve these to the consumer's satisfaction.

Figure 30.2 lays out the functions to be performed within the quality and safety architecture of Victoria's future mental health and wellbeing system.

Figure 30.2: Quality and safety architecture of Victoria's future mental health and wellbeing system



Sources: Adapted from Shilpa Ross and Chris Naylor, *Quality Improvement in Mental Health*, 2017, pp. 3–4; Cathy Balding and Sandra Leggat, 'Making High Quality Care an Organisational Strategy: Results of a Longitudinal Mixed Methods Study in Australian Hospitals', *Health Services Management Research*, 2020, 1–10 (p. 2).

The Commission envisages a mental health and wellbeing system with an effective quality and safety architecture that provides strong oversight and support for quality improvement. Box 30.1 summarises the key terms used throughout this chapter when describing this vision.

Box 30.1: Key terms for oversight and quality improvement

Adverse patient safety event— a critical incident or an 'event that results in unnecessary or avoidable harm to a patient'.[12] This term is commonly used in the delivery of health services.

Clinical governance—'the 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'.[13]

Clinical leadership—leading activities that ensure high-quality and safe clinical care is delivered and that delivery is improved.

Incident—an event or accident that occurs during the delivery of treatment, care and support and harms a consumer or member of staff. This can include a 'near miss' where no harm occurs from the event or accident. This term is commonly used in community services, where there is an approach to assessing the impact on the client and responding accordingly.[14]

Performance monitoring—in this context, how the Department of Health oversees the performance of a provider commissioned to deliver mental health and wellbeing treatment, care and support.

Quality assurance—a range of strategies, including regulation, that are 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 and wellbeing treatment, care and support. This can include oversight of specific practices (such as 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.

Quality improvement or **improvement science**—the systematic use of evidence-based, scientific methodologies for continuous improvement.[15]

Quality management system—an organisation's approach to managing the quality and safety of service delivery. This can include 'a systematic, coordinated, organisation-wide program of planning, governance, mind-set, behaviours, tools, change, measurement, evaluation and action to achieve and maintain the organisation's vision' for high-quality and safe treatment, care and support.[16]

Regulator—a government body with powers (under legislation) relating to inspection, licensing, accreditation and standards monitoring and enforcement.[17]

Sentinel event—an adverse event in the delivery of treatment, care and support that is preventable and that results in serious harm or death to an individual.[18] This term is commonly used in the delivery of health services.

30.1.3 Protecting consumers and prioritising their voices

In health and human service delivery, there is usually a power imbalance between consumers and service providers. It is difficult for a patient or consumer to assess the qualifications, competency or fitness to practice of a care provider, and they may not have choice of providers. The system's quality and safety architecture—particularly the regulatory and independent oversight arrangements—helps to tackle the imbalance of information/knowledge and power between the consumer and staff.[19]

Consumer leadership and participation in independent oversight and improvement processes can also help to confront this imbalance.[20] In addition, lived experience input can lead to greater understanding of the consumer experience and can inform decision making and contribute to broader cultural change.

The Victorian Mental Illness Awareness Council proposed that 'consumer leadership and participation must be core to all regulatory and oversight processes' because consumers can bring further insight to the issues being regulated compared with people who have not experienced compulsory mental health treatment.[21] These processes include accreditation, complaints management, service efforts to improve quality, investigations into incidents and inspections of services.

30.1.4 Data and information

The Department of Health will collect, analyse and report on all domains of high-quality and safe treatment, care and support. This will allow services to assess their progress against benchmarks and identify areas for improvement. The Mental Health and Wellbeing Commission will also collect and publish data on complaints about service delivery, providing insight and feedback on the quality and safety of treatment, care and support.

Furthermore, publishing meaningful and timely data is vital for transparency, which is a foundational principle of good governance and important for community confidence in all public services.[22] As Victoria Legal Aid noted, '[d]ata is critical in helping to improve quality, reach and consistency of service provision, as well as informing consumer choice and ensuring accountability.'[23] Publishing data will be the responsibility of all parties, tailored to their role and functions.

30.1.5 Evolving regulatory landscape

The Commission's recommendations related to funding and commissioning seek to increase the diversity of providers of mental health and wellbeing treatment, care and support. Over time, the mix of service providers may include more community health and non-government organisations delivering mental health and wellbeing services.

In sectors with a wide variety of service providers delivering services under contracts, governments often adopt a broader range of regulatory mechanisms to provide quality assurance and safeguarding. For example, in disability, aged care or early childhood, service providers may have additional registration or accreditation requirements and face a wide set of sanctions for any noncompliance with minimum standards. As the service provider mix in Victoria's mental health and wellbeing system evolves, some of these mechanisms may need to be considered.

30.2 Defining high-quality treatment, care and support

To define high-quality treatment, care and support in Victoria's future mental health and wellbeing system, the Commission explored the definitions used in other sectors.

In health service delivery, definitions of the quality and safety of care are often based on the six domains identified by the Institute of Medicine: safe, effective, patient-centred, timely, efficient and equitable services.[24] These continue to be used today, in some cases with slight refinements.[25] Two of these domains, however, are often considered to relate to connecting with services, rather than the quality and safety of care, so are omitted from definitions of 'high-quality care'. These domains are 'efficient' and 'equitable'.[26]

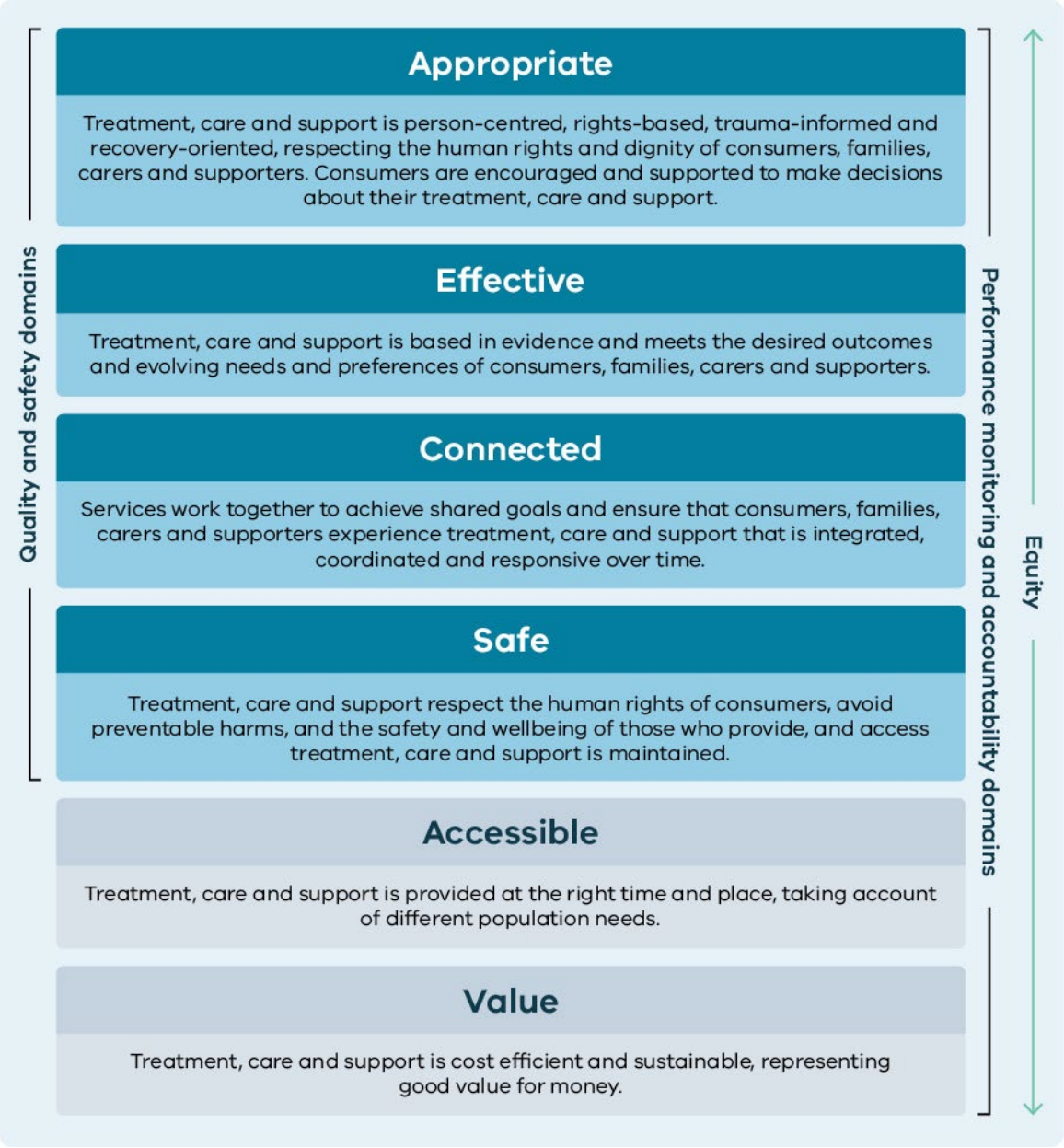
In Victoria, Safer Care Victoria defines high-quality and safe care as effective, person-centred and safe.[27] For mental health and wellbeing service delivery, the Commission also includes 'connected care' as a domain. The Commission considers that high-quality mental health treatment, care and support must be coordinated, integrated and responsive over time—or 'connected'.

This aligns with other health, mental health or human service areas.[28] For example, the Department of Families, Fairness and Housing aims to deliver, fund and regulate community services that are safe, effective, connected and person-centred.[29] With the greater emphasis on community-based treatment, care and support envisaged for the future mental health and wellbeing system, this will be particularly relevant in the future.

In mental health, the national Mental Health Principal Committee endorsed the *National Mental Health Performance Framework 2020*.[30] This adopts the six domains of the *Australian Health System Conceptual Framework*. The Commission recommends that the Victorian Government develops a new performance-monitoring and accountability framework for mental health and wellbeing services using these domains, consistent with those identified in the *National Mental Health Performance Framework* and as described in Chapter 28: *Commissioning for responsive services*.

Figure 30.3, which builds on Figure 30.1, shows how these six domains relate to the quality and safety of mental health and wellbeing service delivery.

Figure 30.3: Domains of high-quality mental health and wellbeing treatment, care and support as part of a new performance monitoring and accountability framework



Source: Adapted by the Commission based on the domains identified in the Australian Institute of Health and Welfare, *National Mental Health Performance Framework 2020*.

30.2.1 Human rights and high-quality treatment, care and support

Incorporating human rights into the vision of what comprises high-quality mental health and wellbeing treatment, care and support will be critical. The Commission considers that each of the domains of quality and safety identified above need to be informed by a human rights approach.

Under international conventions and Victorian legislation, central bodies (such as the Department of Health) and service providers have obligations to consider, protect and promote human rights. Under the Charter of Human Rights and Responsibilities Act (subject to certain exceptions):

> it is unlawful for a public authority to act in a way that is incompatible with a human right or, in making a decision, to fail to give proper consideration to a relevant human right.[31]

This includes the right to freedom of movement, the right to humane treatment when deprived of liberty and the right to be free from torture and cruel, inhuman and degrading treatments or punishments.

Many features of the *Mental Health Act 2014* (Vic) seek to protect and promote human rights. For example, the Act's objectives include that assessment and treatment is administered 'in the least restrictive way possible with the least possible restrictions on human rights and human dignity'.[32]

The Commission has heard from consumers and advocates that mental health services cannot provide high-quality and safe services without upholding the human rights of consumers.[33] The Victorian Mental Illness Awareness Council has included human rights in the fundamental goals for mental health treatment, care and support—that services are 'helpful', '[d]o no harm', and 'respect and uphold human rights'.[34]

Many do not believe that service delivery currently upholds human rights in delivering mental health treatment, care and support. Consumers told the Commission that they experienced a lack of respect for their human rights when getting treatment:

> People hate the services because they make people do things that they don't want to do, services don't listen and don't trust consumers.[35]
>
> We are not all the same, but we are all human beings and we need respect.[36]
>
> Being an inpatient … you're not treated as a human, as a person, you're treated as … someone whose behaviour needs to be managed and controlled, and … you have to seek someone else's permission to do it … I think my voice just wasn't heard.[37]

30.3 The role of service providers in delivering high-quality treatment, care and support

Currently, Victoria's public mental health services are delivered by public health services, community health organisations and non-government organisations.

In public health services, the Victorian Government has adopted a devolved governance model. Under this model, the relevant ministers for health and mental health set expectations for the quality and safety of care provided (via the Department of Health), and the board of the health service is accountable to the minister for the quality and safety of care provided.[38]

The board is responsible for assuring itself that the services delivered are high quality and safe, and for making sure the organisation has the necessary structures and systems in place to achieve this.[39] Providers need an effective quality management system with leadership (including consumer leadership), capabilities and governance arrangements to help deliver high-quality and safe treatment, care and support.[40] Health services usually employ quality managers and staff to support this work across the organisation.[41]

The board's responsibilities also include clinical governance arrangements. This is the 'system by which the governing body, managers and clinicians share responsibility and are held accountable for care, minimising risks to consumers and continuously monitoring and improving the quality of clinical care'.[42]

Achieving best practice in providing high-quality and safe treatment, care and support is challenging; it 'requires grappling with clinical autonomy and patient variability' in 'complex, high-pressure environments'.[43] In 2016, the review of Victorian hospital safety and quality assurance, *Targeting Zero*, found the former Department of Health and Human Services' governance of hospitals was inadequate and that it did 'too little to ensure that all boards are equipped to exercise this function effectively'.[44]

In response, the department established Safer Care Victoria to 'support health services in achieving quality and safety improvements'.[45] In addition to supporting clinical governance arrangements, Safer Care Victoria leads efforts to embed contemporary quality improvement approaches in health services.[46]

Similar to health services, community health and non-government organisations are also responsible for delivering high-quality and safe treatment, care and support under their funding agreements. Their boards are responsible for quality management systems within the organisation.

Traditionally, the standards for service delivery by providers other than health services have set less explicit requirements for providers to have quality management systems or clinical governance frameworks in place. For example, in aged care, until recently, the accreditation standards did not make reference to clinical governance.[47] This is changing, however, and increasingly non-government organisations are incorporating these into their work.[48]

Mr Tass Mousaferiadis, Chair of the Board of Star Health, and Mr Kent Burgess, Acting CEO of Star Health, told the Commission about Star Health's quality management approach:

> At Star Health, our quality and safety system is about continuous quality improvement. We have a quality manager, a committee of the Board for clinical governance, and a quality and safety committee. There is an internal reporting framework that goes up to the Board, which measures us against all the clinical governance and safety standards for both workforce and clients. The framework covers incidents and complaints and all of the various other elements that make up a quality framework. We accredit every three years against the standards.[49]

Meeting expectations for high-quality and safe treatment, care and support can also be challenging for smaller services. While larger organisations will have internal committees and teams dedicated to quality management, smaller public hospitals or non-government organisations may not be big enough to have a dedicated safety and quality team. These services may 'struggle more than larger ones to meet all of the required standards'.[50]

30.3.1 The role of the frontline workforce

Given their role in delivering treatment, care and support, frontline workers are critically important to the quality and safety of mental health service delivery. This can include the skill, capability and number of staff.[51]

As the Commission noted in its interim report, '[a]n empathetic and consumer-driven workforce is integral to delivering evidence-based, safe and responsive services.'[52]

Mental health workers have a strong desire to contribute to real and positive change for consumers.[53] Many shared their passion and commitment for building therapeutic relationships and delivering high-quality and safe treatment, care and support. The Commission heard from many workers who found it a 'tough but rewarding role to work in public mental health'.[54]

Services can support frontline workers to deliver high-quality and safe services in various ways. This includes providing a clear vision for high-quality and safe care and clarity around roles and responsibilities for achieving this vision.[55] It also includes offering appropriate training and resources to plan, implement and monitor change. Building cultures that value learning, innovation and the delivery of high-quality and safe treatment, care and support can also help workers succeed in their roles.

30.3.2 The role of accreditation

All Victorian health services must participate in the Australian Health Service Safety and Quality Accreditation Scheme.[56] This scheme was established in 2011 to 'protect the public from harm and to improve the quality of health service provision'.[57] Health services have to implement national standards and be accredited against the standards every three years.

As part of this scheme, the Department of Health is the regulator—it sets the expectation that health services will participate and monitors the accreditation status of services.[58]

Before 2017 these standards did not include mental health. Rather, health services were required to be accredited against the National Standards for Mental Health Services, which were last updated in 2010.[59] In 2017 the Australian Commission on Safety and Quality in Health Care released the second edition of the *National Safety and Quality in Health Service (NSQHS) Standards*. This edition added mental health service delivery, setting expectations for delivering mental health treatment, care and support, and the delivery of general health care to patients who may experience poor mental health.

This was a major change for health services, and many have only recently been accredited against the new standards. For example, Melbourne Health received accreditation against the new standards in the second half of 2019.[60] Changing to the new standards can be a significant undertaking. Dr Neil Coventry, Victoria's Chief Psychiatrist, noted that this may be a significant burden for smaller health services and that they may need additional support.[61]

However, Professor Richard Newton, the Clinical Director of Peninsula Mental Health Services, highlighted to the Commission the value these standards provide:

> **The integration of mental health into the NSQHS Standards represents outstanding progress. All health services now have a framework to their approach to recognising and responding to mental health needs in patients and to changes in risk. Such a framework did not exist under previous versions of the NSQHS Standards and has been an excellent change across Australia. The NSQHS Standards and training also promote attention to relevant mental health issues within general physical health care components of the health service. For example, the NSQHS Standards now contain a requirement that health services are to have mechanisms for detecting deteriorations in people's mental health.**[62]

The Australian Commission on Safety and Quality in Health Care is also making changes to the accreditation process.[63] These include conducting additional assessments at short notice and reporting to the public on the outcomes of accreditation.[64]

In addition, the Australian Commission on Safety and Quality in Health Care is currently developing a separate set of standards for primary healthcare services (defined for this purpose as 'the first level of contact for individuals, families and communities with the national health system' and including GPs).[65] The National Safety and Quality Primary Health Care Standards will help primary care services (including community health) to minimise the risk of harm and improve care for consumers.

30.3.3 Providing high-quality and safe treatment, care and support in a constrained system

Victoria's public mental health services indicated their commitment to providing high-quality and safe mental health treatment, care and support, but services also highlighted factors that made it difficult to achieve this vision. It can be difficult for mental health and quality management staff to make improvements in a system under stress.

Professor Patrick McGorry AO, Executive Director of Orygen and Professor of Youth Mental Health at the University of Melbourne, appearing in a personal capacity, told the Commission:

> Health and quality improvement is another key pillar in facilitating continuous improvement of service delivery. Currently, services have quality committees that in recent years have too often just been disconnected bureaucratic processes without much meaning—fiddling while Rome burns.[66]

Common themes raised by service providers included:

- constrained resourcing and increased demand
- over-emphasis on risk management
- shortfalls in the capacity and capability of the workforce
- outdated infrastructure
- limitations to data collection and reporting.

Many health services told the Commission that increased demand, alongside system-wide shortfalls in funding, have reduced their capacity to provide high-quality and safe treatment, care and support to all consumers in need—and that this needs to be confronted if improvements are to be achieved.[67] Alfred Health described the challenge to the Commission:

> In 2019, Alfred Health is facing a number of challenges in delivering mental and addiction health services. Our allocation of beds in our acute, sub-acute and non-acute (rehabilitation) settings has remained unchanged since 2004, despite a considerable increase in the population of our catchment and the metropolitan area more broadly. Between 2013 and 2018, the population of our catchment increased about 12 per cent. In the same period, the total number of patients presenting to the emergency department with mental and behavioural disorders grew on average by 4.3 per cent every year.[68]
>
> Funding has not kept up with the growth of patient demand and complexity. The impact of enterprise-based agreements, rising community expectations, and the emergence of new evidence-based treatments are placing cost pressures on services. The requirement for productivity savings year-on-year has had a disproportionate effect on clinical community mental health services, even as increasing emergency demand has placed pressure upon fixed bed numbers.[69]

Monash Health also noted the role of resourcing:

> It is our assessment that the serious problems being experienced by the mental health system in Victoria arise from a reduction in real terms of funding over decades. This chronic lack of resources has contributed to impoverished care and a mindset of scarcity that has meant that current resources are not being optimally used.[70]

Increased demand for acute mental health inpatient units can lead to shorter admissions, which in turn can place pressure on staff to provide effective, therapeutic care. Eastern Health described this problem:

> Box Hill Hospital's adult inpatient unit has run consistently at approximately 98% occupancy over the last 12 months. The unit at Box Hill has seen a significant reduction in length of stay, from an average 11.4 day stay in May, 2018 to an average 9.4 day length of stay in May, 2019. This is well below the State target of 12 days. When length of hospital stay is too short, there is a risk that there is not enough time to establish rapport with a consumer or their family, that the quality of care is not as ideal as clinical staff would like or that it can compromise the ability to undertake comprehensive discharge planning, including basics such as food and accommodation.[71]

Alongside the lack of funding is an increased focus on risk management, at the expense of more effective and recovery-oriented approaches to the delivery of mental health treatment, care and support.[72] In mental health service delivery, providers need to balance managing safety risks with consumers' autonomy, to avoid the 'pre-eminence of a custodial and risk-management culture' in mental health services.[73] The Commission heard concerns that the therapeutic focus in Victoria's mental health services was being undermined by a focus on risk management.[74] Monash Health noted this emphasis:

> Models of mental health care have not kept pace with changing 21st century demographics and values. Our current model largely driven by severe resource constraints, is one of risk mitigation, along with crisis and biomedical management. Specialist and evidence-based treatment can be found within pockets of the system of care but it is by no means commonplace.[75]

The Commission was told that the current regulatory and oversight arrangements contributed to this focus and can impede more thoughtful analysis of risks to both the consumer and services. Professor David Castle, Consultant Psychiatrist at St Vincent's Hospital Melbourne and Professor of Psychiatry at the University of Melbourne, giving evidence in a personal capacity, told the Commission:

> The current approach to regulation is often only responsive to a finding from the Coroner's Court, a fear that something might go wrong, or a concern that a consumer's treatment management plan has the incorrect box ticked. In Victoria, the paperwork is so detailed and different for every health service. This disparate approach to regulation is detrimental to the proper management of risk as it stops practitioners and service providers from actively thinking about the risks.[76]

Services also noted that the challenge of recruiting enough staff with the right skills and capabilities affects the capacity to deliver high-quality and safe treatment.[77] Eastern Health told the Commission:

> Consumers admitted to adult inpatient services have severe, enduring mental health issues complicated by poly-pharmacy [multiple medications], physical health issues, intellectual disability and socio-economic issues including homelessness, unemployment, social isolation, drug and alcohol abuse, family violence, stigma and low self-esteem. Managing the complexity of this cohort requires a multidisciplinary approach. Current levels of inpatient funding do not allow for the required staffing profiles and so it needs review. The staffing profile includes, but is not limited to: allied health workers, dietician/nutritionists, dentists and pharmacists. The multidisciplinary approach needs to continue into the community and work collaboratively with other jurisdictions and agencies including justice, domestic violence, employment and housing.[78]

As highlighted in the Commission's interim report, the lack of investment in mental health service infrastructure has affected the ability of services to respond to safety concerns and the changing needs of consumers, and to provide environments to assist consumers with their recovery. Regional and Rural Area Mental Health Services told the Commission:

> [Area mental health services] are left to make the best of outdated and impractical facilities in order to safely treat and support patients with increasingly complex needs, often at significant cost. All while trying to create an environment that is welcoming, therapeutic and supportive of risk mitigation and patient recovery across all age demographics and service settings.[79]

These challenges can make it difficult for mental health services to meet the expectations that accompanied the enactment of the Mental Health Act.[80]

The Commission's recommendations relating to funding, planning, infrastructure upgrades and system changes respond to these challenges.

30.3.4 Data quality and availability

Measuring quality—and publishing the data—helps to identify where improvements are needed and what changes may be successful.[81] Currently, the capacity of Victorian mental health services to participate fully in a systematic learning cycle is limited because:

- many aspects of the quality of treatment, care and support are not routinely measured and analysed[82]
- the Chief Psychiatrist, the Department of Health (formerly the Department of Health and Human Services) and the Victorian Agency for Health Information provide little information to services about the quality and safety of their services[83]
- where services must publicly report on quality initiatives (via an annual 'quality account'), the focus is limited to seclusion and restraint.[84]

Victorian public mental health services must also report to the department about safety incidents and adverse events (an 'event that results in unnecessary or avoidable harm to a patient').[85] Community services provide this information via the Community Incident Management System, while health services do so via the Victorian Health Incident Management System. Although this system collects a lot of information, it is not possible to obtain meaningful data about incidents specific to mental health services.[86] This makes it difficult to identify, analyse and monitor safety breaches that occur within mental health services, or with people with lived experience of mental illness, across health services. Dr Coventry reported that this information should be available to services, the Chief Psychiatrist and other system leaders in 2022.[87]

The Victorian Managed Insurance Authority—in its role as the insurer for Victorian health services—also holds data about claims relating to allegations of negligence or breaches of duty of care. The Commission understands that when claims are closed (because they were discontinued or finalised by negotiation or a court decision), many include a requirement for confidentiality, limiting the ability to disclose any specific learnings from the incident across the system. The Commission considers there is value in continuing and expanding the work that the Victorian Managed Insurance Authority currently undertakes with departments and agencies identifying systemic trends and challenges to inform policy and practice improvement. This is outlined further in section 30.7.2.

Further, the Commission's recommendations in Chapter 35: *New approaches to information management* include developing, funding and implementing modern information collection technologies that enable the effective, safe and efficient use of information. This will support both service delivery and the development of quality improvement tools such as clinical registries to monitor outcomes from various interventions.[88]

30.4 Consumer experiences

The Commission heard about a wide range of consumer experiences within the Victorian public mental health system. While some consumers told of positive experiences, many reported experiences that lacked dignity, empathy and choice.[89]

The Victorian Mental Illness Awareness Council indicated that, 'Victoria's current approach to mental health fails to help many people, is often significantly harmful, and seriously breaches many human rights.'[90]

Based on complaints about experiences of mental health treatment, care and support, Dr Lynne Coulson Barr OAM, Victoria's Mental Health Complaints Commissioner at the time of giving evidence, described the concerns of consumers, families, carers and supporters:

> An underlying theme in the complaints is that people do not feel at the centre of their treatment and care. This is at odds with the explicitly stated objectives of the [Mental Health] Act when it was introduced to Parliament. People making complaints to our office are often deeply distressed and traumatised by their experiences. Families and carers also express deep levels of distress about their loved ones' experiences, including about issues of access to services, and the quality or nature of treatment and care provided.[91]

The poor experiences of consumers, families, carers and supporters indicate that the aspirations of the Mental Health Act have not been achieved. Victoria Legal Aid told the Commission:

> The experiences of our clients and consumers have been that mental health services are not consistently operating in compliance with the Mental Health Act obligations to provide 'recovery-oriented, least-restrictive treatment and care where people are supported to make their own decisions'.[92]

Dr Coulson Barr also suggested that the complaints about mental health service delivery indicate the 'continued need for recovery-oriented practice, supported decision making and trauma-informed care to be truly embedded in service provision'.[93]

30.4.1 Appropriate and effective treatment, care and support

In the future mental health and wellbeing system, a consumer receiving appropriate, effective and person-centred treatment, care and support can expect care that meets their needs and preferences at the right time. The consumer's values, beliefs and situations will inform how services are delivered, and the consumer will be encouraged to participate in decisions about their care. Treatment, care and support will be evidence-based and meet the desired outcomes of consumers, families, carers and supporters.[94]

The Mental Health Complaints Commissioner reported that one of the most common themes in complaints is 'from consumers, families, carers and nominated persons stating that their views about treatment, and consumers' preferences, have not been adequately considered by the service'.[95]

Rather, consumers described their care as coercive and disrespectful of their autonomy. Two consumers told the Commission:

> Sense of agency makes a big difference. Myself and others feel as though there is no real choice even when something is presented as a choice. They say come voluntarily but you don't really have the choice.[96]

> I was not violent or agitated and I still don't understand why I had to suffer the indignity of being put in the police van, in front of a packed waiting room full of people in the Emergency Department when I had not done anything wrong, I just needed treatment. At that moment, I lost my sense of citizenship.[97]

Consumers also highlighted the negative impact on their human rights when they could not get timely, empathic and high-quality treatment, care and support:

> [Addressing] cultures of patronising, 'doctor knows best' behaviour, leading to denigration of human rights [would help]. Workforce training is needed, especially for more entrenched professions, such as psychiatrists and other medical health professionals.[98]

> supports to enable continual management when primary care is no longer adequate, [are] essential, vital and a human rights issue. We don't give up on cancer and cardiac patients at any point, nor should we with complex mental health cases.[99]

Victoria Legal Aid noted that services often do not treat consumers in the least restrictive way possible,[100] informing the Commission that:

> Clients and consumers often tell us that their treating team does not listen to them, or that their views and preferences are ignored or not genuinely considered as part of the decision-making process.[101]

In addition, the Commission heard that services are not always equipped to provide culturally sensitive care:

> As patients, we are often stereotyped. You are talking about traumatised elders who are exposed to systemic racism when they seek treatment.[102]

Choice of treatment, care and support options is also important to consumers.[103] Community Visitors—volunteers who can visit public mental health inpatient facilities to monitor the adequacy of services—have also reported concerns.[104] Visitors reported that a lack of meaningful activities is common, although some services do have a range of activities:

> Community visitors continue to report that patients are bored and lack meaningful activities. Advertised activities are not always conducted, particularly on weekends or when key staff are absent.[105]

Treatment, care and support that is appropriate also responds to the consumer's needs, including to their age and stage of life. For example, given their different needs and experiences, the Mental Health Act specifies that children and young people should receive services separate from those for adults, whenever possible—although this doesn't always happen.[106]

Many consumers, families, carers and supporters described their treatment as overly focused on medication, without broader consideration of other options or needs.[107] For example, one consumer told the Commission:

> In the mental health hospital, the treatment is horrific. … There are no psychologists, it's medication or nothing. Their trauma is not considered. It's just medicating the symptoms.[108]

Both the Mental Health Complaints Commissioner and Community Visitors report consumer complaints about medication amounts, types, side effects and errors.[109]

Professor Newton argued that many services are not providing evidence-based treatment:

> Despite a strong evidence base for all the main diagnostic categories of severe mental illnesses, public mental health services often fail to deliver evidence-based care. Clear expectations about best-practice pharmacological therapy and psychotherapy will allow community-based services to provide effective care. It is vital that clear expectations and appropriate accountability mechanisms are put in place to ensure that consumers and their carers receive therapies that we know, and have known for decades, work to reduce symptoms and distress and to support people to manage their own illness with more autonomy, dignity and improved quality of life. 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.[110]

Consumers, families, carers and supporters told the Commission that effective treatment, care and support can be hard to find:

> There need to be facilities that are well-staffed, where treatment is much more holistic and healing. We don't believe a place like this exists in Victoria.[111]

30.4.2 Connected treatment, care and support

High-quality treatment, care and support depends on services working together to achieve shared goals so that consumers experience continuity and a sense of autonomy as they move between practitioners, services and systems.[112] It is widely acknowledged that 'people achieve better mental health outcomes when they receive integrated, multidisciplinary care', including peer- and consumer-led care.[113]

Many consumers spoke of how services operate largely in silos (without any real connection to other services) and that this compromised the quality of services they received. A lack of coordination and integration means some people are 'handballed' between different services, or turned away altogether. As one consumer told the Commission:

> Handover in care hasn't been smooth; it takes a while to get their head around the case before they get to speak to you. Information transfers even take time and that's complex. You feel like you are dealing with a fresh slate every day.[114]

Families, carers, supporters and workers were also concerned about the lack of continuity:

> When he's released, where does he go? It's like a revolving door.[115]
>
> The biggest fear we have as professionals is people dropping through the cracks. There's no continuity in the system—there's no beginning, no middle and no end. We all have an incentive and desire for it to work together.[116]

Complaints to the Mental Health Complaints Commissioner point to lack of continuity of care in the current system. Examples of concerns raised include gaps in care 'when a consumer is discharged from an inpatient unit to the community team of the mental health service', or the inadequacy of shared-care arrangements and referrals to private practitioners.[117] In addition, complaints to the Mental Health Complaints Commissioner highlighted the lack of continuity of care between services responding to mental health needs and those dealing with physical health concerns.[118]

High-quality care also includes coordinating care between health, mental health and other services. The Commission heard about opportunities to strengthen this area.[119]

30.4.3 Safe treatment, care and support

Consumers, families, carers, supporters, workers and advocates raised concerns with the Commission about safety, particularly within public acute mental health inpatient units.[120] Consumers emphasised the need for healing and restorative care settings where they are protected from danger or risk and are not exposed to it.[121] The Commission heard that in the current system, too many consumers and workers feel unsafe:

> During this admission I felt very unsafe and was very distressed by the behaviour of male patients.[122]
>
> My daughter was 18 and had lots of drugs to sedate her. She was vulnerable. We ended up taking shifts and staying with her in the hospital to keep her safe.[123]
>
> It is difficult to work in an environment where you do not feel confident that you or your colleagues will be going home safe.[124]

With current data-collection systems, it is difficult to collate meaningful data across the system about safety incidents specific to mental health services.[125] However, during their visits to mental health services, Community Visitors record the safety concerns they observe. These can include hazards, assaults, intimidation or harassment, problematic drug and alcohol use, and self-harm or suicide. Over the years 2015–16 to 2017–18, Community Visitors recorded 891 concerns.[126]

Personal story:

Elizabeth Porter

Elizabeth* had experienced mood instability and intermittent depression since she was 13 years old, but it wasn't until her 20s that she was diagnosed with complex mental health conditions.

At the age of 25, Elizabeth went to see both a GP and a psychologist, as she was having problems sleeping.

> I felt high, my thoughts were racing, and I was distressed. They both said I was fine and dismissed my concerns.

A few days later, Elizabeth's mental health deteriorated, and she was compulsorily admitted to a public hospital for the first time. She said she 'felt unsafe and was very distressed by the behaviour of male patients'.

During Elizabeth's second psychotic episode, at 26 years old, she called the Crisis Assessment and Treatment Team 11 times over a two-week period seeking help. She said she was once again dismissed. However, her parents were taken more seriously when they called the Crisis Assessment and Treatment Team, and she was again compulsorily admitted to a public hospital. She felt the admission could have been prevented if the Crisis Assessment and Treatment Team had supported her earlier.

During that second admission, Elizabeth describes:

> I had a male patient try to come into my room and he was pulled back by staff members. It triggered nightmares and flashbacks of sexual assault. I have a history of rape, and that is largely a trigger of my psychosis and a lot of my delusions are around rape.

Elizabeth was hospitalised three times against her will and restrained on all admissions. During two of her admissions, she was put in seclusion.

> Being restrained reminded me of being raped.
>
> I think seclusion has no therapeutic value—it's done for the convenience of the institution. I feel that I've recovered from my mental health conditions in spite of, not because of the mental health system.

Elizabeth reported that in each admission she was sexually harassed and physically assaulted by male patients, and while staff tried to make the environment safe, they weren't always able to.

> I have about 20 different suicide plans to end my life in preference to being back in a public mental health unit. I am in fear for my life if I have to go back to a public hospital.

Elizabeth said that if she had entered the mental health system at a younger age, the effect of her experiences would have been worse.

> At least by the time I was 25, I knew a bit about myself in the world, I knew what my capabilities were. It was easier psychologically to not feel completely worthless and infantilised because the system is very infantilising. It's hard to rebuild from that psychologically, particularly after so much forced medication, assault, forced confinement.

Elizabeth is passionate about the 'dignity of risk' and says this is why she is still alive.

> Simply put, people with mental health conditions should be able to make informed decisions, to take risks, take responsibility for our choices, and come to terms with the effects of our actions. The dignity of risk is about both not being prevented from having agency; and being enabled to exercise agency.

Source: *Witness Statement of 'Elizabeth Porter' (pseudonym)*, 27 April 2020; 'Elizabeth Porter' (pseudonym), *Correspondence to the RCVMHS*, 2020.

Note: *Name has been changed in accordance with an order made by the Commission.

Gender-based violence is a particularly serious concern in mental health service settings. Gender-based violence not only includes experiences of rape, sexual assault and physical harassment but also consumers experiencing verbal harassment and threats.[127] The Commission heard from consumers, families, carers and supporters that experiencing sexual assaults or threats, or feeling at risk of gender-based violence, is common within mental health service settings. One consumer told the Commission:

> During my second experience of a youth psychiatrist unit, I was sexually assaulted by another patient … and the next day I had to sit next to him to eat.[128]

This is discussed further in Chapter 10: *Adult bed-based services and alternatives*. The Commission's recommendations include investment in more gender-specific acute mental health units.

Safety encompasses more than physical aspects; it includes environmental, emotional and psychological safety.[129] Part of this is cultural safety—where consumers feel there is no denial of their identity, of who they are, or of what they need.[130] The Victorian Mental Illness Awareness Council has argued that the mental health system has prioritised physical safety over other forms of safety.[131]

Consumers in mental health services also face similar safety risks to patients in other health settings.[132] Service providers need to consider aspects of service delivery such as the risk of falls, infection prevention, and control and medication safety.[133] The latter is particularly relevant in mental health service delivery where pharmacological approaches to treatment are common.[134]

Errors relating to medication can be referred to as 'adverse medication events'. The Australian Commission on Safety and Quality in Health Care has developed resources to support services to improve medication safety in mental health.[135] In addition, the Chief Psychiatrist has issued a guideline to services on how to reduce adverse medication events in mental health services.[136]

Consumers also raised other concerns with medication, such as a lack of consideration of or response to side effects.[137] Other pharmacology matters raised included interactions between pain medication and psychiatric medications, and the effects of psychiatric medication on potential pregnancies.[138] Concerns about the use of or over-reliance on medications in treatment, care and support are considered further in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults,* and Chapter 36: *Research, innovation and system learning*.

Mental health and wellbeing services also need to consider the safety of staff. This is explored further in Chapter 31*: Reducing seclusion and restraint*, and Chapter 33: *A sustainable workforce for the future*.

30.5 Current regulatory and independent oversight arrangements

Much work of government involves 'protecting citizens and society from a range of risks, threats, or harms', including via regulation and oversight.[139] Within health and human service systems, governments often establish regulatory or independent oversight mechanisms to provide assurance that minimum quality standards are being met.[140]

Independent oversight arrangements, in particular, provide transparency and help build consumer and community trust in the level of care being provided by services. Oversight provides greater transparency and uses the 'disinfectant of sunlight' to strengthen accountability to consumers, families, carers and supporters, and the Victorian public.[141]

Current regulatory and independent oversight arrangements for Victoria's mental health services are a mix of mental health–specific functions, broader health and community service arrangements, and Victorian and national legislation and standards.

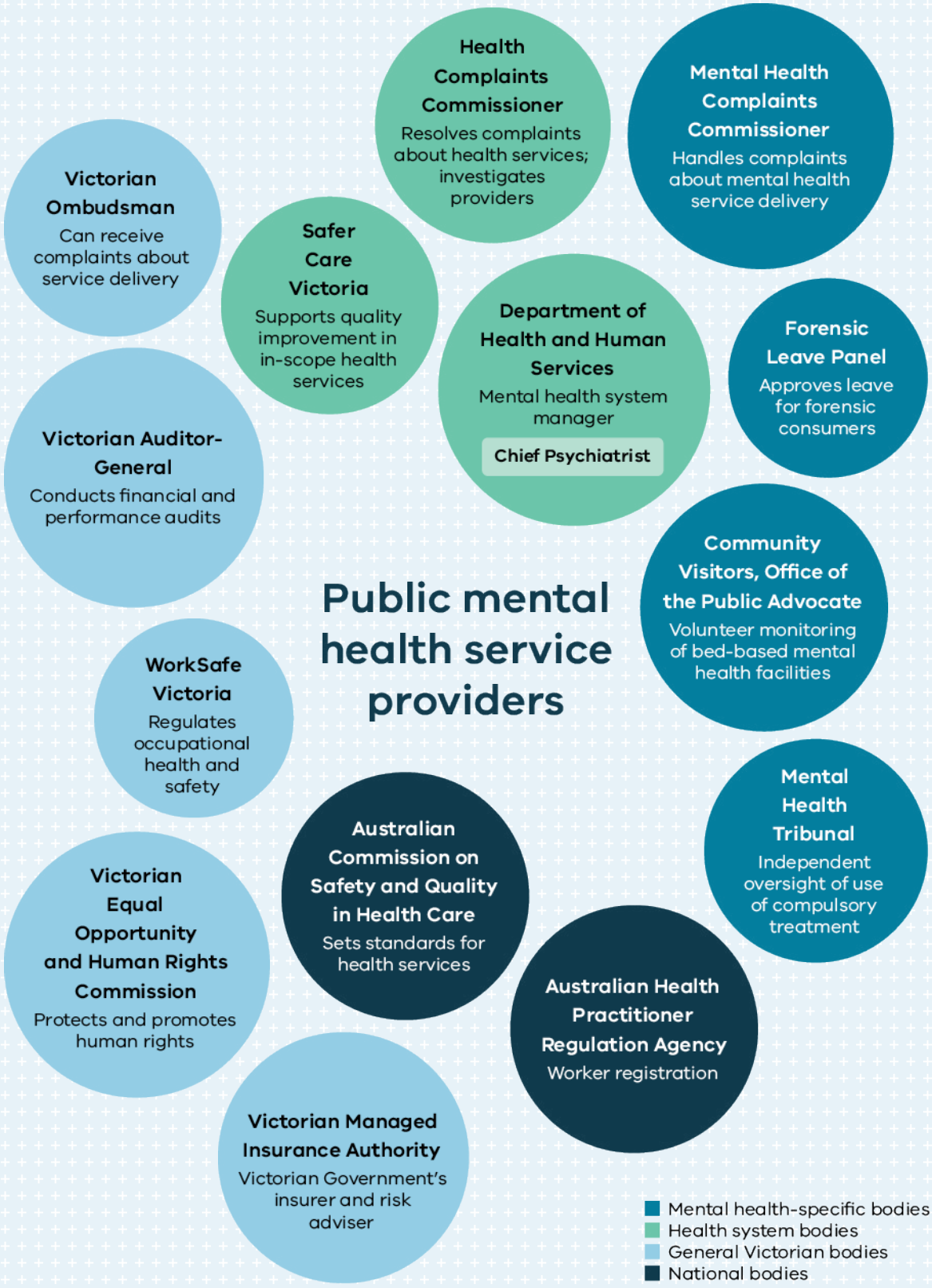
Dr Alice Andrews, Director of Education at the Value Institute for Health and Care and Assistant Professor, Department of Medical Education, Dell Medical School, University of Texas, described the arrangements in health, '[r]egulation of health care is of course complicated (compared to other organisations) because peoples' lives are at stake.'[142] In Australia, key health regulatory mechanisms include:

- regulation of health professions registered under the National Health Regulation Scheme (such as psychologists, psychiatrists, nurses and occupational therapists) and self-regulation of other professions (such as social workers, counsellors and art therapists)[143]
- the Australian Health Service Safety and Quality Accreditation Scheme (described in section 30.3.2 above).[144]

Mental health services also need to adhere to the requirements of the Mental Health Act, including its principles, and any requirements set by the statutory bodies established under the Act.

Figure 30.4 shows the range of government bodies that have roles and responsibilities to oversee, support or improve the quality and safety of mental health treatment, care and support. Table 30.1 provides more details about key system-wide quality and safety roles and responsibilities in the mental health system.

Figure 30.4: Map of bodies with statutory regulatory, independent oversight and quality improvement responsibilities in the Victorian mental health system



Note: Description of each body does not include full range of roles and responsibilities.

Table 30.1: Key system-wide quality and safety roles and responsibilities in Victoria's mental health system

Role	Responsibilities
Chief Psychiatrist	The Chief Psychiatrist has duties, functions and powers under the Mental Health Act, and is subject to the general direction and control of the Secretary. The role of the Chief Psychiatrist is to: • 'provide clinical leadership and expert clinical advice to mental health service providers • promote continuous improvement in the quality and safety of mental health services provided by mental health service providers • promote the rights of persons receiving mental health services from mental health service providers and • provide advice to the Minister and the Secretary about the provision of mental health services by mental health service providers'.[1]
Chief Mental Health Nurse	A non-statutory role within the Office of the Chief Psychiatrist, the Chief Mental Health Nurse provides nursing leadership and supports mental health nursing through workforce development, education and promoting best practice.[2]
Secretary, Department of Health	Under the Mental Health Act, the functions of the Secretary include promoting continuous improvement in the quality and safety of mental health services, and monitoring and evaluating the performance, standards and outcomes of mental health service providers and the quality and safety of mental health services they provide.[3]
Safer Care Victoria	Safer Care Victoria is 'the state's healthcare quality and safety improvement specialist'.[4] Under its Statement of Expectations, Safer Care Victoria's functions include to: • 'support public and private health services to prioritise and improve safety and quality for patients • strengthen clinical governance, lead clinician engagement and drive quality improvement programs and processes implemented in health services • review public and private health services and health service performance, in conjunction with the department, in order to investigate and improve safety and quality for patients'.[5]
Mental Health Complaints Commissioner	The functions of the Mental Health Complaints Commissioner include: • accepting, assessing, managing and investigating complaints relating to mental health service providers, and to resolve complaints • issuing compliance notices • identifying, analysing and reviewing quality, safety and other issues arising out of complaints, and providing information and making recommendations for improving the provision of mental health services.[6]
Mental Health Tribunal	The Mental Health Tribunal is an independent statutory tribunal to protect the rights and dignity of people with mental illness. The primary function of the Tribunal is to determine whether the criteria for compulsory mental health treatment as set out in the Act apply to a person.[7]
Community Visitors	Volunteer Community Visitors can visit Victorian public mental health inpatient facilities to monitor and report on the adequacy of services provided. Community Visitors consider whether services are provided in accordance with the Mental Health Act and can assist consumers to resolve issues or make a complaint.[8]

Sources: 1. *Mental Health Act 2014* (Vic), sec. 120; 2. Department of Health and Human Services, *Chief Psychiatrist's Annual Report 2018-19*, p. 9; 3. *Mental Health Act 2014* (Vic), para. 118(c); 4. Safer Care Victoria, *Strategic Plan 2020–23*, p. 14; 5. Safer Care Victoria, *Strategic Plan 2017–2020*, 2017, p. 2; 6. *Mental Health Act 2014* (Vic), sec. 228; 7. Mental Health Tribunal, Victoria, *Annual Report 2018–19*, 2019, p. 6; 8. *Mental Health Act 2014* (Vic), secs. 214, 216; Office of the Public Advocate, *Submission to the RCVMHS: SUB.0002.0029.0448 (Submission 1)*, p. 9.

Under the Mental Health Act, the Secretary of the Department of Health must promote continuous improvement in the quality and safety of services,[145] while the Chief Psychiatrist is responsible for providing clinical leadership and promoting continuous improvement in the quality and safety of mental health services.[146] Dr Coventry has described his role as Chief Psychiatrist as being 'primarily to intervene at a system-level through promotion of clinical practice improvement'.[147]

The Victorian Government introduced the role of the Mental Health Complaints Commissioner in 2014 as part of the reforms to mental health laws.[148] Dr Coulson Barr, the first Mental Health Complaints Commissioner, noted that the role is unique to Victoria—no other jurisdiction has a specialist mental health complaints body.[149] On 1 July 2020, the Victorian Government appointed Ms Treasure Jennings to the position of Mental Health Complaints Commissioner and Disability Services Commissioner.[150]

Effective oversight of the quality and safety of mental health and wellbeing treatment, care and support is essential. Victoria's mental health system has 'failed to aid those who are most in need of high-quality treatment, care and support'.[151] Mental illness and psychological distress are fundamental health and social concerns, and high-quality treatment, care and support should be available when people need it. In addition, many consumers are treated on a compulsory basis. In this context, oversight of the quality and safety of service delivery is critical.

However, the current arrangements are complex. The Victorian Government noted this 'can create a level of confusion around accountability and may inhibit continuous improvement efforts'.[152] Furthermore, Victoria Legal Aid noted the potential to improve the regulatory and independent oversight system:

> The Royal Commission should consider whether there is unnecessary fragmentation of oversight bodies under current arrangements … In our view, improved systems for oversight would lead to better understanding and implementation of the Mental Health Act and its safeguards, including supported decision-making, least restrictive assessment and treatment and a recovery-focus.[153]

30.5.1 Relationship between service providers and oversight and improvement bodies

Mental health service providers can be required to interact with a range of regulatory and oversight bodies. Alfred Health drew attention to the burden this places on service providers:

> The burden of compliance and governance has continued to increase. Mental health services provided by Alfred Health undergo accreditation every three years through the National Safety and Quality Health Standards (NSQHS). Our services are accountable to the Mental Health Branch, the Office of the Chief Psychiatrist, the Office of the Public Advocate, the Mental Health Tribunal and Worksafe Victoria. Safer Care Victoria, the Office of the Chief Psychiatrist, and the Victorian Coroner each review some or all adverse events involving patient deaths and injuries. Worksafe Victoria undertakes investigations of staff injuries and occasionally patient deaths.[154]

There can be overlap in the relationship between service providers and the Chief Psychiatrist, the Department of Health and Safer Care Victoria:

- For the Chief Psychiatrist, the relationship is largely collaborative and focuses on continuous quality improvement, but the role does have monitoring and oversight responsibilities.
- The department has roles in funding, performance monitoring, accountability, regulation and support for continuous improvement.[155]
- Safer Care Victoria helps improve the quality and safety of treatment, care and support but can also ask services to take specific actions when adverse events occur.

This can lead to potential conflict across these roles.[156] For a service provider, it is not always clear if the body or position is helping to improve the quality and safety of treatment, care and support, or if the interactions are driven by funding and performance monitoring or oversight and accountability. Service providers described the lack of clarity to the Commission:

> A trend has emerged in the past year [since 2018], in which complaints are being made about the same issues through multiple agencies, including the Mental Health Complaints Commissioner, Worksafe Victoria and the Australian Health Practitioners Registration Agency. It must be said that these agencies have had a positive impact on safety, quality, transparency and accountability, but compliance requires resources and training of the workforce, and these have been lacking. Furthermore, the duplication of responsibilities and requirements creates redundancies in process, which are time-consuming, unproductive and should be eliminated.[157]
>
> A number of other structures in place, including The Mental Health Complaints Commission, Community Visitors, The Office of the Chief Mental Health Nurse and Safer Care Victoria could be more coordinated and streamlined. For a service provider, it is not unusual to be asked to respond to four or more agencies regarding a single incident. This is time consuming and inefficient, taking away from time within services to improve the quality of care delivery.[158]

The multiple and overlapping roles can be seen in how a public acute mental health inpatient unit must follow up on a sentinel event. Ms Karyn Cook, Executive Director of Mental Health Services at South West Healthcare, Warrnambool Community Health, noted that in the case of a sentinel event, a service is required to:[159]

- notify the Office of the Chief Psychiatrist within three days
- notify the Mental Health Branch and Regional Director of the department
- register the service's interest with the Coroner's Court of Victoria, and provide relevant clinical notes and documents
- notify the Victorian Managed Insurance Authority
- notify Safer Care Victoria
- commission a root cause analysis or in-depth review (or participate in Safer Care Victoria's sentinel event program)
- respond to follow-up requests for reports or documents from the Office of the Chief Psychiatrist, department, Coroner's Court or Safer Care Victoria.

30.5.2 Gaps and overlaps in current arrangements

The landscape is not only crowded for service providers, it also lacks clarity and there can be gaps. The Mental Health Legal Centre told the Commission:

> There is significant confusion about the purpose of the Office of the Chief Psychiatrist and its role in quality and safety improvement within the system.[160]

Under the Mental Health Act, the purpose, powers and functions of the Chief Psychiatrist role were refocused.[161] Dr Coventry described this as a shift to a 'strategic, system-wide role with responsibilities for clinical leadership and system-wide quality assurance and improvement'.[162]

The Chief Psychiatrist now has four statutory roles: to provide clinical leadership; to promote continuous improvement in quality and safety; to promote the rights of people receiving mental health services; and to provide advice to the Minister and departmental Secretary about service delivery.[163]

Various statutory functions enable the Chief Psychiatrist to fulfil these roles. Each relate to clinical care but differ in focus or type of function. Some functions could be described as 'quasi-regulatory' or focused on oversight, such as the capacity to direct mental health service providers or the requirement to report on rates of restrictive practices and electroconvulsive treatment.[164] If a consumer applies for it, the Chief Psychiatrist has the power 'to review the treatment of a consumer where the authorised psychiatrist of a mental health service provider does not adopt the changes recommended in a second psychiatric opinion report'.[165] Dr Coventry noted, '[m]y statutory functions enable me to … intervene when quality and safety concerns arise.'[166]

Other functions of the Chief Psychiatrist relate more to clinical leadership and continuous quality improvement, such as to 'provide information, training and education to promote improved quality and safety in the provision of mental health services'.[167] These functions can also support quality and safety of service delivery—clinical leadership is an important component of clinical governance frameworks, which in turn are critical for assuring the delivery of high-quality and safe health services.[168]

In describing the role of the Chief Psychiatrist, Dr Coventry told the Commission:

> I may become involved in issues in order to ensure the rights of consumers receiving mental health services are promoted, or to address quality and safety issues in several ways. For example:
>
> - a mental health service may approach my office for assistance, may request a review of their practice, or may disclose an issue and seek support in resolving or responding to that issue
> - a consumer, carer or other individual may raise concerns with my office that have not been satisfactorily addressed through other avenues
> - I may become aware of systemic issues through routine engagement with mental health services, peak and advocacy bodies, such as through site visits and contact with services staff
> - I may respond to issues flagged through the department's regular performance monitoring processes, such as when specific indicators give rise to concerns, or when broader indicators are considered together in relation to service performance.[169]

This mix of responsibilities can create tension. Professor David Copolov AO, Professor of Psychiatry and Pro-Vice-Chancellor of Major Campuses and Student Engagement at Monash University, told the Commission that 'the responsibilities of the Chief Psychiatrist as currently framed appear to be very onerous and difficult'.[170]

Other roles contribute to the complexity and lack of clarity in the overall landscape. Dr Coulson Barr pointed out the limitations of the powers of the Complaints Commissioner. The role does not have the powers or functions to 'conduct own motion investigations, independently review critical incidents in services without a complaint, or inspect a service (unless we are conducting an investigation)'.[171] Nor does the Commissioner have the broader independent oversight, monitoring or strategic functions performed by Mental Health Commissions in other states.[172]

The distinction between some of the functions of the Chief Psychiatrist and the Mental Health Complaints Commissioner can also be unclear. While the Chief Psychiatrist does not have an official role in handling complaints, consumers, families, carers and supporters seek assistance from the Office of the Chief Psychiatrist to resolve problems such as: barriers to care; poor treatment, care and support; and service delivery that does not align with the Mental Health Act.[173] In addition, both the Mental Health Complaints Commissioner and Community Visitors have formal roles in receiving and responding to complaints.[174]

Furthermore, there is a gap in the current oversight arrangements for delivering mental health services in prisons and other custodial settings. In 2014 the former Department of Health and Human Services and the Department of Justice and Community Safety agreed that the Chief Psychiatrist would not exercise their powers under the Mental Health Act in relation to prison-based mental health services.[175] This means that while multiple bodies have oversight roles over such services, mental health service provision in correctional settings is not subject to the Chief Psychiatrist's standards, guidelines, monitoring, data analysis or public reporting.[176]

The Victorian Government is required to establish a new oversight mechanism that will apply to acute mental health inpatient units, as part of its broader human rights obligations. In 2017 the Australian Government ratified the *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*.[177] The Australian Government must implement its obligations under the protocol by January 2022.[178] This protocol requires signatory countries to establish a 'national preventative mechanism' to conduct inspections of all places of detention, including mental health facilities.[179] In Australia, each state will establish a mechanism for inspecting state-run facilities; in Victoria, the government is yet to announce the specific model to be implemented.[180] The first stage of implementation 'only provides for the independent inspection of forensic mental health services'.[181] In addition, it will focus on adherence to human rights requirements.[182]

Across all the above areas, there are significant opportunities to strengthen the independent oversight arrangements for Victoria's public mental health services.

30.5.3 Navigating and resolving complaints

Well-handled complaints provide consumers and service providers with a range of benefits: they can restore trust when things have gone wrong, lead to better outcomes for consumers, and identify ways to improve services for all consumers.[183] Dr Coulson Barr noted that, '[c]omplaints provide vital insights into the nature of people's experiences, and can identify key issues of quality, safety and rights in the provision of mental health services.'[184]

Consumers of Victoria's public mental health services can make a complaint about their experiences—or about the failure of a mental health service to provide services—to the service itself and to the Mental Health Complaints Commissioner.[185] As noted above, consumers, families, carers and supporters may also contact the Chief Psychiatrist.[186]

There are other avenues for consumers to make complaints, either about the same or overlapping concerns. These include:

- the Health Complaints Commissioner—for complaints about experiences when using private mental health services or for complaints about general health service experiences, including the privacy and confidentiality of personal health information[187]
- the Australian Health Practitioner Regulation Agency—for complaints about registered health practitioners[188]
- the Aged Care Quality and Safety Commission—for complaints about an aged care provider's responsibilities[189]
- the Office of the Victorian Information Commissioner—for complaints about how a mental health service handled a consumer's personal information.[190]

The differing scope of complaints handling across each of these bodies can lead to duplication for consumers. For example, if a mental health consumer experiences poor care in an emergency department, there may be multiple ways to lodge a complaint. As the Mental Health Legal Centre pointed out, '[a]n individual who perceives themselves to be receiving a singular episode of care may find themselves having to make multiple complaints to different bodies.'[191]

With the range of options available to consumers for complaints and advocacy, it is not always clear where to complain. As two consumers told the Commission:

> You are given the run-around and you don't know where to complain.[192]
>
> People need to be made to know who they can contact to complain.[193]

There are some supports available to navigate the complaints, advocacy and support arrangements. For example, Community Visitors can assist consumers to make a complaint to the Mental Health Complaints Commissioner.[194] The Mental Health Complaints Commissioner will also help the consumer access advocacy or support from another organisation, when appropriate.[195]

Where consumers seek advocacy and support, rather than to make a complaint, the Independent Mental Health Advocacy service may be able to assist. This service provides support to consumers who are receiving compulsory mental health treatment.[196]

The Commission considers there are opportunities to further improve navigation across complaints, advocacy and support for consumers, families, carers and supporters.

Resolving complaints

Dr Coulson Barr told the Commission::

> The office of the [Mental Health Complaints Commissioner] was created to address the significant barriers people experience in making a complaint about public mental health services, and to provide a statutory mechanism to ensure that the information from complaints was used to drive improvements in the safety and quality of services.[197]

In 2019–20 the Mental Health Complaints Commissioner received 2,369 new enquiries and complaints, with an average of 345 matters open at any one time.[198] Most commonly, the complaints fall into four broad categories: treatment, communication, staff conduct and behaviour, and medication.[199] Examples of these types of complaints include:

- treatment—such as disagreeing about compulsory assessment or treatment[200]
- communication—such as providing inadequate or misleading information to consumers[201]
- staff conduct and behaviour—such as staff behaviour that contributed to consumers experiencing a lack of dignity[202]
- medication—such as unnecessary medication or side effects of medication.[203]

In 2020 the Mental Health Complaints Commissioner added a new principle—driven by lived experience—to strengthen its commitment to the voice and collective experience and wisdom of consumers, families, carers and supporters.[204]

The Commission notes that the Mental Health Complaints Commissioner may encounter tensions between the needs and preferences of different parties when receiving and responding to complaints. Dr Coulson Barr indicated that consumers often want to resolve their individual concerns but also want to prevent similar incidents reoccurring.[205] The Mental Health Legal Centre describes the experiences of their clients in making a complaint:

> Unfortunately, many of our clients find the experience of making a complaint to be invalidating and disempowering despite being positive about the individuals they have dealt with at the [Mental Health Complaints Commissioner]. Consumers proceed with complaints primarily because they want services to be held accountable and they want to prevent other people from experiencing what they have. Many of our clients who have initiated complaints have found the process to be unsatisfying and, in some cases, quite traumatic. The focus on conciliation and an inability to compel a service to act or respond is challenging for clients who perceive that their voice is dismissed.[206]

Dr Coulson Barr also noted the barriers to resolving complaints to the satisfaction of consumers and in achieving broader improvements to the quality and safety of treatment, care and support:[207]

- Many services lack the leadership and capacity to work collaboratively with consumers to respond to and achieve positive change through complaints.
- Where staff and services lack knowledge and understanding of the requirements of the Mental Health Act, it can be difficult to achieve change beyond minimum compliance with the Act.
- Pressures on the service system, such as resource constraints, can make it difficult for services to respond to complaints in a meaningful way and to achieve broader cultural change.

Receiving complaints from families, carers and supporters

Families, carers and supporters can also have poor experiences when their loved one is connecting with mental health treatment, care and support. Currently, under the Mental Health Act, the Mental Health Complaints Commissioner can only accept a complaint from a consumer or someone acting at the consumer's request, unless the Commissioner is satisfied that the person has a genuine interest in the wellbeing of a consumer.[208]

Consumers and carers can have different perspectives about treatment, care and support, and this provision in the Act can help respect the consumer's views and autonomy.[209] However, families, carers and supporters expressed frustration that the Act does not give carers the option to make a complaint to the Mental Health Complaints Commissioner in their own right.[210]

30.5.4 Responding to unwarranted variation

Variation in treatment, care and support that reflects informed choices by consumers can be desirable. But variation that is due to other factors—such as consumers not having access to or not receiving evidence-based treatment, care and support—is undesirable.[211] It can indicate 'that valuable knowledge is not being shared and implemented widely, so that many patients are receiving care that diverges from best practice'.[212] This is often referred to as 'unwarranted variation' and indicates there are opportunities to improve service delivery.

Dr Coventry highlighted variation in a number of outcomes for consumers of mental health services. This included differences in the rates of falls, use of electroconvulsive treatment, and use of seclusion and restraint across mental health services.[213] The Commission's analysis indicates there is also significant variation in use of compulsory treatment orders, which is discussed further in Chapter 32: *Reducing compulsory treatment*.

Many consumers can experience harms as a result of compulsory treatment, or from being secluded or restrained during admission to a mental health inpatient unit. This can include both physical harms and psychological trauma. Consumers told the Commission of these harms:

> The compulsory treatment order made it hard for me to experience good mental health. I felt as if my basic human rights were taken away from me.[214]
>
> Seclusion is barbaric. Worse than prison. You are penalised for being unwell … It's dehumanising.[215]

These harms are explored in more detail in Chapter 31*: Reducing seclusion and restraint* and Chapter 32: *Reducing compulsory treatment*.

As part of their quality and safety accountabilities, service provider boards must identify and respond to unwarranted variation in mental health and wellbeing treatment, care and support by their workforce. This requires appropriate targets and data to benchmark aspects of service delivery. As noted above, their capacity to do this currently is limited.

To help, the Victorian Agency for Health Information has introduced a report for mental health service providers called *Inspire: Mental Health*. This provides benchmark data on a rotating range of indicators such as electroconvulsive treatment use or rates of seclusion and restraint.[216] High levels of variation in practices such as use of seclusion or restraint can indicate a need for improvements such as better standards, more robust clinical governance systems or other interventions to reduce the variation.[217]

At the system level, monitoring variation in care is also useful for service oversight and for identifying providers that may need additional support to deliver high-quality and safe treatment, care and support.[218] Where a provider's performance on a particular indicator is unusual for no obvious reason, the Chief Psychiatrist should write to clinical leaders to ask about the factors that contribute to the variation and to develop a remediation plan.

Dr Coventry suggested the variation in falls, use of seclusion and restraint, and use of electroconvulsive treatment can reflect 'systemic, environmental, staff-related and clinical issues'.[219] It may reflect differences in consumer needs or preferences. Service-specific factors such as poorly designed infrastructure or staffing levels can also contribute:

> We are aware that seclusion of patients is more likely to be used during night shifts, when we have only a quarter of the staff that we have during the day. As a result, there is less management oversight, less scrutiny of practice, less immediate availability of senior medical staff and actually, less staff period.[220]

The Commission's recommendations to develop a *Mental Health and Wellbeing Outcomes Framework*, a new Performance and Accountability Framework and a new information and communications technology (ICT) system will improve data collection about treatment, care and support, strengthening capacity to identify and respond to variation between services. These recommendations are discussed further in Chapter 3: *A system focused on outcomes,* Chapter 28: *Commissioning for responsive services* and Chapter 35: *New approaches to information management*.

30.5.5 Transparency and consumer trust

Consumers, families, carers and supporters want to see mental health services held to account when consumers are provided with treatment, care and support that is not appropriate, effective, connected and safe. A lack of action—particularly in a system that is struggling to provide high-quality services—can contribute to a lack of trust. Ms Erandathie Jayakody, a witness before the Commission, said:

> A law that authorises a mental health service provider to administer compulsory treatment and engage in restrictive practices needs a higher degree of accountability to protect the dignity and rights of persons subject to compulsory treatment. The same law needs to provide rigorous mechanisms to ensure that mental health services are delivering high quality services. The Act needs to hold mental health services accountable by increasing transparency through mandatory public sharing of comprehensive data, reporting against specific Mental Health Quality Frameworks and audits of mental health services, particularly those that engage in restrictive practices.[221]

The Commission heard that the regulatory and independent arrangements in the system were either ineffective or lacked transparency:[222]

> There is a lack of effective regulation and independent oversight mechanisms to drive compliance with Mental Health Act obligations.[223]
>
> There is no real effective, independent sector oversight, and there is a serious lack of transparent accountability for services.[224]
>
> On a broader level, there appears to be a reluctance of regulators to meaningfully enforce the Charter of Human Rights and Responsibilities Act 2006 (Vic) … and the [Mental Health] Act … We are almost six years into the Act, but we do not know if these coercive measures are being used, or who they are being used against. We do not know what is happening within mental health services because the complaints data is not released. And yet consumers are telling us daily that their human rights are being violated, and that the only law that applies is that which allows force against them, not those that protect their human rights.[225]
>
> Consumers are consistently highlighting the harmful impacts of human rights abuses, and yet this does not appear to take precedence in regulatory activities, such as the use of powers by key regulators.[226]

The Commission has also heard of the need for greater transparency concerning mental health service delivery, particularly regarding practices such as seclusion and restraint.[227] Victoria Legal Aid told the Commission:

> There is very limited publicly available data regarding the mental health system, including data on how many people are subject to compulsory treatment, and their geographical location, age, gender, cultural background, type and length of order, and complaints. Data is critical to service design, evaluation and consumer choice, and a key part of ensuring accountability.[228]

The Commission has also heard that it is difficult to see what actions are being taken to hold services to account for quality and safety or human rights failings.[229] Transparency about these activities allows consumers and their advocates to engage in a more meaningful way with the various oversight and improvement arrangements, and hold those charged with these functions to—in turn—be held to account. In contrast, the lack of information about how the Department of Health, the Chief Psychiatrist and other bodies are responding to quality and safety concerns can leave consumers feeling disempowered and distrustful.

Box 30.2 explores the devastating impact of suicides in care, and the arrangements in place across the system to prevent and respond to these tragic events.

Box 30.2: Suicides in care

The death of a loved one by suicide during or immediately after a hospital admission causes immense distress to loved ones, families, carers, supporters and staff. It is the most 'serious adverse outcome' after an interaction with a service.

It is devastating for families, carers and supporters. It is also challenging for staff:

> We've had people discharged straight from the High Dependency Unit (HDU) only to commit suicide hours later. It's just heart-breaking. We just want to make the system compassionate for families.[230]

In 2019–20, 13 consumers died by suicide while being cared for in a Victorian public mental health inpatient unit, while on approved leave from the unit, following transfer from the unit to a medical ward, or within 24 hours of discharge from hospital.[231] In comparison, there were six suicides in 2018–19 and 12 suicides in 2017–18.[232]

In Australia suspected death by suicide in a mental health unit is classified as a 'sentinel event'—that is, an event that is wholly preventable.[233]

There are actions services can take to respond to the risks and to prevent deaths by suicide in care. Audits by the current and former Chief Psychiatrists indicate that most suicides on inpatient wards result from hangings in bedrooms and bathrooms.[234] Improved design of inpatient units improves safety. For example, NorthWestern Mental Health has invested 'heavily in a ligature safety program to remove potential ligature attachment points in bedrooms and en-suite bathrooms'.[235] Alongside this, staff also do more frequent ward checks to identify any unsafe items.[236]

Broader changes to models of care, workforce training and interactions between staff and consumers are also important. Dr Coventry told the Commission:

> **What matters more than physical design [to prevent deaths by suicide in care], however, … is the quality of care provided by clinicians to the people admitted to hospital. Clinicians must respond empathically to people's distress, hear their fears and concerns, and meet their practical, social, psychological and physical needs. These demands are onerous in a stressed, busy system.**[237]

Services echo this when reflecting on the challenges they experience in preventing suicides in care.

Dr Vinay Lakra, Clinical Director of North West Area Mental Health Service, NorthWestern Mental Health, Melbourne Health, noted that the service's capacity to predict a person's risk of suicide is limited.[238] In addition, Monash Health highlighted research indicating fear of adverse events when working with people with suicidal thoughts can reduce the clinician's ability to provide high-quality care.[239]

Implementing the Safewards program may help. Safewards provides a range of interventions to help provide a sense of safety and mutual support for staff and consumers. Since 2014 Victorian public acute mental health inpatient units have implemented the Safewards model.[240]

In addition to Safewards, Latrobe Regional Hospital has implemented its *Zero Suicide Framework*, based on the *Zero Suicide Healthcare Framework* developed in the United States.[241] This includes systematically adopting evidence-based approaches—such as ongoing risk assessment and screening, collaborative safety planning and consistent engagement—across the health service. This framework has four components (Identify, Engage, Treat and Transition) that respond to aspects of clinical care, and three components (Lead, Train and Improve) that relate to service and system-focused approaches.[242] The framework is often implemented alongside a just and restorative culture.[243]

Given the seriousness of a death in an inpatient unit, the quality and safety arrangements for the mental health system include various approaches to ensure services (and the system) learn from any death. This includes Safer Care Victoria's sentinel events program, under which services must conduct a detailed analysis of the circumstances surrounding the event to 'ensure that providers learn as much as possible from these tragic incidents and take action to prevent a recurrence'.[244] There are a range of requirements for this investigation, including that at least one reviewer is from another service.

The Chief Psychiatrist also has a role. Under the Mental Health Act, the Chief Psychiatrist must be notified of any death on an acute mental health inpatient unit. The Chief Psychiatrist monitors all deaths 'with a view to identifying systemic and care-related factors that, if remedied, might improve the care delivered to all consumers and reduce the likelihood of further deaths'.[245] Chief Psychiatrists have conducted two audits of deaths by suicide in mental health care over the past decade.[246]

The Chief Psychiatrist will also work with Safer Care Victoria to review deaths and to ensure services have responded adequately. The Chief Psychiatrist has established 'panels of psychiatrists, mental health nurses, quality and safety managers and consumer and carer advocates to review the analyses of inpatient suicides' undertaken as part of the sentinel events program.[247] The panel provides feedback to each service and, if necessary, asks services to extend the investigation to better understand the factors or develop stronger recommendations for improvement.[248]

Inpatient deaths may also be reportable to the Coroners Court of Victoria for investigation. The Coroner may make recommendations to prevent similar deaths from occurring in the future. This can include recommendations to the service provider or to the Chief Psychiatrist.[249] The Coroner can also use their legal mandate to conduct in-depth reviews and examine patterns in deaths, as the Court does for family violence-related deaths.[250]

The amount of scrutiny over each suicide in health care is a recognition of the seriousness of suicide and the importance of learning from the event to prevent further occurrences. It is a quality and safety system in action.

But quality and safety systems also need to continually improve.
The Commission's recommendations focus on this opportunity.

In the future, the Mental Health Improvement Unit will work with service providers to ensure all necessary and possible steps are being taken to prevent any deaths by suicide in care. In addition, the Mental Health and Wellbeing Commission will prioritise monitoring and oversight of these events to ensure, in particular, that any lessons are identified and acted on.

It is the Commission's hope that in the future these tragedies no longer occur and that families, carers and supporters can be confident their loved ones are receiving high-quality and safe treatment, care and support.

This sits alongside the Commission's recommendations regarding a comprehensive and system-based approach to suicide prevention and response that is based on compassion and includes a substantial workforce as discussed in Chapter 17: *Collaboration for suicide prevention and response*.

30.6 The role of quality improvement

While there is a clear role for regulation and independent oversight—particularly in tackling poor quality and safety—a parallel focus on quality improvement is widely recognised as necessary to support and equip services to achieve the vision of a high-quality and safe mental health system.[251]

Improvement in service delivery can be hard, particularly in health care. Health services are complex, adaptive systems where 'the system's performance and behaviour changes over time and cannot be completely understood by simply knowing about the individual components'.[252] Improvement requires sustained change:

> **Building an organisation-wide commitment to quality improvement requires courageous leadership, a sustained focus over time, and efforts to promote transparency, evaluation and shared learning across the organisation and beyond.**[253]

Internationally, uptake of quality improvement approaches in mental health services is growing. This includes the following:

- Healthcare Improvement Scotland leads a range of mental health quality improvement efforts.[254] This includes the Scottish Patient Safety Programme in Mental Health, which focuses on reducing rates of restraint, violence, self-harm and seclusion, and improving the safety of medicines used in mental health treatment.[255]
- In England, the National Collaborating Centre for Mental Health has quality improvement programs targeting sexual safety, suicide prevention and reducing restrictive practices.[256]
- The New Zealand Health Quality and Safety Commission has established a Mental Health and Addiction Quality Improvement program.[257]

In Victoria, Safer Care Victoria is responsible for building knowledge and skills in quality improvement in health care and community services.[258] The organisation uses and teaches the Institute for Healthcare Improvement's Model for Improvement but recognises that services can adopt other methodologies. In 2018 Safer Care Victoria formed a strategic partnership with the Institute for Healthcare Improvement to increase use of the model and strengthen service capability across Victoria.[259] As part of its partnership with the Institute of Healthcare Improvement, Safer Care Victoria has been building interest and skills in improvement science, bringing together collaborative teams to use quality improvement methodologies to achieve a specific, measurable goal.[260]

To implement contemporary quality improvement approaches, service provider boards and senior managers must set a meaningful ambition, then support all levels of the organisation to achieve this vision.[261] Improvement projects need to be implemented by frontline staff using improvement methodologies based on local data and codesigned with consumers.[262] Successful change often begins with small-scale initiatives based on local intelligence but needs to be supported by an organisation-wide focus on improvement, from the board through to the frontline.

It is important to include people with lived experience of mental illness or psychological distress in the design and implementation of improvement projects. In addition, using consumer feedback and data on current practices and outcomes (including benchmarks with similar services) should be used to design and update improvement efforts.

Improvement science can also align with efforts to increase innovation in mental health and wellbeing treatment, care and support. The Commission's recommendations discussed in Chapter 36: *Research, innovation and system learning* provide dedicated support and resources for innovation in mental health, and drive cultures of enquiry, innovation and learning.

Real improvement gains require broad cultural change—where quality and safety are discussed, expertise is valued rather than seniority or position in the organisational hierarchy, and diversity of opinion is embraced.[263] As Mr Mousaferiadis and Mr Burgess told to the Commission:

> **In relation to quality and safety, there is the accreditation [task], but there is also the cultural piece. Both are important. For our quality and safety systems to work, there has to be a culture of trust within the organisation, and in the way in which information is reported to the Board and the Board committees. We have a great culture at Star Health. Reporting is very honest and forthcoming. You need to proactively create that culture, otherwise you do not know what is going on and people are not going to own up to mistakes and choose to learn from those mistakes.[264]**

Contemporary thinking on cultural change and behaviour in health services could also help embed quality improvement in mental health and wellbeing service delivery. This includes concepts such as 'Safety-I/Safety-II' thinking, where Safety-I—a focus on the absence of adverse incidents—is complemented by a focus on Safety-II, which looks at and learns from where things go right consistently, despite the risk, complexity and stress of the service delivery environment.[265] As Associate Professor Simon Stafrace, Chief Adviser of Mental Health Reform Victoria, told the Commission in a personal capacity:

> **Health service chief executives and board members must take as much interest in what good looks like as they do in what goes wrong. It is only then that an approach to leadership can emerge that favours effectiveness, person-centredness and recovery as much as it does clinical safety and financial, legal, and operational risk.[266]**

Mental health care, in particular, requires clinicians to adapt and be flexible, especially when dealing with people experiencing a mental health crisis.[267] A Safety-II approach is particularly useful in this situation because it supports requirements such as balancing principles of recovery and least-restrictive practice with protecting consumers and the community.[268]

30.6.1 System-wide support for quality improvement

Quality improvement is best driven by the motivation of providers to deliver high-quality and safe treatment, care and support to their consumers.[269] External bodies, though, can offer leadership, development and support for quality improvement.[270]

The Chief Psychiatrist and Safer Care Victoria both have functions that support quality improvement in mental health services.[271] Dr Coventry noted two distinctions in their roles: that the Chief Psychiatrist has a dedicated focus on mental health services; and that the Chief Psychiatrist has additional statutory powers to fulfil the functions of the role.[272]

In 2018 Safer Care Victoria worked with mental health services to establish the Mental Health Clinical Network to facilitate statewide quality improvement projects.[273] Between May 2019 and April 2020, the network undertook a project on consumer-directed care in Victorian mental health services.[274] This included a 'review of literature, examination of existing data sets and direct engagement with health services'.[275] The Commission heard that there were opportunities for Safer Care Victoria to take a more active role in mental health quality improvement.[276]

Organisations can be supported in various ways. System leaders can acknowledge that implementing and embedding new solutions can be hard, and disseminating new approaches difficult.[277] Building communities of practice (networks) can also help disseminate learning and support for new initiatives. External bodies can provide training, resources and tools, including education on specific improvement methodologies, and can help providers develop or use measurement tools—for example, consumer or staff feedback, incident data and so on. As Ms Kym Peake, the then Secretary of the Department of Health and Human Services, noted:

> The methods of improvement are important. All too often healthcare providers embark upon a journey of improvement with no effective methodologies. As social scientist [Professor Mary] Dixon-Woods summarises 'wanting to improve is not the same as knowing how to do it'. Mental health improvement in Victoria, at a system level, has that legacy; wanting to improve without really knowing how to do it.[278]

Services can benefit from open and honest relationships with external bodies tasked with supporting improvement. Dr Coventry highlighted the benefits of a collaborative relationship:

> Having a trusting, open relationship with clinical leaders is critical in my view to the success of this style of communication. It works best when leaders feel able to speak openly with the Chief Mental Health Nurse and me about their issues and concerns in a way that points directly to a shared view of whatever steps are needed to lift standards.[279]

In addition to having a focus on continuous improvement, the Chief Psychiatrist and the Chief Mental Health Nurse also provide clinical leadership (although the latter position is not established under the Mental Health Act) for mental health services.[280] This provides leadership with a strong focus on psychiatry and mental health nursing. There is, however, limited senior representation from other areas of practice or the lived experience workforce.

Dr Coventry told the Commission:

> While senior doctors and nurses are represented through my role, the Deputy Chief Psychiatrists and the Chief Mental Health Nurse, and whilst at any one time there are persons with diverse clinical backgrounds within the Mental Health and Drugs Branch, there are currently no senior positions in the Department of Health and Human Services for a psychologist, occupational therapist, social worker, speech pathologist, or senior lived experience adviser.[281]
>
> This gap in multidisciplinary representation limits our ability to obtain advice from allied health experts in the field, and does not model a best practice approach for the sector.[282]

With a greater emphasis on community-based treatment and a broader range of treatment, care and support options available to consumers in the new mental health and wellbeing system, it will be increasingly important for there to be greater diversity of professional, clinical and practice leadership, along with a clear and shared quality goal.

30.7 A new quality and safety architecture

The Commission's recommendations seek to build an architecture for quality and safety that places consumers and staff in the centre, that supports services to meet expectations and to improve quality, and that holds services to account when standards are not met.

The quality and safety architecture will:

- place the voice of the consumer—and their families, carers and supporters—at the heart of service and system improvement by ensuring greater prominence of lived experience voices in every oversight and improvement function
- help services and their workforce to deliver high-quality and safe treatment, care and support
- provide a clear and coordinated approach to oversight and quality improvement
- strengthen the role of independent oversight to provide assurance that quality expectations are being met
- capitalise on national and international momentum in interest and expertise in mental health quality improvement and bring a contemporary approach to mental health and wellbeing in Victoria.

To achieve stronger oversight and quality improvement across the mental health system, the Commission has recommended both new and updated arrangements:

- The Mental Health and Wellbeing Commission will be responsible for independent oversight of the quality and safety of treatment, care and support, as well as for receiving and responding to complaints about treatment, care and support.
- A new unit within Safer Care Victoria, the Mental Health Improvement Unit, will be responsible for contemporary quality improvement and professional, clinical and practice leadership in mental health and wellbeing service delivery.
- The Chief Psychiatrist will continue to monitor specific practices and incidents, and seek to safeguard against inappropriate clinical practices.

Together with the Mental Health and Wellbeing Division within the Department of Health, these bodies will form the quality and safety architecture of the mental health and wellbeing system.

The Commission notes that the quality and safety architecture itself will need regular review and updating to ensure it remains fit for purpose and provides consumers and government with confidence that high-quality and safe services are being delivered.

30.7.1 The importance of lived experience expertise in oversight and quality improvement

Input from those with lived experience of mental illness or psychological distress into independent oversight and quality improvement provides three important opportunities: to inform decision making; to build understanding of the consumer experience; and to help redress the power imbalance between consumers and services.

The Commission heard from consumers and clinicians about the need for lived experience input into independent oversight (and regulatory) and quality improvement arrangements.[283] Dr Tricia Szirom, then CEO of the Victorian Mental Illness Awareness Council, told the Commission:

> The voice of lived experience needs to be embedded in every aspect of the system including rethinking the system's main activities and intended outcomes, workforce composition and skill requirements, accountability and oversight, and service types.[284]

Across service providers and central bodies, there are opportunities for consumer leadership and participation in efforts to deliver high-quality and safe mental health and wellbeing treatment, care and support. This includes:

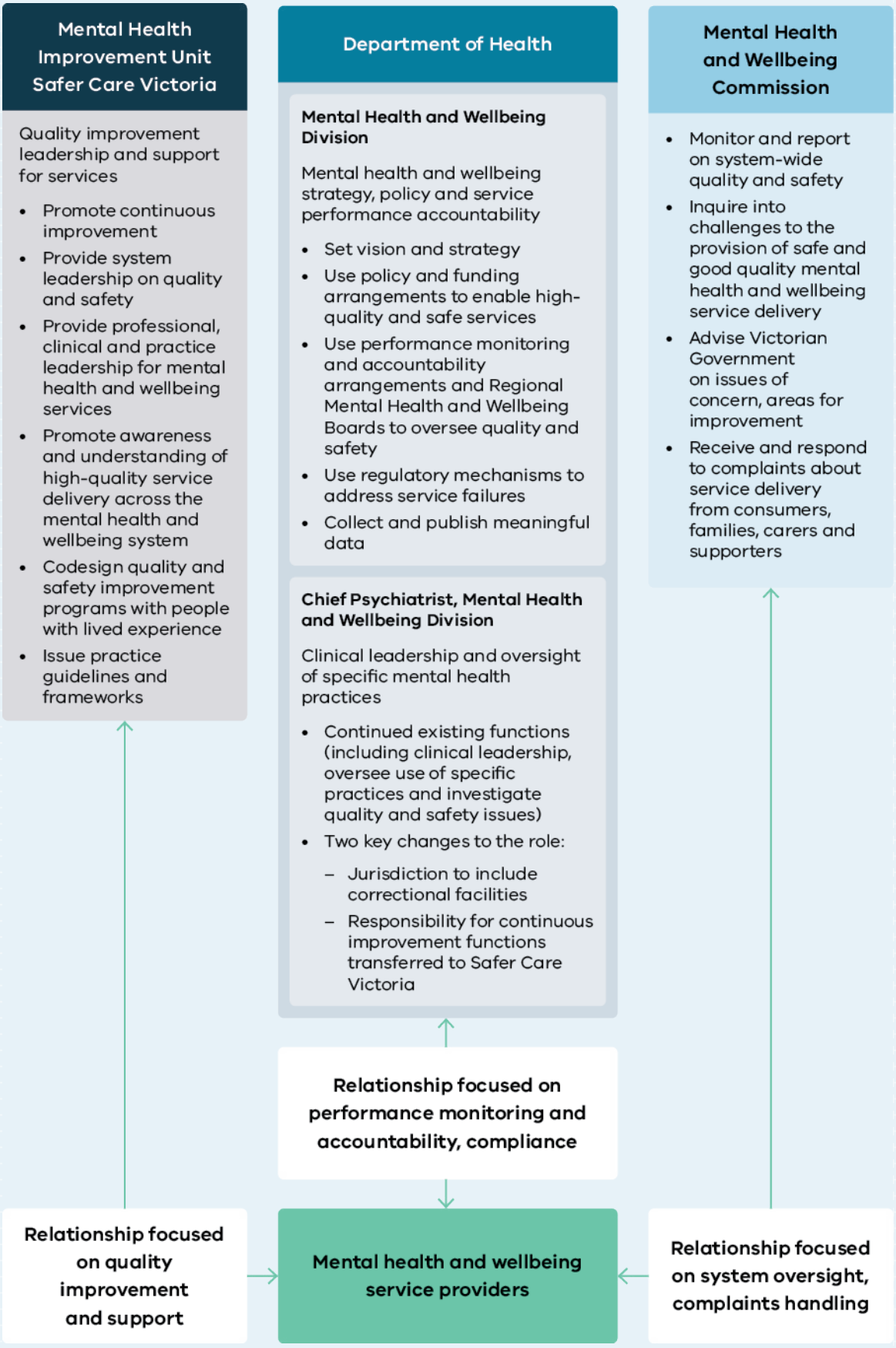
- In the Mental Health and Wellbeing Commission, the Commissioners with lived experience will provide visible leadership and input into independent oversight functions and decision making.
- In the Mental Health Improvement Unit of Safer Care Victoria, lived experience leaders and advisers can support the co-design of an overall vision for high-quality and safe treatment, care and support, and lead or advise on specific quality improvement activities such as local projects and communities of practice.
- Services can appoint lived experience leaders and consultants to quality and safety committees, apply co-design methodologies in quality improvement activities, and provide accessible mechanisms to capture feedback from consumers, families, carers and supporters.

30.7.2 A coordinated approach to oversight, accountability and improvement

To support services to deliver high-quality and safe services, three types of system-wide functions are required: system management (including regulation and performance monitoring and accountability), independent oversight and quality improvement.

The Commission envisages these roles being performed by three central bodies: the Department of Health, the Mental Health Improvement Unit (in Safer Care Victoria) and the Mental Health and Wellbeing Commission. The proposed new arrangements are shown in Figure 30.5.

Figure 30.5: The Commission's recommended quality and safety architecture



The Department of Health and Regional Mental Health and Wellbeing Boards will be responsible for performance and accountability arrangements (described in Chapter 5: *A responsive and integrated system*). The department will also continue to have regulatory roles and responsibilities, particularly in relation to accreditation against national standards (refer to section 30.3.2).

Clarity of roles

With the range of quality and safety functions required across the mental health system, some dispersing of responsibilities is inevitable. Given this, clarity of both roles and relationships will be necessary. The coordination of activity between each party will be critical to the success of the system's quality and safety architecture.

Key roles and responsibilities will be allocated as follows:

- The Department of Health will be responsible for quality and safety strategy, policy and performance accountability. The department will fulfil this by:
  - setting expectations for high-quality and safe service delivery by articulating a vision for the system and incorporating the domains of quality (outlined earlier) into the system's performance-monitoring and accountability framework
  - using policy and funding arrangements to enable and support providers to deliver high-quality and safe services
  - using performance-monitoring and accountability arrangements, in conjunction with Regional Mental Health and Wellbeing Boards, to oversee the delivery of high-quality and safe services
  - using regulatory approaches or tools to deal with situations where services do not meet minimum standards, including minimum legislated requirements
  - collecting and publishing comprehensive and meaningful data on the quality and safety of mental health and wellbeing service delivery.
- The Mental Health Improvement Unit within Safer Care Victoria will provide leadership and support to services to improve the quality of service delivery. It will achieve this via:
  - setting annual improvement goals
  - providing professional, clinical and practice leadership
  - supporting services to achieve improvements through training, resources, communities of practice and other mechanisms.
- The Mental Health and Wellbeing Commission will have a statutory responsibility to provide independent oversight of the quality and safety of service delivery as part of its broader oversight role. This will encompass:
  - independent, system-wide oversight, including conducting inquiries into quality and safety areas of concern
  - receiving, investigating and responding to complaints about service delivery from consumers, families, carers and supporters.

In the short term, the quality and safety architecture will include the role of the Chief Psychiatrist. The Commission's position on the future of this role and its responsibilities is explained later in this section'.

Clarity of expectations under the Mental Health and Wellbeing Act

The Commission's reforms include introducing a new Mental Health and Wellbeing Act (refer to Chapter 26: *Rebalancing mental health laws—a new Mental Health and Wellbeing Act*). Delivering high-quality and safe mental health and wellbeing treatment, care and support will depend on effecting implementation of the objectives or principles of this legislation among service providers.

Support for implementation will be critical. While the Department of Health will lead the implementation, the Mental Health Improvement Unit will have a key role in supporting mental health and wellbeing services to embed the objectives or principles of the Act in delivering treatment, care and support. Implementation will align the legislative requirements for service delivery with contemporary clinical practice.[285]

The Mental Health Improvement Unit and Chief Psychiatrist will work together to ensure any standards, guidelines and advisories provide clear and consistent direction on how services are expected to provide treatment, care and support. This will be particularly important for embedding principles such as 'least restrictive practice', where workers need to balance human rights, clinical and practice considerations in their decisions. Clarity of expectations will also support the Mental Health and Wellbeing Commission to fulfil its oversight functions, including monitoring service delivery and handling and investigating complaints. This will also assist the department and the Mental Health Improvement Unit to monitor and analyse unwarranted variation in the delivery of mental health and wellbeing services.

Clarity of relationships

Each of the three central bodies and the Chief Psychiatrist will need to have clear relationships with mental health and wellbeing service providers. The Commission envisages:

- The Mental Health and Wellbeing Commission's relationship with providers will focus on system oversight and complaints management.
- The Mental Health Improvement Unit's relationship with providers will be collaborative and focus on support and improvement.
- The Department of Health's relationship with providers will focus on commissioning, funding and performance monitoring of service delivery.
- The Chief Psychiatrist's relationship with providers will focus on clinical leadership and oversight of specific mental health and wellbeing practices.

The relationships between each of the bodies will be critical to the success of the quality and safety architecture. These should be formally articulated via publicly available memorandums of understanding. The Commission envisages the following relationships:

- The Mental Health and Wellbeing Division in the Department of Health will be accountable to the relevant ministers. The division can advise the Mental Health Improvement Unit and refer activities to it but cannot direct the unit. The division will be able to refer matters to the Mental Health and Wellbeing Commission to undertake an inquiry.
- The Chief Psychiatrist will report to the head of the Mental Health and Wellbeing Division, at least in the short term.
- The Mental Health Improvement Unit will be accountable to the CEO of Safer Care Victoria and to the relevant ministers. The unit will be able to accept referred work from the Mental Health and Wellbeing Division and to provide advice to the division on quality and safety concerns.
- The Mental Health and Wellbeing Commission will be independent and annually report to the Victorian Parliament. The Mental Health and Wellbeing Commission will make recommendations to the Premier, any minister and the heads of public service bodies. This may include recommendations for the Chief Psychiatrist, or recommendations that can be referred to the Mental Health Improvement Unit.

While the Mental Health and Wellbeing Commission may draw attention to areas of service delivery that require improvement, it will not have a formal role in directing the Mental Health Improvement Unit.

Furthermore, each of these bodies will need to establish relationships with other bodies across the system. In particular:

- The Mental Health and Wellbeing Commission will need relationships with bodies such as the Australian Health Professional Regulation Agency, the Health Complaints Commissioner and other bodies involved in the oversight of service delivery or the health and mental health and wellbeing workforce.
- The Mental Health Improvement Unit will benefit from relationships with the Collaborative Centre for Mental Health and Wellbeing, organisations that provide practice leadership and other bodies involved in mental health innovation, evaluation and implementation.

The department should also consider who should hold the principal relationship with the Coroner for sentinel events. The Commission considers there is value in a strong relationship between the Coroner and the Mental Health Improvement Unit.

The role of the Chief Psychiatrist

The Commission's evidence indicates there can be confusion about the purpose and functions of the Chief Psychiatrist role, difficulties in fulfilling the various statutory functions allocated to the role, and a need for greater transparency about the Chief Psychiatrist's use of powers.[286]

The current Chief Psychiatrist, Dr Coventry, noted that 'domains of activity' of Chief Psychiatrists across Australian states and territories vary.[287] The breadth of the role in Victoria, Dr Coventry suggested, made it 'unique' in Australia.[288] Dr Coventry said a combination of factors are beneficial:

> I believe that my role as Chief Psychiatrist combines clinical expertise with statutory authority, proximity to departmental commissioning and funding bodies, access to data and data analysts, a trusting relationship with service leaders, and a lived experience viewpoint. This particular combination of strengths and assets is not replicated elsewhere and offers a springboard for further opportunities to strengthen the quality and safety of Victorian mental health services.[289]

The Commission can see the benefit in having a role with breadth. It increases the visibility of problems, enables a strategic and system-wide view, and provides opportunities for considerable contact with services, which can deepen and extend relationships.

The Commission understands that any confusion and overlaps may have been well managed by Dr Coventry. But on balance, the Commission considers that the range of statutory functions allocated to the role appears to have an inherent tension. This creates an ongoing risk of confusion about the purpose, powers and how the role operates in practice. This tension could be resolved in various ways; for example:

> As part of service improvement, the role of the Chief Psychiatrist should remain in place, but be redefined, especially to focus on regulation and compliance with the *Mental Health Act 2014* (Vic).[290]
>
> The Chief Psychiatrist should be a part of Safer Care Victoria (alongside the Chief Nurse and Midwife, Chief Medical Officer and Chief Paramedic).[291]

The Commission considered numerous options for reforming the role of the Chief Psychiatrist to deal with this tension. As the Commission's recommendations for system management, quality improvement and independent oversight—as well as reforms to delivering mental health and wellbeing treatment, care and support—are implemented, the ideal remit for a Chief Psychiatrist position may change.

In particular, the need for the Chief Psychiatrist to provide assistance to mental health services to resolve quality and safety concerns, and to help consumers, families, carers and supporters to find avenues to tackle problems, will decrease significantly. Indeed, there may not be an ongoing need for a chief practitioner role like the Chief Psychiatrist's role as currently conceived, given that the head of the Mental Health and Wellbeing Division in the Department of Health will be a role defined in legislation, and to whom appropriate system management, service performance and legislative compliance responsibilities could potentially be allocated.

Given this, the Commission has not recommended more substantial changes to the role or functions of the Chief Psychiatrist in the short term. Rather, as the system evolves, the Victorian Government should consider and review the utility of the current responsibilities of the role and make any required adjustments as part of subsequent legislative reforms (refer to Chapter 26: *Rebalancing mental health laws—a new Mental Health and Wellbeing Act*).

However, one adjustment in particular should be considered as an immediate priority. As noted above, there is a gap in the current oversight arrangements for delivering mental health services in the correctional system. The Chief Psychiatrist does not currently exercise powers under the Mental Health Act in relation to prison-based mental health services. This gap should be dealt with as part of the Commission's first wave of legislative reforms so that mental health service provision in correctional settings is subject to the Chief Psychiatrist's standards, oversight, monitoring and public reporting.

The Commission also considered the governance arrangements for the Chief Psychiatrist—in particular, whether the role is most appropriately located within the department (and if so, where within the department's structure), or if alternative arrangements would strengthen the role. The position could potentially move to another body for either greater independence from the department, or for increased alignment of functions with a quality improvement focus.

Dr John Reilly, Queensland's Chief Psychiatrist, pointed out that a Chief Psychiatrist role located within the department responsible for administering the mental health system can mean that the role is 'perceived as lacking independence from the administering department'.[292] However, Dr Reilly also noted the benefits of this arrangement, and added that the statutory nature of the role provides sufficient independence.[293] Furthermore, Dr Coventry pointed out that integrating the role within the Mental Health and Drugs Branch in the department enabled the Chief Psychiatrist to provide input into broader policy and performance processes.[294]

Noting this, the Commission proposes that the Chief Psychiatrist role continues to be integrated into the department's Mental Health and Wellbeing Division. In the immediate future, as the Commission's reforms are being implemented, overlaps in functions should be managed via memorandums of understanding between the Chief Psychiatrist and the Mental Health Improvement Unit. In particular, these memorandums of understanding should transfer responsibility for continuous improvement functions to the Mental Health Improvement Unit.

Quality and safety data

The Commission's recommendations include developing, funding and implementing modern information management arrangements that will enable the effective, safe and efficient collection of information as described in Chapter 35*: New approaches to information management*. This will support both service delivery and the development of quality improvement tools, such as clinical registries. It will enable services to collect data about decisions on treatment, care and support that are not aligned with a consumer's preferences in order to monitor compliance with the principles of the new Act. It will also enable the Mental Health Improvement Unit (and Chief Psychiatrist) to identify and analyse any unwarranted variation in service delivery.

The department's Mental Health and Wellbeing Division will be responsible for collating and sharing data about the quality and safety of mental health and wellbeing treatment, care and support. The division will also develop and publish regular service-level data on important quality and safety matters such as the use of compulsory treatment and restrictive practices.

The Mental Health and Wellbeing Division should also consider establishing formalised arrangements with organisations that hold data relevant to monitoring the quality and safety of mental health and wellbeing service delivery. This should include occupational health and safety data held by WorkSafe Victoria and information about trends relating to relevant claims held by the Victorian Managed Insurance Authority. The purpose of these arrangements should be to maintain a comprehensive view of the experiences of consumers, families, carers and supporters, and the workforce. Analysis should consider service delivery risks, challenges and areas requiring dedicated focus and improvement. Such an approach could build on the recent partnership between the Department of Health (then Department of Health and Human Services) and Victorian Managed Insurance Authority on the Safewards initiative.

Data relating to the quality and safety of services should be shared with the Mental Health and Wellbeing Commission and the Mental Health Improvement Unit to help them deliver their functions.

30.7.3 A new oversight regime

The Commission allocates responsibility for system-wide oversight of the quality and safety of mental health service delivery to the Mental Health and Wellbeing Commission, providing a degree of independence from the role and responsibilities of the Department of Health.

The Commission has heard that the current failings of the mental health system indicate a lack of regulation and independent oversight.[295]

Rather than introduce additional regulation specific to mental health services, the Commission's recommendations include strengthening the independent oversight arrangements across all mental health services, regardless of the type of provider delivering treatment, care and support. This will provide greater transparency and use the 'disinfectant of sunlight' to strengthen accountability to consumers, families, carers and supporters, and the Victorian public.[296]

As described above, current regulatory and independent oversight arrangements are a mix of mental health–specific functions, broader health and community service arrangements, and Victorian and national legislation and standards. The department's role as a regulator will continue as the mental health system reforms are implemented. This role varies between health services (with devolved governance arrangements) and community services (with purchaser–provider arrangements).

The Commission considers that the mental health system requires a dedicated mechanism for oversight, rather than relying only on existing regulatory and oversight arrangements for either health or community services. As Ms Peake noted:

> While there may be synergies in combining some health and mental health system stewardship functions … there is a strong argument for separate and bespoke approaches for … oversight of the quality and safety of the mental health system …[297]

Because mental health is a major health and social concern, publicly funded mental health and wellbeing services should provide a high standard of treatment, care and support to consumers. In addition, when consumers can be treated on a compulsory basis under the Mental Health Act, it is particularly important that consumers receive high-quality treatment, care and support, and that this is subject to a high degree of external scrutiny.[298] Dedicated mental health oversight functions are also appropriate where services are operating in an environment with legislation and standards set both nationally and at the state level.

The Victorian Mental Illness Awareness Council noted that a lack of independence of safeguarding and oversight bodies leads to a 'loss of faith in them by the consumer community'.[299] Creating an oversight mechanism that is independent or separate from the department provides the oversight body with an opportunity to be bolder in drawing attention to service delivery that is poor quality or unsafe.

The Mental Health and Wellbeing Commission's roles and responsibilities

Table 30.2 outlines the functions of the Mental Health and Wellbeing Commission regarding quality and safety. The Commission's capabilities, powers and data-sharing requirements are then explained.

To undertake these functions, the Mental Health and Wellbeing Commission will require the expertise to establish the oversight functions. It will also need staff with diverse expertise including clinical and practice skills, capabilities and experiences. The role of the Mental Health Complaints Commissioner should also be incorporated into the Mental Health and Wellbeing Commission.

Consumers in particular, but also families, carers and supporters, should inform all aspects of the independent oversight and complaint-handling functions. The staffing of these functions should include dedicated lived experience roles, including senior operational positions.

Given the importance of a human rights approach in mental health service delivery, the Commission will also require the knowledge and understanding to apply a human rights lens to oversight of quality and safety.

To fulfil its quality and safety oversight and complaint-handling functions, the Commission will need appropriate statutory powers. As outlined in Chapter 27: *Effective leadership and accountability for the mental health and wellbeing system—new system-level governance*, the Commission will have statutory powers to:

- initiate its own inquiries into quality and safety matters
- make recommendations to the Premier, any minister and heads of public service bodies
- publish reports in respect to the performance and quality and safety of the mental health and wellbeing system and progress towards improving mental health and wellbeing outcomes for Victorians
- seek data and information from all government agencies about mental health and wellbeing service delivery, system performance and outcomes, and other relevant information
- work with and share data and information with the department and other relevant entities.

Table 30.2: Quality and safety oversight functions of the Mental Health and Wellbeing Commission

Function	Detail
Monitor and report on system-wide quality	The Mental Health and Wellbeing Commission will monitor the delivery of mental health and wellbeing treatment, care and support across the four domains of quality: effective, appropriate, connected and safe. The Commission will report regularly on system-wide performance across all the domains, as well as report as necessary on specific matters or areas of practice (such as use of compulsory treatment or restrictive practices).
Respond to complaints about mental health and wellbeing service delivery	The Mental Health and Wellbeing Commission will receive, investigate, respond to and mediate complaints about mental health and wellbeing service delivery. As per current arrangements for the Mental Health Complaints Commissioner, the Commission will investigate complaints, make recommendations to service providers, accept an undertaking from a provider to take remedial action, or issue a compliance notice if the provider has not complied with this undertaking or has acted in contravention of the Mental Health Act.
Inquire into system-wide quality and safety challenges or concerns	The Mental Health and Wellbeing Commission will conduct system-wide inquiries into matters relating to mental health and wellbeing treatment, care and support. This will give the Commission the capacity to initiate and conduct its own inquiries or at the request of any minister, the Secretary of the Department of Health or the Chief Officer for Mental Health and Wellbeing (the statutory head of the Mental Health and Wellbeing Division).
Advise government on areas of concern and areas for improvement	The Mental Health and Wellbeing Commission will provide advice to parliament and relevant ministers on the quality and safety of mental health and wellbeing service delivery based on insights gained from oversight and complaint-handling functions.

In addition, the current powers of the Mental Health Complaints Commissioner should be transferred to the new Commission. This will include managing complaints about mental health service provision and, in relation to complaints, the:

- capacity to undertake investigations into quality and safety concerns in mental health services (in response to either an individual complaint or when complaints indicate a broader or systemic problem)
- power to accept an undertaking from a mental health service provider to take remedial action
- power to issue a compliance notice if the provider has not complied with the undertaking or has acted in contravention of the Mental Health Act.

The scope of the Commission's quality and oversight functions will include all providers funded by the Victorian Government to deliver mental health and wellbeing treatment, care and support. This will include services delivered by public health, community health, non-government and private organisations. It will also cover delivery in hospitals, the community, public and private prisons, and police cells.

The Mental Health and Wellbeing Commission will need the power to seek data and information on the quality and safety of mental health and wellbeing treatment, care and support. The Mental Health and Wellbeing Commission should support the department's Mental Health and Wellbeing Division to develop meaningful and contemporary quality and safety measures. This should include data on service delivery, on other indicators of high-quality treatment, care and support (such as lived experience input into service delivery and other activities), on accreditation and other quality management activities, and on consumer, family, carer and supporter input.

The Mental Health and Wellbeing Commission will also develop strong links with the department and relevant regulators to build a comprehensive understanding of the quality and safety concerns in service delivery settings. This will include an understanding of incidents and adverse events as relevant to mental health services and the experiences of people living with mental illness in seeking out other health and community services.

Receiving and responding to complaints

The Commission's recommendations include transferring the role of the Mental Health Complaints Commissioner into the Mental Health and Wellbeing Commission, described in Chapter 27: *Effective leadership and accountability for the mental health and wellbeing system—new system-level governance*. The Commission heard of the value of an independent complaints commissioner and considered that this should remain a feature of the overall architecture.

This Commission notes that as of 1 July 2020 (during the period of the Commission's work), the Victorian Government appointed one individual (Ms Treasure Jennings) to the roles of Disability Services Commissioner and Mental Health Complaints Commissioner. The Commission acknowledges that moving the mental health complaints function into the independent Mental Health and Wellbeing Commission will have an impact on this but does not feel bound to maintain the current arrangement. On balance, the Commission considers there is merit in making this change in order to improve oversight and safeguarding of the quality and safety of mental health and wellbeing treatment, care and support. These functions align with the objectives of the new Mental Health and Wellbeing Commission related to holding government to account for the performance of the mental health system and promoting consumer leadership, and are discussed in Chapter 18: *The leadership of people with lived experience of mental illness or psychological distress*.

The Mental Health and Wellbeing Commission will receive, investigate, respond to and mediate complaints about mental health service delivery. This will include complaints from consumers and from families, carers and supporters (where the complaint relates to the experience of the person as a family member, carer or supporter).

The Commission will:

- continue to develop the complaint-handling processes developed by the Mental Health Complaints Commissioner, with a focus on complaints made requiring immediate resolution (for example, many oral complaints) and complaints made after an incident or experience of treatment, care or support
- work with services to understand the importance of consumer complaints and to build the capacity to respond to complaints in a way that achieves positive outcomes
- use the insights into the quality and safety of mental health and wellbeing service delivery captured through complaints to initiate and inform reviews and inquiries.

Dr Coulson Barr noted that the Mental Health Complaints Commissioner developed a 'no wrong door' approach to complaints.[300] The Mental Health and Wellbeing Commission will build on this approach to improve access and navigation to complaints about mental health and wellbeing treatment, care and support.

This should include:

- using the mental health website—described in Chapter 8: *Finding and accessing treatment, care and support*—to direct consumers to the right place to make a complaint about mental health services, or to seek advocacy or other supports (this should include a self-help tool to assist consumers to navigate the various avenues for making a complaint or seeking support)
- staff of Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services being proactive in identifying where consumers may want to make a complaint or seek advocacy, either about mental health and wellbeing service delivery or public life more broadly, and referring consumers to the appropriate body for complaints or for legal and non-legal advocacy
- clear referral pathways between relevant bodies (legal advocacy, non-legal advocacy, complaints and service providers).

These mechanisms will build on existing referrals between bodies such as the Chief Psychiatrist, the Mental Health Complaints Commissioner and the Independent Mental Health Advocacy. As the Commission's reforms are implemented (particularly the improvements to the quality and safety architecture) these arrangements may need review and updating.

The Commission notes that the *Health Complaints Act 2016* (Vic)—which establishes the office and role of the Health Complaints Commissioner—is currently being reviewed by the Department of Health. The department will consider if the Act is working as intended to resolve complaints and to identify and act on systemic issues.[301] The process of establishing the Mental Health and Wellbeing Commission as the mental health complaints handling body will provide the opportunity for alignment with any reforms arising from the review of the Health Complaints Act.

30.7.4 A new approach to quality improvement

Contemporary improvement approaches provide an opportunity to respond to poor quality and safety in mental health and wellbeing treatment, care and support in a systematic and evidence-based way.[302] The Mental Health Improvement Unit, in Safer Care Victoria, will provide a strong focus on building the knowledge, capability and expertise of contemporary quality improvement approaches and methodologies in Victoria's mental health and wellbeing services.

Ms Peake proposed that the Mental Health Improvement Unit be established in Safer Care Victoria.[303] This also provides the opportunity for the unit to implement a 'whole of state learning healthcare system for mental health'—a first for mental health in Australia.[304]

The recommended changes to quality improvement also seek to broaden the clinical and practice leadership on which it is based. This will reflect the multidisciplinary (including lived experience) workforce and the importance of comprehensive and integrated treatment, care and support for consumers. There are also synergies between clinical and practice leadership and quality improvement functions, as both benefit from collaborative and open relationships between central bodies and service providers.

In contrast with the oversight and complaint-handling functions, there is less need for independence or separation between the role of the department as system manager and the body responsible for quality improvement. Rather, closer links can be advantageous. Establishing a dedicated unit with links to the system manager can drive quality improvement in partnership with clinical leaders, and work with performance and accountability systems.[305] The statutory functions of the department's Secretary to promote continuous improvement in the quality and safety of mental health services can be delegated to the head of Safer Care Victoria.

As an administrative office of the department, Safer Care Victoria also has a formal relationship with system management functions.[306] As part of this relationship, the CEO of Safer Care Victoria is a member of the departmental executive board.[307]

The Mental Health Improvement Unit's roles and responsibilities

Table 30.3 outlines the proposed functions of the Mental Health Improvement Unit. The unit's main capabilities and data-sharing requirements are then explained.

The Mental Health Improvement Unit will need skills and capability to lead quality improvement. It will also need professional, clinical and practice leadership skills and experience across disciplines such as psychiatry, psychology, mental health nursing, social work, occupational therapy and lived experience work.

Dr Coventry noted the potential benefit of involving different allied health professionals:

> progress on specific pieces of work could potentially be enhanced by an allied health lead. For example:
>
> (a) a lead with expertise in psychology could contribute to the personality disorder program, and would have some input into specialist programs such as eating disorder and parent-infant programs
>
> (b) a lead occupational therapist could make a significant contribution to the interface between [National Disability Insurance Scheme] and clinical services
>
> (c) the social work discipline could further promote family sensitive practice, as well as enhance discussions relating to homelessness, family violence, housing and child protection work and the interface with external agencies
>
> (d) a speech pathology lead could make considerable contributions to work on child and youth services, and on communication issues and barriers relating to autism spectrum disorder and intellectual disability.[308]

Table 30.3: Functions of the new Mental Health Improvement Unit

Function	Detail
Providing system leadership on quality and safety improvement	The unit will establish annual goals for quality improvement across the system, with rolling priorities where needed.
Providing clinical and practice leadership	The unit will provide expert advice to the Mental Health and Wellbeing Division in the Department of Health on quality and safety matters. The unit will also provide professional leadership to the sector.
Promoting learning cultures across the mental health and wellbeing system	The unit will help service providers to embed contemporary approaches to quality improvement in delivering mental health and wellbeing treatment, care and support. This could be via training in improvement methods, developing resources, establishing communities of practice and providing targeted grants to support local or statewide improvement projects to tackle specific risks.
Co-designing improvement programs with services and consumers	The unit will work with people with lived experience and services to identify projects and programs to respond to quality and safety priorities. This will include system-wide efforts (similar to the implementation of Safewards) or locally driven initiatives. Each project and program will incorporate contemporary quality improvement methodologies.
Issuing practice guidelines and frameworks	The unit will develop materials to support its quality improvement functions. This may include, for example, guidance on how to implement particular methodologies in mental health settings, how to embed a human rights approach, or how to deal with a specific concern (such as preventing gender-based violence or eliminating the use of restrictive practices).
Developing relationships with bodies with key mental health improvement roles and responsibilities	The unit will work with other bodies that will also contribute to improving mental health and wellbeing treatment, care and support, including the Collaborative Centre for Mental Health and Wellbeing.
Working with agencies in other jurisdictions and through Commonwealth committees to lead improvement in mental health and wellbeing care at the national level	The unit will work with similar bodies across Australia to build expertise and knowledge in mental health and wellbeing quality improvement. The unit will also represent Victoria on relevant national safety and quality committees.

Furthermore, roles that have professional or clinical 'gravitas' tend to have the credibility to lead and support services in improvement efforts because they are trusted and have an understanding of the operating environment.

The unit will also need the knowledge and capabilities to embed a human rights approach to quality improvement efforts. This will require an understanding of the role and relevance of human rights in mental health and wellbeing service delivery, including the ways in which this both overlaps within and outside of service delivery contexts and is distinct from general health quality improvement. Consumer leadership and participation will contribute to this understanding.

Given the diversity of the current and future mental health and wellbeing system—including non-government organisations that offer non-psychiatric clinical services—it is important that the unit has a multidisciplinary orientation and recognition of the significant expertise and value that all disciplines can contribute to quality improvement efforts. To achieve this, the head of the unit should be appointed based on merit and could come from psychiatry or other disciplines. In addition, the current role of the Chief Mental Health Nurse should be incorporated into the Mental Health Improvement Unit.

The unit will not have specific powers under the Mental Health Act. It will work with all publicly funded mental health and wellbeing service providers, including providers that are not health services, to improve the quality of treatment, care and support.

The unit will require access to data and information about the delivery of mental health and wellbeing treatment, care and support. This should include access to the data collected by the department for performance monitoring and accountability. It should also include data collected (and published) by the Mental Health and Wellbeing Commission on the quality and safety of mental health treatment, care and support, including data on complaints.

If quality and safety improvements are not put in order of priority, staff and organisations can become overwhelmed.[309] Therefore, the unit should identify priority statewide areas for improvement each year, with rolling priorities where needed, and support services to identify and implement change locally. How change in each area is achieved will depend on service-level analysis of the problem and local co-designed improvement projects. Based on the Commission's analysis, the initial focus should include reducing restrictive interventions, reducing compulsory treatment, preventing gender-based violence and preventing suicides in mental healthcare settings.

As part of its partnership with the Institute for Healthcare Improvement, Safer Care Victoria has developed large-scale collaboratives (or major projects) and used new tools to grow quality improvement leadership in the Victorian health system.[310] Establishing the Mental Health Improvement Unit may provide an opportunity to harness the institute's expertise in mental health quality improvement.

With the establishment of the unit, Victoria's mental health and wellbeing system will be well positioned to become a national leader in contemporary approaches to quality improvement. With strong practice leadership and an approach informed both by human rights and improvement science, the unit will support mental health and wellbeing services to deal with important concerns and to improve the quality and safety of mental health and wellbeing treatment, care and support.

1 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 13.

2 *Witness Statement of Kym Peake*, 4 October 2020, para. 104; Shilpa Ross and Chris Naylor, *Quality Improvement in Mental Health*, 2017, p. 3.

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

4 Mental Health Legal Centre, *Submission to the RCVMHS: SUB.0002.0032.0106 (Submission 1)*, 2019, p. 29.

5 Department of Health, Victoria, *Framework for Recovery-Oriented Practice*, 2011, p. 2; Mike Slade, *100 Ways to Support Recovery. A Guide for Mental Health Professionals: Second Edition*, 2013, p. 8.

6 Cathy Balding, *The Point of Care: How One Leader Took a Health Service from Ordinary to Extraordinary*, A Business Fiction (Melbourne: Qualityclass Press, 2018), p. 4.

7 Sandra G. Leggat and Cathy Balding, 'A Qualitative Study on the Implementation of Quality Systems in Australian Hospitals', *Health Services Management Research*, 30.3 (2017), 179–186 (pp. 180 and 185).

8 Mary Dixon-Woods, 'How to Improve Healthcare Improvement—An Essay by Mary Dixon-Woods', *BMJ*, 366.8216 (2019), 1–4 (pp. 1–4).

9 The Adult Psychiatry Imperative, *Submission to the RCVMHS: SUB.3000.0001.0070*, 2019, pp. 82–83.

10 Chris Ham, Don Berwick and Jennifer Dixon, *Improving Quality in the English NHS: A Strategy for Action*, 2016, p. 5; Charles Vincent and others, 'Redesigning Safety Regulation in the NHS', *BMJ*, 368:760 (2020), 1–4 (p. 3).

11 Peter Beaver, 'The Challenges of Safety Improvement in New Zealand Public Hospitals', *Kōtuitui: New Zealand Journal of Social Sciences Online*, 14.1 (2019), 112–125 (p. 114); Future Social Service Institute, *Community Services of the Future: An Evidence Review*, 2018, pp. 53 and 56.

12 Safer Care Victoria, Victorian Sentinel Events Guide: Essential Information for Health Services About Managing Sentinel Events in Victoria, 2019, p. 6.

13 Department of Health and Human Services, *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality of Care. Report of the Review of Hospital Safety and Quality Assurance in Victoria*, 2016, p. 3.

14 Department of Health and Human Services, 'Client Incident Management Guide', 2020, p. 24.

15 The Health Foundation, Evidence Scan: Improvement Science, 2011, p. 3.; Martin Marshall, Peter Pronovost and Mary Dixon-Woods, 'Promotion of Improvement as a Science', *The Lancet*, 381 (2013), 419–421 (p. 419); Safer Care Victoria, *Strategic Plan 2020–23*, 2019, p. 11.

16 Sandra G. Leggat and Cathy Balding, 'Bridging Existing Governance Gaps: Five Evidence-Based Actions That Boards Can Take to Pursue High Quality Care', *Australian Health Review*, 43.2 (2017), A–G (p. A).

17 Department of Health and Human Services, *Better Regulatory Practice Framework*, 2018, p. 3.

18 Safer Care Victoria, Victorian Sentinel Events Guide: Essential Information for Health Services About Managing Sentinel Events in Victoria, p. 3.

19 Stephanie Aldridge, 'The Regulation of Health Professionals: An Overview of the British Columbia Experience', *Journal of Medical Imaging and Radiation Sciences*, 39 (2008), 4–10 (p. 4).

20 Judith Healy, 'Chapter 34: Patients as Regulatory Actors in Their Own Health Care', in *Regulatory Theory: Foundations and Applications* (Canberra: ANU Press, 2017), pp. 591–609 (pp. 591 and 606).

21 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. 32.

22 Victorian Public Sector Commission, Governance, <vpsc.vic.gov.au/governance/>, [accessed 28 September 2020].

23 Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, 2019, p. 69.

24 Committee on Quality of Health Care in America, Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (National Academy Press, Washington, 2001), pp. 5–6.

25 The National Health Information and Performance Principal Committee, *The Australian Health Performance Framework*, 2017, p. 6.

26 Lord Darzi, *The Lord Darzi Review of Health and Care Interim Report*, 2018, p. 32.

27 Safer Care Victoria, *Strategic Plan 2020–23*, p. 6.

28 Department of Health and Human Services, *Community Services Quality Governance Framework. Safe, Effective, Connected and Person-Centred Community Services for Everybody, Everytime*, 2018, p. 11; Department of Health and Wellbeing, South Australia, *Mental Health Services Plan 2020–2025*, 2019, p. 2; Productivity Commission, Report on Government Services 2020—13. Mental Health Management, <www.pc.gov.au/research/ongoing/report-on-government-services/2020/health/mental-health-management>, [accessed 7 July 2020].

29 Department of Health and Human Services, *Community Services Quality Governance Framework. Safe, Effective, Connected and Person-Centred Community Services for Everybody, Everytime*, p. 11; Lord Darzi, *Better Health and Care For All. A 10–Point Plan for the 2020s: The Lord Darzi Review of Health and Care Final Report*, 2018, p. 53; Safer Care Victoria, *Delivering High-Quality Healthcare: Victorian Clinical Governance Framework*, 2017, p. 5; Organisation for Economic Co-operation and Development, Health Care Quality Framework, <www.oecd.org/health/health-care-quality-framework.htm>, [accessed 21 May 2020].

30 Australian Institute of Health and Welfare, National Mental Health Performance Framework 2020, <meteor.aihw.gov.au/content/index.phtml/itemId/721188>, [accessed 18 December 2019].

31 *Charter of Human Rights and Responsibilities Act 2006* (Vic), sec. 38(1); Castan Centre for Human Rights Law, *Submission to the RCVMHS: SUB.1000.0001.2641*, 2019, p. 2.

32 *Mental Health Act 2014* (Vic), sec 10(b).

33 *Witness Statement of the Honourable Professor Kevin Bell AM QC*, 26 August 2020, paras. 5 and 7; Victorian Mental Illness Awareness Council, *Submission to the RCVMHS: SUB.0002.0028.0645*, 2019, p. 4.

34 Victorian Mental Illness Awareness Council, p. 3.

35 RCVMHS, *Seymour Community Consultation—May 2019*.

36 RCVMHS, *Melbourne Community Consultation—May 2019*.

37 *Evidence of Teresa*, 3 July 2019, p. 118.

38 *Witness Statement of Dr Neil Coventry*, 29 July 2020, paras. 102 and 364; Chris Ham and Nicholas Timmins, *Managing Health Services Through Devolved Governance. A Perspective from Victoria, Australia*, 2015, p. 6; Department of Health, *The Victorian Health Services Governance Handbook: A Resource for Victorian Health Services and Their Boards*, 2012, pp. 6–7 and 33.

39 Department of Health, p. 6.

40 Leggat and Balding, A Qualitative Study on the Implementation of Quality Systems in Australian Hospitals, pp. 180 and 185.

41 Cathy Balding, 'From Quality Assurance to Clinical Governance', *Australian Health Review*, 32.3 (2008), 383–391 (p. 388).

42 Department of Health, p. 38.

43 Department of Health and Human Services, *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality of Care. Report of the Review of Hospital Safety and Quality Assurance in Victoria*, p. xi.

44 Department of Health and Human Services, *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality of Care. Report of the Review of Hospital Safety and Quality Assurance in Victoria*, p. xii.

45 *Witness Statement of Kym Peake*, 24 July 2019, para. 229.1.

46 Safer Care Victoria, *Strategic Plan 2020–23*, p. 7.

47 Kate Carnell AO and Professor Ron Paterson ONZM, *Review of National Aged Care Quality Regulatory Processes*, 2017, p. 144.

48 *Witness Statement of Dr Robyn Miller*, 7 August 2020, para. 122.

49 *Joint Witness Statement of Tass Mousaferiadis and Kent Burgess*, 20 May 2020, para. 93.

50 *Witness Statement of Dr Neil Coventry*, 2020, para. 208; Department of Health and Human Services, *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality of Care. Report of the Review of Hospital Safety and Quality Assurance in Victoria*, p. 25.

51 *Witness Statement of Dr Kevin Cleary*, 6 July 2020, para. 45.

52 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 455.

53 RCVMHS, *Whittlesea Community Consultation—April 2019*; Dr Ben Samuel, *Submission to the RCVMHS: SUB.0002.0019.0030*, 2019, p. 5; Brendan Cox, *Submission to the RCVMHS: SUB.0002.0021.0022*, 2019, p. 4; *Evidence of Erica Williams*, 8 July 2019, pp. 443–444.

54 ORIMA Research, 2020. *Workforce Survey Open Ended Comments,* [accessed 18 December 2020].

55 Leggat and Balding, 'Bridging Existing Governance Gaps: Five Evidence-Based Actions That Boards Can Take to Pursue High Quality Care', p. E.

56 Department of Health and Human Services, *Accreditation Policy for Victorian Publicly Funded Health Services Organisations*, 2019, p. 8.

57 Australian Commission on Safety and Quality in Health Care, *Review of the Australian Health Service Safety and Quality Accreditation Scheme: Improving the Reliability of Health Service Organisation Accreditation Processes*, 2018, p. 2; Australian Commission on Safety and Quality in Health Care, Australian Health Service Safety and Quality Accreditation Scheme, <www.safetyandquality.gov.au/standards/national-safety-and-quality-health-service-nsqhs-standards/assessment-nsqhs-standards/australian-health-service-safety-and-quality-accreditation-scheme>, [accessed 11 November 2020].

58 Department of Health and Human Services, *Accreditation Policy for Victorian Publicly Funded Health Services Organisations*, p. 7.

59 Commonwealth Government, *National Standards for Mental Health Services*, 2010.

60 The Royal Melbourne Hospital, *Annual Report 2019–20*, 2020, pp. 2 and 8.

61 *Witness Statement of Dr Neil Coventry*, 2020, para. 208.

62 *Witness Statement of Professor Richard Newton*, 7 May 2020, para. 20.

63 Australian Commission on Safety and Quality in Health Care, Australian Health Service Safety and Quality Accreditation Scheme.

64 Australian Commission on Safety and Quality in Health Care, *Review of the Australian Health Service Safety and Quality Accreditation Scheme: Improving the Reliability of Health Service Organisation Accreditation Processes*, pp. 4 and 9.

65 Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Primary Healthcare Standards: Public Consultation*, 2020, p. 4.

66 *Witness Statement of Professor Patrick McGorry AO*, 22 June 2020, para. 139.

67 Bendigo Health, *Submission to the RCVMHS: SUB.0002.0030.0051*, 2019, p. 8; Monash Health, *Submission to the RCVMHS: SUB.7000.0003.0001*, 2019, p. 5.

68 Alfred Health, *Submission to the RCVMHS: SUB.0002.0028.0156*, 2019, p. 7.

69 Alfred Health, p. 9.

70 Monash Health, p. 6.

71 Eastern Health, *Submission to the RCVMHS: SUB.0002.0028.0585*, 2019, p. 18.

72 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 239.

73 Murray Wright and others, *Review of Seclusion, Restraint and Observation of Consumers with a Mental Illness: NSW Health Facilities*, 2017, p. 23.

74 Royal Commission into Victoria's Mental Health System, *Interim Report,* pp. 213–214.

75 Monash Health, p. 10.

76 *Witness Statement of Professor David Castle*, 29 May 2020, para. 35.

77 Bendigo Health, pp. 3–5.

78 Eastern Health, p. 21.

79 Regional and Rural Area Mental Health Services, *Submission to the RCVMHS: SUB.0002.0029.0415*, 2019, p. 6.

80 *Witness Statement of Matthew Carroll*, 27 April 2020, para. 25; *Witness Statement of Dr Neil Coventry*, 28 June 2019, para. 71.

81 Department of Health, England, *High Quality Care For All: NHS Next Stage Review Final Report*, 2008, p. 48; *Witness Statement of Louise Glanville*, 8 July 2019, para. 59(f).

82 *Witness Statement of Peter Kelly*, 29 May 2020, para. 240.

83 Peninsula Health, *Submission to the RCVMHS: SUB.0002.0028.0109*, 2019, pp. 4–5.

84 Safer Care Victoria, *Victorian Quality Account Reporting Guidelines for 2017–18*, 2018, p. 9.

85 Safer Care Victoria, Victorian Sentinel Events Guide: Essential Information for Health Services About Managing Sentinel Events in Victoria, p. 6.

86 *Witness Statement of Dr Neil Coventry*, 2020, para. 218.

87 *Witness Statement of Dr Neil Coventry*, 2020, para. 219.

88 Public Health and Preventive Medicine, Monash University, What Are Clinical Registries?, <www.monash.edu/medicine/sphpm/registries/what-are-clinical-registries>, [accessed 5 November 2020].

89 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 225.

90 Victorian Mental Illness Awareness Council, *Submission to the RCVMHS: SUB.0002.0028.0645*, 2019, p. 3.

91 *Witness Statement of Dr Lynne Coulson Barr OAM*, 4 June 2020, para. 35.

92 Victoria Legal Aid, p. 71.

93 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 38.

94 Department of Health and Human Services, *Community Services Quality Governance Framework. Safe, Effective, Connected and Person-Centred Community Services for Everybody, Everytime*, p. 11.

95 Mental Health Complaints Commissioner, *Submission to the RCVMHS: SUB.4000.0001.0179*, 2019, p. 33. A person can formally nominate another person, under the *Mental Health Act 2014*, to provide them with support and help and to represent their interests and rights.

96 RCVMHS, *St Kilda Community Consultation—May 2019*.

97 *Witness Statement of Julie Dempsey*, 23 July 2019, para. 25.

98 A Smith, *Submission to the RCVMHS: SUB.0002.0028.0597*, 2019, p. 2.

99 Amanda Sorenson, *Submission to the RCVMHS: SUB.0002.0032.0093*, 2019, p. 2.

100 Victoria Legal Aid, pp. 11–12.

101 Victoria Legal Aid, p. 17.

102 RCVMHS, *Whittlesea Community Consultation—April 2019*.

103 *Witness Statement of Dr Tricia Szirom*, 12 May 2020, para. 12.

104 *Mental Health Act 2014* (Vic), secs. 214 and 216; Office of the Public Advocate, *Submission to the RCVMHS: SUB.0002.0029.0448 (Submission 1)*, 2019, p. 9; Office of the Public Advocate, *Community Visitors Annual Report 2018–19*, 2019, p. 57.

105 Office of the Public Advocate, *Community Visitors Annual Report 2018–19*, p. 57.

106 *Mental Health Act 2014* (Vic), sec. 11(1)(i); Victorian Auditor-General's Office, *Child and Youth Mental Health*, 2019, p. 33.

107 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 239.

108 RCVMHS, *Box Hill Community Consultation—May 2019*.

109 Office of the Public Advocate, *Community Visitors Annual Report 2018–19*, p. 52; Mental Health Complaints Commissioner, *Submission to the RCVMHS: SUB.4000.0001.0179*, p. 24; Mental Health Complaints Commissioner, *Annual Report 2018–19*, 2019, p. 24.

110 *Witness Statement of Professor Richard Newton*, para. 14.

111 *Joint Witness Statement of 'Aaron Robinson' and 'Kristy Robinson' (pseudonyms)*, 12 June 2020, para. 30.

112 Department of Health and Human Services, *Community Services Quality Governance Framework. Safe, Effective, Connected and Person-Centred Community Services for Everybody, Everytime*, p. 11; Bendigo Health, p. 11.

113 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 246; *Witness Statement of Indigo Daya*, 12 May 2020, para. 24; *Witness Statement of Cath Roper*, 2 June 2020, para. 41.

114 RCVMHS, *Melbourne Community Consultation—May 2019*.

115 RCVMHS, *Dandenong Community Consultation—May 2019*.

116 RCVMHS, *Dandenong Community Consultation—May 2019*.

117 Mental Health Complaints Commissioner, *Submission to the RCVMHS: SUB.4000.0001.0179*, p. 51.

118 Mental Health Complaints Commissioner, *Submission to the RCVMHS: SUB.4000.0001.0179*, p. 49.

119 Anglicare Victoria, *Submission to the RCVMHS: SUB.0002.0028.0718*, 2019, p. 33.

120 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 237.

121 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.

122 *Witness Statement of 'Elizabeth Porter' (pseudonym)*, 27 April 2020, para. 10.

123 RCVMHS, *Warragul Community Consultation—May 2019*.

124 ORIMA Research, 2020. *Workforce Survey Open Ended Comments,* [accessed 18 December 2020].

125 *Witness Statement of Dr Neil Coventry*, 2020, p. 218.

126 Office of the Public Advocate, *Submission to the RCVMHS: SUB.0002.0029.0448 (Submission 1)*, p. 19.

127 Mental Health Complaints Commissioner, *The Right to Be Safe: Ensuring Sexual Safety in Acute Mental Health Inpatient Units: Sexual Safety Project Report*, 2018; Australia's National Research Organisation for Women's Safety, *Preventing Gender-Based Violence in Mental Health Inpatient Units: Key Findings and Future Directions*, 2020; Jayashri Kulkarni and Cherrie Galletly, 'Improving Safety for Women in Psychiatry Wards', *Australian and New Zealand Journal of Psychiatry*, 51.2 (2017), 192–194; Jayashri Kulkarni and others, 'Establishing Female-Only Areas in Psychiatry Wards to Improve Safety and Quality of Care for Women', *Australasian Psychiatry*, 22.6 (2014), 551–556.

128 RCVMHS, *Melbourne Community Consultation—May 2019*.

129 Tiffany Conroy and others, 'Role of Effective Nurse-Patient Relationships in Enhancing Patient Safety', *Nursing Standard*, 31.49 (2017), 53–63 (pp. 53–58).

130 Australian Human Rights Commission, *Social Justice Report 2011: Aboriginal and Torres Strait Islander Social Justice Commissioner*, 2011, p. 123.

131 Victorian Mental Illness Awareness Council, p. 10.

132 Bethan Thibaut and others, 'Patient safety in Inpatient Mental Health Settings: A Systematic Review', *BMJ Open*, 9.12 (2019), 1–19, (p. 1).

133 Thibaut and others, p. 3.

134 Professor Libby Roughead and others, *Medication Safety in Mental Health*, 2017, p. 6.

135 Australian Commission on Safety and Quality in Health Care, Medication Safety in Mental Health, <www.safetyandquality.gov.au/our-work/mental-health/medication-safety-in-mental-health>, [accessed 12 November 2020].

136 health.vic, Reducing Adverse Medication Events in Mental Health Services, <www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/reducing-adverse-medication-events>, [accessed 12 November 2020].

137 Mental Health Complaints Commissioner, *Submission to the RCVMHS: SUB.4000.0001.0179*, p. 34.

138 Mental Health Complaints Commissioner, *Submission to the RCVMHS: SUB.4000.0001.0179*, p. 49.

139 Malcolm K Sparrow, 'Introduction', in *Fundamentals of Regulatory Design* (Independently Published, 2020), pp. 1–10 (p. 4).

140 Ham, Berwick and Dixon, p. 8; Department of Health and Human Services, *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality of Care. Report of the Review of Hospital Safety and Quality Assurance in Victoria*, pp. xi and 68.

141 Ham and Timmins, p. 4.

142 *Witness Statement of Alice Andrews*, 7 July 2020, para. 51.

143 Australian Association of Social Workers, *Submission to the RCVMHS: SUB.1000.0001.0031*, 2019, pp. 2 and 10; *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic).

144 Australian Commission on Safety and Quality in Health Care, Australian Health Service Safety and Quality Accreditation Scheme.

145 *Mental Health Act 2014* (Vic), sec. 118(c).

146 *Mental Health Act 2014* (Vic), sec. 120.

147 *Witness Statement of Dr Neil Coventry*, 2020, paras. 18 and 21.

148 Parliament of Victoria, Mental Health Bill 2014, Legislative Assembly Second Reading Speech, 20 February 2014, <hansard.parliament.vic.gov.au/?IW_DATABASE=*&IW_FIELD_TEXT=HOUSENAME%20CONTAINS%20(ASSEMBLY)%20AND%20SPEECHID%20CONTAINS%20(50355)%20AND%20SITTINGDATE%20CONTAINS%20(20%20February%202014)&Title=MENTAL%20HEALTH%20BILL%202014&IW_SORT=n:OrderId&LDMS=Y>, [accessed 5 March 2020].

149 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 102.

150 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 94.

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

152 Victorian Government, *Submission to the RCVMHS: SUB.5000.0001.0001*, 2019, p. 26.

153 Victoria Legal Aid, p. 71.

154 Alfred Health, p. 8.

155 Victorian Auditor-General's Office, *Contract Management Capability in DHHS: Service Agreements*, 2018, p. 48.

156 Victorian Auditor-General's Office, *Contract Management Capability in DHHS: Service Agreements*, p. 48.

157 Alfred Health, p. 8.

158 Barwon Health, *Submission to the RCVMHS: SUB.0002.0029.0222*, 2019, p. 7.

159 *Witness Statement of Karyn Cook*, 21 May 2020, para. 179.

160 Mental Health Legal Centre, p. 32.

161 *Witness Statement of Dr Neil Coventry*, 2020, para. 24.

162 *Witness Statement of Dr Neil Coventry*, 2020, para. 24.

163 *Mental Health Act 2014* (Vic), sec. 120.

164 *Mental Health Act 2014* (Vic), secs. 99 and 121.

165 *Witness Statement of Dr Neil Coventry*, 2020, para. 26.

166 *Witness Statement of Dr Neil Coventry*, 2019, para. 20.

167 *Mental Health Act 2014* (Vic), sec. 121(c).

168 Australian Commission on Safety and Quality in Health Care, *National Model Clinical Governance Framework*, 2017, pp. 2 and 20.

169 *Witness Statement of Dr Neil Coventry*, 2019, para. 22.

170 *Witness Statement of Professor David Copolov AO*, 7 July 2020, para. 188(b).

171 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 145.

172 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 150.

173 *Witness Statement of Dr Neil Coventry*, 2020, para. 100.

174 *Mental Health Act 2014* (Vic), secs. 216(b)(iii) and 228.

175 *Witness Statement of Dr Neil Coventry*, 2020, para. 606.

176 *Witness Statement of Dr Neil Coventry*, 2020, para. 607.

177 *Witness Statement of Kristen Hilton*, 15 July 2020, para. 48; General Assembly of the United Nations, *Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 2002.

178 *Witness Statement of Kristen Hilton*, para. 44.

179 Victorian Ombudsman, *OPCAT in Victoria: A Thematic Investigation of Practices Related to Solitary Confinement of Children and Young People*, 2019, p. 14.

180 *Witness Statement of Kristen Hilton*, para. 44.

181 *Witness Statement of Kristen Hilton*, para. 38.

182 Victorian Ombudsman, *OPCAT in Victoria: A Thematic Investigation of Practices Related to Solitary Confinement of Children and Young People*, p. 14.

183 Mental Health Legal Centre, p. 30; Victorian Ombudsman, *Complaints: Good Practice Guide for Public Sector Agencies*, 2016, p. 2.

184 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 34.

185 *Mental Health Act 2014 (Vic)*, sec. 234.

186 *Witness Statement of Dr Neil Coventry*, 2020, para. 100.

187 *Witness Statement of Dr Neil Coventry*, 2020, para. 146(c); Mental Health Legal Centre, p. 30; Health Complaints Commissioner, About Complaints, <hcc.vic.gov.au/public/about-complaints>, [accessed 18 December 2020].

188 *Witness Statement of Dr Neil Coventry*, 2020, para. 146; Mental Health Legal Centre, p. 30.

189 Aged Care Quality and Safety Commission, *Regulatory Strategy*, 2020, pp. 8–9.

190 Office of the Victorian Information Commissioner, Complaints, <ovic.vic.gov.au/privacy/for-the-public/complaints/>, [accessed 7 December 2020].

191 Mental Health Legal Centre, p. 30.

192 RCVMHS, *Whittlesea Community Consultation—April 2019*.

193 Anonymous 355, *Submission to the RCVMHS: SUB.0002.0016.0071*, 2019, p. 3.

194 *Mental Health Act 2014* (Vic), sec. 216(b); Office of the Public Advocate, *Community Visitors Annual Report 2018–19*, p. 14.

195 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 66.

196 Independent Mental Health Advocacy, Eligibility for Our Service, <www.imha.vic.gov.au/get-help/eligibility-for-our-service>, [accessed 14 July 2020]; *Witness Statement of Dr Neil Coventry*, 2020, para. 106(g).

197 Mental Health Complaints Commissioner, *Submission to the RCVMHS: SUB.4000.0001.0179*, p. 7.

198 Mental Health Complaints Commissioner, *Annual Report 2019–20*, p. 6.

199 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 33; Mental Health Complaints Commissioner, *Submission to the RCVMHS: SUB.4000.0001.0179*, p. 25.

200 Mental Health Complaints Commissioner, *Annual Report 2018–19*, p. 20.

201 Mental Health Complaints Commissioner, *Annual Report 2018–19*, p. 20.

202 Mental Health Complaints Commissioner, *Annual Report 2018–19*, p. 21.

203 Mental Health Complaints Commissioner, *Annual Report 2018–19*, p. 24.

204 Mental Health Complaints Commissioner, *Driven by Lived Experience—Beginnings, Present and Future: Our Framework and Strategy*, 2020, p. 11.

205 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 36.

206 Mental Health Legal Centre, p. 30.

207 *Witness Statement of Dr Lynne Coulson Barr OAM*, paras. 85 and 87–88.

208 *Mental Health Act 2014* (Vic), sec. 232(1).

209 Mental Health Complaints Commissioner, *Submission to the RCVMHS: SUB.4000.0001.0179*, p. 58.

210 RCVMHS, *Melbourne Community Consultation—May 2019*; RCVMHS, *St Kilda Community Consultation—May 2019*.

211 Australian Commission on Safety and Quality in Health Care and Australian Institute of Health and Welfare, *The Third Australian Atlas of Healthcare Variation*, 2018, pp. 2–3.

212 Department of Health and Human Services, *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality of Care. Report of the Review of Hospital Safety and Quality Assurance in Victoria*, p. xi.

213 *Witness Statement of Dr Neil Coventry*, 2020, para. 100(d).

214 rei Onekawa, *Submission to the RCVMHS: SUB.0002.0027.0037*, 2019, p. 5.

215 RCVMHS, *Box Hill Community Consultation—May 2019*.

216 *Witness Statement of Dr Neil Coventry*, 2020, para. 125.

217 *Witness Statement of Professor Richard Newton*, para. 59; Australian Commission on Safety and Quality in Health Care and Australian Institute of Health and Welfare, p. 3.

218 *Witness Statement of Dr Neil Coventry*, 2020, paras. 125 and 181.

219 *Witness Statement of Dr Neil Coventry*, 2020, para. 125.

220 *Witness Statement of Peter Kelly*, para. 229.

221 *Witness Statement of Erandathie Jayakody*, 4 June 2020, para. 125.

222 Victoria Legal Aid, p. 73; Victorian Mental Illness Awareness Council, p. 9; *Witness Statement of Louise Glanville*, 8 July 2019, para. 62.

223 Victoria Legal Aid, p. 71.

224 Victorian Mental Illness Awareness Council, p. 9.

225 *Witness Statement of Dr Christopher Maylea*, 30 April 2020, paras. 22–23.

226 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'*, p. 15.

227 Victorian Mental Illness Awareness Council, *Submission to the RCVMHS: SUB.0002.0028.0645*, p. 11; 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'*, p. 29; *Witness Statement of Erandathie Jayakody*, paras. 116–117.

228 Victoria Legal Aid, p. 4.

229 The Royal Australian and New Zealand College of Psychiatrists, *Submission to the RCVMHS: SUB.0002.0029.0227*, 2019, pp. 14–15.

230 RCVMHS, *Warragul Community Consultation—May 2019*.

231 Department of Health and Human Services, *Office of the Chief Psychiatrist Annual Report 2019–20*, 2020, p. 14.

232 Department of Health and Human Services, *Chief Psychiatrist's Annual Report 2018–19*, 2019, p. 19.

233 Safer Care Victoria, Victorian Sentinel Events Guide: Essential Information for Health Services About Managing Sentinel Events in Victoria, p. 4.

234 *Witness Statement of Dr Neil Coventry*, 2020, para. 316.

235 *Witness Statement of Peter Kelly*, para. 208(c).

236 *Witness Statement of Peter Kelly*, para. 208(b).

237 *Witness Statement of Dr Neil Coventry*, 2020, para. 318.

238 *Witness Statement of Dr Vinay Lakra*, 22 June 2020, para. 39.

239 Monash Health, p. 12.

240 health.vic, The Safewards Story, <www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/safewards/safewards-story>, [accessed 24 April 2020].

241 Latrobe Regional Hospital, *Submission to the RCVMHS: SUB.0002.0028.0034*, 2019, pp. 1 and 8; Zero Suicide Institute of Australasia, *Submission to the RCVMHS: SUB.0002.0029.0387*, 2019, p. 4.

242 Beth S. Brodsky, Aliza Spruch-Feiner and Barbara Stanley, 'The Zero Suicide Model: Applying Evidence-Based Suicide Prevention Practices to Clinical Care', *Frontiers in Psychiatry*, 9.33 (2018), 1–7 (p. 2).

243 Kathryn Turner and others, 'Inconvenient Truths in Suicide Prevention: Why a Restorative Just Culture Should Be Implemented alongside a Zero Suicide Framework', *Australian and New Zealand Journal of Psychiatry*, 54.6 (2020), 571–581 (pp. 571 and 577).

244 *Witness Statement of Dr Neil Coventry*, 2020, para. 312.

245 Department of Health and Human Services, *Chief Psychiatrist's Audit of Inpatient Deaths 2011–2014*, 2017, p. 8.

246 Department of Health and Human Services, *Chief Psychiatrist's Audit of Inpatient Deaths 2011–2014*, p. 6.

247 *Witness Statement of Dr Neil Coventry*, 2020, para. 314.

248 *Witness Statement of Dr Neil Coventry*, 2020, para. 314.

249 Department of Health and Human Services, *Chief Psychiatrist's Audit of Inpatient Deaths 2011–2014*, p. 13.

250 Coroners Court of Victoria, *Annual Report 2018–19*, 2019, p. 31.

251 Darzi, *Better Health and Care For All. A 10–Point Plan for the 2020s: The Lord Darzi Review of Health and Care Final Report*, p. 56; Ham, Berwick and Dixon, p. 13; Chris Ham, *Reforming the NHS from Within: Beyond Hierarchy, Inspection and Markets*, 2014, p. 20.

252 Jeffrey Braithwaite, 'Changing How We Think about Healthcare Improvement', *BMJ*, 17:361 (2018), 1–5 (p. 1).

253 Ross and Naylor, p. 3.

254 Healthcare Improvement Scotland, *Summary of Our Mental Health Work 2019–2020*, 2019, p. 1.

255 Healthcare Improvement Scotland, p. 2.

256 Royal College of Psychiatrists, United Kingdom, National Collaborating Centre for Mental Health Quality Improvement Programmes, <www.rcpsych.ac.uk/improving-care/nccmh/quality-improvement-programmes>, [accessed 26 October 2020].

257 Health Quality and Safety Commission New Zealand, Questions and Answers about the Mental Health and Addiction (MHS) Quality Improvement Programme, <www.hqsc.govt.nz/our-programmes/mental-health-and-addiction-quality-improvement/questions-and-answers/>, [accessed 28 January 2020].

258 Safer Care Victoria, *Strategic Plan 2020–23*, p. 11.

259 Victorian Agency for Health Information and Safer Care Victoria, Media Release: Partnering with IHI to Deliver the Victorian Patient Safety Program, 24 September 2018, <www.bettersafercare.vic.gov.au/news-and-media/partnering-with-ihi-to-deliver-the-victorian-patient-safety-program>, [accessed 31 August 2020].

260 Safer Care Victoria, *Annual Report 2019–20*, 2020, p. 44.

261 Leggat and Balding, 'Bridging Existing Governance Gaps: Five Evidence-Based Actions That Boards Can Take to Pursue High Quality Care', p. E.

262 Department of Health and Wellbeing, South Australia, p. 15.

263 Safety Differently, Why Do Things Go Right?, <safetydifferently.com/why-do-things-go-right/>, [accessed 31 August 2020].

264 *Joint Witness Statement of Tass Mousaferiadis and Kent Burgess*, para. 96.

265 Professor Erik Hollnagel, Professor Robert L. Wears and Professor Jeffrey Braithwaite, *From Safety-I to Safety-II: A White Paper*, 2015, pp. 3–4.

266 *Witness Statement of Associate Professor Simon Stafrace*, 14 August 2020, para. 38.

267 Turner and others, p. 574.

268 Turner and others, p. 575.

269 Ham, Berwick and Dixon, p. 13.

270 Ham, Berwick and Dixon, pp. 13 and 15.

271 *Mental Health Act 2014* (Vic), sec. 120; Safer Care Victoria, *Strategic Plan 2017–2020*, 2017, p. 2.

272 *Witness Statement of Dr Neil Coventry*, 2020, paras. 71–72.

273 Safer Care Victoria, *Annual Report 2017–18: Outstanding Healthcare For All Victorians. Always*, 2018, p. 22.

274 Safer Care Victoria, Consumer Directed Care in Victorian Mental Health Services Summary, 2020, p. 1.

275 Safer Care Victoria, Consumer Directed Care in Victorian Mental Health Services Summary, p. 1.

276 *Witness Statement of Professor Suresh Sundram*, 19 May 2020, para. 111; *Witness Statement of Professor David Copolov AO*, para. 188(a).

277 Braithwaite, p. 2.

278 *Witness Statement of Kym Peake*, 2020, para. 104.

279 *Witness Statement of Dr Neil Coventry*, 2020, para. 123.

280 *Mental Health Act 2014* (Vic), sec. 120(a); Department of Health and Human Services, *Chief Psychiatrist's Annual Report 2018–19*, p. 9.

281 *Witness Statement of Dr Neil Coventry*, 2020, para. 54.

282 *Witness Statement of Dr Neil Coventry*, 2020, para. 55.

283 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'*, p. 32.

284 *Witness Statement of Dr Tricia Szirom*, para. 19.

285 *Witness Statement of Dr John Reilly*, 29 May 2020, paras. 147–148.

286 Mental Health Legal Centre, p. 32; *Witness Statement of Professor David Copolov AO*, para. 188(b); *Witness Statement of Dr Christopher Maylea*, 30 April 2020, para. 25.

287 *Witness Statement of Dr Neil Coventry*, 2020, paras. 58 and 59.

288 *Witness Statement of Dr Neil Coventry*, 2020, para. 61.

289 *Witness Statement of Dr Neil Coventry*, 2020, para. 67.

290 *Witness Statement of Professor David Copolov AO*, para. 188(b).

291 Mental Health Legal Centre, p. 32.

292 *Witness Statement of Dr John Reilly*, para. 158.

293 *Witness Statement of Dr John Reilly*, paras. 158–159.

294 *Witness Statement of Dr Neil Coventry*, 2020, para. 45.

295 Victoria Legal Aid, p. 72.

296 Ham and Timmins, p. 4.

297 *Witness Statement of Kym Peake*, 2020, para. 119.

298 *Witness Statement of Erandathie Jayakody*, para. 125; *Witness Statement of Professor Penelope Weller*, 27 August 2020, para. 47.

299 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'*, p. 28.

300 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 66.

301 health.vic, Review of the Health Complaints Act 2016, <www2.health.vic.gov.au/about/legislation/health-complaints/review-of-operation-of-the-act>, [accessed 18 December 2020].

302 Ross and Naylor, p. 3.

303 *Witness Statement of Kym Peake*, 2020, para. 109.

304 *Witness Statement of Kym Peake*, 2020, para. 110.

305 Department of Health and Human Services, *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality of Care. Report of the Review of Hospital Safety and Quality Assurance in Victoria*, p. xvii.

306 Safer Care Victoria, *Strategic Plan 2020–23*, pp. 9 and 16.

307 Department of Health and Human Services, Leadership and Governance, <www.dhhs.vic.gov.au/leadership-and-governance>, [accessed 12 November 2020].

308 *Witness Statement of Dr Neil Coventry*, 2020, para. 56.

309 KPMG Global, Continuous Improvement in Healthcare, <home.kpmg/xx/en/home/insights/2019/01/continuous-quality-improvement-in-health.html>, [accessed 26 October 2020].

310 Safer Care Victoria, *Annual Report 2019–20*, pp. 1–2.

Chapter 31

Reducing seclusion and restraint

The Commission recognises the strength of people living with mental illness and those experiencing psychological distress, their families and carers, 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 may contain information that could be distressing. You may want to consider how and when you read this chapter.

If you are upset by any content in this chapter, or if you or a loved one require 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**.
- **For situations that are harmful or life-threatening contact emergency services immediately on Triple Zero (000).**

Recommendation 54:

Towards the elimination of seclusion and restraint

The Royal Commission recommends that the Victorian Government:

1. act immediately to reduce the use of seclusion and restraint in mental health and wellbeing service delivery, with the aim to eliminate these practices within 10 years.
2. regulate the use of chemical restraint through legislative provisions in the new Mental Health and Wellbeing Act (refer to recommendation 42(2)(e)).
3. ensure the Chief Officer for Mental Health and Wellbeing (refer to recommendation 45(1)) develops and leads a strategy to reduce the use of seclusion and restraint.
4. enable the Mental Health Improvement Unit within Safer Care Victoria (refer to recommendation 52(1)) to co-design with mental health and wellbeing services and people with lived experience a range of programs and supports aligned with the strategy that focus on:

    a. working with each mental health and wellbeing service to investigate local data and practices in order to identify priority areas for change;
    b. making workforce training available for services; and
    c. continuing to support services to embed Safewards.

31.1 Working towards a future without seclusion and restraint

The Commission's hope is for a mental health and wellbeing system where services deliver high-quality and safe treatment, care and support, without the need for seclusion, restraint and other coercive practices.

The terms 'seclusion' and 'restraint' are defined in Box 31.1.

Box 31.1: Defining seclusion and restraint

The *Mental Health Act 2014* (Vic) currently defines two forms of 'restrictive interventions':

- **Bodily restraint** is defined as 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.[1]
- **Seclusion** is defined as the sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave.[2]

Under the Act, seclusion and restraint can only be used in designated mental health services.[3]

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'.[4]

Restrictive interventions can also be referred to as 'restrictive practices'. The term 'restrictive practices' is used in this chapter and throughout the report when necessary to reflect the use of the term in source data or evidence.

In its interim report, the Commission highlighted the profound, dehumanising and often long-term negative effects that seclusion and restraint can have. Consumers described their experiences as 'triggering', 'disempowering', 'traumatising' and 'controlled'.[5] Rates of both seclusion and physical restraint in public acute clinical mental health services in Victoria are worse than the national average, despite efforts to reduce their use. Individuals and organisations have called for the elimination of restrictive practices in the Victorian mental health system.[6]

Many consumers have told the Commission they were left distressed, fearful and hurt by the experience, with lasting negative impacts. One consumer described their experience:

> Being in seclusion was incredibly distressing for me. My borderline personality disorder is pronounced when I'm psychotic, and I will often experience intense feelings of abandonment and intense suicidality. While I was in seclusion, I felt abandoned and suicidal. As a result, I have about 20 different suicide plans about how to end my life in preference to being back in a public mental health unit. I am in fear for my life if I have to go back to a public hospital.[7]

Dr Tricia Szirom, then CEO of the Victorian Mental Illness Awareness Council, observed a similar pattern:

> In my experience, and from decades of [Victorian Mental Illness Awareness Council's] advocating with and for the consumer community, many people live with a lifetime of traumatic memories of seclusion and other restrictive practices. As a result, some consumers decide that it is not safe to ever ask for help again, leaving them isolated and at risk during future periods of distress.[8]

There is broad agreement among consumers, families, carers, supporters and the mental health workforce about the harms experienced when consumers are secluded or restrained. One consumer told the Commission:

> In all of my compulsory admissions I was restrained, and in two admissions I was secluded as a way of protecting me from the dangerous behaviour of other male patients … Seclusion and restraint were incredibly counterproductive and damaging for me. I think they could have been prevented if the environment had been calming, if I had not been left alone, and if a compassionate practitioner had built rapport with me.[9]

The use of seclusion and restraint restricts a person's freedom of movement and may constitute cruel, inhuman or degrading treatment under international human rights law.[10]

The United Nations Committee on the Rights of Persons with Disabilities has expressed concerns about the use of seclusion, physical restraint and psychotropic medications (antidepressants and other medications that affect people's emotions and behaviours) in Australia and urged the elimination of restrictive practices in all settings.[11]

There is widespread commitment to reducing and, where possible, eliminating the use of restrictive practices within Victorian mental health and wellbeing services. In submissions to the Commission, many organisations called for eliminating or prohibiting seclusion and restraint in mental health services.[12] Across the system, there have been—and continue to be—significant efforts to minimise and, where possible, eliminate use.[13]

In recent years the use of seclusion and restraint has often been described as a service failure.[14] As the Mental Health Legal Centre stated:

> Restraint and seclusion no longer have a place in mental health care and their continued use highlights a mental health system operating in a bygone era. The experience of our clients demonstrates that much more needs to be done to change the culture within services and to ensure that the safeguards we have are adequate and actually followed by those on the front line.[15]

However, many people do consider that eliminating all forms of restrictive practices is a difficult ambition to achieve within the current mental health system. Limited capacity within services, underfunding and a rising number of people in crisis coming to services make it difficult to deliver treatment, care and support without some seclusion or restraint. There are formidable challenges to overcome to confront factors that contribute to the use of seclusion and restraint and to provide truly safe and supportive environments for consumers and staff (refer to section 31.4).

While acknowledging this, the Commission considers that working towards eliminating seclusion and restraint—within the context of a redesigned system—is necessary to uphold the rights of consumers and to respond to service failure. Over time, early intervention, less compulsory treatment, well-designed facilities, increased staffing levels and better training and support will remove the need for practices of 'last resort' and establish alternative approaches as routine practice. Any lesser aspiration will impair the efforts to achieve a system that is safe for both consumers and staff, and that provides the highest standard of treatment, care and support for people experiencing severe distress or who are in crisis.

31.1.1 A mental health system without seclusion and restraint

The Commission envisages a mental health and wellbeing system in which the dignity and rights of people living with mental illness are respected.[16] In addition, the mental health and wellbeing system will provide trauma-informed care and a recovery-oriented approach[17] characterised by early intervention, services provided in community settings and home-based treatment, care and support.

When treatment, care and support are recovery-oriented, consumers are supported to build and maintain a self-defined and self-determined meaningful life, regardless of whether symptoms of mental illness are present.[18] Trauma-informed care recognises the prevalence and effects of trauma and seeks to ensure service provision does not result in retraumatisation.[19] Professor George Braitberg AM, Executive Director of Strategy, Quality and Improvement at The Royal Melbourne Hospital, told the Commission that a community-based approach should encourage a reduction in seclusion and restraint:

> I think the current approach to dealing with individuals who are experiencing a mental health crisis can be quite punitive. Often restrictive practices are required when a patient presents in crisis (to protect themselves and others). Some of these presentations may be avoided if the mental health system prioritises programs targeted at wellbeing, proactively minimising the frequency of presentations with a mental health crisis. If additional and appropriately resourced community-based care is available, presentation to hospital can be a last resort for these individuals rather than a first step.[20]

Between July 2014 and June 2019, the Mental Health Complaints Commissioner received 266 complaints about seclusion and physical or mechanical restraint—or 4 per cent of all complaints received by the Commissioner.[21] These complaints indicated that restrictive practices are 'highly intrusive practices that have a traumatic and enduring impact on consumers'.[22]

Further, the use of seclusion and restraint conflicts with recovery-oriented and trauma-informed practice.[23] As Ms Cath Roper, Consumer Academic in the Centre for Psychiatric Nursing at the University of Melbourne, told the Commission, 'you cannot use recovery principles to seclude someone. Seclusion and recovery-oriented principles do not go together.'[24]

In addition, the future system will build 'a culture where human rights are understood, valued and applied in providing care'.[25] Services will have a strong commitment to human rights, making them less likely to use seclusion and restraint.[26]

A commitment to eliminate seclusion and restraint

Within this context, to eliminate the use of seclusion and restraint, the system will need:

- a clear vision and targets for using seclusion and restraint, with progressive reductions to work towards elimination within 10 years
- support for the workforce to use alternative approaches, through leadership, consumer expertise, training, guidance, resources, effective use of data and Communities of Practice
- oversight of current practices, including comprehensive reporting of current use and responses when practices return, increase or vary without adequate explanation.

Targets are important to set expectations for reducing the use of seclusion and all forms of restraint. This must include an immediate reduction in the accepted levels of seclusion and introducing targets for physical and mechanical restraint. Data that provides a comprehensive picture of the use of seclusion and restraint in each service should be published regularly. This data should also be used to monitor variations between services and to understand where additional efforts to reduce use are required. Current reporting arrangements are considered in section 31.6.

Collaboration between consumer experts and clinicians will help design and implement local initiatives to target seclusion and restraint practices in each service or unit. These initiatives should incorporate improvement science—that is, where evidence-based methodologies are used to drive quality improvement. (Improvement science is described in Chapter 30: *Overseeing the safety and quality of services*.) Workforce training should incorporate strategies that have helped reduce the use of restrictive practices. Guidelines will help integrate these methodologies, define effective practice at high-risk points of intervention (such as admission processes from emergency departments) and reinforce consumers' human rights.

Strong oversight by the Mental Health and Wellbeing Commission will bring transparency to current use and help drive reductions in the use of seclusion and restraint.

These steps will create the imperative for elimination. Broad changes are also required to create safe and therapeutic cultures and environments where staff can deliver treatment, care and support without using seclusion and restraint.

Other recommendations to support elimination

Another three areas of reform will be critical to achieving a mental health and wellbeing system that operates without seclusion and restraint:

- less reliance on compulsory treatment
- hospital-based mental health units and other services delivered in residential settings ('bed-based services') with reduced demand on their services and greater ability to deliver high-quality and safe treatment, care and support
- using other strategies to keep consumers and staff safe.

First, the future mental health and wellbeing system will rely less on compulsory treatment (which is the treatment of a person for mental illness pursuant to an order under the Mental Health Act). Chapter 32: *Reducing compulsory treatment* outlines the evidence before the Commission in relation to compulsory treatment orders and the Commission's recommendations to reduce their use. The Commission's analysis indicates a strong link between compulsory treatment and seclusion and restraint—97 per cent of consumers who were secluded in acute clinical mental health inpatient units were admitted on compulsory treatment orders.[27] Ms Indigo Daya, Consumer Academic in the Centre for Psychiatric Nursing at the University of Melbourne, appearing before the Commission in a personal capacity, noted that compulsory treatment is a barrier to alternative approaches:

> Neither collaboration, nor empowerment, are possible while compulsory treatment and detention is common practice. Even voluntary patients witness restriction and compulsion and this damages trust, safety and recovery.[28]

Using advance statements may also help reduce seclusion and restraint. A person can make an advance statement that sets out treatment preferences in case they become a compulsory patient. This can provide a sense of agency and may help reduce the distress caused by feeling controlled. Advance statements must be considered at certain decision points in a consumer's treatment, care and support.

Second, the system will provide high-quality and safe bed-based services. The Commission's recommendations seek to reduce the rate at which people experience acute crisis, which is likely to lower demand for bed-based services and reduce the range of pressures currently affecting those environments. The Commission's recommendations will also deliver a range of new bed-based services including peer-led services and Hospital in the Home services (where acute mental health treatment, care and support are delivered in the familiarity of a person's home or usual place of residence).[29]

Updates to models of care in bed-based services will include a broad range of therapeutic interventions and more non-clinical, recovery-oriented supports centred on community connection and social wellbeing. These activities will reduce feelings of being 'contained' rather than cared for.

Investment is needed to upgrade bed-based services. Research indicates that good building design principles—incorporating privacy, adequate space, exposure to daylight, use of colour and access to gardens—can reduce the use of seclusion and restraint.[30] In addition, the Commission's recommendations assert that all bedrooms and bathrooms, high dependency units and, where possible, places where people receive treatment, should allow for gender separation to help keep people safe.

Third, staff need alternative strategies to avoid using seclusion or restraint. This requires that staff can identify factors or situations that may lead to conflict or the use of seclusion and restraint, and to make changes or plan accordingly. It also requires staff to have the necessary skills, capacity and resources to support consumers who are distressed and agitated, or who exhibit aggressive or violent behaviours, without using restrictive practices.[31] Mr Peter Kelly, Director of Operations for NorthWestern Mental Health at The Royal Melbourne Hospital, told the Commission:

> **Having excellent communication skills cannot be over-emphasised. A clinician with excellent verbal and non-verbal communication skills is able to convey that they are actively listening, that they understand what the consumer is saying, they can convey empathy, respect, concern and compassion and they can often de-escalate a situation that is rapidly escalating. Conversely, a poor communicator can convey disrespect, disdain, disinterest and a lack of compassion which can quickly escalate a situation.[32]**

The Commission's recommendations in Chapter 33: *A sustainable workforce for the future* will increase professional practice supports and help create safe and supportive working environments in which staff can provide the therapeutic treatment, care and support they aspire to.

31.2 The impact of restrictive practices

Experiences of seclusion and restraint can be profoundly distressing and traumatic for consumers. They can leave the person with feelings of fear, anger, isolation, mistrust and despair. These feelings can stay with the person long after their admission, as Ms Daya described:

> I remember one time when I attempted suicide while I was an inpatient. I often used to believe that I was a bad person, and that I should protect the world by killing myself. The attempt failed. When the staff found me, I was forcibly walked straight to a seclusion room and locked in by myself. This was a terrifying and deeply shaming experience. There was nothing whatsoever to distract me from the overwhelming emotions, and I concluded that I must indeed be a terrible person, because they were punishing me. I remember hitting myself in the head, over and over. Looking back, I think this was absolutely cruel and inhuman treatment, and a very serious rights violation. I wish that those staff had instead been able to sit with me in a quiet room, show some compassion and empathy, and just asked me what had led me to feel this way.[33]

The experience of seclusion and restraint can also be retraumatising; that is, it can cause people to 'relive' earlier trauma. Many consumers of mental health inpatient services report a history of trauma, neglect and physical or sexual abuse.[34] Many have also experienced institutionalised care or time in custody, with systems that can feel controlling rather than therapeutic, leaving the person carrying trauma from their time in these services.[35] Experiences of seclusion and restraint can 'reawaken' trauma by 'creating a similar power dynamic to past relationships of abuse'.[36]

The use of restrictive practices can adversely affect the therapeutic relationship between the consumer and clinician.[37] These experiences of trauma and retraumatisation can also make a consumer reluctant to seek help again, leaving them at risk during future periods of distress.[38]

As noted earlier in this chapter, seclusion and restraint do, by their nature, infringe on the human rights of consumers under international human rights law.[39] Seclusion and restraint can be 'violations of bodily integrity and restrictions of liberty'.[40] More specifically, the World Health Organization and others state that restrictive practices limit the following rights:

- the right to liberty and security
- the right to health
- the right to legal capacity
- the right to be free from violence and abuse
- the right to be free from being treated in a cruel, inhuman or degrading way
- the right to be treated with humanity when deprived of liberty
- the right to integrity of the person
- the right to privacy.[41]

Under international law, these rights are protected for people with disabilities on an equal basis with others under the *Convention on the Rights of Persons with Disabilities*, to which Australia is a party.[42]

These rights are also protected in Victorian law under the *Charter of Human Rights and Responsibilities Act 2006* (Vic).[43] Rights protected under the Charter of Human Rights and Responsibilities include the right to equal protection before the law, the right to be free from being treated in a cruel, inhuman or degrading way, the right to be treated with humanity when deprived of liberty, and the right to privacy (which includes the right to personal autonomy).[44]

Witness before the Commission Ms Lucy Barker described experiences that she identified as a denial of these human rights:

> I was studying human rights law a few semesters ago and … I was sitting there in class thinking that sounds a lot like seclusion … The amount of times I've been thrown into the back of a divvy van and chucked into seclusion, and had all my clothes taken off me—it's ridiculous. I was never told of my rights and the only reason they needed to treat me this way was because I appeared to have a mental illness. We shouldn't be treating people that way.[45]

Dr Lynne Coulson Barr OAM, Victoria's Mental Health Complaints Commissioner at the time of giving evidence, said that themes in complaints about restrictive practices include the lack of dignity experienced during restrictive practices—'for example having to urinate in a seclusion room due to a lack of bathroom facilities or being undressed by staff to use a bed pan while in four-point restraints'.[46]

Seclusion and restraint can also lead to physical harms such as pain, injury, medical decline or death.[47] Dr Coulson Barr told the Commission that consumers had reported pain, bruising, pressure injuries and broken bones as a result of staff using physical or mechanical restraint or excessive force to place them in seclusion.[48] Mr Kelly told the Commission:

> Physical impacts include the increased risk of medical deterioration due to reduced capacity to monitor and assess the individual. Consumers placed in seclusion are often simultaneously receiving large doses of antipsychotic medications which pose significant risks of respiratory depression. Consumers, when left alone in seclusion rooms are at risk of either accidental or intentional self-harm, falls, head strike or other self-harming behaviours, head banging, scratching, using bedding as ligatures to attempt hanging or asphyxiation. Whilst there are close monitoring requirements, these behaviours and subsequent deterioration can be unwitnessed, leading to potentially life threatening medical compromise.[49]

31.2.1 The impact on family, carers, supporters and staff

For families, carers and supporters, seeing someone they care for being restrained or secluded can also be traumatic. A foster carer, who also works in the mental health system, told the Commission about her terror for a young person in her care experiencing restrictive practices:

> Young people [who] are traumatised often end up experiencing a lot of psychological distress. And I'm really fearful about young people that come into my care and about them entering the mental health system. And one of the young people that was in my care did end up in the mental health system and I was horrified and torn … because I wanted to tell her what her rights were. Because … she was experiencing restrictive practices which are impinging her rights, but I was also really terrified for her.[50]

Another family member told the Commission about feelings of 'guilt, shame and anger as a family member who was consciously or unconsciously co-opted into these practices, but not being given … accessible, alternative options that actually heal, not harm'.[51]

Professor Lisa Brophy, Discipline Lead in Social Work and Social Policy in the Department of Occupational Therapy, Social Work and Social Policy at La Trobe University, appearing before the Commission in a personal capacity, noted that staff found it challenging to work in cultures that sanction restrictive practices:

> Working in organisations that are highly risk-averse was described as difficult for staff in both our locked wards study in Queensland and in the Safewards projects. This common problem, of trying to be recovery-oriented while also having a high level of tolerance of restrictive interventions and working in very risk-averse environments in which consumers were not given much choice and control, created tension and 'mixed messages' for staff.[52]

The Commission also heard from workers concerned about the use of seclusion:

> Acute wards in hospitals are not good environments. The level of acuity has increased enormously—particularly with drug-affected patients and those with psychosis. Then there are other patients with clinical depression and other issues and they are all in the same mix. They may not be helping each other in their recovery. But seclusion is also an issue.[53]

Ms Roper highlighted that consumer experts can support staff in understanding the impact of involuntary treatments including seclusion, with a view to changing their practice:

> the violence of involuntary treatment and its administration is real regardless of justification and has an impact on consumers and clinicians. These consequences must be noted and regretted rather than papered over and clinicians need to be supported so that they can hold these truths. It is a great pity, I think, that there are not opportunities on wards, for example, where staff can be led safely through ethical dialogues by consumer experts.[54]

Box 31.2 gives voice to the impact and experiences of seclusion and restraint on consumers, families, carers and supporters.

Box 31.2: The impact and experiences of seclusion and restraint on consumers, families, carers and supporters

Consumers

> Seclusion is worse than a prison—you are given a petri dish to urinate and cups of water to stay hydrated. You are in a very enclosed environment. Extremely demoralising and embarrassing. Seclusion is creating more detriment to a person's recovery … I was put in there because I attempted suicide but I shouldn't be punished for that.[55]
>
> Consumers can be put in seclusion for weeks as a punishment—you are not provided with adequate water and no access to sunlight while secluded.[56]
>
> I have been … sectioned to a public hospital and put in seclusion, and kept in there for weeks, I was told the demons in my head I have to sit in there in seclusion and listen to the voices. But with the silence—you're exposed more to the voices in your head—it amplifies the voices. The seclusion was making me worse.[57]
>
> I was in the mental health system but was diagnosed with an eating disorder only two years later … I was traumatised because every day my treatment consisted of security, restraints and a nasogastric tube.[58]
>
> I was caught in the act [of attempting to take my life]. Rather than being provided with any counselling, de-escalation, comfort or help, I was grabbed by both the arms and marched to seclusion … I was forced to take medication I did not want to take. I was told that it would be forced down my throat if I refused to take it.[59]

Families, carers and supporters

> [My Grade 4 son] was in a room with security staff constantly trying to restrain him for hours, and then trying to force medication into him. … When I saw Matthew, I saw a kid in a room with these big adults still in there, and this had been going on since five in the afternoon. … I think we all had some sort of post-traumatic stress after the incident. [60]
>
> When my son was in seclusion he wasn't assessed and he didn't get any treatment. They were just keeping an eye on him … I found the whole process incredibly dehumanising. You don't go to hospital to get well. It's traumatic.[61]

31.3 Prevalence of restrictive practices in Victoria's mental health system

Victoria's Mental Health Act regulates the use of seclusion and two forms of bodily restraint: physical and mechanical. These can be used to prevent imminent and serious harm to the person or to another person.[62] Also, restraint can be used 'to administer treatment or medical treatment to the person'.[63]

Seclusion and restraint can only be used after all reasonable and less restrictive options have been tried, or when they have been considered and have been thought to be unsuitable.[64] The Mental Health Act does not define 'less restrictive options'. The Chief Psychiatrist's restrictive practices guidelines indicate that clinicians have a responsibility to use practices that 'rely on reducing the risk factors for harm as well as enhancing protective factors that promote a safe, secure, understanding and accepting environment'.[65]

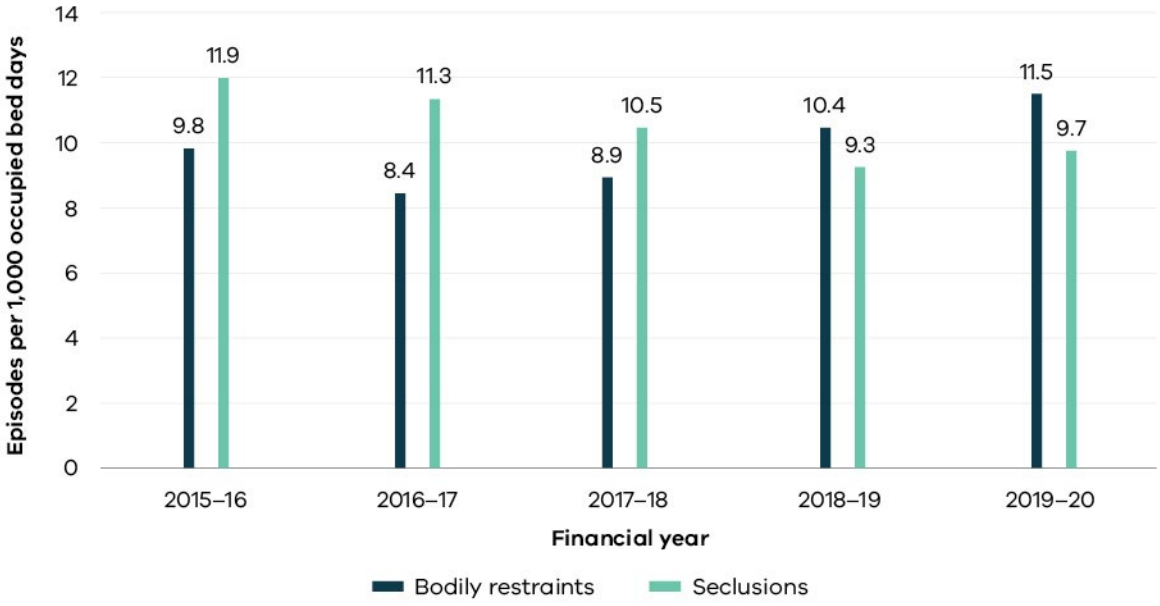
The Department of Health uses the rate of seclusions per 1,000 occupied bed days as a key performance indicator for mental health services.[66] This is set at 15 seclusions per 1,000 occupied bed days for adult, child and adolescent and aged acute mental health services.[67] Recently the former Department of Health and Human Services (now Department of Health) took steps to decrease the target to 10 seclusions per 1,000 occupied bed days for adult and child and adolescent services, and to five seclusions per 1,000 occupied bed days for aged acute mental health services.[68]

Under the Mental Health Act, services must report their use of seclusion and restraint to the Chief Psychiatrist,[69] but there can be variation in how seclusion or restraint is reported.[70] To improve reporting, the Chief Psychiatrist and Chief Mental Health Nurse have worked with mental health service providers. Dr Neil Coventry, Victoria's Chief Psychiatrist, told the Commission:

> **In recent years, our strong engagement with services has strengthened clinical leadership at the service unit level and has improved data recording and data governance. This is reflected in the data reported by services, which shows increased rates of physical restraint but a shorter average duration and may reflect improved understanding of reporting requirements and more rigorous reporting of any type of hands-on restraint.**[71]

Figure 31.1 indicates that the rate of seclusion in adult public acute clinical mental health services in Victoria has decreased in recent years, with a slight increase in 2019–20. In contrast, the rate of restraint events has increased slightly over the past four years. Most commonly, these are physical rather than mechanical restraints.

Figure 31.1: Seclusion and bodily restraint episodes per 1,000 occupied bed days, adult public acute clinical mental health services, Victoria, 2015–16 to 2019–20



Source: Department of Health and Human Services, *Chief Psychiatrist's annual report 2019–20*, pp. 17–18.

Note: Bed days is defined as the total number of days for patients who were admitted for an episode of care during a specified reference period.

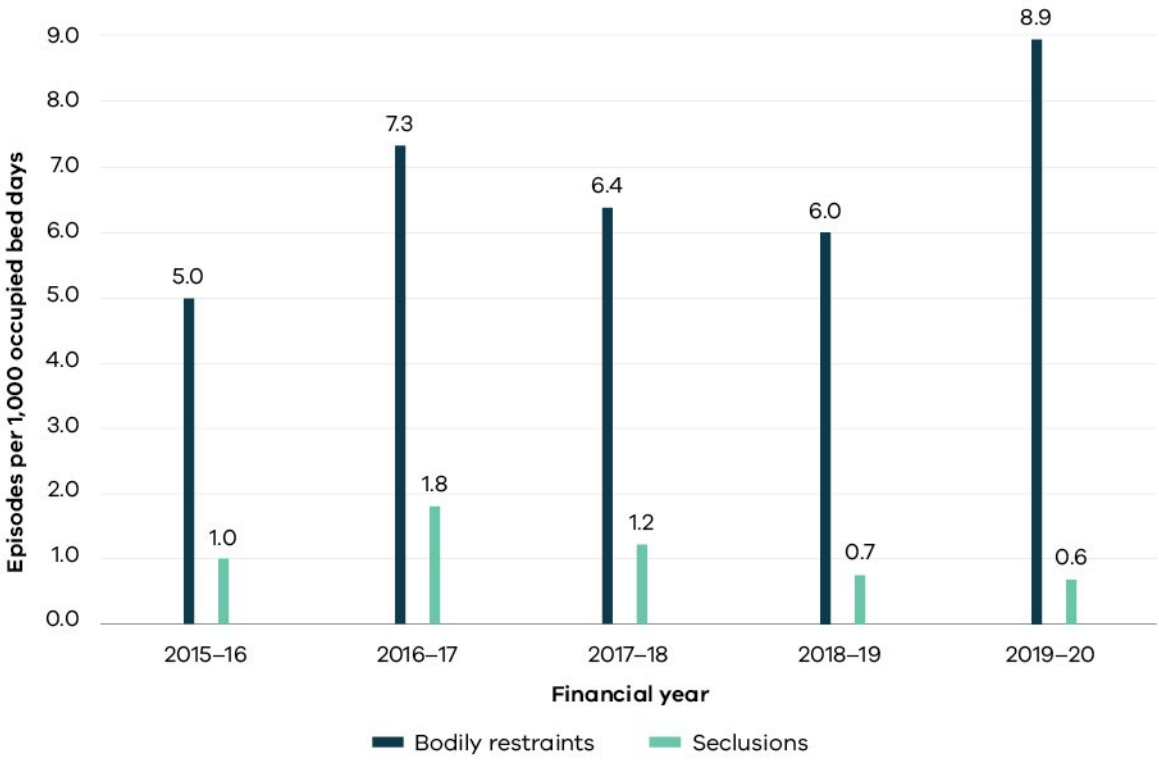
Figure 31.2 indicates that the use of seclusion and restraint is lower in aged public acute clinical mental health services than other services. Some aged services do not use seclusion at all. Commission analysis indicates that the rates of seclusion and restraint are often higher for consumers diagnosed with dementia than for other consumers.[72] Dr Coventry suggested that the lower rates of both seclusion and restraint may 'reflect models of therapeutic engagement and redirection generally used in environments with older people with cognitive impairment and behavioural and psychological symptoms of dementia'.[73]

The Commission is concerned that the seclusion rate in child and adolescent acute mental health inpatient units in Victoria has increased, as shown in Figure 31.3.[74] In addition, the average duration of seclusion 'increased substantially' from 1.1 hours in 2018–19 to 3.2 hours in 2019–20, particularly for consumers aged 15 years and over.[75]

The Commission's analysis indicates the increase in seclusion is concentrated on consumers aged 12–17 years, rather than consumers aged under 12 years.[76] The Chief Psychiatrist reported:

> Rates have increased again in child and adolescent units, in part because of the challenges presented by a very small number of young people with complex combinations of mental illness and intellectual or developmental disability.[77]

Figure 31.2: Seclusion and bodily restraint episodes per 1,000 occupied bed days, aged public acute clinical mental health services, Victoria, 2015–16 to 2019–20



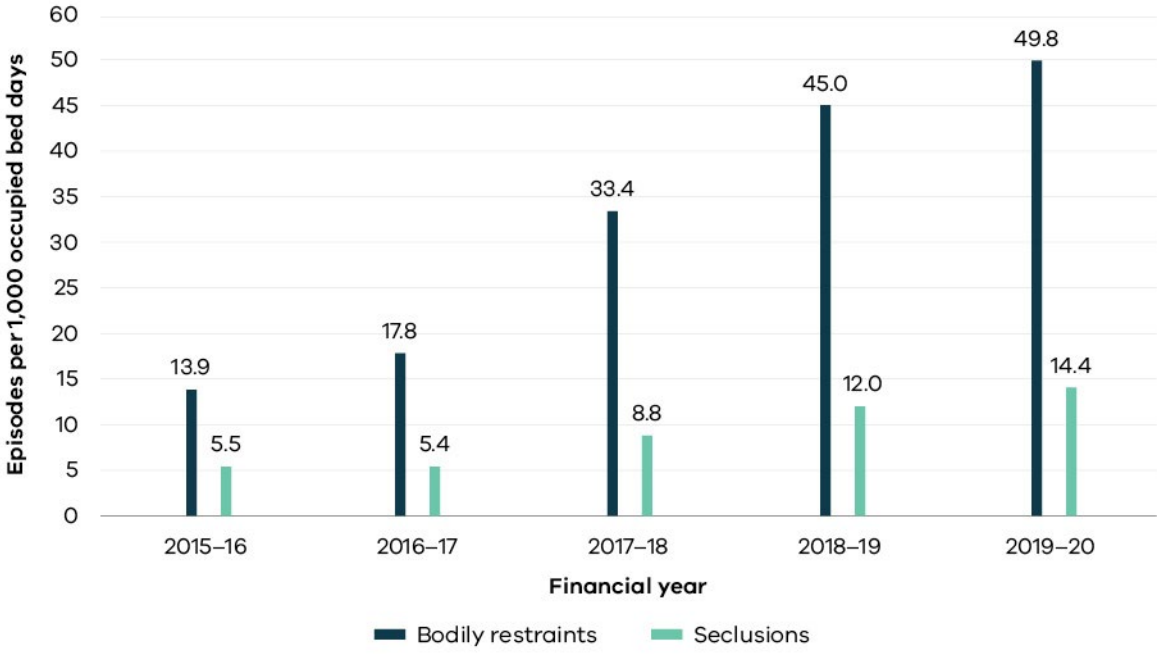
Source: Department of Health and Human Services, *Chief Psychiatrist's annual report 2019–20*, pp. 17–18.

Note: Bed days is defined as the total number of days for patients who were admitted for an episode of care during a specified reference period.

In 2018–19 the Victorian Government funded 63 clinical nurse consultant roles so that each child and youth inpatient service could 'achieve improved outcomes and meet the needs of consumers and their families/carers', including a focus on reducing the use of restrictive practices.[78] This indicates the Victorian Government was concerned about rates of restrictive practices in child and adolescent acute mental health inpatient units.

The Commission's recommendations for infant, child and youth mental health services will help reduce the need for acute inpatient care over time, improve the quality of care provided to young people within acute inpatient units and help reduce the use of restrictive practices. This includes a range of subacute residential options based in the community, mobile assertive outreach for young people and youth-specific acute inpatient services for 18–25-year-olds. The Commission's recommendations on these services are described 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*.

Figure 31.3: Seclusion and bodily restraint episodes per 1,000 occupied bed days, child and adolescent public acute clinical mental health services, Victoria, 2015–16 to 2019–20



Source: Department of Health and Human Services, *Chief Psychiatrist's annual report 2019–20*, pp. 17–18.

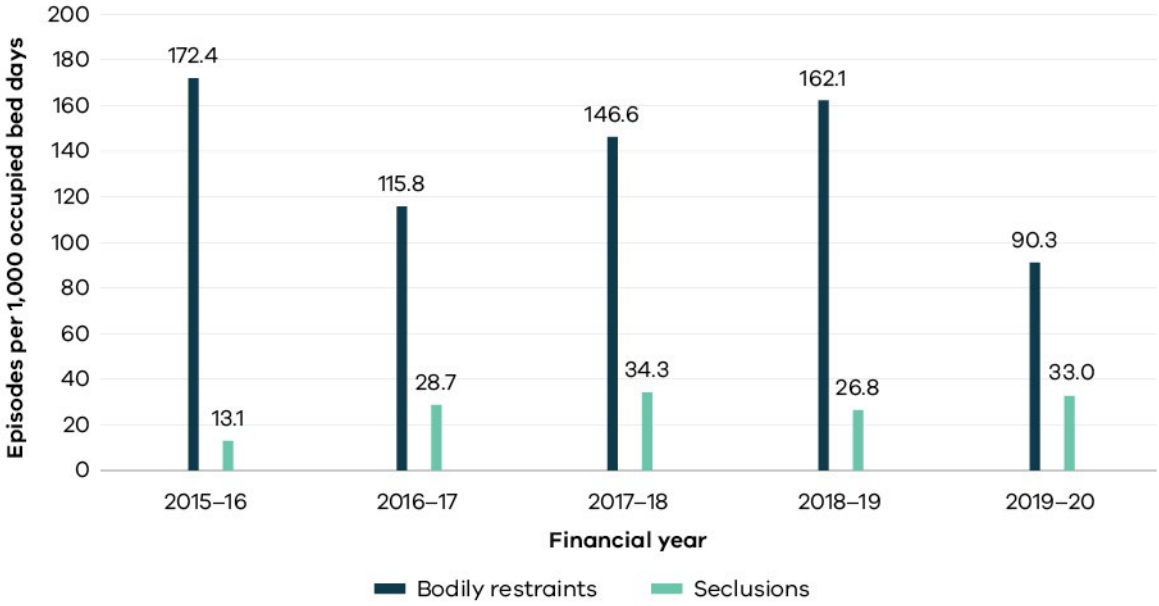
Note: Bed days is defined as the total number of days for patients who were admitted for an episode of care during a specified reference period.

As well as considering the use of restrictive practices across mental health services for different age groups, the Chief Psychiatrist also reports on seclusion and restraint rates in forensic settings (where people who are detained in custody are treated, as well as a small proportion of consumers on compulsory treatment orders). In Victoria, forensic inpatient care is delivered at Thomas Embling Hospital, a secure forensic mental health hospital operated by the Victorian Institute of Forensic Mental Health (or 'Forensicare'). The use of seclusion and restraint at the hospital is significantly higher than at other mental health services.

Figure 31.4 shows that rates of both seclusion and restraint at Thomas Embling Hospital have varied significantly in recent years. Forensicare has recently undertaken a comprehensive review of the use of seclusion and is implementing the findings.[79] The Chief Psychiatrist is also supporting Forensicare to reduce rates of seclusion and restraint.[80] Dr Margaret Grigg, Forensicare's CEO, noted that reducing restrictive practices at the hospital is difficult due to inadequate infrastructure (such as lack of a high dependency unit or other spaces to segregate patients with different needs), the delay in access to treatment for some prisoners, and the behaviours of a small number of consumers who put staff and consumer safety at risk.[81]

Across all acute inpatient services it is likely that demand for inpatient services (including more people presenting in crisis) and pressures on the model of care are contributing to the rate of restrictive practices.[82] Other factors—such as the physical environment of inpatient units or emergency departments—can also drive use of seclusion and restraint, as discussed in section 31.4.

Figure 31.4: Seclusion and bodily restraint episodes per 1,000 occupied bed days, Forensicare, Victoria, 2015–16 to 2019–20



Source: Department of Health and Human Services, *Chief Psychiatrist's annual report 2019–20*, pp. 17–18.

Note: Bed days is defined as the total number of days for patients who were admitted for an episode of care during a specified reference period.

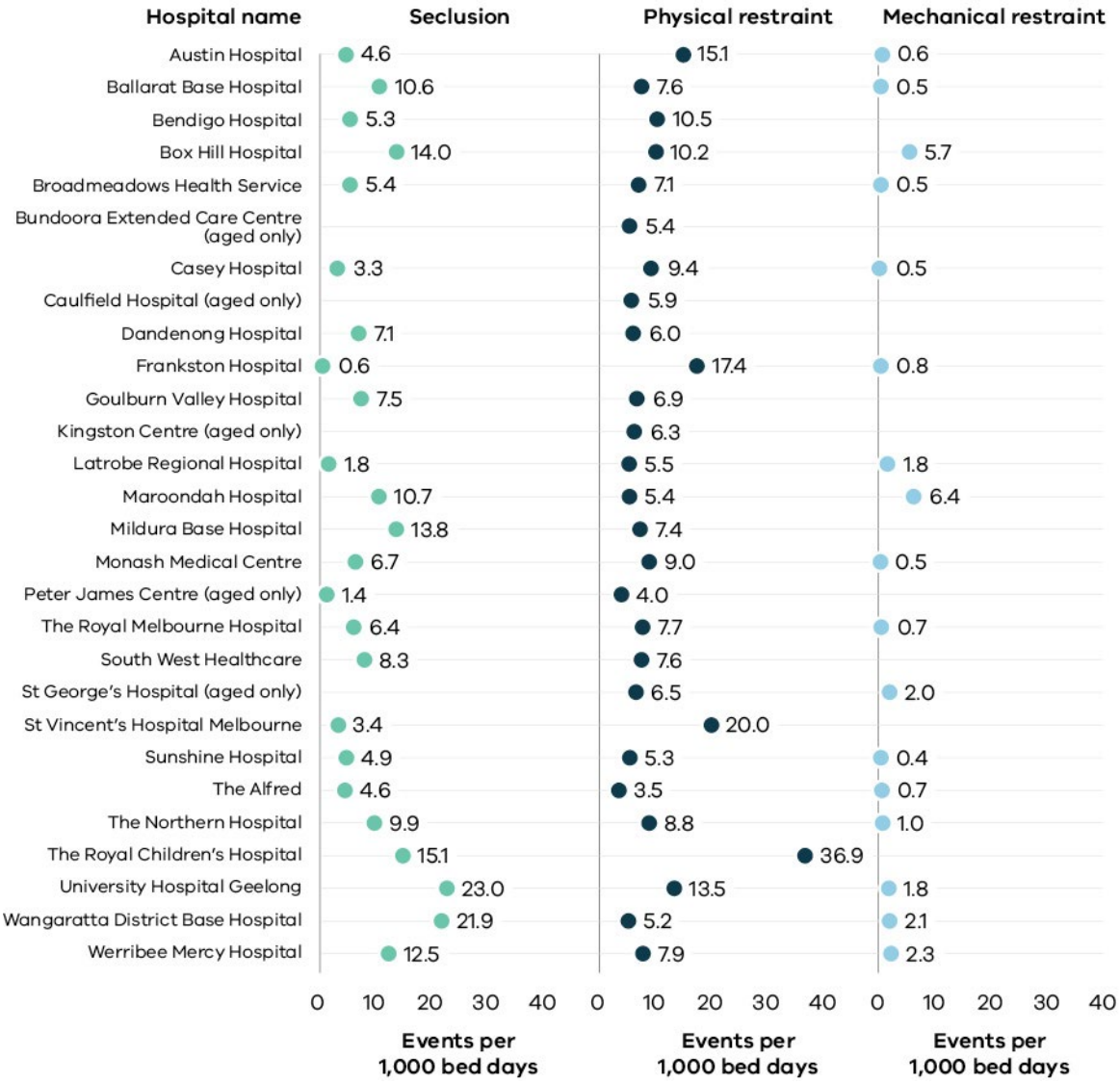
Given the drivers are varied, eliminating the use of seclusion and restraint requires a systemic response. This includes changes that specifically seek to reduce seclusion and restraint, as well as reforms that deal with the broader pressures on the system.

The Commission's reforms respond to the pressures on the current system through structural change to create a responsive and integrated system that will reduce demand, boost access to services in the community and improve how consumers access support during mental health crises. The changes are described in Chapter 9: *Crisis and emergency responses* and Chapter 28: *Commissioning for responsive services*. A Mental Health Workforce Wellbeing Committee to increase wellbeing and professional practice supports will also drive the creation of safe and supportive environments and a therapeutic practice culture, as set out in Chapter 33: *A sustainable workforce for the future*. Expanded forensic facilities and community rehabilitation units will operate in the least restrictive way possible, as described in Chapter 23: *Improving mental health outcomes across the criminal justice, forensic mental health and youth justice systems*. In addition, the investments in research and innovation outlined in Chapter 36: *Research, innovation and system learning* will contribute to improvements in models of care across the system for all age groups.

31.3.1 Variation in seclusion and restraint rates across services

The data provided above indicate differences in how prevalent restrictive practices are in Victorian acute clinical mental health inpatient units for different age groups and for consumers in forensic services. The same data show significant variation in rates of seclusion and restraint between individual services (refer to Figure 31.5).

Figure 31.5: Rates of seclusion, physical restraint and mechanical restraint events across Victorian public acute clinical mental health services, by hospital, Victoria, 2018–19



Source: Australian Institute of Health and Welfare, Mental Health Services in Australia, Restrictive Practices 2018–19 Table RP.10, <www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/reportcontents/summary-of-mental-health-services-in-australia>, [accessed 27 October 2020].

Notes: Because Victoria's service delivery model produces a higher threshold for acute admission—that is, people need to be more distressed to be admitted—the seclusion and restraint rates may be inflated compared with other jurisdictions. See the Australian Institute of Health and Welfare's data quality statement for more information.

Bed days is defined as the total number of days for patients who were admitted for an episode of care and who separated during a specified reference period. A patient who is admitted and separated on the same day is allocated one bed day.

Professor Richard Newton, Clinical Director of Peninsula Mental Health Service, stated that this variation indicates the need for better standards and improved action to reduce the use of seclusion and restraint:

> In my experience as a Clinical Director at Peninsula Health and previously as Chair of the Victorian Branch of [the Royal Australian and New Zealand College of Psychiatrists], I have noticed an extraordinary variation in the use of seclusion and restrictive practices between services. In the last quarter, daily seclusion rates between mental health services varied from 0.7 per 1,000 beds to 26 per 1,000 beds. This level of variation should not be acceptable, and indicates that we need to set better standards and have a much more robust clinical governance system that explicitly identifies and acts to reduce variation when it is an indication of low quality.[83]

A range of factors affect the use of restrictive practices (refer to section 31.4), and these factors can create different challenges for services in different contexts. Even so, the variation in data on restrictive practices indicates the need to reduce its use.

Variation unrelated to consumer needs (often described as 'unwarranted variation') can be a sign that consumers are not consistently receiving the care they need, or that they are receiving inappropriate treatment, care and support.[84] The Victorian Mental Illness Awareness Council proposed that variation in restrictive practices suggests that use could be reduced in some services.[85]

Research on seclusion rates in New Zealand's public mental health system suggests variation may reflect differences in models of care and other practices.[86] The researchers reported:

> Rates of seclusion vary across New Zealand's publicly funded district health board (DHB) adult mental health inpatient services as indicated by national data. Anecdotally, this variation has been attributed to a range of factors directly relating to the people admitted to acute inpatient services. This study examined the extent to which variation in seclusion rates could be explained by the sociodemographic and clinical differences between populations admitted … Results indicate DHB variation in seclusion rates cannot be attributed to the sociodemographic and clinical factors of people admitted …[87]

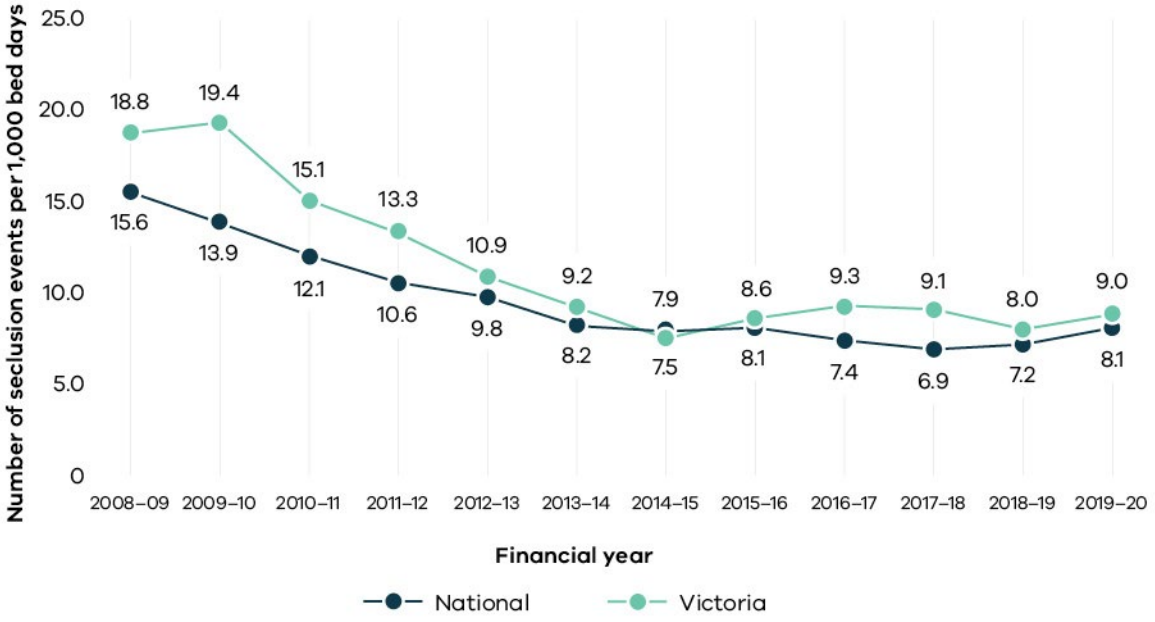
Monitoring variation in practice and tackling unwarranted variation is part of good clinical governance (the set of relationships and responsibilities within health services that ensure good clinical outcomes).[88] This should involve a clear and proactive commitment to eliminate seclusion and restraint that is built into management, monitoring and support processes at the team, unit, service and system levels.

31.3.2 Victoria's seclusion and restraint rates compared with the national average

Figure 31.6, Figure 31.7 and Figure 31.8 show that overall rates of seclusion and restraint in Victoria are consistently higher than the national average. Consumers getting treatment, care and support in Victoria's acute mental health inpatient units are even more likely to experience seclusion and restraint than consumers in other states.

Dr Coventry indicated that this may be due to reporting differences, a high admission threshold to services and suboptimal access to community clinical mental health services in Victoria.[89] The Commission has heard that the differences may also reflect system underfunding (which in turn affects the sufficiency of facilities and staffing levels) and limited exploration of use of alternatives, including more recovery-oriented treatment, care and support.[90] Other factors that affect Victoria's rates are considered further in section 31.4.

Figure 31.6: Rates of seclusion events for public acute clinical mental health services, Australia and Victoria, 2008–09 to 2019–20

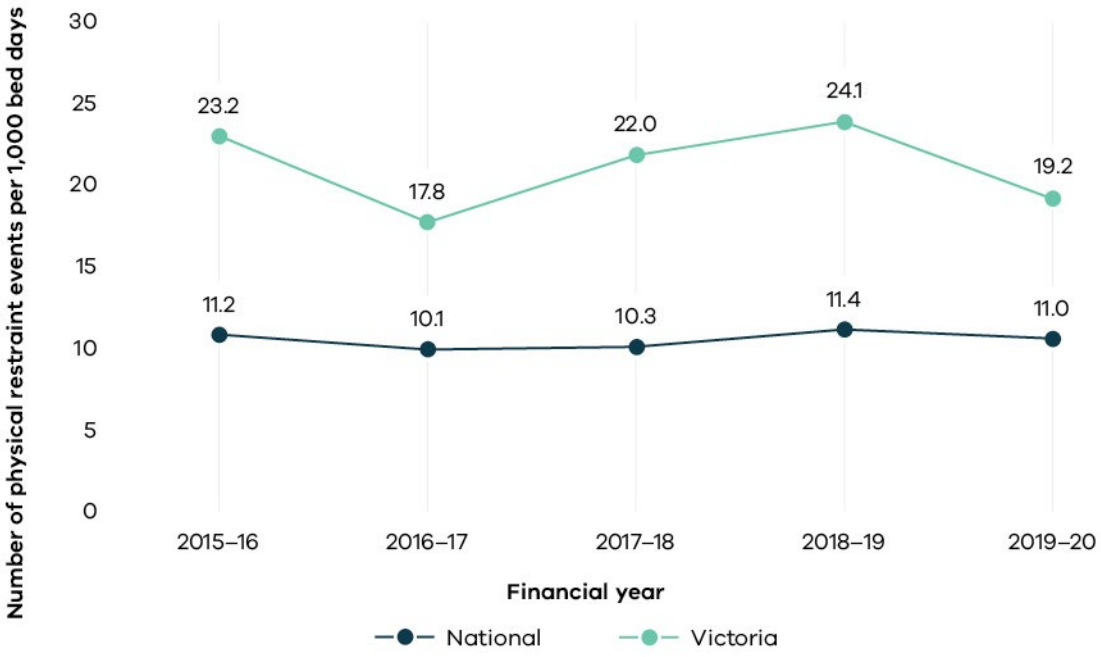


Source: Australian Institute of Health and Welfare, Mental Health Services in Australia: Key Performance Indicators for Australian Public Mental Health Services 2019–20 Table KPI.15.2, <www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/reportcontents/summary-of-mental-health services-in-australia>, [accessed 29 January 2021].

Notes: Victoria's service delivery model produces a higher threshold for acute admission and the seclusion and restraint metrics may be inflated compared to other jurisdictions. See the Australian Institute of Health and Welfare's data quality statement for more information.

Bed days is defined as the total number of days for patients who were admitted for an episode of care and who separated during a specified reference period. A patient who is admitted and separated on the same day is allocated one bed day.

Figure 31.7: Rates of physical restraint events for public acute clinical mental health services, Australia and Victoria, 2015–16 to 2019–20



Source: Australian Institute of Health and Welfare, Mental Health Services in Australia: Key Performance Indicators for Australian Public Mental Health Services 2019–20 Table KPI.16.2, <www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/reportcontents/summary-of-mental-health services-in-australia>, [accessed 29 January 2021].

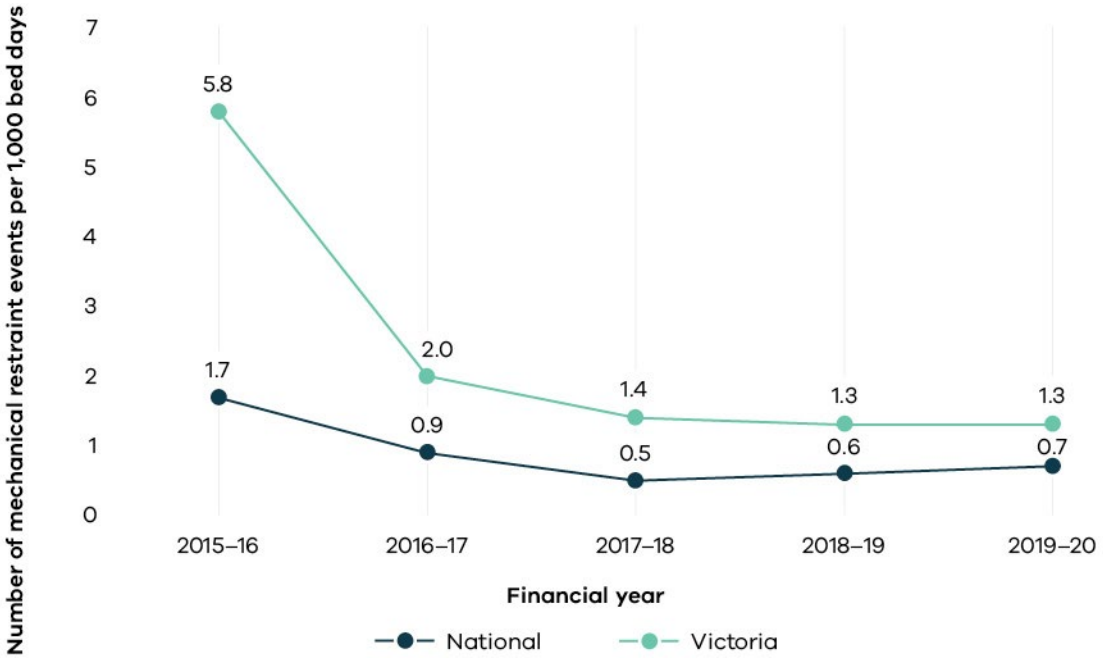
Notes: Victoria's service delivery model produces a higher threshold for acute admission and the seclusion and restraint metrics may be inflated compared to other jurisdictions. See the Australian Institute of Health and Welfare's data quality statement for more information.

Bed days is defined as the total number of days for patients who were admitted for an episode of care and who separated during a specified reference period. A patient who is admitted and separated on the same day is allocated one bed day.

Current Victorian targets for restrictive practices are higher than in other Australian jurisdictions. The Department of Health has a current key performance indicator of 15 seclusions per 1,000 bed days for acute mental health inpatient units.[91] As noted earlier, the department has taken steps to reduce the target to 10 seclusions per 1,000 bed days for adult and child and adolescent services, and to five seclusions per 1,000 bed days for aged acute mental health services.[92] New South Wales by contrast has a current target of fewer than 5.1 episodes per 1,000 bed days.[93] This suggests there is scope to further reduce the target for Victorian services

That Victoria's rates are consistently higher than the national average highlights the need for sustained efforts to reduce and eliminate restrictive practices. As noted, the Commission has heard that various factors contribute to these results, including reporting differences and underinvestment, which are—largely—beyond the control of individual service providers. The Commission considers that this may have led to a sense of disempowerment and a culture of acceptance of Victoria's high rates.

Figure 31.8: Rates of mechanical restraint events for public acute clinical mental health Australia and Victoria, 2015–16 to 2018–19



Source: Australian Institute of Health and Welfare, Mental Health Services in Australia: Key Performance Indicators for Australian Public Mental Health Services 2019–20 Table KPI.15.2, <www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/reportcontents/summary-of-mental-health services-in-australia>, [accessed 29 January 2021].

Notes: Victoria's service delivery model produces a higher threshold for acute admission and the seclusion and restraint metrics may be inflated compared to other jurisdictions. See the Australian Institute of Health and Welfare's data quality statement for more information.

Bed days is defined as the total number of days for patients who were admitted for an episode of care and who separated during a specified reference period. A patient who is admitted and separated on the same day is allocated one bed day.

31.4 Factors contributing to the use of seclusion and restraint

Mental health services can use seclusion when necessary to prevent imminent and serious harm to the person or to another person.[94] Bodily restraint may be used in a designated mental health service if it is necessary to prevent imminent and serious harm, or to administer treatment.[95]

Within mental health inpatient units a wide range of factors can influence when and how staff use seclusion and restraint. Understanding these factors can help identify the barriers to change and where services may need system-wide support to significantly reduce the use of restrictive practices.

Since 2014 Victorian public acute mental health inpatient units have trialled and implemented the Safewards model (refer to Box 31.3).[96] This is designed to improve safety and, ultimately, to reduce the use of seclusion, restraint and other forms of coercion in mental health wards. The model identifies six 'originating domains' that can lead to 'flashpoints' that, depending on how both staff and consumers respond, may result in a consumer being secluded or restrained.[97]

Box 31.3: Safewards

Since 2016 Victoria's Chief Mental Health Nurse, Ms Anna Love, has overseen implementation of the Safewards model across the Victorian mental health system.[98] Safewards is a model that provides 10 interventions to reduce conflict and therefore provide a sense of safety and mutual support for staff and patients.[99]

At the time, the Victorian Managed Insurance Authority (which provides medical indemnity insurance for public health services) was facing increasing claims from mental health services.[100] Implementing the Safewards model provided an opportunity to improve the relationship between staff and patients and minimise the harms experienced by consumers and staff.[101] The Victorian Managed Insurance Authority has supported the model to improve patient outcomes and to 'make emergency departments safer places to work for public health staff'.[102]

The model was trialled in seven Victorian services (across 18 inpatient units) in 2017–18, followed by implementation in all public acute mental health inpatient units including adult, aged, youth and secure extended care units.[103] The model is currently being trialled in Peninsula Health and Bendigo Health emergency departments.[104]

The model and approach to care as outlined in the *Overview: Safewards Model*, prepared by the former Department of Health and Human Services, identifies the following interventions:[105]

- **Know each other:** Patients and staff share some personal interests and ideas with each other, displayed in unit common areas. This builds rapport, connection and sense of common humanity.
- **Clear mutual expectations:** Patients and staff work together to create mutually agreed aspirations that apply to both groups equally. This counters some power imbalances and creates a stronger sense of shared community.
- **Positive words:** Staff speak positively in handover about each patient. Staff use psychological explanations to describe challenging actions. This increases positive appreciation and helpful information for colleagues to work with patients.
- **Discharge messages:** Before discharge, patients leave messages of hope for other patients on a display in the unit. This strengthens the patient community and generates hope.
- **Mutual help meeting:** Patients offer and receive mutual help and support through a daily, shared meeting. This also strengthens the patient community and creates opportunities to give and receive help.
- **Reassurance:** Staff debrief every patient after every conflict on the unit. This reduces a common flashpoint and increases patients' sense of safety and security.
- **Bad news mitigation:** Staff understand, proactively plan for and mitigate the effects of bad news received by patients. This reduces the impact of common flashpoints and provides extra support.
- **Soft words:** Staff reduce the limits faced by patients, create flexible options and use respect if limit-setting is unavoidable. This reduces a common flashpoint and builds respect, choice and dignity.
- **Calm down methods:** Staff support patients to draw on their strengths and use/learn coping skills before using as-needed medication or containment. This strengthens patient confidence and skills to cope with distress.
- **Talk down methods:** De-escalation processes focus on clarifying issues and finding solutions together. Staff maintain self-control, respect and empathy. This increases respect, collaboration and mutually positive outcomes.

Each intervention is explained in more detail on the Safewards Victoria website <www.health.vic.gov.au/safewards>.

While staff may use these interventions (or alternative approaches) when consumers are highly distressed and agitated, there are some factors that are beyond the control of staff or even, in some cases, service providers. The six 'originating domains' provide a helpful way to consider the factors that contribute to situations where staff may consider seclusion or restraint, and whether these can be managed by the service provider or need system-level intervention. The six domains are:

1. staff team—how staff deal with their own feelings, how they support each other, and the rules of the ward
2. physical environment—features ranging from environments that are comfortable and evoke greater care, and whether separate spaces are available, through to locked doors that restrict movement
3. outside hospital—outside world stressors that can continue to be present even when a consumer is admitted to a unit
4. patient community—in a ward environment, the ways in which consumers can be affected by the feelings and behaviour of other consumers around them
5. patient characteristics—this can include the presenting needs of the consumer, symptoms they may be experiencing and demographic factors such as age or gender
6. regulatory environment—the operations of the Mental Health Act including compulsory treatment, and system and hospital policies that define how patients and their rights are treated broadly, as well as the use of coercive and restrictive intervention specifically.[106]

Some of these domains can be directly influenced by service providers. Others are more difficult for services to change, particularly in a system with constrained resources and increasing demand.

Dr Coulson Barr noted that systemic pressures such as under-resourcing and outdated infrastructure make it difficult for committed staff to provide responsive and safe care.[107] These and other challenges experienced by the workforce must be dealt with to create the safe conditions within which all services can adopt alternative strategies and integrate them into routine practice.

31.4.1 A lack of resources to respond to people in crisis and distress

Increasing demand and limited capacity within mental health services have increased the threshold for access so that only the most acute and severely unwell consumers are seen.[108] The Commission's interim report found that population growth, increases in prevalence and presentation rates, and under-investment over many years have placed considerable pressure on a system that now 'functions in a state of crisis'.[109] The pressures on emergency departments in particular are described in section 31.5.

The Commission heard that current resourcing of inpatient units does not match the level of clinical acuity of the consumers being admitted.[110] Professor Newton noted that '[t]o be admitted into a psychiatric ward, a patient will generally have to present a high risk of aggressive behaviour'.[111] When combined with under-resourcing and increasing demand, this has contributed to a culture of risk aversion within inpatient units.[112] Professor Patrick McGorry AO, Executive Director of Orygen and Professor of Youth Mental Health at the University of Melbourne, appearing before the Commission in a personal capacity, contends that under-resourcing means the mental health system only intervenes with 'a core of patients that it cannot avoid treating'.[113] He observes that this lack of capacity to provide earlier support contributes to higher levels of acuity, more compulsory treatment and increased use of restrictive practices:[114]

> As a result [of under-investment], more people are ending up in such a state that they can only be treated on an involuntary basis. This is a pure reflection of under resourcing and late intervention. It also results in excessive levels of restraint and seclusion and the advent of wall to wall security staff in [emergency departments] and inpatient settings is a sad marker of this collapse. These measures now appear necessary for staff safety and are difficult to wind back.[115]

Being treated on a compulsory basis—or compelled in other ways to accept treatment—can be a frightening and distressing experience for consumers. Compulsory treatment can contribute to frustration and agitation, leading to situations where staff may, without the confidence or capacity to use other strategies, respond with seclusion or restraint.[116] Not being able to freely come and go from inpatient units can add to this.[117] As outlined in Chapter 32: *Reducing compulsory treatment*, the Commission recommends pursuing a significant reduction in the use of compulsory treatment such that it is only used as a last resort.

The Commission also reasserts recommendation 8 of its interim report for 'a substantial increase in investment in Victoria's mental health system'.[118] The interim report noted that the current level of investment is insufficient to meet the needs of even the most acutely in need.[119]

31.4.2 Physical environment: lack of appropriate spaces and conditions for therapeutic treatment

The physical environment in inpatient units and emergency departments can also contribute to conflict and the use of seclusion and restraint.[120] As identified by the Commission in its interim report, services have been hampered by a lack of capital investment in infrastructure.[121] Many have shared bedrooms and limited space. Mental health service staff told the Commission this both contributed to, and made it difficult to respond to, consumer distress and agitation.[122] Professor Brophy told the Commission:

> The design of inpatient units may be contributing to high rates of restrictive practices being utilised, as may overcrowding, excess noise and lack of privacy in those units … improved design of inpatient units, including, for example, reducing custodial features and creating a more homelike environment, had significant potential to reduce the use of restrictive interventions.[123]

Professor David Castle, Consultant Psychiatrist at St Vincent's Hospital Melbourne and Professor of Psychiatry at the University of Melbourne, appearing before the Commission in a personal capacity, said: '[f]or some units, a complete rebuild is required with attention to modern design elements and open space access.'[124]

In addition to fixing infrastructure, replacing worn-out furniture, installing acoustic shielding in noisy spaces, providing access to drinks and snacks and other improvements to amenities can all help create inpatient units where consumers feel comfortable and respected.[125] Mr Kelly told the Commission:

> The built environment can instil a sense of dread, hopelessness and despair, a general feeling of not being cared about. Whilst orientating consumers to the ward upon admission, staff often feel the need to apologise for the quality of the facilities or lack thereof, we reassure consumers that areas are cleaned regularly as appliances and surfaces are so worn that they look dirty and there are also difficulties in maintaining a high standard of infection prevention.[126]

Alfred Health submitted that inpatient facilities can be designed to help eliminate seclusion, but that balancing safe and therapeutic environments is challenging:

> We believe that acute inpatient facilities can and must be designed to provide trauma-informed care and therapeutic interventions. They must also minimise exposure of patients and clinicians to violence, and other forms of harm while eliminating seclusion, in-hospital suicide and sexual assault. This balance is difficult and at the root of the complexity of care in [Victoria's mental health system].[127]

The Commission considered in its interim report:

> The lack of capital investment over time has … resulted in facilities that are outdated, hindering the delivery of recovery-oriented treatment, care and support … [and compromising safety] … in some cases mental health services cannot offer separate care environments across genders, or for different experiences of illness.[128]

As a consequence, there is 'a clear need for additional capital funding for Victoria's mental health system'.[129]

31.4.3 Challenges for the workforce

Mental health services have a responsibility to provide a safe environment for both consumers and staff—although this can be difficult within the current system. Safety concerns within inpatient units have negative effects on people living with mental illness and their families, carers and supporters, as well as the workforce.[130]

In its interim report, the Commission observed that a lack of safety in service settings is caused by a range of factors including increased acuity levels in adult mental health inpatient units due to people becoming more unwell before admission, under-resourcing, poorly designed physical infrastructure, insufficient workforce capability and ability to implement de-escalation strategies, and leadership shortcomings.[131]

The Commission notes that an 'empathetic and consumer-driven workforce is integral to delivering evidence-based, safe and responsive services'[132] but recognises that safety is a major concern for a workforce that is 'ill-equipped, overstretched and not supported in their efforts to deliver the compassionate care they want to deliver'.[133] Chapter 33: *A sustainable workforce for the future* outlines the Commission's recommendations to ensure the safety and wellbeing of all staff to enable them to deliver the best practice treatment, care and support they aspire to provide.

Mental health services report safety incidents to the Victorian Agency for Health Information, but current limitations of the data collected include that it does not provide meaningful data about clinical or occupational incidents on a service-by-service basis.[134] This means it is not possible to analyse the scale of the problem or the factors that contributed to each incident.

However, Mr Colin Radford, CEO of WorkSafe Victoria, advised that 'the major safety challenge facing the mental health service is work-related violence, which can result in stress, vicarious trauma, and mental injuries', as well as physical harm.[135]

Further, despite the lack of system-wide data about safety incidents, services gave the Commission some idea of the extent of the issue. Eastern Health, for example, reported that at any one time there are multiple members of its mental health team who are on long-term personal leave directly related to safety and harm in the workplace.[136] In 2019 NorthWestern Mental Health recorded 350 incidents of occupational violence during a 90-day period; most of these incidents involved physical harm to staff.[137] The risk of incidents, and broader community expectations, has resulted in security staff being routinely employed in health service settings (refer to Box 31.4).

Box 31.4: Use of security staff

Hiring security staff, particularly for emergency departments and acute mental health inpatient units, has become widespread because healthcare workers are at risk of occupational violence.[138]

Security staff may be carefully selected and may be trained in de-escalation techniques.[139] Dr Vinay Lakra, Clinical Director of North West Area Mental Health Service in NorthWestern Mental Health, told the Commission that at North West Area Mental Health Service, security staff 'are led by clinical staff, not the other way around'.[140] Dr Lakra continued:

> We find that this means that there is security involvement only so much as is necessary or appropriate having regard to the needs of everyone to feel safe, and only insofar as is clinically appropriate, and security involvement is only insofar as is clinically appropriate.[141]

Professor Braitberg told the Commission that the hospital is actively increasing the number of 'planned' code grey calls, which are emergency responses to situations of verbal or physical aggression.[142] This involves anticipating situations when support may be required and arranging security personnel to be present—for example, when telling a patient that they need to be admitted. Professor Braitberg said, '[t]his method is working well and the [Royal Melbourne Hospital] aims to increase the proportion of "planned" code greys rather than reactive code greys taking place.'[143]

Professor Newton advised that the Peninsula Mental Health Service has evaluated the impact of introducing trained security staff in its high dependency unit when they have consumers who present extreme risks of harm to others:

> Importantly, this practice has a moderating effect on the consumers' behaviour, staff felt supported, and the other consumers and their carers who were sharing the space reported that they felt safer with security present.[144]

However, the Commission also heard that consumers and families, carers and supporters can find the presence of security guards threatening.[145] Having security guards in inpatient units can also increase anxiety and contribute to the feeling that units are prison-like.[146] Ms Barker told the Commission:

> Sometimes it's when people come in with the threat of force that people behave in a particular way that might warrant restraint. For example, I am quite passive and if you just talk to me that would be great. But if I see five burly security guards running at me, I'm ready to run. When I run, that's when restraints are put on me.[147]

In focus groups, some nurses told the Commission they think there should be less security presence in inpatient settings:

> So, are security guards the answer in our inpatient settings in our emergency departments? Absolutely not. Do they create extra conflict and extra restraint at times? I think so. They can contribute because people see them dressed like that. They know they're security guards; they can actually fire clients up. I'm actually a big advocate for getting rid of security as best we can. We didn't always have security in inpatient settings, and we used to manage clients' aggression and behaviour.[148]
>
> I'm another great advocate for getting rid of security guards. A lot of people feel threatened; that does give that sort of prison-like environment, and that sort of thing. And if necessary, put on more staff—more nursing staff—to be able to assist in keeping things safe rather than bringing in security. [149]

On balance, the Commission's view is that the use of security personnel is an indicator of a mental health system under stress but also a reflection of broader community changes that have led to increased need for security in hospitals. The changes proposed to settings and practices to reduce restrictive practices should, in time, lessen the need for security officers in mental health service settings.

Ward staff can feel pressure to reduce restrictive practices, and to tolerate an increased level of risk, without complaint.[150] Participants in the Commission's roundtables with mental health nurses and directors of nursing noted that while elimination is a worthy ambition, not having access to seclusion and restraint in the current environment could leave staff feeling fearful.[151] However, while staff may take some comfort from having access to restrictive practices in especially difficult circumstances, this does not mean they want to use them. In fact, using restrictive practices can place staff at risk of physical injury and psychological trauma.[152] This was underlined in one submission:

> **What needs to occur in the short term is that any further investigation of Restrictive Interventions, particularly as they pertain to the reduction in use of seclusion be ceased, until proponents of such measures adequately investigate tangible alternatives that are proven to maintain the safety of [mental health] staff. [Mental health] staff do not utilise seclusion as an easy way out or respite from disruptive patients as some attempt to characterise. In reality maintaining someone in seclusion as per necessity and adherence of the Mental Health [Act], is often more perilous to [mental health] staff… [A] system of workforce welfare, support and/or peer mentorship should be created and implemented.**[153]

Research capturing nurses' views has suggested that, while seclusion and restraint may be considered 'part of the job' and 'inevitable', nurses also experience distress in using seclusion and restraint.[154] They often blame themselves and experience emotional reactions and personal conflict, including uneasiness, when incidents of seclusion or restraint occur.[155] Dr Coulson Barr observed that 'staff are concerned about the use of restraint and seclusion and may experience distress during or following the use of restraint or seclusion'.[156] Mr Kelly described feelings of defeat, disheartenment and failure when a seclusion episode occurs after attempts to explore alternative treatment options. He noted that injuries to staff often occur during physical restraint and that '[i]t is not uncommon for these staff injuries to be career changing or career ending in nature.'[157]

Ultimately, the lack of ability within services to provide therapeutic treatment, care and support has a degrading effect on the workforce as well as on patients. When the system is too constrained to provide person-centred care and the therapeutic relationship between staff and consumers is lost, it can become 'dehumanising' for both the consumer and workers.[158]

The Commission is concerned that the safety and wellbeing of staff is being compromised in a system that is under pressure and under-resourced, which will act as a barrier to achieving high standards of professional practice, treatment and care. As Professor Newton advised:

> **Having safety as a central tenet for all staff and consumers is an important component of culture. If services take a patient-centred approach informed by human rights they will be able to positively influence the use of restrictive practices.**[159]

Mental health services are unlikely to eliminate the use of seclusion and restraint unless staff feel safe at work.[160] This will require alternatives—such as early intervention or de-escalation techniques—that allow staff to respond to consumers without restrictive practices. These alternatives have been used to good effect elsewhere (refer to Box 31.5).[161] Professor Newton noted:

> **If staff react to aggressive behaviour by attempting to restrain a consumer, it may only worsen the consumer's behaviour and increase the risk of harm to the staff member. Where staff use alternative techniques, including de-escalation, the clinically observable result is that patient behaviour improves, making a safer environment for both patients and staff.**[162]

Mental health services need alternatives to restrictive interventions to improve the safety of consumers and staff and to reduce the use of seclusion and restraint. International studies have identified ways to prevent conflict, support earlier intervention in situations that lead to seclusion and restraint, and enable staff to use de-escalation techniques.[163]

The recommendations in Chapter 33: *A sustainable workforce for the future* to establish a Mental Health Workforce Wellbeing Committee to respond to occupational health and safety problems, and to ensure services provide the right workplace supports, are vital to creating the conditions to eliminate restrictive practices.

Workforce experience and skills, staff numbers and the availability of staff outside business hours all affect the use of restrictive practices. More senior staff can bring 'clinical experience, life experience, knowledge … and offer coaching, mentoring, problem solving and conflict resolution skills' but often acute public mental health inpatient units are staffed by the most junior and inexperienced staff.[164] Low staff numbers can mean limited time for staff to interact with consumers and, where necessary, to provide one-to-one treatment, care and support. High levels of staff who are not familiar with consumers can contribute to the use of restrictive practices.[165] Rates can increase outside business hours when staff are not supported by a multidisciplinary team.[166] Workplace characteristics, including rostering, shifts and access to training, can shape rates of seclusion and restraint.[167]

Research also indicates that boredom and a lack of meaningful activities in inpatient wards (which can be a consequence of not having enough staff available) can lead to consumer frustration and contribute to conflict with staff.[168]

The Commission considers, as part of a strong clinical governance approach to reducing seclusion and restraint, it is incumbent upon services to examine and monitor the factors that contribute most significantly to their use, and to take action locally to remediate their effects.

31.5 Restrictive practices in emergency departments and during transport

Assessment and treatment in emergency departments is necessary and appropriate for some people experiencing crises related to mental illness, psychological distress or drug intoxication. These include people with co-occurring physical injuries or acute illnesses, or acute or rapidly escalating psychosis.

In its interim report, the Commission acknowledged that emergency department staff often provide treatment, care and support in very difficult circumstances.[169] Presentations related to alcohol and other drug intoxication accounted for the greatest proportion of all mental health–related emergency department presentations during the decade to 2019–20.[170] One of the greatest increases was for stimulants, which include methamphetamine ('ice').[171] People affected by ice can experience acute, severe behavioural disturbance, including violent behaviours that do not respond to usual verbal interventions.[172] The Commission was informed that multiple emergency department staff members may be required to manage people in these situations, often without input from mental health clinicians, which can result in the person being sedated or subject to physical or mechanical restraint.[173] Experiencing restraint in an emergency department is upsetting and stigmatising.[174]

Ms Sandra Keppich-Arnold, Director of Operations and Nursing, Mental Health and Addiction Health at Alfred Health, said that more resources are required in emergency departments to 'treat and contain' mental health consumers to avoid sedation or restraint, including investment in 'more welcoming, private, less chaotic, yet safe environments'.[175] Some—but not all—emergency departments have a behavioural assessment room that is a separate space for clinicians to work with people who are showing severe behavioural disturbance.

The provisions for using restrictive practices apply equally to the ways in which patients are transported to hospitals. Under the Mental Health Act, bodily restraint and sedation may be used when transporting a person to a designated mental health service (or another place). The 2014 *Protocol for the Transport of People with Mental Illness* provides guidance on using restraint and sedation for safe transport.[176] Mr Simon Thomson, Regional Director of Ambulance Victoria, told the Commission that paramedics use sedation or restraint as a last resort.[177]

It is difficult to identify how many patients are restrained during transport to hospital, or during an admission to emergency departments in hospitals, because data reportable to the former Department of Health and Human Services does not explicitly capture their use in these contexts. This information should be recorded, analysed and reported to inform the delivery of treatment, care and support and to improve oversight and accountability.

One study commissioned by the Office of the Chief Psychiatrist indicated that most patients who were subject to chemical, physical or mechanical restraint within emergency departments were not being managed under the Mental Health Act.[178] Therefore, the governance framework and policies for patients managed under the Act did not apply to most people who were subject to restraint in an emergency department.[179] Instead, these patients were managed under a common-law duty of care to prevent injury to individual patients and others.[180] Specific practices reflect local hospital procedures and clinical guidance from Safer Care Victoria.[181]

Where a person presenting to an emergency department is being cared for under a compulsory treatment order, the provisions of the Mental Health Act relating to seclusion and restraint apply to any use of restrictive practices. This includes authorisation by an authorised psychiatrist (including retrospectively, if the psychiatrist is not immediately available), and requirements for continuous review, documented clinical assessments and regular review by a psychiatrist or medical practitioner.[182]

Dr Coulson Barr highlighted that complaints data indicate a higher risk of mechanical restraint (particularly for prolonged periods) in emergency departments compared with other areas of designated mental health services.[183] Dr Coulson Barr noted that emergency departments are unsuitable for people who are acutely unwell and that long waits for a bed in an acute mental health unit can mean people are restrained for long periods.[184]

Just as for consumers in inpatient units, being restrained in an emergency department can be traumatic to patients and may limit their human rights.[185]

A parent also described the use of restraint in an emergency department:

> My young son ended up in the emergency department because of a mental health crisis. All they could do was restrain him and medicate him until he was sedated.[186]

In addition, Dr Coventry drew attention to research that indicated 'people who are physically restrained while in an emergency department are less likely to attend for mental health outpatient follow-up treatment than those who are not restrained'.[187] The research suggested that a traumatic experience of care during a crisis may limit later attempts to seek help.

Dr Coventry stated that emergency department staff often do not have the training and skills to respond to consumers who are agitated or distressed.[188] Clinicians and nurses also may not be aware of their responsibilities under the Mental Health Act.[189]

Ms Karyn Cook, Executive Director of Mental Health Services at South West Healthcare, Warrnambool Community Health, told the Commission:

> A challenge is that there is variability in how restraint and seclusion is used across emergency services and the various non-mental health units across hospitals within our catchment to keep staff and consumers safe. We work with our colleagues in [the emergency department] at [South West Healthcare] to assist them in understanding that the whole of Warrnambool Base Hospital is a designated mental health service facility and reinforce the regulatory requirements. This has proven to be a successful education piece for us … For example, to ensure [emergency department] staff appreciate that if they contain someone in a safe assessment room that would fall within the meaning of seclusion under the Mental Health Act, and therefore would require relevant authorisation, observations and adherence to reporting requirements.[190]

Where people presenting to emergency departments are being treated under the provisions of the Mental Health Act, it is critical that all staff know and understand the rights of the patient, and the professional obligations relating to their treatment, under the law. It is the responsibility of service providers to ensure staff have the skills and capacity to meet these obligations.

Irrespective of whether people are being treated under the Mental Health Act or under a general duty of care, they should experience an environment and professional practice that upholds their dignity and rights. All health services must ensure staff have the training and support to employ de-escalation strategies and alternatives to seclusion or restraint. This must be a particular priority for staff working in the high-pressure environments of emergency departments.

As mentioned earlier in this chapter, with the support of the Victorian Managed Insurance Authority, the Chief Mental Health Nurse is overseeing a trial of the Safewards model in emergency departments at Peninsula Health and Bendigo Health.[191] (Refer to Box 31.3 for more information about the Safewards model.) The University of Melbourne is evaluating the trial project, which was due to be completed in December 2020 but has been delayed due to the COVID-19 pandemic.[192] The Commission notes that evaluation findings are likely to assist in guiding further implementation of Safewards across emergency and general wards.

The Commission has also recommended that the Victorian Government develops an integrated and networked approach to responding to mental health crises, as described in Chapter 9: *Crisis and emergency responses*. This will include 'safe places' as alternatives to emergency departments, where consumers can access treatment, care and support in environments that are less likely to exacerbate their distress. The reforms will also help consumers avoid unnecessary involvement with police.

31.6 Reporting rates of seclusion and restraint

Under the Mental Health Act services must report the use of 'restrictive interventions' to the Chief Psychiatrist.[193] The Office of the Chief Psychiatrist publishes system-level information on the use of seclusion and restraint in its annual report.[194] Services must also report on seclusion, physical restraint and mechanical restraint in their annual quality accounts, including their performance against the indicator for seclusion and the action they have taken to reduce restrictive interventions.[195]

The Victorian Agency for Health Information produces the biannual *Inspire: Mental Health* report on the safety and quality of mental health services.[196] This is distributed to service providers. This report enables statewide benchmarking on the use of seclusion and bodily restraint and helps 'services and clinicians to reflect on their position relative to peer services, identify variations in practice across these areas, and proactively work to deliver care that is least restrictive, person-centred, safe and trauma-informed'.[197] The variation between services is discussed in section 31.3.1.

Data on rates and length of episodes are published across a range of sources including the Chief Psychiatrist's annual report, departmental reporting on mental health service performance and the Australian Institute of Health and Welfare's mental health reports.[198] These reports provide the following information:

- The Chief Psychiatrist's annual report provides data on seclusion and restraint (including total number of episodes, number of episodes by age and gender and rates across different age groups and service types, as well as the length and frequency of episodes in a single admission).
- The former Department of Health and Human Services' (now Department of Health) annual report on mental health services includes information on the rate and duration of seclusion and restraint.[199]
- The Victorian Agency for Health Information publishes quarterly key performance indicator data for mental health services, including the rate of seclusions and the proportion of admissions where a consumer was secluded more than once.[200]
- The Australian Institute of Health and Welfare reports on the rate of seclusion and restraint at the state and individual health service levels.[201]

The Commission notes that no single measure can provide meaningful information about how and when restrictive practices are used.[202] While each of those reports provide relevant information, none provide a source of information about seclusion and restraint that is comprehensive, accessible and timely.[203]

The Victorian Mental Illness Awareness Council noted the lack of accessible and public data, and suggests that this hides the use of restraint.[204] The council has prepared reports on the use of seclusion but does not have access to enough data to provide a full report on all forms of restrictive practices.[205] Ms Erandathie Jayakody, a witness before the Commission, said:

> Restrictive practices (literally) take place behind locked wards when people are experiencing great distress and are at their most vulnerable. It is an environment where medical professionals exert enormous power over a vulnerable group of people. Patients have very little access to advocacy services, families and friends in such situations. It is paramount there is greater transparency and scrutiny of such practices. Data on restrictive practices needs to be published quarterly in a meaningful way to enable proper analysis and better understanding of practice trends and how to address them ultimately leading to better quality of care.[206]

31.7 Defining and regulating chemical restraint

Although Victoria's mental health legislation defines physical and mechanical restraint, consumers, families, carers and supporters also point to the use of 'chemical' and 'emotional' or 'psychological' restraint.[207] 'Chemical restraint' refers to using medication to control behaviour. The terms 'emotional' or 'psychological' restraint, on the other hand, describe situations where consumers feel they are constrained by aspects of their experiences of treatment, care and support from expressing themselves or their views openly and honestly.[208]

The Mental Health Act only refers to using medication in the context of transporting a consumer from one place to another, although this is referred to as sedation rather than chemical restraint.[209] The Chief Psychiatrist's guidelines for 'restrictive interventions' do not include a definition but do indicate that chemical restraint is inappropriate in mental health service delivery.[210]

There has been continuing debate about the use of chemical restraint in mental health treatment, care and support.[211] Research indicates that, despite interest in understanding the use of chemical restraint, there is still limited agreement on if and how chemical restraint should be used in the context of mental health treatment, care and support.[212]

Consumers and clinicians may hold different views about how it should be defined and whether it is necessary to regulate it through legislation.

Consumers used the term 'chemical restraint' to describe a range of uses of medication in Victoria's mental health services. While system-wide data on medication use in mental health units has not been compiled, consumers told the Commission of their experiences of being given medication that felt over-sedating and unnecessary or part of a coercive approach to treatment.[213] Ms Daya argued that use of chemical restraint is commonplace:

> **Neither chemical nor psychological restraint are measured or publicly reported in Victoria, despite them both quite clearly being common practice on inpatient units.**[214]

Between July 2014 and June 2019 the Mental Health Complaints Commissioner received 61 complaints about over-sedation and 153 complaints relating to unnecessary medication.[215] This included 'concerns reported by consumers that their medication was excessive and that, in their view, it was prescribed for behavioural rather than treatment reasons'.[216]

Clinicians told the Commission of the challenges of defining chemical restraint and of varying approaches within mental health services:

> When referring to restrictive practices, I am referring only to seclusion and physical or mechanical restraints, and not to chemical restraints. It is difficult to define the concept of chemical restraint, as medications that have a restraint effect are primarily administered for the treatment of a patient. In managing patients experiencing severe psychotic distress or drug withdrawal, for example, those patients may be administered medication that may have the effect of calming or sedating them. There is a duality of purpose, as while the effect of the medication may sedate the patient, it is administered for treatment purposes.[217]
>
> Issues around chemical restraint are more complex. The community understands chemical restraint to be a reference to the unnecessary use of medication to restrain people. The more appropriate area of concern is excessive or inappropriate use of psychotropic medication.[218]
>
> Whilst involuntary sedative medication is not included within this definition [under the Act], it is included in our practical consideration of restrictive practice if the intent is to effectively chemically restrain an individual by administering a drug at a dose which prevents the individual's freedom of movement.[219]

As described by these clinicians, there are obvious challenges in defining chemical restraint in the context of mental health service delivery, given medication can be used to treat and sedate.[220] Medication prescribed to treat an illness may have strong sedative effects.[221] It can be difficult to determine whether a clinician's intent is to treat symptoms or control behaviour.[222] Choice of drugs and dosage can also be important. For example, pro re nata (or PRN) medication (medication that should only be taken when needed) may be over-prescribed.[223] Rapid tranquilisation—or using emergency medication to calm or sedate a person when they are aggressive or agitated—has also been described as chemical restraint.[224]

Notwithstanding the above, across Australia four states have resolved this issue and updated their mental health regulations or policies to include the use of chemical restraint (refer to Table 31.1). The changes were:

- In 2013 the Tasmanian Government introduced a definition of chemical restraint as part of the *Mental Health Act 2013*.[225]
- In 2016 the Queensland Government introduced provisions in the *Mental Health Act 2016* relating to the inappropriate use of medication.[226]
- In 2017 the South Australian Government amended the *Mental Health Act 2009* to add chemical means to the forms of restraint covered by the legislation.[227]
- In 2020 New South Wales Health updated their policy directive on using seclusion and restraint (in all health settings) to include a definition of chemical restraint.[228]

Table 31.1: Definitions and provisions related to chemical restraint in Australian jurisdictions

Jurisdiction	Definition
Tasmania *Mental Health Act 2013*	'**restraint** means any form of chemical, mechanical or physical restraint'.[229] '**chemical restraint** means medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition'.[230] 'For the purposes of this Act, **treatment** does not include seclusion, chemical restraint, mechanical restraint or physical restraint.'[231]
Queensland *Mental Health Act 2016*	'**Medication**, of a patient, includes sedation of the patient.'[232] 'A person must not administer medication to a patient unless the medication is clinically necessary for the patient's treatment and care for a medical condition.'[233] 'To remove any doubt … a patient's treatment and care for a medical condition includes preventing imminent serious harm to the patient or others.'[234]
South Australia *Mental Health Act 2009*	'**restrictive practice**, in relation to a patient, includes— (a) the use of physical, mechanical or chemical means to restrain the patient; and (b) seclusion or the confinement of the patient on his or her own in an area from which he or she cannot leave of his or her own volition'.[235]
New South Wales *Seclusion and Restraint in NSW Health Settings* (policy directive PD2020_004—March 2020)	Chemical restraint is defined as: '[t]he use of a medication or chemical substance for the primary purpose of restricting a person's movement.'[236] 'Medication (including PRN) prescribed for the treatment of, or to enable treatment of, a diagnosed disorder, a physical illness or a physical condition in line with current clinical guidelines is not considered chemical restraint.'[237] Note: The *Mental Health Act 2007* does not define chemical restraint or use of medication specifically in relation to restraint.
Other jurisdictions	The following do not define chemical restraint or make provisions about using medication specifically for restraint: • Western Australia—*Mental Health Act 2014* • Australian Capital Territory—*Mental Health Act 2015*.

In Victoria the Commission did not find a clear consensus among commentators on whether chemical restraint should be included in the Mental Health Act. Dr Coventry told the Commission that 'the use of medication to restrict movement can be hazardous, and has no defined place in the [Mental Health Act] or in practice'.[238] In contrast, Ms Daya argued that not enough is being done in Victoria:

> For far too long, [the former Department of Health and Human Services] and [the] Chief Psychiatrists have avoided measuring chemical restraint by delaying an agreed national definition: yet chemical restraint is clearly and consistently defined internationally, and in the Australian disability sector.[239]

One potential benefit of defining chemical restraint in mental health legislation is to measure, report and then potentially decrease its use by monitoring.[240] Dr John Reilly, Queensland's Chief Psychiatrist, highlighted how introducing legislative provisions for inappropriate medication use allowed his office to develop more comprehensive oversight arrangements, including data collection.[241]

In the absence of a definition in legislation or policy, some service providers have taken action to reduce over-sedation and other undesirable side effects.[242] Mr Kelly told the Commission:

> At [NorthWestern Mental Health], we have reduced the use of physical restraint, and … to ensure that pharmacological management is now used in a much more judicious way such that it does not result in people being overly sedated, as may have occurred in years past. In other words there is a much greater emphasis on achieving symptomatic control over distressing symptoms such as command type auditory hallucinations which may be inciting suicide, without causing undesirable side effects such as over-sedation, drooling or movement disorders.[243]

People with a disability, older Victorians and their advocates have also expressed considerable concern about the use of chemical restraint.[244] The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability has released an issues paper on restrictive practices (including chemical restraint).[245] The Royal Commission into Aged Care Quality and Safety is considering what regulatory, policy or practice changes are required to reduce the use of chemical restraint in aged care,[246] noting:

> Behind the use of these restrictive practices lies a history of neglect … and a surprisingly neglectful approach to the use and prolonged use of chemical restraint …[247]

Chemical restraint is subject to particular regulation in aged care and disability settings. In both, it is defined as:

> the use of medication or chemical substance for the primary purpose of influencing a person's behaviour or movement, but does not include the use of medication prescribed by a medical practitioner for the treatment, or to enable treatment, of a diagnosed mental disorder, a physical illness or a physical condition.[248]

Under the regulations, service providers can only use chemical restraint on an ongoing basis with adequate planning and informed consent.[249]

Over-prescription of psychotropic medications for older Australians—for the purpose of controlling behaviour—is a particular a concern in residential aged care. The Royal Commission into Aged Care Quality and Safety highlighted this problem in its 2019 interim report.[250] Since then, the Commonwealth Government has strengthened the regulation of chemical restraint to make it clear that it should only be used as a last resort, and clarifying the prescriber's responsibility to obtain informed consent.[251]

The Commission considers that defining and regulating the use of chemical restraint under the new Mental Health and Wellbeing Act (refer to Chapter 26: *Rebalancing mental health laws—a new Mental Health and Wellbeing Act*) will protect consumers and enable this practice to be appropriately monitored.

31.8 A vision to eliminate seclusion and restraint

The use of restraints in the care of people experiencing mental illness or psychological distress has a long history.

Laws established in the 1700s granted authorities the right to restrain 'unruly people' based on the assumption that it would benefit the person.[252] Advocacy and efforts to reduce the use of restrictive practices date back to the 18th century.[253] By the 1830s, physicians were introducing new approaches into their asylums in an attempt to eliminate mechanical restraint.[254]

Despite these efforts, restrictive practices continued to be seen as therapeutic.[255] By the 1990s serious concerns were being raised about the harms experienced by consumers when secluded or restrained.[256] A growing focus on recovery-oriented and trauma-informed care, along with developments in human rights law, has driven efforts to reduce restrictive practices in mental health services.[257] Increasingly, seclusion and restraint have been viewed as necessary for consumer and staff safety, rather than therapy.[258]

In 1998 investigative reporting in the United States[259] prompted creation of national standards and renewed efforts to reduce the use of seclusion and restraint.[260] The reports led to the *Six Core Strategies for Reducing Seclusion and Restraint Use*,[261] founded on the principles of consumer leadership and involvement and trauma-informed care.[262] Specifically, the strategies highlight the need for organisational change, data-informed practices and workforce development to reduce the use of seclusion and restraint. They also emphasise that consumers' role in their own care should be honoured. These strategies are used internationally, across a range of settings, as a basis for reducing or eliminating seclusion and restraint.[263]

31.8.1 Relevant research and case studies

Research over the past two decades indicates there are many interventions that can be adopted—either at the service or system level—to reduce or eliminate the use of restrictive practices.[264] Most commonly these are based on one of the two models discussed above: the six core strategies and the Safewards model.[265] These approaches and research findings are summarised in Box 31.5.

Three elements that are critical for eliminating seclusion and restraint underpin these examples.

First, a strong vision and sustained, committed leadership are needed to achieve and integrate the required practice and cultural changes, at both the system and service levels.[266] As Dr Grigg told the Commission, '[l]eadership is one of the most critical factors in influencing the use of restrictive interventions within mental health services.'[267]

Second, consumer leadership and participation is vital. Understanding how consumers perceive seclusion and restraint can have a powerful influence on service culture, and consumers will bring a critical perspective to the design and implementation of specific efforts to reduce these practices.[268] Consumer leadership also helps develop trauma-informed care.

Finally, services need the workforce skills and capacity to identify local patterns in seclusion and restraint use and to enable staff and consumers to design interventions together. Analysis of local data can show patters such as higher use of seclusion during night shifts.[269] While there are benefits to having consistent approaches to reducing seclusion and restraint across the system, contemporary approaches to improvement focus on collecting local knowledge and devising solutions that help with specific local needs.[270] These need to be informed by detailed data and analysis to identify where change is needed and to monitor progress.[271]

Both the research and experiences of service providers—in Victoria and more broadly—indicate that the use of seclusion and restraint can be significantly reduced and even eliminated in mental health and wellbeing services. The evidence also suggests that adopting multiple strategies concurrently has more impact on reduction than implementing a single intervention.[272]

31.8.2 Efforts to reduce restrictive practices in Victoria

Over the past two decades Chief Psychiatrists, Chief Mental Health Nurses and the former Department of Health and Human Services have introduced initiatives to support services in reducing their use of seclusion and restraint. Dr Coventry told the Commission that, for his office, eliminating the use of seclusion and restraint is an ongoing long-term goal:

> Our ultimate aim is to eliminate the use of restrictive interventions, and planning has commenced for a long term program of work to eliminate the use of restrictive interventions in Victoria. This is an ambitious objective which will require fundamental change and sustained efforts in partnership with mental health services, consumers and carers, and industrial bodies. Leadership, commitment and motivation will be critical to the success of this work, as will a change culture underpinned by recovery with a focus on workforce and training.[273]

Key initiatives to reduce seclusion and restraint over the past decade are summarised in Box 31.6.

Box 31.5: Approaches to reduce seclusion and restraint

Pennsylvania: Pennsylvania's state mental health system is renowned for reducing restrictive practices and eliminating certain types of them. State hospital reporting from 2019 (the most recent publicly available data) indicates that seclusion has not been used since 2013, and mechanical restraint since 2015.[274]

The change was achieved without compromising staff safety. Strong leadership, critically reviewing data, adopting a trauma-informed system of care and employing a lived experience workforce were important to this success.[275]

New Zealand: Mental health services have formed a partnership with the Health Quality and Safety Commission New Zealand to eliminate the use of seclusion in service delivery.[276] The Commission set a national goal and developed a methodology based on improvement science.[277] It then supported each mental health service to set up local teams to design service changes with consumers, using the six core strategies.[278]

Australian Capital Territory: A decade ago services in Canberra demonstrated how partnering with consumers can change practices. Service leaders established a seclusion and restraint review meeting at which lived experience experts met regularly with mental health unit psychiatrists, nurses, wards people and allied health practitioners.[279] Hearing about and understanding what consumers experience when they are secluded or restrained helped staff to see restrictive practices as untherapeutic and a failure of care.[280]

Alfred Health: Concerned with increasing rates of seclusion, Alfred Health has made significant changes in practice in acute mental health inpatient units. The hospital established a local response team that they called Psychiatric Response to Behaviours of Concern.[281] 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. This approach has reduced the use of seclusion.[282]

Research into alternatives to seclusion and restraint

Research in Australia and New Zealand indicates that sensory modulation in particular is a useful alternative to help consumers self-manage crises or distressing emotions. Key components include therapeutic use of modalities or activities, environmental modifications (such as multisensory rooms) and using visual, auditory and tactile cues to create safety and establish trust.[283] Other strategies can include using individual safety plans, verbal de-escalation and one-to-one nursing.[284]

A formal evaluation of Safewards in Victoria, and the experiences of services that have adopted the model, indicate this has contributed to cultural and practice change within these units.[285]

Box 31.6: Initiatives to reduce seclusion and restraint in Victoria

System-wide initiatives to reduce seclusion and restraint in Victoria include:[286]

- the Creating Safety: Addressing Restraint and Seclusion Practices project (Victoria's Chief Psychiatrist in partnership with the Victorian Quality Council, 2009), which demonstrates elements that can reduce the use of restraint and seclusion[287]
- development of the Creating Safety program, which provides online training to help managers and staff move away from restraint and seclusion practices[288]
- the launch of the Reducing Restrictive Interventions project (2013), which aimed to reduce and, where possible, eliminate restrictive interventions as a critical component of the reform of Victoria's Mental Health Act[289]
- as part of the Reducing Restrictive Interventions project, development of the *Framework for Reducing Restrictive Interventions* (2013), which guides health services in developing a local, systematic response[290]
- the statewide rollout of the Safewards model (as described in section 31.4), which was trialled as part of the Reducing Restrictive Interventions initiative[291]
- the Chief Psychiatrist's guideline *Restrictive Interventions in Designated Mental Health Services*, which sets out evidence-based best practice guidelines for using restrictive interventions in line with the legal requirements of the Mental Health Act.[292]

The Chief Mental Health Nurse, in particular, has championed the rollout of the Safewards model, promoting its use initially in public adult acute mental health inpatient units, then more broadly.[293]

The Chief Psychiatrist, Chief Mental Health Nurse and their staff also work with each service to reduce their use of seclusion and restraint by analysing data, supporting service managers and bringing together networks of staff.[294] The program of work has a strong local focus and emphasis on co-design and is being led by a senior consumer adviser.[295] This correlates with the advice of consumer experts that actions to reduce seclusion and restraint must be tailored to local services with input from people in the local community.[296]

Many, if not all, mental health service providers have taken steps to reduce the use of seclusion and restraint.[297] Some services have revised their model of care to better respond to consumers and to provide more therapeutic care than was previously offered.[298] Other services have introduced response teams, where groups of experienced staff are 'on call' to help staff deal with difficult situations without using coercive approaches.[299] Many have introduced regular review meetings to understand patterns of use and to identify opportunities to reduce restrictive practices.[300]

Despite these efforts, the Commission heard that services can find it difficult to reduce seclusion and restraint within the constraints of the current system. System pressures such as service demand have made it hard for some services to fully implement Safewards.[301] While it is important to continue implementing alternative approaches, structural barriers such as poor infrastructure and facilities, consumers being admitted with the need for intensive treatment, care and support, and a lack of workforce experience in caring for highly distressed and agitated consumers will make it difficult to enact these, and to change culture and practice.[302] Increasing levels of aggression among consumers affected by alcohol and other drugs can also make it challenging to avoid using restrictive practices.[303] As Professor Castle told the Commission:

> **Since 2014, St Vincent's Health has taken a number of steps to reduce the use of restrictive practices, including clear algorithms for medication use [decision tree to guide medication use], attention to risk indicators with early intervention and skilling of staff in the use of the least restrictive measures. Some of the key enablers to support professionals in making seclusion and restrictive practices an option of last resort include strong ongoing education and a collegiate environment with a reward rather than blame culture. However, reducing the use of restrictive practice remains difficult in certain circumstances such as the treatment of substance-affected and forensic consumers.**[304]

As discussed in section 31.4.3, the Commission recognises that the use of restrictive practices is currently a protective response by staff experiencing high levels of occupational violence and that addressing staff safety will be paramount to supporting alternative approaches. Creating safe and supported workplaces must be a high priority for all interested parties. The Mental Health Workforce Wellbeing Committee described in Chapter 33: *A sustainable workforce for the future* will include representatives of mental health service employers, professional colleges, representative and professional bodies and unions working with the Victorian Government to identify and respond to risks to the health, safety and wellbeing of staff.

31.8.3 A goal of elimination

The Commission supports the goal of eliminating the use of seclusion and restraint in mental health and wellbeing services—including in emergency departments—given that restrictive practices harm both consumers and staff physically and psychologically, and infringe consumers' human rights. This goal of elimination aligns with the Victorian Government's support for eliminating restraint in mental health services outlined by the Australian Health Ministers' Advisory Council.[305]

The evidence presented to the Commission indicates that it is possible to achieve significant reductions—and even eliminate[306]—the use of seclusion and restraint through leadership, consumer participation, investigation of seclusion and restraint data, and developing alternative approaches that keep consumers and staff safe.

Alone, however, these efforts are unlikely to lead to eliminating seclusion and restraint.

Achieving elimination will require broader changes across the mental health and wellbeing system. In particular, this will only be possible with recovery-oriented and trauma-informed care. As Dr Coventry advised the Commission, 'restrictive interventions are less likely to be used where recovery-oriented practice, trauma-informed care, supported decision making, and family and carer-inclusive practice inform workplace practices'.[307]

The Commission considers that the mental health and wellbeing workforce is motivated to provide the best possible treatment to people in their service. Rather than achieve change only via prescriptive legal or policy rules, the Commission envisages a system where a well-trained and appropriately supported workforce practise in therapeutic environments, driving uptake of alternative strategies. Changes in capabilities and culture will mean that, over time, mental health professionals will redefine their own culture and expectations, rendering seclusion and restraint as abnormal and inappropriate practices.

The National Mental Health Consumer and Carer Forum states that 'there may be specific circumstances where involuntary seclusion and restraint are required for the safety of the individual and of other people'.[308] The Commission considers that it is appropriate to retain legal provisions that clearly state when and how seclusion and restraint can be used, to protect the rights of both consumers and staff. Regulating the use of seclusion and restraint ensures that everyone in the therapeutic environment is afforded a legal right to protect themselves in situations of extreme conflict or violence in an appropriate and defined way.

The legal provisions do need to be supported by effective regulatory and monitoring arrangements.[309] Regulating the use of seclusion and restraint ensures that, whenever they are used, these incidents are subject to rules and oversight and that they are formally recorded and monitored. This prevents seclusion and restraint from becoming invisible and provides the basis for review, investigation and accountability in what should increasingly become exceptional circumstances.

It has been proposed that prohibiting the use of seclusion and restraint through legislation is the only approach that will eliminate seclusion and restraint.[310] Professor Penelope Weller, Professor of the Centre for Business and Human Rights at RMIT University, appearing before the Commission in a personal capacity, observed that '[s]ome commentators argue that the inclusion of the current framework of safeguards has legitimised and encouraged the use of such restrictive practices.'[311] This indicates a view that, as long as the option to seclude or restrain a consumer remains available, staff will continue to use these practices rather than find alternatives.

However, the Commission notes that the American state of Pennsylvania has successfully eliminated seclusion and mechanical restraint through a shared and unwavering commitment, without making regulatory changes to prohibit their use.[312] In 1997 Mr Charles Curie, Deputy Secretary of the State Office of Mental Health and Substance Abuse Services, announced that the use of seclusion and restraint represented 'treatment failure'.[313] He did not ban the use of seclusion or restraint:

> the announcement served as a challenge to the system to find more positive ways of supporting a person in crisis. The announcement put to rest arguments [that seclusion and restraint were necessary tools to manage a crisis and maintain safe environments] and established direction for … systemwide changes.[314]

Mr Curie attributed reductions in the use of seclusion and restraint to improved data collection and benchmarking between hospitals, statewide improvement projects and staff training in crisis management and alternative approaches.[315]

Ultimately, the use of seclusion and restraint can cause trauma, can 're-awaken' previous trauma, breaches human rights and is contrary to recovery-oriented and trauma-informed treatment, care and support. Therefore, seclusion and restraint should only ever be used in extreme emergencies.

On balance, the Commission views the regulation of seclusion and restraint within a redesigned system as a protection, not permission. Its use should be eliminated as an accepted practice.

31.9 Taking action to eliminate seclusion and restraint

The Commission recommends that the Victorian Government works towards eliminating seclusion and restraint as acceptable practice in mental health services and wellbeing delivery within 10 years. The Commission acknowledges that there may always need to be the ability to seclude or restrain in extreme emergencies. A high threshold for this should be set, and restrictive practices should be considered a deviation in practice rather than a necessary protection.

As a matter of priority, the Victorian Government should work to eliminate the use of mechanical restraint. This form of restraint is used less frequently than other restrictive practices.[316] Given this, it may be helpful to prioritise its elimination. Research indicates that, like other forms of restraint, use depends on factors such as culture and training.[317]

The changes outlined below should reduce the use of restrictive practices.

31.9.1 A strong vision and clear leadership

The Commission suggests that the Department of Health articulate a vision to eliminate the use of seclusion and restraint in all forms in mental health service delivery. The department should invite mental health and wellbeing services, including people in senior leadership roles such as CEOs, clinical directors and other relevant staff, to publicly commit to—and work towards—eliminating seclusion and restraint.

Change will require strong leadership and commitment, which will need to continue over the next decade.[318]

The Victorian Government must allocate clear leadership roles and responsibilities in relation to seclusion and restraint:

- The Chief Officer for Mental Health and Wellbeing should be responsible for achieving elimination by setting the vision, establishing targets for reductions in seclusion and restraint, and managing system changes that will contribute to these reductions.
- The Mental Health Improvement Unit should be responsible for helping to achieve elimination by supporting services with practical guidance, practice expertise and facilitating dedicated efforts to eliminate use in all but emergency situations.
- The Mental Health and Wellbeing Commission should hold the system to account for achieving elimination by taking a systemic view, having the power to monitor progress and inquire into system challenges, and advising the government on matters of concern.

To support these efforts, the Mental Health Improvement Unit should establish and host a Reducing Restrictive Practices network. This should include Regional Mental Health and Wellbeing Boards and service leaders or CEOs from each acute public mental health service.

31.9.2 Regulating chemical restraint

The Commission recommends that chemical restraint use be legislatively regulated. A similar regulatory approach to that used in Tasmania should be adopted. In that state, chemical restraint is defined via the Mental Health Act and Chief Psychiatrist's guidelines:

- Under Tasmania's Mental Health Act, chemical restraint is defined broadly as 'medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition'.[319]
- The Tasmanian Chief Psychiatrist's guidelines on chemical restraint exclude from this definition medication given to treat a mental illness or physical condition that may have a sedating effect. Rather: 'chemical restraint occurs when medication is intentionally given to exert control over a patient's movements or behaviour'.[320]

The Chief Psychiatrist's guideline (which all services must adhere to) provides that chemical restraint may only be lawfully used when 'absolutely necessary, and when less restrictive interventions have been tried without success, or have been considered but excluded as inappropriate or unsuitable in the circumstances'.[321]

The Commission considers that the Victorian Government should introduce similar requirements into the new Mental Health and Wellbeing Act, where chemical restraint is only permitted when all reasonable and less restrictive options have been tried, or when they have been considered and are thought to be unsuitable. The Department of Health should work with public mental health services to set targets, develop, monitor and report on appropriate measures and work towards eliminating the use of chemical restraint.

31.9.3 A strategy to reduce seclusion and restraint

The Chief Officer for Mental Health and Wellbeing will lead development and implementation of the government's strategy to reduce the use of seclusion and restraint. The strategy will improve monitoring and accountability, lead and support changes in workforce practice—including through continued implementation of Safewards—and ensure the voices of consumers informs planning and implementation. The strategy must also emphasise the need to create a safe service delivery environment for consumers and workers.

Improved accountability and transparency

The Department of Health should use targets to set expectations of reduced seclusion and all forms of restraint. This must include an immediate reduction in the accepted levels of seclusion and the introduction of targets for physical and mechanical restraint.

The Commission recommends the following reductions:

- an immediate decrease from 15 episodes per 1,000 bed days to eight episodes for adult and forensic services, and five episodes for child, adolescent and aged services
- a subsequent reduction of two episodes per 1,000 bed days every two years across all services.

Current targets are higher than in other Australian jurisdictions. For example, as previously mentioned New South Wales has a current target of fewer than 5.1 episodes per 1,000 bed days[322] compared with Victoria's indicator of 15 seclusions per 1,000 occupied bed days.

The Commission notes the limitations of using one measure (such as a rate) to describe the use of seclusion and restraint but considers this appropriate for setting targets for reduction and elimination. Reports on the use of seclusion and restraint across mental health services should include additional information, as described below.

The department should work with consumers, service providers and the Mental Health and Wellbeing Commission to develop and report against a suite of measures that capture the use of seclusion and restraint. The suite of measures should include information about use within each mental health and wellbeing service stream at each service, including information about rates of seclusion and restraint of children and of young people. This data must be published regularly and in an accessible format.

Transparency of rates and trends in seclusion and restraint is critical for public confidence in mental health service delivery. Consumers and service providers have called for the comprehensive and detailed reporting of all forms of seclusion and restraint to be held in one place.[323]

Having access to comprehensive data on the use of restrictive practices is also critical for services to understand current patterns of use, to benchmark performance against comparable services, and to monitor the impact of any interventions to reduce use. This needs to include clear reporting on the use of restrictive practices in emergency departments.[324] Given that no single measure can provide all information about the use of seclusion and restraint, the data must be detailed and comprehensive to provide a clear picture of how and when restrictive practices are used.[325]

While there may be some overlap with publishing information on system and service performance, the intent is for consumers and service providers to receive information about the use of seclusion and restraint in each service.

Oversight and monitoring of services' use of seclusion and restraint can also contribute to reductions in the use of these practices.[326] This includes making sure services comply with the legislative requirements for using seclusion and restraint.[327]

The department will be responsible for collecting data on the use of restrictive practices, and for providing consumers, families, carers and supporters, as well as service providers, with comprehensive data on their use.

The Mental Health and Wellbeing Commission, as part of its independent oversight role, will receive and respond to complaints about seclusion and restraint. It will also monitor the use of seclusion and physical, mechanical and chemical restraint and, when necessary, conduct inquiries into the use of restrictive practices.

Practice leadership and support

Locally driven efforts to reduce seclusion and restraint will be important to achieve change. The Mental Health Improvement Unit will support each provider of acute mental health inpatient units to eliminate the use of seclusion and restraint by:

- working with each mental health service to investigate local data and practices to identify priority areas for change
- making workforce training available
- developing guidance, tools and resources for services
- organising Communities of Practice or other forums to share knowledge across services.

The unit will support each provider to design and implement local projects or initiatives to target seclusion and restraint practices in each service or unit, incorporating the six core strategies and quality improvement methodologies. This support will include assisting each service to establish ways to co-design projects with consumers, families, carers and supporters. Projects or initiatives to address rates of seclusion and restraint in child and youth mental health and wellbeing services should be a high priority.

The unit will also work with each provider to identify opportunities to strengthen internal capability (such as through additional support for Safewards or establishing a local response team) or access to external support and advice (such as through the specialist behaviour response program described in Chapter 10: *Adult bed-based services and alternatives*).

The unit will also update the restrictive practice guidelines on seclusion and restraint to guide use as the Commission's recommendations are implemented. This will include:

- explaining the negative impact of seclusion and restraint and their limitations on human rights
- recognising gender and trauma history
- explicitly providing consumers with an option to make a complaint following every episode of seclusion or restraint
- requiring services to have appropriate admission procedures, particularly for consumers who are transferring from emergency departments.

The unit will continue to support services to integrate Safewards, including in emergency departments. This support will include making training for Safewards implementation available on a continuing basis.

The consumer voice at the centre

The Commission envisions lived experience at the centre of all efforts to eliminate the use of seclusion and restraint. Consumer leadership in efforts to eliminate seclusion and restraint is essential for change.[328] As indicated throughout this report, lasting change will only be achieved through the full and effective participation of consumers in decision-making processes that concern them.

Services should seek opportunities for engagement with consumers, families, carers and supporters during assessment and care planning, particularly in developing personal plans, to prevent the use of seclusion and restraint.[329] Collaboration between consumer experts and clinicians can be valuable in understanding the experiences of consumers, developing clinician empathy and identifying alternatives.[330]

Through the Collaborative Centre for Mental Health and Wellbeing, consumer experts will help design and lead workforce development programs that support therapeutic approaches to treatment, care and support. In particular, experts have advised the Commission that a strong and visible role for peer support workers can help reduce the use of seclusion and restraint.[331]

At the system level, the Mental Health Improvement Unit, described in Chapter 30: *Overseeing the safety and quality of services,* will support all mental health services to increase consumer leadership and participation in all activities seeking to reduce the use of seclusion and restraint. The Mental Health and Wellbeing Commission will include consumer leadership and participation in overseeing the use of restrictive practices. In addition, the Department of Health will use a co-design process to develop measures to report on the use of seclusion and restraint. These measures will provide the basis for monitoring progress and holding the system to account.

1 *Mental Health Act 2014* (Vic), sec. 3.

2 *Mental Health Act 2014* (Vic), sec. 3.

3 *Mental Health Act 2014* (Vic), secs. 105, 110 and 113.

4 *Mental Health Act 2014* (Vic), sec. 105.

5 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 232.

6 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 233.

7 *Witness Statement of 'Elizabeth Porter' (pseudonym)*, 27 April 2020, para. 58.

8 *Witness Statement of Dr Tricia Szirom*, 12 May 2020, para. 21.

9 Anonymous 236, *Submission to the RCVMHS: SUB.0002.0021.0007*, 2019, pp. 4–5.

10 Castan Centre for Human Rights Law, *Submission to the RCVMHS: SUB.1000.0001.2641*, 2019, p. 3; United Nations, Human Rights Council, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,* 2013, para. 63.

11 United Nations, *Committee on the Rights of Persons with Disabilities: Concluding Observations on the Combined Second and Third Periodic Reports of Australia*, 2019, p. 8.

12 Victorian Mental Illness Awareness Council, *Policy Position Paper #3: Seclusion and Restraint*, 2020, p. 2; Castan Centre for Human Rights Law, p. 7; Office of the Public Advocate, *Submission to the RCVMHS: SUB.0002.0029.0448 (Submission 1)*, 2019, p. 22.

13 Refer to section 31.8.2 for examples.

14 Department of Health, *Providing a Safe Environment for All: Framework for Reducing Restrictive Interventions*, 2013, p. 8; Victorian Mental Illness Awareness Council, *Policy Position Paper #3: Seclusion and Restraint*, p. 2.

15 Mental Health Legal Centre, *Submission to the RCVMHS: SUB.0002.0032.0106 (Submission 1)*, 2019, p. 34.

16 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 13.

17 Commonwealth Department of Health and Ageing, *A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers*, 2013, p. 19; Department of Health, *Providing a Safe Environment for All: Framework for Reducing Restrictive Interventions*, p. 7; *Witness Statement of Dr Lynne Coulson Barr OAM*, 4 June 2020, para. 247; *Witness Statement of Dr Neil Coventry*, 29 July 2020, para. 483.

18 Department of Health, Victoria, *Framework for Recovery-Oriented Practice*, 2011, p. 2; Mike Slade, *100 Ways to Support Recovery. A Guide for Mental Health Professionals: Second Edition*, (London: Rethink Mental Illness, 2013), p. 8.

19 Department of Health, Victoria, p. 10.

20 *Witness Statement of Professor George Braitberg AM*, 19 May 2020, para. 18.

21 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 52(a).

22 Mental Health Complaints Commissioner, *Submission to the RCVMHS: SUB.4000.0001.0179*, 2019, p. 29.

23 *Witness Statement of 'Rachel Bateman' (pseudonym)*, 16 June 2020 para. 133; *Witness Statement of Cath Roper*, 2 June 2020, para. 72.

24 *Witness Statement of Cath Roper*, para. 72.

25 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 173.

26 Bernadette McSherry, 'Regulating Seclusion and Restraint in Health Care Settings: The Promise of the Convention on the Rights of Persons with Disabilities', *International Journal of Law and Psychiatry*, 53 (2017), 39–44 (p. 39).

27 Commission analysis of Department of Health and Human Services Client Management Interface/Operational Data store, 2015–16 to 2019–20.

28 *Witness Statement of Indigo Daya*, 12 May 2020, para. 63.

29 Australian Nursing and Midwifery Federation, Victoria, *Submission to the RCVMHS*: SUB.2000.0001.0002, 2019, p. 93.

30 Lisa Brophy and others, *Designing Mental Health Facilities That Prevent the Use of Seclusion and Restraint: An Evidence Check*, 2020, p. 6.

31 Te Pou, New Zealand, *Reducing and Eliminating Seclusion in Mental Health Inpatient Services*, 2018, pp. 28–29; RCVMHS, *Restrictive Practices Human-Centred Design Focus Group, Session 2: Record of Proceedings*, 2020.

32 *Witness Statement of Peter Kelly*, 29 May 2020, para. 232.

33 *Witness Statement of Indigo Daya*, para. 132.

34 *Witness Statement of Peter Kelly*, para. 211.

35 *Witness Statement of Peter Kelly*, para. 211.

36 *Witness Statement of Professor Richard Newton*, 7 May 2020, para. 68.

37 The Australian Psychological Society, *Evidence-Based Guidelines to Reduce the Need for Restrictive Practices in the Disability Sector*, 2011, p. 8; *Witness Statement of Dr Neil Coventry*, 2020, para. 473.

38 *Witness Statement of Dr Tricia Szirom*, para. 21; *Witness Statement of Dr Neil Coventry*, 2020, para. 474; *Witness Statement of Professor Richard Newton*, para. 69; *Witness Statement of Dr Vinay Lakra*, 22 June 2020, para. 56; *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 228.

39 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws Discussion Paper*, 2014, pp. 195–196; Castan Centre for Human Rights Law, pp. 3–5.

40 *Witness Statement of Professor Lisa Brophy*, 29 April 2020, para. 42.

41 World Health Organization, *Strategies to End Seclusion and Restraint: WHO Quality Rights Specialized Training*, 2019, p. 8; Castan Centre for Human Rights Law, pp. 3–5.

42 General Assembly, United Nations, *Convention on the Rights of Persons with Disabilities, Entry into Force: 3 May 2008, in Accordance with Article 45(1)*, 13 December 2006, pp. 9–11, 13 and 15; Victorian Mental Illness Awareness Council, *Policy Position Paper #3: Seclusion and Restraint*, p. 3.

43 *Charter of Human Rights and Responsibilities Act 2006* (Vic); Castan Centre for Human Rights Law, p. 3; Parliament of Victoria, *The Mental Health Act Statement of Compatibility*, 2014, p. 461.

44 *Charter of Human Rights and Responsibilities Act 2006* (Vic), secs. 8, 10 and 21–22.

45 *Witness Statement of 'Lucy Barker' (pseudonym)*, 29 June 2020, para. 39.

46 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 224(e).

47 Marie Chieze and others, 'Effects of Seclusion and Restraint in Adult Psychiatry: A Systematic Review', *Frontiers in Psychiatry*, 10 (2019) 1-19 (1 and 13); *Witness Statement of Peter Kelly*, para. 214.

48 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 227.

49 *Witness Statement of Peter Kelly*, para. 214.

50 RCVMHS, *Restrictive Practices Human-Centred Design Focus Group, Session 2: Record of Proceedings*.

51 RCVMHS, *Restrictive Practices Human-Centred Design Focus Group, Session 2: Record of Proceedings*.

52 *Witness Statement of Professor Lisa Brophy*, para. 89.

53 RCVMHS, *Box Hill Community Consultation—May 2019*.

54 *Witness Statement of Cath Roper*, para. 75.

55 RCVMHS, *Box Hill Community Consultation—May 2019*.

56 RCVMHS, *Healesville Community Consultation—May 2019*.

57 RCVMHS, *Box Hill Community Consultation—May 2019*.

58 RCVMHS, *Melbourne Community Consultation—May 2019*.

59 Anonymous 60, *Submission to the RCVMHS: SUB.0002.0022.0023*, 2019, p. 4.

60 *Witness Statement of 'Erin Davies' (pseudonym),* 1 July 2020, paras. 16–19.

61 RCVMHS, *Geelong Community Consultation—April 2019*.

62 *Mental Health Act 2014* (Vic), sec. 113(a) and 115(1); *Witness Statement of 'Erin Davies' (pseudonym)*, 1 July 2020, paras. 16

63 *Mental Health Act 2014* (Vic), sec. 113(b).

64 *Mental Health Act 2014* (Vic), sec. 105.

65 Department of Health, *Restrictive Interventions in Designated Mental Health Services: Chief Psychiatrist's Guideline*, 2014, p. 4.

66 A bed day is a day during which a person is admitted to a bed and in which the patient stays overnight in a hospital. Same-day cases are excluded unless stated otherwise.

67 Department of Health and Human Services, *Key Performance Measures and Underlying Risk Factors 2019–20*, 2019, p. 10.

68 Department of Health and Human Services, *Mental Health Performance and Accountability Framework*, 2020, p. 30.

69 *Mental Health Act 2014* (Vic), sec. 108.

70 Victorian Auditor-General's Office, *Child and Youth Mental Health*, 2019, pp. 50–51.

71 *Witness Statement of Dr Neil Coventry*, 2020, para. 533.

72 Commission analysis of Department of Health and Human Services, Client Management Interface/Operational Data store 2015–16 to 2019–20.

73 *Witness Statement of Dr Neil Coventry*, 2020, para. 487.

74 Department of Health and Human Services, *Office of the Chief Psychiatrist Annual Report 2019–20*, pp. 17–18.

75 Commission analysis of Department of Health and Human Services, Client Management Interface/Operational Data store 2015–16 to 2019–20. Note that there is a small number of consumers in child and adolescent acute mental health inpatient units, compared to adult units, which means rates of seclusion and restraint can vary more from year to year and across services.

76 Commission analysis of Department of Health and Human Services, Client Management Interface/Operational Data store 2015–16 to 2019–20. Note that there is a small number of consumers in child and adolescent acute mental health inpatient units compared with adult units, which means rates of seclusion and restraint can vary more from year to year and across services.

77 Department of Health and Human Services, *Office of the Chief Psychiatrist Annual Report 2019–20*, p. 16.

78 *Witness Statement of Dr Neil Coventry*, 2020, para. 488.

79 *Witness Statement of Dr Margaret Grigg*, 28 May 2020, paras. 144–145.

80 Department of Health and Human Services, *Chief Psychiatrist's Annual Report 2018–19*, p. 20.

81 *Witness Statement of Dr Margaret Grigg*, para. 146.

82 Eastern Health, *Submission to the RCVMHS: SUB.0002.0028.0585*, 2019, p. 24; NorthWestern Mental Health (A Division of Melbourne Health), *Submission to the RCVMHS: SUB.0002.0030.0061*, 2019, p. 29.

83 *Witness Statement of Professor Richard Newton*, para. 59.

84 Australian Commission on Safety and Quality in Health Care and Australian Institute of Health and Welfare, *The Third Australian Atlas of Healthcare Variation*, 2018, pp. 2–3.

85 Victorian Mental Illness Awareness Council, *Seclusion Report*, 2019, p. 13.

86 Jennifer Lai and others, 'Variation in Seclusion Rates across New Zealand's Specialist Mental Health Services: Are Sociodemographic and Clinical Factors Influencing This?', *International Journal of Mental Health Nursing*, 28.1 (2019), 288–296 (pp. 288–296).

87 Lai and others, p. 288.

88 Australian Commission on Safety and Quality in Health Care, National Model Clinical Governance Framework, <www.safetyandquality.gov.au/topic/national-model-clinical-governance-framework>, [accessed 16 June 2020].

89 *Witness Statement of Dr Neil Coventry*, 2020, para. 504.

90 *Witness Statement of Dr Christopher Maylea*, 30 April 2020, paras. 76–77.

91 A bed day is a day during which a person is admitted to a bed and in which the patient stays overnight in a hospital. Same-day cases are excluded, unless stated otherwise.

92 Department of Health and Human Services, *Mental Health Performance and Accountability Framework*, 2020, p. 30.

93 Bureau of Health Information, *Healthcare Quarterly, Activity and Performance, Emergency Department, Ambulance, Admitted Patients, Seclusion and Restraint, and Elective Surgery, October to December 2019*, 2020, p. 35.

94 *Mental Health Act 2014* (Vic), sec. 110.

95 *Mental Health Act 2014* (Vic), sec. 113.

96 health.vic, The Safewards Story, <www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/safewards/safewards-story>, [accessed 24 April 2020]; Bridget Hamilton and others, *Safewards Victorian Trial Final Evaluation Report* (Centre for Psychiatric Nursing, 2016), p. 4; Department of Health and Human Services, *Chief Psychiatrist's Annual Report 2014–15*, 2015, p. 23.

97 Len Bowers, *The Safewards Model. Safewards: A New Model of Conflict and Containment on Psychiatric Wards*, 2014, pp. 4–5.

98 Department of Health and Human Services, *Chief Psychiatrist's Annual Report 2015–16*, 2016, p. 3; Department of Health and Human Services, *Chief Psychiatrist's Annual Report 2018–19*, p. 13.

99 Department of Health and Human Services, Safewards Victoria, <www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/safewards>, [accessed 24 September 2019]; Department of Health and Human Services, *Safewards Handbook: Training and Implementation Resource for Safewards in Victoria*, 2016, p. 6.

100 Victorian Managed Insurance Authority, Safewards—An Insurer's Perspective, 2017, p. 19.

101 Victorian Managed Insurance Authority, pp. 20–21.

102 Victorian Managed Insurance Authority, *Annual Report 2019–20*, 2020, p. 19.

103 Department of Health and Human Services, *Chief Psychiatrist's Annual Report 2017–18*, 2018, p. 15; *Witness Statement of Dr Neil Coventry*, 2020, paras. 238 and 522.

104 *Witness Statement of Dr Neil Coventry*, 2020, paras. 522 and 529.

105 Department of Health and Human Services, Overview: Safewards Model. Adapted from material developed by Professor Len Bowers, United Kingdom.

106 Bowers, p. 5.

107 Mental Health Complaints Commissioner, p. 5.

108 *Witness Statement of Dr Neil Coventry*, 28 June 2019, paras. 80, 116 and 195; *Witness Statement of Jennifer Williams AM*, 22 July 2019, para. 52; *Witness Statement of Associate Professor Dean Stevenson*, 4 July 2019, para. 38; Australian Psychological Society, *Submission to the RCVMHS: SUB.0002.0029.0349*, 2019, p. 18; Victorian Government, *Submission to the RCVMHS: SUB.5000.0001.0001*, 2019, p. 13.

109 Royal Commission into Victoria's Mental Health System, *Interim Report,* pp. 32. 89, 172 and 175.

110 *Witness Statement of Dr Neil Coventry*, 2020, para. 480; *Witness Statement of Professor Richard Newton*, para. 66(c); *Witness Statement of Associate Professor Ruth Vine*, 29 April 2020, para. 154(d).

111 *Witness Statement of Professor Richard Newton*, para. 77.

112 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 140.

113 *Witness Statement of Professor Patrick McGorry AO*, 22 June 2020, para. 103.

114 *Witness Statement of Professor Patrick McGorry AO*, 2020, para. 103.

115 *Witness Statement of Professor Patrick McGorry AO*, 2020, para. 103.

116 Bowers, p. 10.

117 Cath Roper, 'Ethical Peril, Violence, and "Dirty Hands": Ethical Consequences of Mental Health Laws', *Journal of Ethics in Mental Health*, 10 (2019), 1–17 (pp. 5–6).

118 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 543.

119 Royal Commission into Victoria's Mental Health System, *Interim Report,* pp. 543–544.

120 Bowers, p. 7; *Witness Statement of Professor Lisa Brophy*, para. 87(c); *Witness Statement of Dr Vinay Lakra*, para. 58.

121 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 546.

122 RCVMHS, *Restrictive Practices Human-Centred Design Focus Group, Session 2: Record of Proceedings*.

123 *Witness Statement of Professor Lisa Brophy*, para. 87(c).

124 *Witness Statement of Professor David Castle*, 29 May 2020, para. 45.

125 Jeffrey J Borckardt and others, 'Systematic Investigation of Initiatives to Reduce Seclusion and Restraint in a State Psychiatric Hospital', *Psychiatric Services*, 62.5 (2011), 477–483 (p. 479); Bowers, p. 7; *Witness Statement of Peter Kelly*, para. 224; Murray Wright, *Review of Seclusion, Restraint and Observation of Consumers with a Mental Illness: NSW Health Facilities*, 2017, p. 40; *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 239(a).

126 *Witness Statement of Peter Kelly*, para. 224.

127 Alfred Health, *Submission to the RCVMHS: SUB.0002.0028.0156*, 2019, p. 11.

128 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 547.

129 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 546.

130 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 143.

131 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 143; Eastern Health, p. 24; *Witness Statement of Professor Richard Newton*, para. 66(c); *Witness Statement of Associate Professor Ruth Vine*, 2020, para. 154(d).

132 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 526.

133 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 279.

134 *Witness Statement of Dr Neil Coventry*, 2020, paras. 216–218.

135 *Witness Statement of Colin Radford*, 26 August 2020, para. 163.

136 Eastern Health, p. 25.

137 *Witness Statement of Peter Kelly*, para. 217.

138 *Witness Statement of Dr Neil Coventry*, 2020, para. 493; *Witness Statement of Professor Patrick McGorry AO*, 2020, para. 103.

139 *Witness Statement of Professor Richard Newton*, paras. 80 and 84.

140 *Witness Statement of Dr Vinay Lakra*, para. 73.

141 *Witness Statement of Dr Vinay Lakra*, para. 73.

142 *Witness Statement of Professor George Braitberg AM*, para. 10.

143 *Witness Statement of Professor George Braitberg AM*, para. 63.

144 *Witness Statement of Professor Richard Newton*, para. 84.

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

146 RCVMHS, *Nurses Workforce Human-Centred Design Focus Group: Record of Proceedings*; RCVMHS, *Melbourne Community Consultation—May 2019*.

147 *Witness Statement of 'Lucy Barker' (pseudonym)*, para. 40.

148 RCVMHS, *Nurses Workforce Human-Centred Design Focus Group: Record of Proceedings*.

149 RCVMHS, *Nurses Workforce Human-Centred Design Focus Group: Record of Proceedings*.

150 Robin Digby, Hannah Bushell and Tracey K Bucknall, 'Implementing a Psychiatric Behaviours of Concern Emergency Team in an Acute Inpatient Psychiatry Unit: Staff Perspectives', *International Journal of Mental Health Nursing*, 2020, 1–11, (p. 7).

151 RCVMHS, *Nursing Roundtable: Record of Proceedings*, 2019; RCVMHS, *Nurses Workforce Human-Centred Design Focus Group: Record of Proceedings*.

152 *Witness Statement of Professor Lisa Brophy*, para. 86; *Witness Statement of Peter Kelly*, para. 218; *Witness Statement of Sandra Keppich-Arnold*, 18 May 2020, para. 115.

153 Brendan Cox, *Submission to the RCVMHS: SUB.0002.0021.0022*, 2019, p. 4.

154 Stuart Bigwood and Marie Crowe, ''It's Part of the Job, but It Spoils the Job': A Phenomenological Study of Physical Restraint', *International Journal of Mental Health Nursing*, 17.3 (2008), 215–222 (pp. 218 and 221); Eimear Muir-Cochrane, Deb O'Kane and Candice Oster, 'Fear and Blame in Mental Health Nurses' Accounts of Restrictive Practices: Implications for the Elimination of Seclusion and Restraint', *International Journal of Mental Health Nursing*, 27.5 (2018), 1511–1521 (p. 1515).

155 Eimear Muir-Cochrane, Deb O'Kane and Candice Oster, 'Fear and Blame in Mental Health Nurses' Accounts of Restrictive Practices: Implications for the Elimination of Seclusion and Restraint', *International Journal of Mental Health Nursing*, 27.5 (2018), 1511–1521 (p. 1518); Bigwood and Crowe, p. 221.

156 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 230.

157 *Witness Statement of Peter Kelly*, para. 218.

158 The Royal Australian and New Zealand College of Psychiatrists, *Submission to the RCVMHS: SUB.0002.0029.0228 (Appendix 1)*, 2019, p. 18.

159 *Witness Statement of Professor Richard Newton*, para. 75.

160 The Australian College of Mental Health Nursing, *Safe in Care, Safe at Work*, 2019, p. 48; *Witness Statement of Professor Lisa Brophy*, para. 86.

161 Gregory M. Smith and others, 'Relationship Between Seclusion and Restraint Reduction and Assaults in Pennsylvania's Forensic Services Centers: 2001–2010', *Psychiatric Services*, 66:12 (2015), 1326–1332 (p. 1326).

162 *Witness Statement of Professor Richard Newton*, para. 70.

163 Piers Gooding and others, *Alternatives to Coercion in Mental Health Settings: A Literature Review*, 2018, pp. 47–90; Piers Gooding and other, 'Preventing and Reducing "Coercion" in Mental Health Services: An International Scoping Review of English-Language Studies', *Acta Psychiatrica Scandinavica*, 141.2 (2020), 1–14 (pp. 7–9).

164 *Witness Statement of Peter Kelly*, para. 231.

165 *Witness Statement of Professor Richard Newton*, para. 72.

166 *Witness Statement of Peter Kelly*, para. 222.

167 *Witness Statement of Professor Lisa Brophy*, para. 89.

168 Bowers, p. 21; Len Bowers and others, *Inpatient Violence and Aggression: A Literature Review*, 2011, p. 63; *Witness Statement of Professor Lisa Brophy*, para. 87(a).

169 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 200; *Witness Statement of Dr Ainslie Senz*, 9 July 2019, para. 54.

170 Department of Health and Human Services, Victorian Emergency Minimum Dataset 2010–11 to 2019–20.

171 Department of Health and Human Services, Victorian Emergency Minimum Dataset 2010–11 to 2019–20; *Witness Statement of Professor George Braitberg AM*, para. 9.

172 *The Commission, Special Commission of Inquiry into Crystal Methamphetamine and Other Amphetamine-Type Stimulants Report, Volume 2,* 2020, p. 504.

173 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 200; *Witness Statement of Dr Ainslie Senz*, para. 55; The Commission, p. 505.

174 Mind Australia, *Submission to the RCVMHS: SUB.0010.0029.0372*, 2019, p. 14.

175 *Witness Statement of Sandra Keppich-Arnold,* paras. 61–62.

176 Department of Health, *Protocol for the Transport of People with Mental Illness*, 2014, p. 15.

177 *Evidence of Simon Thomson*, 11 July 2019, p. 777.

178 Associate Professor Jonathan Knott and others, *Restrictive Interventions in Victorian Emergency Departments: A Review of Current Clinical Practice*, 2019, p. 6.

179 Knott and others, pp. 8 and 10.

180 Under common law principles of negligence and the *Wrongs Act 1958* (Vic) sec. 48, as amended by the *Wrongs and Other Acts (Law of Negligence) Act 2003* (Vic), care providers must exercise reasonable care to prevent service users and others from foreseeable injury. The Law Handbook 2020, Negligence and Duty of Care, <www.lawhandbook.org.au/2020_08_06_06_negligence_and_duty_of_care/>, [accessed 11 November 2020].

181 Safer Care Victoria, *Caring for People Displaying Acute Behavioural Disturbance: Clinical Guidance to Improve Care in Emergency Settings—Draft for Consultation*, 2020, p.2; Knott and others, p. 8.

182 *Mental Health Act 2014* (Vic), secs. 114–116.

183 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 234; Safer Care Victoria, Caring for People Displaying Acute Behavioural Disturbance: Clinical Guidance to Improve Care in Emergency Settings - Draft for Consultation, 2020, p. 2; Knott and others, p. 8; *Mental Health Act 2014* (Vic), secs. 114–116.

184 *Witness Statement of Dr Lynne Coulson Barr OAM*, paras. 235 and 237.

185 Ambrose H. Wong and others, 'Experiences of Individuals Who Were Physically Restrained in the Emergency Department', *JAMA Network Open*, 3.1 (2020), 1–12 (pp. 1 and 5); *Witness Statement of Dr Lynne Coulson Barr OAM*, p. 39.

186 RCVMHS, *Melbourne Community Consultation—May 2019*.

187 *Witness Statement of Dr Neil Coventry*, 2020, para. 474; Glenn W. Currier, Patrick Walsh and David Lawrence, 'Physical Restraints in the Emergency Department and Attendance at Subsequent Outpatient Psychiatric Treatment', *Journal of Psychiatric Practice*, 17.6 (2011), 387–393 (p. 387).

188 *Witness Statement of Dr Neil Coventry*, 2020, para. 491(d).

189 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 236.

190 *Witness Statement of Karyn Cook*, 21 May 2020, para. 192.

191 *Witness Statement of Dr Neil Coventry*, 2020, pp. 522 and 529.

192 Department of Health and Human Services, *Chief Psychiatrist's Annual Report 2018–19*, p. 13.

193 *Mental Health Act 2014* (Vic) sec. 108.

194 Department of Health and Human Services, *Chief Psychiatrist's Annual Report 2018–19*, pp. 20–26.

195 Safer Care Victoria, *Victorian Quality Account: Reporting Guidelines for Public Health Services 2018–19*, 2018, p. 9.

196 Better Safer Care, Special Mental Health Issue of Inspire Released, <www.bettersafercare.vic.gov.au/mentalhealthInspire>, [accessed 12 October 2020].

197 *Witness Statement of Dr Neil Coventry*, 2020, paras. 125 and 536.

198 Department of Health and Human Services, *Chief Psychiatrist's Annual Report 2018–19*, pp. 20–26; Department of Health and Human Services, *Victoria's Mental Health Services Annual Report 2018–19*, 2019, pp. 71–72; Victorian Agency for Health Information, Mental Health, <vahi.vic.gov.au/reports/victorian-health-services-performance/mental-health>, [accessed 26 October 2020]; Australian Institute of Health and Welfare, Mental Health Services in Australia: Restrictive Practices, <www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/restrictive-practices>, [accessed 26 October 2020].

199 Department of Health and Human Services, *Victoria's Mental Health Services Annual Report 2019–20*, pp. 31, 53, 64 and 73.

200 Victorian Agency for Health Information, *Extended Mental Health Treatment Setting Quarterly KPI Report: January-March 2020*, 2020, pp. 2–5.

201 Australian Institute of Health and Welfare, Mental Health Services in Australia, Restrictive Practices 2018–19.

202 Bureau of Health Information, *Measurement Matters: Reporting on Seclusion and Restraint in NSW Public Hospitals*, 2019, p. 10; *Witness Statement of Sandra Keppich-Arnold*, para. 132.

203 *Witness Statement of Erandathie Jayakody*, 4 June 2020, paras. 117 and 121.

204 United Nationals General Assembly, Victorian Mental Illness Awareness Council, *Policy Position Paper #3: Seclusion and Restraint*, p. 1.

205 Victorian Mental Illness Awareness Council, *Seclusion Report*, pp. 2 and 10–11.

206 *Witness Statement of Erandathie Jayakody*, para. 118.

207 *Mental Health Act 2014* (Vic), sec. 3; National Mental Health Consumer and Carer Forum, *Ending Seclusion and Restraint in Australian Mental Health Services*, 2009, p. 6.

208 National Mental Health Consumer and Carer Forum, p. 6; Cath Roper, Bernadette McSherry and Lisa Brophy, 'Defining Seclusion and Restraint: Legal and Policy Definitions Versus Consumer and Carer Perspectives', *Journal Law and Medicine*, 23.2 (2015), 297–302 (pp. 298–300).

209 *Mental Health Act 2014* (Vic), sec. 350.

210 Department of Health, *Restrictive Interventions in Designated Mental Health Services: Chief Psychiatrist's Guideline*, pp. 6–7.

211 Eimear Muir-Cochrane, Candice Oster and Karen Grimmer, 'International research into 22 years of use of chemical restraint: An evidence overview', *Journal of Evaluation in Clinical Practice*, 26.3 (2020), 927–956 (p. 938).

212 Muir-Cochrane, Oster and Grimmer, p. 938.

213 Melbourne City Mission, *Submission to the RCVMHS: SUB.0002.0029.0066*, 2019, p. 15; Victorian Aboriginal Legal Service, *Submission to the RCVMHS: SUB.0002.0030.0226*, 2019, p. 56.

214 *Witness Statement of Indigo Daya*, para. 66.

215 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 217.

216 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 217.

217 *Witness Statement of Sandra Keppich-Arnold*, para. 114.

218 *Witness Statement of Dr Vinay Lakra*, para. 59.

219 *Witness Statement of Dr Stuart Lewena*, 11 May 2020, para. 33.

220 *Witness Statement of Sandra Keppich-Arnold*, para. 114.

221 Bernadette McSherry and Juan José Tellez, 'Current Challenges for the Regulation of Chemical Restraint in Health Care Settings', *Journal Law and Medicine*, 24.1 (2016), 15–19 (p. 18).

222 Australian Commission on Safety and Quality in Health Care, *Guide for Multi-Purpose Services and Small Hospitals*, 2017, p. 172.

223 McSherry and Tellez, p. 18.

224 Eimear Muir-Cochrane and others, 'The Effectiveness of Chemical Restraint in Managing Acute Agitation and Aggression: A Systematic Review of Randomized Controlled Trials', *International Journal of Mental Health Nursing*, 29.2 (2020), 110–126 (p. 110).

225 Melbourne Social Equity Institute, The University of Melbourne, *Seclusion and Restraint Project Report*, 2014, p. 30; *Mental Health Act 2013* (Tas), sec. 3.

226 *Witness Statement of Dr John Reilly*, 29 May 2020, para. 149.

227 *Mental Health Act 2009* (SA), sec. 3(1).

228 New South Wales Health, *Seclusion and Restraint in NSW Health Settings*, 2020, p. 4.

229 *Mental Health Act 2013* (Tas), sec. 3.

230 *Mental Health Act 2013* (Tas), sec. 3.

231 *Mental Health Act 2013* (Tas), sec. 6(3).

232 *Mental Health Act 2016* (Qld), sec. 271.

233 *Mental Health Act 2016* (Qld), sec. 272(1).

234 *Mental Health Act 2016* (Qld), sec. 272(3).

235 *Mental Health Act 2009* (SA), sec. 3(1).

236 New South Wales Health, p. 4.

237 New South Wales Health, p. 4.

238 *Witness Statement of Dr Neil Coventry*, 2020, para. 482(d).

239 *Witness Statement of Indigo Daya*, para. 66.

240 McSherry, p. 43.

241 *Witness Statement of Dr John Reilly*, para. 167.

242 *Witness Statement of Professor David Castle*, para. 46.

243 *Witness Statement of Peter Kelly*, para. 209.

244 People with Disability Australia, Restrictive Practices, <pwd.org.au/drc-hub/issues/restrictive-practices/>, [accessed 26 October 2020]; Carmelle Peisah and Ellen Skladzien, *The Use of Restraints and Psychotropic Medications in People with Dementia*, 2014, p. 4.

245 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Issues Paper: Restrictive Practices*, 2020, pp. 1 and 6.

246 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, pp. 1 and 6; Royal Commission into Aged Care and Quality and Safety, *Interim Report: Neglect, Volume 1*, 2019, p. 216.

247 Royal Commission into Aged Care and Quality and Safety, p. 216.

248 Parliament of Australia, *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018*, 2018, sec. 6(b); Parliament of Australia, *Quality of Care Principles 2014, Made Under Section 96–1 of the Aged Care Act 1997, Compilation No. 6*, 2019, sec. 15G.

249 Parliament of Australia, *Quality of Care Principles 2014, Made Under Section 96–1 of the Aged Care Act 1997, Compilation No. 6*, sec. 15G.

250 Royal Commission into Aged Care and Quality and Safety, p. 216.

251 Commonwealth Department of Health, Minimising Inappropriate Use of Restraint in Aged Care, <www.health.gov.au/initiatives-and-programs/minimising-inappropriate-use-of-restraint-in-aged-care>, [accessed 3 September 2020].

252 Kim J. Masters, 'Physical Restraint: A Historical Review and Current Practice', *Psychiatric Annals*, 47.1 (2017), 52–55 (p. 52).

253 Masters, pp. 53–54.

254 Robert Gardiner Hill, *Total Abolition of Personal Restraint in the Treatment of the Insane. A Lecture on the Management of Lunatic Asylums, and the Treatment of the Insane*, 1838, p. v.

255 Paul Doedens and others, 'Influence of Nursing Staff Attitudes and Characteristics on the Use of Coercive Measures in Acute Mental Health Services—A Systematic Review', *Journal of Psychiatric and Mental Health Nursing*, 27.4 (2020), 446–459 (p. 450); S. A. Kinner and others, 'Attitudes towards Seclusion and Restraint in Mental Health Settings: Findings from a Large, Community-Based Survey of Consumers, Carers and Mental Health Professionals', *Epidemiology and Psychiatric Sciences*, 26.5 (2017), 535–544 (p. 538); Mary Whaley and Lust Ramirez, 'The Use of Seclusion Rooms and Physical Restraints in the Treatment of Psychiatric Patients', *Journal of Psychiatric Nursing and Mental Health Services*, 18.1 (1980), 13–16 (p. 16).

256 Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into Human Rights of People with Mental Illness Volume 1*, 1993, pp. 269–271.

257 Sophie Hirsch and Tilman Steinert, 'Measures to Avoid Coercion in Psychiatry and Their Efficacy', *Deutsches Aerzteblatt Online*, 116 (2019), 336–343 (p. 336); Melbourne Social Equity Institute, The University of Melbourne, p. 168; Gooding, McSherry and Roper, p. 2.

258 Doedens and others, p. 450; Kinner and others, p. 538; Whaley and Ramirez, p. 16.

259 Hartford Courant, Connecticut News, Hundreds of the Nation's Most Vulnerable Have Been Killed by the System Intended to Care for Them, 1998, <www.courant.com/news/connecticut/hc-xpm-1998-10-11-9810090779-story.html>, [accessed 20 October 2020].

260 Paul S. Appelbaum, 'Seclusion and Restraint: Congress Reacts to Reports of Abuse', *Psychiatric Services*, 50.7 (1999), 881–885 (p. 881); Masters, p. 53.

261 National Association of State Mental Health Program Directors, *Six Core Strategies for Reducing Seclusion and Restraint Use*, 2006.

262 Te Pou, New Zealand, pp. 23 and 25.

263 Hirsch and Steinert, p. 340; Te Pou, New Zealand, p. 6.

264 Corrado Barbui and others, 'Efficacy of Interventions to Reduce Coercive Treatment in Mental Health Services: Umbrella Review of Randomised Evidence', *The British Journal of Psychiatry*, 2020, 1–11 (p. 1); Gooding, McSherry, and Roper, p. 7.

265 Marie-Hélène Goulet, Caroline Larue and Alexandre Dumais, 'Evaluation of Seclusion and Restraint Reduction Programs in Mental Health: A Systematic Review', *Aggression and Violent Behavior*, 34 (2017), 139–146 (p. 144).

266 Kevin Ann Huckshorn, 'An Evidence-Based Practice to Prevent Conflict and Violence in Inpatient and Residential Settings', 2015, p. 2; *Witness Statement of Peter Kelly*, para. 221; *Witness Statement of Professor Richard Newton*, para. 74; *Witness Statement of Professor Lisa Brophy*, para. 88.

267 *Witness Statement of Dr Margaret Grigg*, para. 139.

268 Bensemann, p. 29; Melbourne Social Equity Institute, The University of Melbourne, pp. 170–171; Wright, p. 35.

269 *Witness Statement of Peter Kelly*, 29 May 2020, para. 229

270 Martin Marshall, Peter Pronovost and Mary Dixon-Woods, 'Promotion of Improvement as a Science', *The Lancet*, 381 (2013), 419–421 (p. 419); Shilpa Ross and Chris Naylor, *Quality Improvement in Mental Health*, 2017, p. 41;

271 Wright, p. 37.

272 Hirsch and Steinert, pp. 336 and 341; Gooding, McSherry and Roper, p. 1; Goulet, Larue and Dumais, p. 145.

273 *Witness Statement of Dr Neil Coventry*, 2020, para. 465.

274 Pennsylvania Department of Human Services, *Pennsylvania State Hospital Risk Management Summary and Indicator Report, November 2019*, p. 11.

275 Gregory M. Smith and others, 'Pennsylvania State Hospital System's Seclusion and Restraint Reduction Program', *Psychiatric Services*, 56.9 (2005), 1115–1122 (pp. 1115, 1120–21); Smith, Ashbridge, and others, p. 1326.

276 Dr Clive Bensemann, 'Zero Seclusion: Towards Eliminating Seclusion by 2020', 2018, p. 12; Te Pou, New Zealand, p. 12.

277 Quality improvement is a concept that focuses on exploring how to undertake quality improvement well. The Health Foundation Inspiring Improvement, Evidence Scan: Improvement Science, 2011, p. 3.

278 Bensemann, pp. 4–5, 13 and 26–32.

279 Bradley Foxlewin, W*hat Is Happening at the Seclusion Review That Makes a Difference? A Consumer Led Research Study*, 2012, p. 11.

280 Foxlewin, p. 4.

281 *Witness Statement of Sandra Keppich-Arnold*, para. 124.

282 *Witness Statement of Sandra Keppich-Arnold*, para. 117.

283 Te Pou o te Whakaaro Nui, 'Evidence Update for Least Restrictive Practice in Aotearoa New Zealand', 2020, p. 1.

284 The Australian College of Mental Health Nursing, p. 15; Te Pou, New Zealand, p. 29; Tessa Maguire and others, 'Risk Assessment and Subsequent Nursing Interventions in a Forensic Mental Health Inpatient Setting: Associations and Impact on Aggressive Behaviour', *Journal of Clinical Nursing*, 27.5–6 (2018), e971–e983 (p. e980)

285 *Witness Statement of Professor Lisa Brophy*, para. 83; *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 250; *Witness Statement of Professor Richard Newton*, para. 93; Hamilton and others, p. 6; NorthWestern Mental Health (A Division of Melbourne Health), p. 25.

286 *Witness Statement of Dr Neil Coventry*, 2020, para. 478.

287 Department of Health, *Providing a Safe Environment for All: Framework for Reducing Restrictive Interventions*, p. 27.

288 health.vic, Safety Training Resources to Reduce Restrictive Interventions, <www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/reducing-restrictive-interventions/safety-training-resources-to-reduce-restrictive-interventions>, [accessed 26 October 2020].

289 Department of Health, *Providing a Safe Environment for All: Framework for Reducing Restrictive Interventions*, p. 26.

290 Department of Health, *Providing a Safe Environment for All: Framework for Reducing Restrictive Interventions*, p. 3.

291 Department of Health and Human Services, Safewards Victoria.

292 Department of Health, *Restrictive Interventions in Designated Mental Health Services: Chief Psychiatrist's Guideline*, p. 2.

293 health.vic, The Safewards Story; Hamilton and others, pp. 8–9.

294 *Witness Statement of Dr Neil Coventry*, 2019, para. 244.2; *Witness Statement of Dr Neil Coventry*, 2020, para. 464.

295 Office of the Chief Psychiatrist, Department of Health and Human Services, *Towards Elimination of Restrictive Interventions*, 2020, pp. 2 and 5.

296 RCVMHS, *Restrictive Practices Human-Centred Design Focus Group, Session 1: Record of Proceedings*, 2020.

297 For example: Albury Wodonga Health, *Quality Account 2018–19*, 2019, p. 29; Alfred Health, *Quality Account 2018–19*, 2019, p. 37; *Witness Statement of Dr Stuart Lewena*, para. 40; *Witness Statement of Professor David Castle*, para. 46; *Witness Statement of Sandra Keppich-Arnold*, para. 117.

298 Victorian Institute of Forensic Mental Health, *Annual Report 2018–19*, 2019, p. 20.

299 World Health Organization, p. 61; Ilan Rauchberger and Fiona Whitecross, 'Reflection of a 2–Year Journey since the Introduction of Psychiatric Behaviour of Concern (Psy-BOC) Call, a Medical Emergency Team (MET) Call Equivalent for the Deteriorating Mental Health of Patients', *Australasian Psychiatry*, 2020, 1–3 (p. 2); RCVMHS, *Restrictive Practices Human-Centred Design Focus Group, Session 2: Record of Proceedings*.

300 *Witness Statement of Karyn Cook*, para. 189; RCVMHS, *Restrictive Practices Human-Centred Design Focus Group, Session 2: Record of Proceedings*; Albury Wodonga Health, p. 29; Ballarat Health Services, *Quality Account 2018–19*, 2019, p. 46; Barwon Health, *Quality Account 2018–19*, 2019, p. 52.

301 *Witness Statement of Gail Bradley*, 26 June 2019, para. 57; Donna Matthews, *Submission to the RCVMHS: SUB.0002.0023.0045*, 2019, p. 2.

302 Eastern Health, p. 9; *Witness Statement of Peter Kelly*, paras. 222 and 224; *Witness Statement of Professor Patrick McGorry AO*, 2020, para. 103; *Witness Statement of Professor Richard Newton*, para. 66; *Witness Statement of Associate Professor Ruth Vine*, 2020, para. 154(d).

303 RCVMHS, *Restrictive Practices Human-Centred Design Focus Group, Session 2: Record of Proceedings*.

304 *Witness Statement of Professor David Castle*, para. 46.

305 Australian Health Ministers' Advisory Council, Mental Health, Drug and Alcohol Principal Committee, *National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services*, 2016.

306 *Witness Statement of Professor Penelope Weller*, 27 August 2020, para. 61.

307 *Witness Statement of Dr Neil Coventry*, 2020, para. 482.

308 National Mental Health Consumer and Carer Forum, p. 7.

309 *Witness Statement of Dr Christopher Maylea*, para. 80; *Witness Statement of Professor Bruce Bonyhady AM*, 16 June 2020, para. 85; *Witness Statement of Erandathie Jayakody*, para. 116; RCVMHS, *Restrictive Practices Human-Centred Design Focus Group, Session 2: Record of Proceedings*.

310 *Witness Statement of Dr Christopher Maylea*, paras. 79 and 84; *Witness Statement of Professor Penelope Weller*, para. 61.

311 *Witness Statement of Professor Penelope Weller*, para. 61.

312 Pennsylvania Department of Human Services, *Pennsylvania State Hospital Risk Management Summary and Indicator Report*, November 2019, p. 11; Smith and others, *Pennsylvania State Hospital System's Seclusion and Restraint Reduction Program*, pp. 1118–1119.

313 Smith and others, *Pennsylvania State Hospital System's Seclusion and Restraint Reduction Program*, p. 1118.

314 Smith and others, *Pennsylvania State Hospital System's Seclusion and Restraint Reduction Program*, p. 1118.

315 Smith and others, *Pennsylvania State Hospital System's Seclusion and Restraint Reduction Program*, p. 1118.

316 Australian Institute of Health and Welfare, *Mental Health Services in Australia,* <www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/restrictive-practices>, [accessed 27 October 2020].

317 G. Newton-Howes and others, 'The Use of Mechanical Restraint in Pacific Rim Countries: An International Epidemiological Study', *Epidemiology and Psychiatric Sciences*, 29 (2020), 1–7 (p. 5).

318 *Witness Statement of Dr Neil Coventry*, 2020, para. 465; Huckshorn, p. 2.

319 *Mental Health Act 2013* (Tas), sec. 3.

320 Department of Health and Human Services, T*asmania, Chemical Restraint: Chief Civil Psychiatrist Clinical Guideline 10*, 2017, p. 1.

321 Department of Health and Human Services, Tasmania, p. 2.

322 Bureau of Health Information, *Healthcare Quarterly, Activity and Performance, Emergency Department, Ambulance, Admitted Patients, Seclusion and Restraint, and Elective Surgery, October to December 2019*, p. 35.

323 *Witness Statement of Erandathie Jayakody*, paras. 116–117; *Witness Statement of Sandra Keppich-Arnold*, para. 140; Victorian Mental Illness Awareness Council, *Seclusion Report*, p. 15.

324 Wright, p. 37.

325 Bureau of Health Information, *Measurement Matters: Reporting on Seclusion and Restraint in NSW Public Hospitals*, p. 10; *Witness Statement of Sandra Keppich-Arnold*, para. 133.

326 *Witness Statement of Dr Vinay Lakra*, para. 74; *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 247.

327 *Witness Statement of Professor Bruce Bonyhady AM*, para. 85; *Witness Statement of Erandathie Jayakody*, para. 116; *Witness Statement of Dr Christopher Maylea*, para. 80; RCVMHS, *Restrictive Practices Human-Centred Design Focus Group, Session 2: Record of Proceedings*.

328 Melbourne Social Equity Institute, The University of Melbourne, p. 171.

329 Wright, pp. 35–36.

330 Foxlewin, p. 2.

331 Forensicare, *Submission to the RCVMHS: SUB.0002.0030.0126*, 2019, p. 22; *Witness Statement of Professor Lisa Brophy*, para. 87(b); *Witness Statement of Dr Christopher Maylea*, para. 79.

Chapter 32

Reducing compulsory treatment

Recommendation 55:

Ensuring compulsory treatment is only used as a last resort

The Royal Commission recommends that the Victorian Government:

1. act immediately to ensure that the use of compulsory treatment is only used as a last resort.
2. set targets to reduce the use and duration of compulsory treatment on a year-by-year basis and gather and publish service-level and system-wide data in this regard.
3. when commissioning mental health and wellbeing services, set expectations they will provide non-coercive options for people living with mental illness or psychological distress, including those at risk of compulsory treatment, in both Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services.
4. ensure the Mental Health Improvement Unit within Safer Care Victoria (refer to recommendation 52(1)) works with mental health and wellbeing services to:

    a. increase consumer leadership and participation in all activities to reduce compulsory treatment;

    b. support the design and implementation of local programs, informed by data, to reduce compulsory treatment; and

    c. make available workforce training on non-coercive options for treatment that is underpinned by human rights and supported decision-making principles.

Recommendation 56:

Supporting consumers to exercise their rights

The Royal Commission recommends that the Victorian Government:

1. promote, protect and ensure the right of people living with mental illness or psychological distress to the enjoyment of the highest attainable standard of mental health and wellbeing without discrimination.
2. include a legislative provision in the new Mental Health and Wellbeing Act (refer to recommendation 42) enabling an opt-out model of access to non-legal advocacy services for consumers who are subject to or at risk of compulsory treatment.
3. increase access to legal representation for consumers who appear before the Mental Health Tribunal, particularly when consecutive compulsory treatment orders in the community are being sought.
4. align mental health laws over time with other decision-making laws with a view to promoting supported decision-making principles and practices.

32.1 Compulsory treatment as a last resort

The Commission's vision is for a new mental health and wellbeing system that responds to people's needs and respects their preferences. This system and its workforce must be resourced to provide treatment, care and support that allows consumers to make their own decisions on their own terms. Compulsory treatment must only be used as a last resort.

The World Psychiatric Association's position statement describes how a person's rights are denied when they are subject to compulsory treatment:

> Of central concern is the protection of human rights, and the extent to which coercive interventions violate these. These include rights to: liberty; autonomy; freedom from torture, inhuman or degrading treatment; physical and psychological integrity of the person; non-discrimination; and a home and family life.[1]

Evidence provided to the Commission described the negative impacts of compulsory treatment, including how demoralising it can be.[2] Witness Ms Lucy Barker shared her experiences in a personal story. Ms Barker explained the trauma she experienced as a result of compulsory treatment:

> The thing with compulsory treatment is that the measures that are taken are extreme. You wouldn't treat anybody else that way, but because you are perceived to have a mental illness, you can be restrained to a bed for hours or thrown in a seclusion room or chucked in the back of a divvy van or jabbed in the butt, and then knocked unconscious for a day. It's that kind of stuff that makes compulsory treatment terrible. Yes, your life was saved, but to what extent? I now have significant trauma from compulsory treatment.[3]

In Victoria, the *Mental Health Act 2014* (Vic) provides the legal framework for compulsory treatment. Ms Cath Roper, Consumer Academic for the Centre for Psychiatric Nursing at the University of Melbourne, told the Commission, however, that the Act fails to promote human rights:

> The legislation does not promote human rights—it actually tells us where it is legal to breach them. That legislative approval papers over the reality of those breaches, because it declares that the treatment is necessary.[4]

While the Mental Health Act includes principles of recovery and supported decision making, people told the Commission that these principles, for a range of reasons, often fall short in practice.[5] Consumers told the Commission that they were not listened to, and their preferences were ignored.[6] For example, witness Ms Mary Corbett said:

> In meetings when it was just the doctors and me, I found it really intimidating. I felt very powerless and alone when they approached me and asked me questions. I felt I was at their mercy, and it didn't matter what I said, because I knew they wouldn't believe me or listen to me.[7]

Witnesses told the Commission that despite the Mental Health Act defining the limited circumstances under which compulsory treatment can be used, and the efforts of many to reduce compulsory treatment, constraints on the mental health system have contributed to an increase in its use.[8] While there are many factors that have led to this, chief among them is that the workforce has not been supported with resources to reduce the use of compulsory treatment, such as having the time to engage with people.[9] Indeed, compulsory treatment can be concerning for the professionals who use it. As one member of the workforce told the Commission:

> **The entire tone of [the] current Victorian Mental Health Act seems to presuppose that workers do not innately want to respect and protect patients' rights.**[10]

The Commission considers both the rate and duration of compulsory treatment orders in the Victorian mental health system are too high, and that it is a systemic failure that compulsorily treating a person has become, in some instances, the default response.

A concerted effort must be made to reduce the use and duration of compulsory treatment throughout Victoria so it is only used as a last resort. To achieve this objective, a well-resourced system that can offer a diverse range of treatment, care and support options in line with a person's needs and preferences, particularly in community settings, must be available. Witness Ms Elizabeth Porter reflected on the opportunities to prevent compulsory treatment in a responsive mental health system:

> **I reflect on these three compulsory admissions with sadness. I wonder how my mental health trajectory could have been different if the GP I'd seen in the lead up to my first episode had organised an urgent psychiatric referral and I'd been supported to sleep; if the [Crisis Assessment and Treatment Team] had come the first time I'd called them and helped prevent my second episode; if the private hospital had treated me adequately rather than discharging me and prevented my third episode.**[11]

The Commission considers that using compulsory treatment only as a last resort will be a critical indicator of the success of its vision for a redesigned mental health and wellbeing system.

To deliver this vision and reduce the use of compulsory treatment in Victoria, community-wide stigma and discrimination must also be confronted.[12] Ms Mary O'Hagan MNZM, Manager of Mental Wellbeing at Te Hiringa Hauora in New Zealand, said '[d]iscrimination is the biggest single barrier to recovery and it pervades the justifications, criteria and processes involved in legal coercion in mental health.'[13]

This chapter examines the use of compulsory treatment in Victoria, including the factors that influence its high rate of use, and its impacts, particularly on consumers. It recommends opportunities to reform the system and support service providers and the workforce to establish practices that ensure compulsory treatment is only used in rare circumstances—as a last resort, and with strong oversight, transparency and accountability.

The chapter also puts forward recommendations to embed supported decision-making practices and support consumers to exercise their rights. The success of these reforms will depend on leadership from a range of actors within the system. In particular, as the people most affected by compulsory treatment, with profound and personal experiences of it, consumers must play a leading role in these significant reforms.

Box 32.1: Defining compulsory assessment and treatment

The Act enables people to be assessed and treated for mental illness when legislative criteria are met, without their consent in certain circumstances. The Act also provides the power to detain people in a hospital for assessment and treatment, for periods of time determined by the Act.

Key definitions include:

Advance statement—a document made under the *Mental Health Act 2014* (Vic) that sets out a person's preferences for treatment in the event they are subject to compulsory treatment. This non-binding document must be considered by the authorised psychiatrist and Mental Health Tribunal at certain points.[14]

Assessment Order—an order made under the *Mental Health Act 2014* (Vic) that requires a person to be compulsorily examined by an authorised psychiatrist in order to determine whether the treatment criteria, specified in the 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.[15]

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 *Sentencing Act 1991* (Vic).[16] This can include the administration of medication, hospital stays, electroconvulsive treatment and neurosurgery for mental illness. Compulsory treatment can sometimes be referred to as involuntary treatment.

Electroconvulsive treatment—the 'application of electric current to specific areas of a person's head to produce a generalised seizure'. Also known as electroconvulsive therapy.[17]

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 subject to, or at risk of, 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.[18]

Safeguards—mechanisms to help protect the rights of a person under the *Mental Health Act 2014* (Vic). These currently include statements of rights, advance statements, nominated persons, second psychiatric opinions, the Mental Health Tribunal, the Mental Health Complaints Commissioner, Community Visitors and the Chief Psychiatrist. Some people may also access legal representation when appearing before the Mental Health Tribunal and independent non-legal advocacy.

Second psychiatric opinions—a scheme under the *Mental Health Act 2014* (Vic) that enables 'compulsory patients' who are on either a Temporary Treatment Order or a Treatment Order, 'security patients' and 'forensic patients' to seek a second opinion on their treatment and/or if the treatment criteria apply to them.[19]

Statement of rights—a document approved by the Secretary of the Department of Health that sets out a person's rights under the *Mental Health Act 2014* (Vic) and also provides information to the person. The Act requires that the document be provided to 'compulsory patients', 'forensic patients' and 'security patients', by the authorised psychiatrist at certain points.[20]

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 permits an authorised psychiatrist to provide compulsory treatment to a person. The order is either an Inpatient Temporary Treatment Order or Community Temporary Treatment Order.[21]

Treatment criteria—the four criteria that must all be met in order to place a person under a Temporary Treatment Order or Treatment Order. The treatment criteria are:

a) the person has mental illness; and

b) because the person has mental illness, the person needs immediate treatment to prevent –

(i) serious deterioration in the person's mental or physical health; or

(ii) serious harm to the person or to another person; and

c) the immediate treatment will be provided to the person if the person is subject to a Temporary Treatment Order or Treatment Order; and

d) there is no less restrictive means reasonably available to enable the person to receive the immediate treatment.[22]

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 permits an authorised psychiatrist to provide compulsory treatment to a person. The order is either an Inpatient Treatment Order or Community Treatment Order.[23]

Personal story:

Lucy Barker

Lucy* has experienced the mental health system for around 11 years, including more than 80 inpatient admissions. She has found accessing the system very difficult.

> as one psychiatrist put it, I had too many complex issues for them to deal with. It took so much persistence to access any service and by the time I finally found a service, things had gotten much more severe.

Lucy has been subject to compulsory treatment several times. Lucy believes, in some instances, it has saved her life. However, she said it has also put her in traumatic and stressful situations.

> Compulsory treatment is more of a practical lifesaving mechanism as opposed [to] a wonderful great experience which has saved my life and improved my mental health in the long term.
>
> I don't feel comfortable with men. However, sometimes when I have been in compulsory treatment in medical wards, I have [been] given one-on-one care with a male nurse … It means every time I need to go to the bathroom, he's in the bathroom with me. It's a terrifying experience.

Lucy would also like to see more cultural sensitivity in mental health services.

> as part of treatment in the eating disorder unit, they try to re-establish your eating patterns. Culturally, my main meal of the day is lunch, not dinner. Dinner to me is a foreign concept … The problem with the clinic is that there is no flexibility and I'm being taught to eat in a way that I can't maintain when I go home. I am being set up to fail.

Lucy believes that there would not be a need for compulsory treatment if the system was not so crisis-based.

> At the moment you can't get a service unless you are in crisis or your mental health has deteriorated to the point that you need someone to intervene … I had to be actively suicidal to get help.
>
> It was the same for my eating disorder—it had to get to the point where my organs were failing before I could be admitted as an involuntary patient. If I had been offered help a month earlier, I would not have deteriorated to a point where I needed compulsory treatment.

Source: *Witness Statement of 'Lucy Barker' (pseudonym)*, 29 June 2020.

Note: *Name has been changed in accordance with an order made by the Commission.

32.1.1 Obligations to protect and promote human rights

The Mental Health Act, like all Victorian laws, needs to be interpreted and applied in the context of human rights laws, frameworks and obligations.

Victoria is one of three Australian jurisdictions, along with the Australian Capital Territory and Queensland,[24] that has specific human rights legislation that draws upon protected human rights at the international level. The *Charter of Human Rights and Responsibilities Act 2006* (Vic) sets out the rights, freedoms and responsibilities shared by everyone in Victoria and protected by law.

The Charter of Human Rights and Responsibilities seeks to protect and promote human rights in several ways, including by requiring 'public authorities' to act compatibly with human rights, and to properly consider human rights when making decisions.[25]

Human rights must also be taken into account when new laws are developed. All new bills introduced into parliament must be accompanied by a 'statement of compatibility', which is a public document that describes how the proposed law complies or does not comply with rights set out in the Charter of Human Rights and Responsibilities.[26]

At the time the current Mental Health Act was introduced, it was argued that the limits on rights posed by compulsory treatment were needed because 'people may suffer unnecessarily and experience serious harm or deterioration in their mental health or may harm another person'.[27] These limits were deemed reasonable and proportionate for a range of reasons, including that only a small number of people would be subject to compulsory treatment; that safeguards such as advance statements and nominated persons provided some protection for consumers; and that oversight mechanisms were in place to monitor the use of compulsory treatment (for example, the Mental Health Tribunal was empowered to make decisions around its use).[28]

The statement of compatibility concluded that the Act's limitations on rights, including the right not to be subject to medical treatment without full, free and informed consent and the right to privacy, were reasonable, proportionate and compatible with the Charter of Human Rights and Responsibilities.[29]

Along with human rights obligations imposed under Victorian law, international treaties also require that human rights are protected and promoted. Australia is a party to core international human rights treaties, including the United Nations *Convention on the Rights of Persons with Disabilities*. Under this Convention, Australia is obliged to recognise 'that persons with disabilities have the right to enjoyment of the highest attainable standard of health without discrimination on the basis of disability'.[30] This Convention clarifies that 'disability' includes 'mental impairments'.[31]

The adoption of the *Convention on the Rights of Persons with Disabilities* challenged Australia, and indeed jurisdictions from around the world, to end coercive practices, including compulsory treatment.

The United Nations Committee on the Rights of Persons with Disabilities has advised that nations must replace substituted decision-making frameworks with supported decision-making alternatives.[32] The Committee has also recommended that Australia:

> repeal all legislation that authorizes medical intervention without the free and informed consent of the persons with disabilities concerned, committal of individuals to detention in mental health facilities, or imposition of compulsory treatment, either in institutions or in the community, by means of Community Treatment Orders.[33]

In addition, the Special Rapporteur's report on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health called for 'immediate action … to radically reduce medical coercion and facilitate the move towards an end to all forced psychiatric treatment and confinement'[34] and proposed that countries adopt a road map explaining how coercive practices will be reduced. The Special Rapporteur asserted that the road map should comprise reduction strategies and a 'well-stocked basket of non-coercive alternatives',[35] including more research, better data collection and greater information exchange between jurisdictions.

The view that the *Convention on the Rights of Persons with Disabilities* represents a shift away from substituted decision-making and compulsory treatment is supported by some human rights and academic experts.[36] Dr Martin Zinkler, from the Academic Teaching Hospital of Ulm University's Department of Psychiatry, Psychotherapy and Psychosomatic Medicine in Germany, argued that:

> Changes in mental health practice towards a system based only on support are possible and can be conceptualized. The principles of mental healthcare will change as it loses its coercive interventions and therefore its function as an agent of social control … Intensity and form of support will always follow the will and the preferences of the person concerned.[37]

It is important to note that, in ratifying the *Convention on the Rights of Persons with Disabilities*, Australia made an interpretive declaration that Australia's understanding of the Convention is that it allows for substituted decision-making arrangements and compulsory treatment as last resorts and subject to safeguards.[38]

Others share the view that the *Convention on the Rights of Persons with Disabilities* should be interpreted as permitting compulsory treatment and substituted decision making in certain circumstances.[39] For example, Professor John Dawson from the Faculty of Law at University of Otago, New Zealand, argued that while efforts should focus on promoting supported decision making, a realistic approach to interpreting the Convention should be taken. This approach would permit substituted decision making and compulsory treatment in certain circumstances.[40]

This view was encapsulated by Associate Professor Ruth Vine, Director at Forensicare and now Deputy Chief Medical Officer for Mental Health, who said that 'leaving a person untreated, tormented by auditory hallucinations and delusions and at great risk of harm, is not compatible with international conventions on human rights'.[41] Indeed, most countries around the world continue to allow for compulsory treatment in limited circumstances.

Nonetheless, it is clear that human rights obligations under Victorian and international law apply in relation to compulsory treatment. This means taking into account the full range of people's needs and rights, which include the right to the highest attainable standard of health, to promote respect for the inherent dignity of people, and to remove barriers that hinder full and effective participation in society on an equal basis with others.[42]

32.1.2 Compulsory treatment is frequently a negative experience for consumers

Consumers described the serious and harmful consequences of being subject to compulsory treatment. This included distress and disempowerment—including deep fears for their safety and experiences of significant trauma as a result of being subject to treatment against their will. Some of these accounts included:

> When you're a compulsory patient, you're staring at the walls. There's nothing to do—no therapy, no programs. There was a broken piano and a few broken crayons. Everyone's contained in one small space.[43]

> The compulsory treatment order made it hard for me to experience good mental health. I felt as if my basic human rights were taken away from me.[44]

> My three compulsory admissions for psychotic episodes were actively harmful, caused intense suicidal ideation related to being assaulted by male patients during the admissions, and in significant ways, were more challenging to recover from than my mental health conditions.[45]

Some Victorians are subject to compulsory treatment at greater rates than the rest of the population. In particular, people from Aboriginal backgrounds are over-represented on compulsory assessment and treatment orders compared with the Victorian population more broadly.[46] While the causes of this over-representation are unclear, it is particularly confronting in the context of the dispossession and intergenerational trauma wrought by colonisation and post-invasion government activity on the lives of Aboriginal people.[47]

Some consumers and advocates told the Commission that the effects of compulsory electroconvulsive treatment can be severe, long-lasting and traumatic.[48] For example, witness Ms Julie Dempsey stated:

> Over the years I have had extensive [electroconvulsive treatment], primarily against my will. The [electroconvulsive treatment] typically destroys my cognitive ability for at least two years. I have extensive memory loss—the last time I had [electroconvulsive treatment] I was a practicing Buddhist, meditating two times a day and in advanced level dharma classes, having read extensively on the subject. After [electroconvulsive treatment] I had no recollection of any of my learnings and my spirituality was destroyed. I attempted to go back into Buddhist study, however I have not been able to regain my sense of spirituality, it is only limited theory to me now.[49]

For Ms Dempsey, and many others, interaction with Victoria Police marked the start of their experience with compulsory treatment. Under the Mental Health Act, police officers can apprehend a person if they 'appear mentally ill and may be of serious and imminent harm to themselves or others', to take them to a hospital.[50] Ms Dempsey and others shared how confronting and upsetting being apprehended by police can be,[51] and of their distress over police involvement in mental health responses:

> I was in a hospital Emergency Department needing transport to hospital, a psychiatric hospital. There were no ambulances available so they decided to use a divi van. I wasn't agitated or aggressive … I've never committed a crime in my life and I'm thrown in the back of this divi van in front of a waiting room full of people at the Emergency Department; it was so degrading.[52]
>
> Sometimes you have to ring triple zero just to get services to arrive. Police arrive, and then often you're treated worse than perpetrators in the justice system.[53]

Families, carers and supporters also told of their distress of police involvement with their loved ones:

> It is heartbreaking seeing your child being forcibly taken for treatment. Whilst the Police do the best they can, there should be other options before it becomes life threatening for either the consumer or the family member.[54]
>
> It can be difficult in crisis as if there is a risk of violence the Police are notified which can be traumatic to both the consumer and the family.[55]

This is not a universal experience. Throughout the Commission's community consultations, many people spoke of how police were, in some instances, the only services that responded when they asked for help.[56]

Nonetheless, in the context of these negative experiences, many consumers and advocates called for more focus on, and access to, non-coercive alternatives, and some advocated for compulsory treatment to be abolished. Some of these representations to the Commission included:

> I will continue to advocate for the abolition of compulsory treatment. In the meantime, we should reduce the rate at which compulsory treatment is used by enacting a framework for supported decision-making.[57]
>
> I would be delighted to see an immediate end to compulsory treatment, however I recognise this is highly unlikely to occur in the immediate future. So instead, I suggest a gradual reduction in compulsory detention and treatment could be supported …[58]
>
> I would very strongly support the abolition of involuntary treatments to be done in the context … of providing all those other necessary supports …[59]

Other legal experts and human rights advocates also called for the radical reduction, or abolition, of compulsory treatment.[60] Tina Minkowitz, human rights lawyer, founder of the Center for the Human Rights of Users and Survivors of Psychiatry and contributor to the drafting of the *Convention on the Rights of Persons with Disabilities*, asserted that:

> Any legal provisions that make exceptions to free and informed consent for any persons with disabilities, or that authorize compulsory treatment of any kind to be performed on any persons with disabilities must be derogated.[61]

Some families, carers and supporters have expressed concerns about the harms associated with compulsory treatment.[62] For example, 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, told the Commission that when his daughter, Jessica, was subject to compulsory treatment it was part of the response from a system that was not able to effectively support, nor respond to, her individual needs:

> it was and is a one-size-fits-all system, one that is built upon a blunt medical model, one that does not generally apply an age and gender perspective and one in which coercion is a central and not a back-up component: admission, diagnosis, compulsory order, compulsory medication, stabilisation, discharge, medical supervision in the community (not care-support), rewind, play again. It is a very familiar path that is too often associated with chronic mental illness, as it was with Jessica. Also, unfortunately, her needs as a girl in her teenage years were not a feature of the treatment.[63]

There were also occasions where families, carers and supporters considered that the use of compulsory treatment on their loved one was unnecessary or inappropriate.[64] For example, Mr Jacob Corbett, a carer for his sister, Mary, and a witness before the Commission explained:

> I … recall that during Mary's first few relapses in the 1990s, she was put on a [compulsory treatment order] because the doctors and staff were worried about her escaping and leaving the hospital. This was totally unnecessary because she is always obliging and compliant, and it only served to make us all very afraid and feel powerless.[65]

The Commission contends that these negative experiences and the traumatic effects of compulsory treatment make it necessary to reduce the use of compulsory treatment. This will involve expanding the role and reach of services to offer different voluntary methods of treatment, care and support, in line with consumers' needs and preferences.[66]

32.1.3 The role of compulsory treatment

Some consumers told the Commission that although they had a negative experience of compulsory treatment, it resulted in some positive outcomes:

> I feel that my treatment as an involuntary patient could have been more humane, but the intervention needed to happen for me when it happened, and I'm grateful for the treatment I received.[67]

> In some instances, compulsory treatment has saved my life. I say this because of the timing … Had I not been forced to go to a medical ward, I would have probably eventually died. In that sense, it saved my life …[68]

Some families, carers and supporters shared their views about how compulsory treatment supported a loved one:

> Involuntary Treatment has resulted in a more accurate diagnosis and a gradual improvement in our daughter's health. The change in diagnosis, and so more effective medication, would certainly not have happened without the capacity to Involuntarily Treat. In fact she has been as well in the last six months as at any time in the last ten years.[69]
>
> He was on a [Community Treatment Order] for 5 years and during that time, he was compliant with his medication, had stable housing and he worked. If they kept him on [the order], he would still be taking his medication.[70]
>
> An involuntary treatment order meant that my daughter had to attend appointments and engage with services.[71]

A small study of Victorian carers in 2015 suggested that most felt that Community Treatment Orders were beneficial for consumers, and that, after a Community Treatment Order ended, consumers could need more treatment.[72] It is important to note that these views and studies need to be considered in the context of a constrained mental health system, which also affects the experience of families, carers and supporters.

Some clinicians consider that in certain circumstances compulsory treatment can be lifesaving, benefit the person's relationships with family and friends and prevent the loss of employment and housing.[73] For example, Associate Professor Vine contended:

> Compulsory treatment can be life-saving—not just by reducing the risk of suicide but also by reducing the risk of dangerous behaviour. It can also avert loss of family, employment, housing and finances, and can reduce the risk of criminal offending.[74]

Clinicians also described that compulsory treatment can be beneficial, because it places an obligation on the system to provide services to people.[75] For example, Professor Richard Newton, Clinical Director of Peninsula Mental Health Service, told the Commission that '[t]he undersupply of services encourages some GPs and private psychiatrists to send patients to hospital under the Mental Health Act because it will ensure that they are treated.'[76] These views are also held by some consumers, families, carers and supporters.[77]

Nonetheless, there is consensus that 'involuntary treatment should be used conservatively, and that once implemented its restrictions on autonomy should be as minimal as possible'.[78] Some argue that compulsory treatment should be limited to circumstances where consumers cannot be supported to make their own decisions, or where it is considered necessary to prevent harm.[79]

Many clinicians argue that compulsory treatment should only be used in limited circumstances.[80] For example, Mr Peter Kelly, Director of Operations at NorthWestern Mental Health, stated that 'compulsory treatment is a serious imposition on an individual's freedom of choice and should only be used in the smallest number of cases and for the shortest period of time'.[81] Professor Suresh Sundram, Head of the Department of Psychiatry in the School of Clinical Sciences at Monash University and Director of Research in the Monash Health Mental Health Program, gave evidence in a personal capacity and holds the view that compulsory treatment should be a 'transient step'.[82]

Dr Neil Coventry, Victoria's Chief Psychiatrist, reiterated this sentiment, stating, 'compulsory treatment should never be used without significant consideration, and the consumer and their legally protected rights must always be central to any decision making'.[83] It is clear that any potential benefits that may be associated with compulsory treatment must be weighed against the significant infringements on human rights.

Compulsory treatment in the community

The evidence for the effectiveness of using compulsory treatment in the community is contested.[84] Professor Lisa Brophy, Discipline Lead in Social Work and Social Policy in the Department of Occupational Therapy, Social Work and Social Policy at La Trobe University giving evidence in a personal capacity, pointed to conflicting results of studies and trials in relation to Community Treatment Orders:

> Randomised controlled trials have tended to focus on readmission to hospital and other outcomes and have not established evidence for the use of [Community Treatment Orders]. However, other studies, such as case-control studies that have followed people over time have found inconsistent and conflicting results. There is often speculation that the positive results are due to the increased contact with services that come with a [Community Treatment Order].[85]

For example, the following research supports the notion that there are mixed results:

- Two historical Victorian studies suggested that Community Treatment Orders helped people with higher levels of need to experience shorter hospital stays,[86] with one indicating that community-initiated Community Treatment Orders could prevent additional hospital involvement.[87] However, both of these studies relied on administrative data, so there may be limitations to the conclusions.[88] They were also both conducted before the introduction of the current Mental Health Act in 2014, which departed from the *Mental Health Act 1986* (Vic) in some ways. For example, the current Act places stricter timeframes on the duration of compulsory treatment orders.[89] A recent New South Wales study also suggested people on Community Treatment Orders had rehospitalisation delayed during the operation of the Community Treatment Order.[90]
- Conversely, a study that looked at international research relating to Community Treatment Orders indicated that these orders did not prevent or shorten the length of hospital admission.[91] A meta-analysis of the only three randomised controlled trials related to Community Treatment Orders to date suggested they may not lead to significant differences in readmission, social functioning or symptoms.[92]

- An international review suggested there is no difference in service use, social functioning or quality of life between people on Community Treatment Orders and those accessing services voluntarily.[93]

Overall, despite some studies identifying benefits of Community Treatment Orders in some groups,[94] the sum of the evidence does not support their effectiveness in preventing relapse and readmission.[95] It is difficult to distinguish whether any posited benefits are driven by the legal framework of the order, or the extra services given to a person when they are on the Community Treatment Order.[96]

Compulsory treatment in inpatient settings

The evidence supporting the effectiveness of compulsory treatment provided in inpatient settings is limited. One 2006 study in Victoria looked at people on Inpatient Treatment Orders who were discharged earlier than others (within 30 days). The study suggested that people who had a diagnosis other than dementia or schizophrenia, who had an involuntary status on their first inpatient admission, and who had greater community supports were discharged earlier and had less subsequent inpatient care.[97]

One long-term observational study of people on compulsory treatment orders in inpatient settings in the United Kingdom that continued following participants after discharge found that 'the clinical and social benefits patients experience following involuntary admission and subsequent treatment are on average rather limited'.[98] Another international study indicated that inpatient compulsory treatment for patients with anorexia nervosa could be beneficial in the short term.[99]

Dr Christopher Maylea, Senior Lecturer in Social Work at RMIT University and the then Chair of the Committee of Management of the Victorian Mental Illness Awareness Council, giving evidence in a personal capacity, and as a representative for the Victorian Mental Illness Awareness Council, believes there is no overall benefit to compulsory treatment. Dr Maylea highlighted that there are:

> obvious alternatives to compulsory treatment required, which would involve investment into Victoria's mental health services (particularly in community mental health services) and a re-focus on general themes of recovery-based treatment, early intervention and support, choice and the increased availability of peer work services and workers.[100]

Others agree that compulsory treatment can be reduced through improved access to services, a better resourced mental health system and the ability to engage with consumers in a recovery-focused way.[101]

Given the limitations on human rights, the negative experience of compulsory treatment experienced by many consumers, and the contested evidence on its effectiveness when used in community settings, the Commission has formed the view that the Victorian Government should focus on reducing compulsory treatment. This includes expanding non-coercive alternatives and ensuring diverse, well-resourced community-based mental health and wellbeing services are readily available. The Commission's reforms to community-based mental health and wellbeing services are described in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*.

32.2 Systemic factors leading to high rates of compulsory treatment use

The way the criteria for compulsory or involuntary treatment have been framed in mental health acts has changed over time.[102]

From the earliest days of colonisation up until the *Mental Health Act 1986*, previous mental health acts focused on permitting institutionalisation, which brought with it a resultant loss of liberty and autonomy.[103]

The 1986 Act tightened the criteria for involuntary treatment with the aim of reducing involuntary treatment and establishing 'a legislative framework for the provision of services to the mentally ill well into the 21st century and beyond'.[104]

The current *Mental Health Act 2014* repealed and replaced the 1986 Act. The purpose of the current Act is to 'provide a legislative scheme for the assessment of persons who appear to have mental illness and for the treatment of persons with mental illness'.[105] One of the government's main objectives in introducing the new legislation was to minimise the use and duration of compulsory treatment.[106] When introducing the current Mental Health Act into parliament, the then Minister for Mental Health said:

> **The bill seeks to promote and enable voluntary assessment and treatment in preference to compulsory assessment and treatment wherever possible. Where compulsory treatment is required, the bill seeks to minimise its duration and ensure that it is provided in the least restrictive and least intrusive manner possible.**[107]

The Mental Health Act places strict timeframes on the duration of compulsory assessment and treatment, with the intention that people will not be subject to indefinite orders by providing expiry periods for each order.[108]

The legislation also introduced independent oversight of compulsory treatment, whereby a Temporary Treatment Order is automatically reviewed by the Mental Health Tribunal before its expiry within 28 days, if it is not revoked before the hearing.[109] A person can only be subject to compulsory treatment for longer than 28 days if the Tribunal makes a Treatment Order. The use of consecutive orders means that people can experience long periods of compulsory treatment, with oversight from the Mental Health Tribunal.[110] The legislation requires that the order be revoked by an authorised psychiatrist, at any time, if the treatment criteria are not met.[111]

The Act continues to regulate electroconvulsive treatment. It provides the Tribunal the power to approve applications for electroconvulsive treatment on people under the age of 18, and all adults who are deemed to not have capacity to provide informed consent to the treatment.[112] Under the Act, the Tribunal is also responsible for the independent oversight of neurosurgery for mental illness and must consider applications to use this treatment for all people.[113]

32.2.1 Unrealised intentions to reduce compulsory treatment

The Victorian Government's aspiration to minimise the use and duration of compulsory treatment has not occurred and the rates of compulsory treatment use in Victoria remain high.[114] Since 2015–16, the number of compulsory Assessment, Temporary Treatment and Treatment Orders made in Victoria continues to increase on average by approximately 2–3 per cent per year for each type of order across all ages (refer to Figure 32.1).[115]

The number of people subject to compulsory treatment can vary on any given day.[116] For example, on 30 June 2020, there were 24,801 people aged 12 years or older considered active clients of public mental health services.[117] Of all those clients, 3,323 (13.4 per cent) were subject to compulsory assessment or treatment on that particular day.[118]

The characteristics of the 'average compulsory patient' over the past five years is a 42-year-old male who lives in metropolitan Melbourne and has spent 61.7 days on compulsory treatment each year over the past five years.[119] He is most likely to have a diagnosis recorded by public mental health services in the category of schizophrenia, paranoia and acute psychotic disorder.[120]

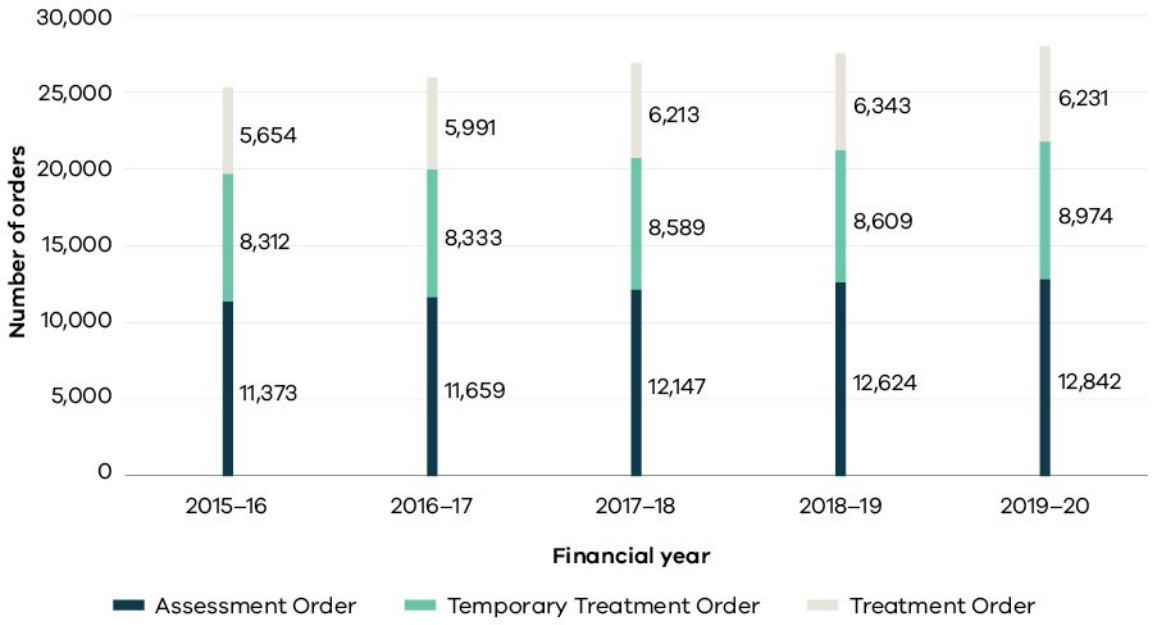
These characteristics do vary slightly within different age cohorts. For example, the 'average compulsory patient' among children and young people under the age of 26 is a 21-year-old male, who is more likely to identify as an Aboriginal Victorian than the other age cohorts.[121] Among people aged 65 and older, the 'average compulsory patient' is a 75-year-old female who is more likely to be from a culturally diverse background than the other age cohorts.[122]

Men are more likely to be placed on compulsory treatment orders than women, with 55 per cent of 'compulsory patients' identifying as male.[123] People who live in metropolitan Melbourne make up 72 per cent of the people under compulsory treatment.[124] The duration of Treatment Orders for adults is longer in metropolitan Melbourne than in regional Victoria.[125] Aboriginal people are also over-represented, making up approximately 3 per cent of active clients who are placed on compulsory treatment orders.[126] People from culturally diverse communities are also over-represented on compulsory treatment orders, making up 22 per cent of active clients in Victoria and experience the longest periods of compulsory treatment.[127]

The number of compulsory assessment and treatment orders made is rising

Since the introduction of the Mental Health Act, the number of compulsory assessment and treatment orders made across all three stages has continued to rise (refer to Figure 32.1). However, in the past financial year the number of Temporary Treatment Orders increased by 4 per cent on the previous year, and the number of Treatment Orders decreased by 2 per cent. This may be related to a change of practice by the Mental Health Tribunal in response to the effects of the COVID-19 pandemic, which led to hearings for people on a Treatment Order who had already had a Tribunal hearing during their current episode of treatment given less priority, due to decreased Tribunal capacity.[128]

Figure 32.1: Number of orders made, by order type, Victoria, 2015–16 to 2019–20



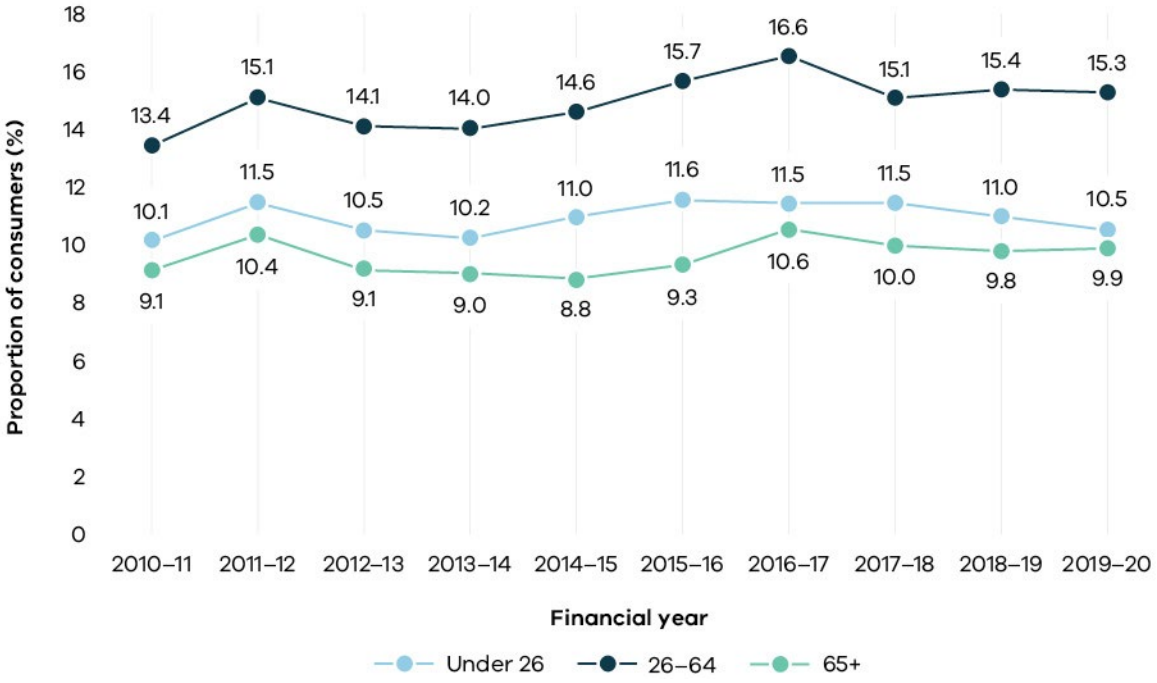
Source: Department of Health and Human Services, Client Management Information/Operational Data Store 2015–16 to 2019–20.

It is not only the numbers of orders that are increasing across Victoria—the number of people subject to compulsory treatment is also increasing. In 2019–20, 0.20 per cent of the Victorian population aged 26–64 years were subject to compulsory treatment orders, which has increased from 0.17 per cent of the population in 2010–11.[129]

Figure 32.2 shows the proportion of consumers who were subject to both compulsory assessment and treatment across three age groups. Compulsory assessment and treatment continues to be used more frequently among people between the ages of 26 and 64 years.

Among children and young people, there has been a slight reduction in compulsory assessment and treatment over the past two years. The data suggests that 40 per cent of people aged under 26 years of age who are placed on an Assessment Order are not subsequently placed on a Temporary Treatment Order.[130] Of the 44 per cent of people in this age group who are placed on a Temporary Treatment Order, and are not subsequently placed on a Treatment Order, the duration of compulsory treatment is 11 days, which is shorter than for all other cohorts.[131]

Figure 32.2: Proportion of consumers with a consecutive order starting, by age group, Victoria, 2010–11 to 2019–20



Source: Department of Health and Human Services, Client Management Information/Operational Data Store 2010–11 to 2019–20.

Note: Includes consumers aged 12 years and over. Consecutive order is defined in the glossary.

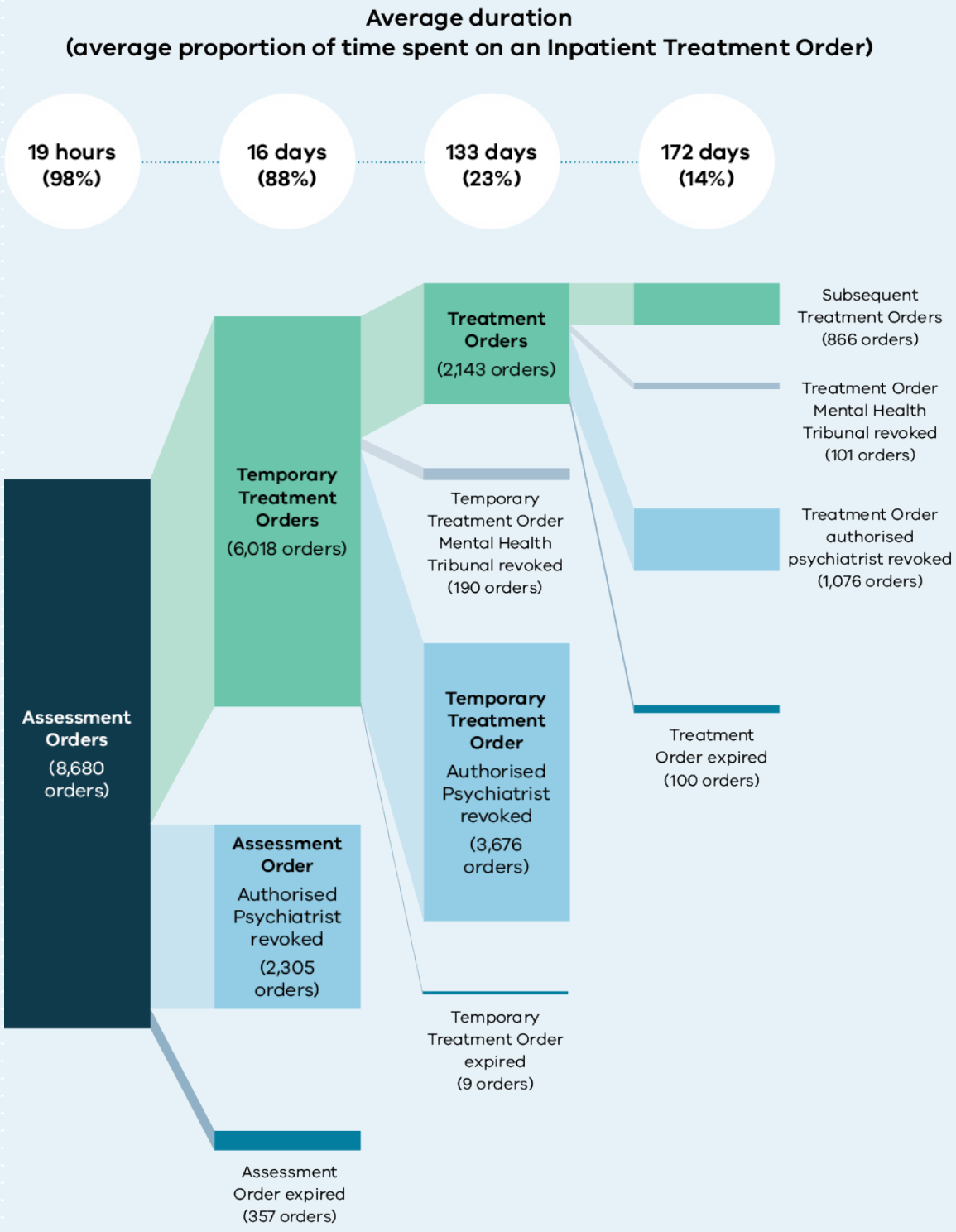
The duration of compulsory assessment and treatment orders

Figure 32.3 depicts the use of compulsory assessment and treatment for consumers aged 26–64 years who were subject to an Assessment Order in 2018–19 and follows this experience for two years. The data indicates that 69 per cent of people on an Assessment Order go on to be placed on a Temporary Treatment Order and 36 per cent of people on a Temporary Treatment Order go on to be placed on a Treatment Order by the Mental Health Tribunal.

As reflected in Figure 32.3, the Tribunal revoked less than 10 per cent of Temporary Treatment Orders and Treatment Orders in 2018–19, which confirms authorised psychiatrists are taking people off compulsory treatment before the order expires in most cases.[132] The rate at which the Tribunal revokes Temporary Treatment Orders and Treatment Orders is explored further in section 32.4.2.

For people who are placed on a Treatment Order, when comparing the duration of orders made by the Mental Health Tribunal with the time people actually spent on Treatment Orders, the data indicates that the orders are often ended by an authorised psychiatrist earlier than the duration of the order made by the Tribunal. For example, 25 per cent of people are given 12-month Community Treatment Orders; however, only 14 per cent actually spend that long on the order.[133] While 30 per cent of people spend six months on Treatment Orders, 49 per cent of people are given a Treatment Order of that duration (refer to Figure 32.4).

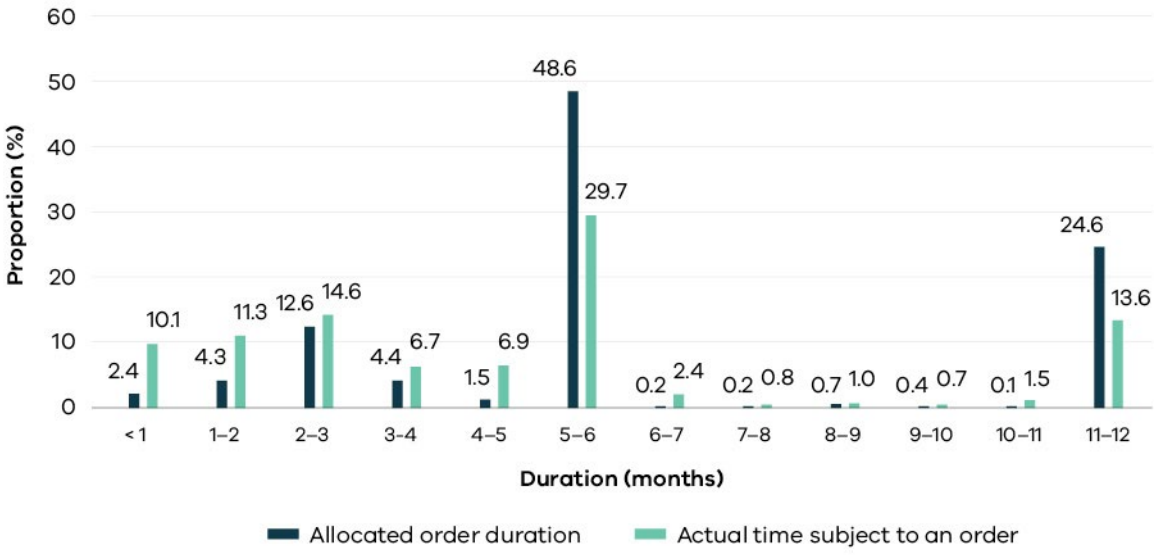
Figure 32.3: Compulsory assessment and treatment use among consumers aged 26–64, Victoria, 2018–19



Source: Department of Health and Human Services, Client Management Interface/Operational Data Store 2018–19.

Note: Includes people who started an order in 2018–19. Excludes any consecutive orders that had a non-civil order component. Thirty instances have been omitted due to data integrity issue (22 people did not start with an Assessment Order and eight people had two Assessment Orders in a row).

Figure 32.4: Time allocated for Treatment Orders and actual time subject to Treatment Orders, by order length, Victoria, 2015–16 to 2019–20



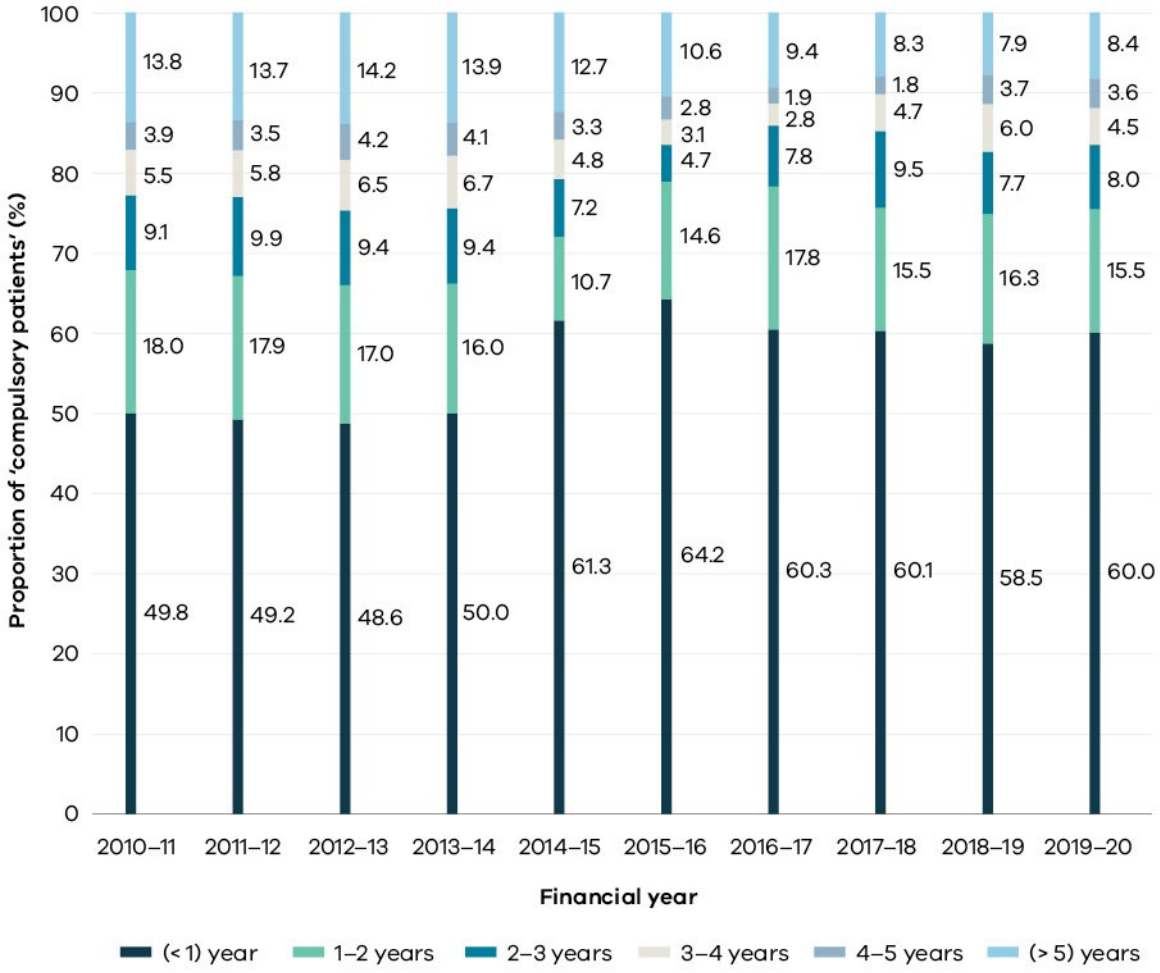
Source: Department of Health and Human Services, Client Management Information/Operational Data Store 2015–16 to 2019–20.

The use of compulsory treatment for long periods of time

Before a Treatment Order expires, a new application can be made by an authorised psychiatrist to the Mental Health Tribunal for another Treatment Order.[134] This means people can be compulsorily treated for more than 12 months using consecutive orders. As shown in Figure 32.5, across all ages since 2014–15 the duration of consecutive orders is less than one year for 60 per cent of people, but this means that 40 per cent of consecutive orders are longer than one year in duration.[135] However, in 2019–20, 79 per cent of people under 26 years on a compulsory treatment order spent less than a year on a consecutive order.[136]

Since the introduction of the current Mental Health Act, there has been a decrease in the proportion of people on consecutive orders for more than 12 months. However there still remains a significant proportion of people who experience compulsory treatment for more than 12 months. For example, in 2019–20, 12.0 per cent of people were subject to compulsory treatment for more than four years, 4.5 per cent for three to four years and 8.0 per cent for two to three years (refer to Figure 32.5).

Figure 32.5: Proportion of 'compulsory patients' on consecutive orders, by total order length, all ages, Victoria, 2010–11 to 2019–20



Source: Department of Health and Human Services, Client Management Information/Operational Data Store 2010–11 to 2019–20.

Note: Order length determined as at 30 June of the relevant financial year. Totals may not add to 100 per cent due to rounding.

The use of compulsory assessment and treatment orders varies between services

Compulsory treatment use is not consistent across Victoria, neither in the average duration nor the rates of compulsory assessment and treatment. The duration of Treatment Orders for adults is longer in metropolitan Melbourne than in regional Victoria.[137] As Table 32.1 shows, for people between the ages of 26 and 64 years, there appear to be different practices in the use of compulsory assessment and treatment, with some services having higher rates than other services of people who move from an Assessment Order to a Temporary Treatment Order or who move from a Temporary Treatment Order to a Treatment Order.

The average length of consecutive orders also varies greatly between services. However, services with smaller numbers of 'compulsory patients' may appear to have a higher average due to some long-term compulsory treatment orders increasing the average.

The rate of people who start compulsory treatment again within three months of stopping also varies between services, which may reflect that the current system is not resourced to provided adequate treatment, care and support to people transitioning from compulsory treatment.[138] These differences between services may be partially explained by a number of factors that include, but are not limited to, clinician experience and sociodemographic features.[139]

Table 32.1: Compulsory assessment and treatment measures, consumers aged 26–64, by individual mental health service, 2019–20

Health service[140]	Percentage of Assessment Orders per active clients	Percentage of Assessment Orders that become Temporary Treatment Orders	Percentage of Temporary Treatment Orders that become Treatment Orders	Average length of consecutive orders (days) at 30 June 2020	Percentage of Treatment Orders longer than two years at 30 June 2020	Use of compulsory treatment within three months of discharge from compulsory treatment
Albury Wodonga Health	9%	60%	19%	890	13%	17%
Alfred Health	22%	78%	40%	904	16%	15%
Austin Health	11%	77%	44%	904	20%	18%
Ballarat Health Services	13%	73%	28%	862	10%	15%
Barwon Health	14%	65%	30%	603	8%	21%
Bendigo Health	15%	70%	30%	708	9%	22%
Eastern Health	19%	74%	41%	826	13%	17%
Goulburn Valley Health	12%	70%	30%	308	3%	13%
Latrobe Regional Hospital	20%	57%	23%	649	5%	21%
Melbourne Health	18%	73%	39%	717	9%	15%
Mercy Health	25%	75%	35%	578	7%	17%
Mildura Base Hospital	9%	56%	33%	1200	28%	9%

Health service[140]	Percentage of Assessment Orders per active clients	Percentage of Assessment Orders that become Temporary Treatment Orders	Percentage of Temporary Treatment Orders that become Treatment Orders	Average length of consecutive orders (days) at 30 June 2020	Percentage of Treatment Orders longer than two years at 30 June 2020	Use of compulsory treatment within three months of discharge from compulsory treatment
Monash Health	25%	76%	40%	796	13%	16%
Peninsula Health	14%	67%	29%	753	7%	20%
South West Health	11%	73%	19%	1111	9%	22%
St Vincent's Hospital Melbourne	16%	63%	38%	661	14%	23%
Victorian average	**18%**	**72%**	**36%**	**764**	**11%**	**17%**

Source: Department of Health and Human Services, Client Management Information/Operational Data Store 2019–20.

Notes: Any comparisons between services need to be interpreted with caution, as the figures do not take into account the differences in population (including growth), demographics (such as homelessness and culturally diverse communities) and service demand of the different areas (including from prison and courts). There are also differences in the services provided, for example, emergency department use varies between services, as does access to acute inpatient mental health beds and community mental health resources.

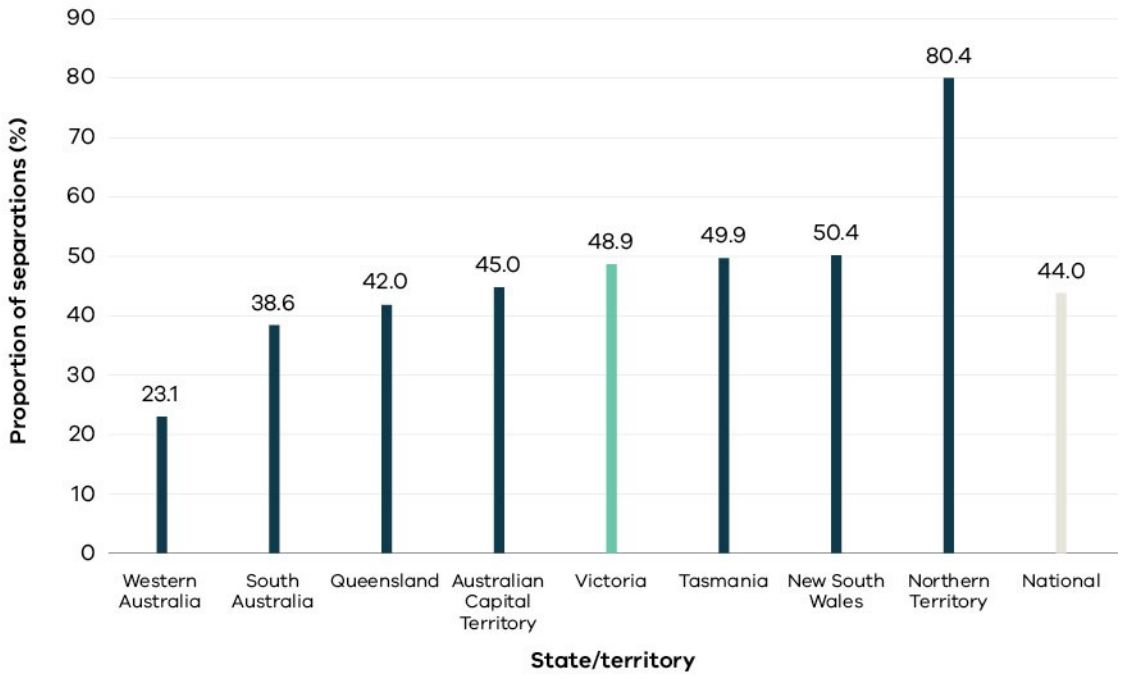
The use of compulsory assessment and treatment varies between jurisdictions

It is important to understand Victoria's use of compulsory treatment in the context of similar jurisdictions, noting that each Australian jurisdiction has a different compulsory assessment and treatment scheme. Any comparisons need to be interpreted with caution because they do not take into account differences in legislation or approaches.

As shown in Figure 32.6, Victoria is slightly higher than the national average for the proportion of acute separations (or hospital stays) that had a period during the separation that was involuntary.

A review of the rates of Community Treatment Order use in 2016–17 indicated that Victorians were subject to Community Treatment Orders at higher rates per population than people in New South Wales, Queensland and Western Australia.[141] With the rate of people subject to a Community Treatment Order in Victoria at 76.4 per 100,000 people, Victorian compulsory treatment rates are significantly higher than most other states and territories. For example, the rate of people subject to Community Treatment Orders in New South Wales was 48.1 per 100,000 people and was 40.9 per 100,000 people in Western Australia.[142] Over time, this rate has varied considerably in Victoria, from 55 per 100,000 people in 2005 to 98.8 per 100,000 people in 2012.[143]

Figure 32.6: Proportion of acute separations with specialised mental health care days that are involuntary, states and territories, 2017–18



Source: Australia Institute of Health and Welfare, *Mental health services in Australia: Restrictive practices 2018–19*, Table RP.3 <www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/restrictive-practices> [accessed 18 November 2020].

Notes: The use of involuntary treatment is governed by either legislation (a Mental Health Act or equivalent) or mandatory policy within each state and territory. The definitions used within the legislation and policies vary between jurisdictions including, but not limited to, forensic-related legislation that applies to admitted patient mental health services. These variations should be recognised in the interpretation of the data.

In terms of access to services, it is estimated that, in 2019–20, active adult clients of public mental health services received about 5 per cent of their community contact hours from a consultant psychiatrist.[144] For those adults who did receive community mental health services from a consultant psychiatrist in 2019–20, the average total service hours per client was 2.1 hours.[145]

Notwithstanding that these are averages and estimates only, it does indicate deficiencies in access to community-based mental health services. The Victorian Government's submission acknowledged 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.[146] With additional investment, the Commission notes that Victoria's annual community contacts per population have improved but are still lower than the national average and most other states and territories.[147]

Based on the above data it is clear that the current Mental Health Act has not led to a reduction in the use or duration of compulsory treatment as envisaged. It is also clear that more than legislative change is required to reduce the use of compulsory treatment in the future.

32.2.2 An under-resourced mental health system

As described in the Commission's interim report, the under-resourcing of the mental health system has led to a reliance on a crisis-driven model of care. Scarce resources have meant that public mental health services have had little choice but to concentrate the delivery of services on crisis responses and acute inpatient services.[148] This has made it difficult to focus on early intervention and recovery through community-based mental health services, which are approaches that would help to avoid crisis and reduce compulsory treatment use.[149]

Many consumers have relayed that it was only when their mental health deteriorated that they were able to receive services.[150] For example, Ms Barker said:

> I think that there wouldn't really be a need for most compulsory treatment if our system wasn't crisis based. At the moment, you can't get a service unless you're in crisis or your mental health has deteriorated to the point that you need someone to intervene. If services were offered to everyone that wanted help for their mental health earlier, then things wouldn't escalate to the point that they usually do. I myself struggled to get into the system to begin with, and by the time that I did, I had to be actively suicidal to get help.[151]

Another person with experience of compulsory treatment explained to the Commission:

> I received no meaningful, helpful preventative care. Numerous times actually I've been turned away by practitioners or services that either deemed my symptoms to not be serious enough or the service lacked the resources to respond … All three of my psychotic episodes were preventable.[152]

Compulsory treatment has been described as the only way to open the door to the mental health system:[153]

> The only benefit in respect of compulsory treatment is that currently it is the sole way that people can access the best quality and free mental health treatment and services in Victoria.[154]

Some members of the mental health workforce shared the view that a scarcity of resources can contribute to the use of compulsory treatment.[155] Further, Dr Coventry told the Commission:

> 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 often resulting in increased severity of symptoms … This increases the likelihood of the need for compulsory treatment. The numbers of consumers being treated compulsorily restricts the capacity of services to accommodate individuals who seek treatment voluntarily.[156]

Ms Anna Wilson, a carer and witness before the Commission, reflected on the 'overloaded and under-resourced workforce', telling the Commission that early discharge from services before clinicians build rapport with the consumer 'means that the only way to get access to support is through a treatment order, because under this they have to receive help'.[157]

It was also reported to the Commission that, contrary to the principles of the Mental Health Act, which envisages mental health services to be provided on a voluntary basis wherever possible,[158] compulsory treatment can be used as a means of guaranteeing access to services.[159] For example, Professor Newton explained that:

> Due to high demand, a consumer will need to become seriously unwell before they are able to access services. In practice, this means that only people who are involuntary patients can be admitted when beds are very scarce. Anecdotally, this may lead to some consumers inappropriately being placed under the Mental Health Act in order to obtain a bed …[160]

Professor Brophy described concerns with using Community Treatment Orders in this way:

> one of the concerns about [Community Treatment Orders] being a 'gateway' for guaranteed service delivery is the length of time that a person remains on a compulsory order, first in the inpatient unit and then in the community. This does not take into account the potential harms, such as loss of self-efficacy and stigma, that are being inflicted on the person as a result of being a compulsory patient.[161]

Members of the mental health workforce shared with the Commission that having the resources to engage meaningfully with consumers and develop therapeutic relationships would help reduce the use of compulsory treatment:

> If there is sufficient time for treatment, there are many alternatives to compulsory treatment, such as voluntary treatment or working with people in a manner that maximises therapeutic alliance to identify what matters to the consumer. In an acute crisis situation, however, people often experience distress in a very short timeframe and have limited capacity to make choices that are safe.[162]
>
> The need for compulsory treatment can be reduced by:
>
> (a) improving the accessibility and intensity of treatment in both bed-based and community (clinic-based and outreach) services, and improving the amenity of these services such that they feel safe and welcoming;
>
> (b) having better engagement and consistency of care such that there is a stronger therapeutic alliance between individual clinicians at the health service and the person living with mental illness …[163]

Dr Coventry told the Commission that compulsory treatment can be averted when treatment, care and support that matches consumers' needs and preferences can be accessed.[164]

The Commission is of the view that under-investment in the current system does not allow consumers to receive treatment, care and support when it would make the most difference nor enable the workforce to provide services in a way that would reduce the use of compulsory treatment. Ms Barb Birthisel shared her experiences with compulsory treatment and her hopes for the future system in a personal story.

Personal story:

Barb Birthisel

Barb said she is still unsure why she was given compulsory treatment. She thought she was going to hospital for a scan for her epilepsy but 'ended up in a psychiatric ward'.

Following her discharge, Barb saw the Crisis Assessment and Treatment Team. She found this helpful because the counsellor took Barb's disclosures about her experience with family violence seriously, but she was readmitted to hospital after approaching the police for assistance.

> [The counsellor] kept asking me if I had been to the police and got a restraining order on my ex-partner because that was one of the reasons that I'd gone into hospital in the first place—I'd just gone through a relationship breakdown. I had child support issues, a child support hearing going on, and I lost my job and it was Christmas time.

During her second admission, Barb was medicated against her will.

> When I went back to hospital, they made me take medication, and most of the time this absolutely slammed me. The first admission I wasn't on any medication. I told them: I'm not on any medication, I don't need to be and they never put me on it … And [on the second admission] the hospital doctors made me take it. They were going to jab me if I didn't take it. I was restrained until I took it. I didn't know what was going on. It was horrible.

Barb believes that she should not have been put on a compulsory treatment order. She said it was a result of 'everything that was happening in my life at the time, lots of stress and I was distressed'. Barb tried to get more information about her treatment order, but the hospital was unhelpful.

> The hospital wasn't giving me the information that I requested. I had to make a huge effort to get a copy of my order so I knew why they had placed me on the treatment order. It was a very involved and complicated process.

Barb's journey in the mental health system has made her a strong advocate for herself and others. She has joined the Independent Mental Health Advocacy Consumer Advisory Group, has a Diploma in Community Services, and works as a disability support worker. She would like to become a peer worker.

> people need to be listened to and treated like a human being … If someone had have listened to me, I would have been fine … They basically shut you down and shut you up.

In a future mental health and wellbeing system, Barb would like to see better crisis responses including alternatives to emergency departments, with more staff with lived experience.

> [Emergency departments] are horrible environments and many of the mental health workers are under-skilled.
>
> There should be places for people to go where they are having breakdowns. Mental health care should be taken out of hospitals so that these can be places of care and healing.

Source: RCVMHS, *Interview with Barb Birthisel*, April 2020; *Personal Story of Barb Birthisel, Collected by Victoria Legal Aid.*

32.2.3 Expectations to manage all risks are placed on the workforce

Many mental health workers provide high-quality and safe treatment, care and support to consumers, families, carers and supporters, but they work in a system that does not always support them to deliver services as they may want to, with difficult expectations placed on them.[165]

Although the word 'risk' does not appear in the treatment criteria for compulsory treatment, compulsory treatment is commonly misconceived as a way to eliminate the risk of harm occurring to a person and others.[166] Dr Paul Denborough, Clinical Director of Alfred Child and Youth Mental Health Service and headspace at Alfred Health, giving evidence in a personal capacity, told the Commission that there is fear among clinicians that they will be 'blamed' if they do not initiate compulsory treatment and an adverse incident occurs:

> in my experience many clinicians have a level of fear of being blamed for a patient's suicide or other serious negative outcome. This stems from the way that suicide investigations are undertaken within Victoria … There is also a fear of criminal sanctions as a result of these investigations … I believe that more clinicians are acting in a fearful and risk adverse way which would be more likely to involve the additional use of compulsory treatment and for longer periods of time. This increased culture of fear and risk aversion actually inadvertently increases the risk to individuals with mental health issues … We should be reducing the number of incidents of compulsory treatment in order to improve outcomes for patients … If the mental health system could reduce the level of fear that clinicians are experiencing, they would be free to practice in a more confident way which is focused on assisting patients to achieve the best treatments and outcomes in a manner that is collaborative.[167]

A participant at the Commission's workforce roundtable on compulsory treatment presented a similar view:

> a lot of it comes down to some really deep attitudes around a fear of things going wrong and so people have very defensive practice. You know, if I have this person on an order and something goes wrong, no one can say, I wasn't doing my best, but if I take them off the order, or if I allow them to make their own decisions, and something goes wrong, people say why didn't you do something?[168]

These concerns were also observed by Mr Matthew Carroll, President of the Mental Health Tribunal, who believes that the discussions around risk have the wrong focus:

> People who are being asked to make decisions that are less risk averse do not feel confident that, should something go wrong at some point in the future, they will be supported. From my observation they were also provided with little, if any, advice on how less risk averse decision making intersects with their duty of care. They are justifiably concerned that the scrutiny of their decision making will be framed as 'why did you fail to make an accurate prediction about this risk and how to prevent it?' rather than 'was your decision-making process thorough and in accordance with the law?' This lack of balance and fluency around risk intersects with the misconceived notion of the 'risk criterion' …[169]

This experience accords with some research. Studies into the use of Community Treatment Orders suggest that psychiatrists feel they are 'most likely to be blamed' if any harm occurs to the person they are treating or to others, and this leads them to rely on Community Treatment Orders even though it conflicts with principles of recovery-oriented practice such as personal autonomy.[170]

Professor Dan Lubman, Executive Clinical Director of Turning Point at Eastern Health and Professor of Addiction Study and Services at Monash University, giving evidence in a personal capacity, reflected on the different approaches of the alcohol and other drugs and mental health sectors to risk and the difference the legislative framework to treatment makes:

> in the alcohol and drug system, we manage people who are incredibly risky, but we don't have that involuntary frame, we don't have that risk frame … Having worked in the mental health system where the focus is much more on risk and just the nature of the demand on the mental health system, often when you work in that system you don't have the luxury of waiting to work out and understand people's problems and be able to have the time to actually understand where people are coming from; it's much more that risk-based system.[171]

Dr Anna Arstein-Kerslake and Dr Yvette Maker submitted that a risk lens can diminish respect for a person's choice and preferences:

> The problem with the dominant paradigm of risk-aversion in health care is that professionals, not persons with psychosocial disability, have the responsibility of managing risk. The health professional decides what is in the 'best interests' of a person with psychosocial disability, and this is often does not take into consideration the will and preferences of persons with psychosocial disability.[172]

The Commission has been told that to reduce the use of compulsory treatment, a system that enables consumers and the mental health workforce to connect in a way that 'maximises therapeutic alliance to identify what matters to the consumer' is required.[173] But these practices do not seem compatible with the community expectations of managing risk that are placed on the workforce. It is apparent that an increasingly risk-averse society that arbitrarily holds individual clinicians accountable for system failures has contributed to the high rates of compulsory treatment.

32.2.4 Respecting consumers' dignity of risk

One of the principles in the Mental Health Act is that 'persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk'.[174] The intention of the Act is for services to support people and respect their dignity of risk, including when they are subject to compulsory treatment. However, as outlined previously, a range of factors affect consumers' dignity of risk being respected.

Mr Kelly explained the dignity of risk as 'allowing a person to make their own decision which may well be against the practitioner's better judgement'.[175] This is consistent with recovery-oriented practice and involves 'optimising informed choice and consumer-led decision making, even where this involves a degree of perceived risk'.[176]

Ms Porter told the Commission about the importance of being supported to make decisions that may involve risks and the gains she has made personally by doing so:

> For me, personally, the dignity of risk is why I am alive. Simply put, people with mental health conditions should be able to make informed decisions to take risks, take responsibility for our choices, and come to terms with the effects of our actions. The dignity of risk is about both not being prevented from having agency; and being enabled to exercise agency. Recently, I decided to try to come off my medication. I made this decision for various reasons, including the debilitating side effects my medication has had on me … My doctor and I weighed up the potential consequences including psychosis, debilitating depression and death, versus the long term health deficits, major loss of meaning in life, not wanting to live and also possible death. My doctor, who has an understanding of agency and risk, was willing to support my choice and go through this with me—to support me over a year coming off my medication … Initially, it had positive aspects … however as the year progressed, I became increasingly manic and depressed. But what was important was that … my doctor was there to support me; who I could call and ask for help … So having a doctor who respected my choice made it possible for me to live.[177]

Associate Professor Simon Stafrace, Chief Adviser at Mental Health Reform Victoria, told the Commission in a personal capacity that there is a tension between the dignity of risk and the expectations of harm minimisation on the mental health system:

> Competing commitments are evident when clinicians strive to respect the dignity of risk and limit restrictive treatments, and then choose to deploy coercive treatment to minimise the possibility patients could be harmed by their own actions or as a result of accidental neglect during acute episodes of illness. Risk aversion may be driven by the fear or lived experience of being publicly sanctioned by the coroner, investigated by multiple oversight bodies in relation to the same issue, or sued for damages in civil courts … I have witnessed clinicians being subjected to all these outcomes …[178]

The Victorian Branch of the Royal Australian College of Psychiatrists supports the following approach to the dignity of risk within mental health practice:

> a balanced clinical approach that integrates and respects the dignity of risk alongside issues of safety for the individual and the community. This clinical approach should consider the right for those with capacity to make decisions that clinicians and those in a support role may not agree with.[179]

Community-wide stigma and discrimination, and the expectations placed by society on the mental health workforce conflict with goals of affording consumers' the dignity of risk, respecting consumer preferences and measures to support consumers to make their own decisions.

32.3 Consumers are not properly supported to exercise their rights

Despite the benefits experienced by consumers, many are not aware of, or do not have access to, rights-upholding mechanisms such as non-legal advocacy, legal representation and safeguards such as advance statements and nominated persons.[180]

32.3.1 Supported decision-making practices are not embedded

A participant at the workforce roundtable on compulsory treatment told the Commission, '[s]upported decision making needs to be properly embedded within the mental health system. And it's not.'[181]

The Mental Health Act was considered an improvement on previous mental health legislation because of its promotion of supported decision making (defined in Box 32.2).[182] Yet, the aspiration to embed supported decision making into treatment, care and support has not been realised.[183]

The Commission was told about a lack of resources, including workforce education and training on how to promote and apply supported decision making. In turn, this has meant that many mental health workers do not have the resources to support consumers to make decisions.[184]

As well as enhancing rights, including self-determination and autonomy, supported decision making is also targeted at reducing the power imbalance that exists between consumers and clinicians.[185] As described by Ms Julie Anderson, Senior Consumer Adviser in the Office of the Chief Mental Health Nurse and the Office of the Chief Psychiatrist in Victoria, who gave evidence in a personal capacity:

> Consumer choice is essential, but I think that when people suffer mental health issues, they are disempowered. This makes it hard to make those choices. Therefore, support that is centred around consumer choice, from a nominated person or an advocate about making those choices, is vital. Clinicians often argue that people don't have capacity, but I have never met a person who has not been able to say what they want or need, even when they have mental health issues.[186]

In an edition of *Public Health Reviews,* Dr Soumitra Pathare and Laura Shields explained that supported decision making can consist of organisations, networks, provisions or agreements that aim to assist a person to make and communicate decisions. They stress that in supported decision making, the individual is always the primary decision-maker.[187]

Box 32.2: Defining supported decision making and substituted decision making

Supported decision making is an idea that emerged from disability and human rights–related activities. While there is no single definition of supported decision making, the Office of the High Commissioner for Human Rights defines it as 'the process whereby a person with a disability is enabled to make and communicate decisions with respect to personal or legal matters'.[188] Dr Magenta Simmons and Dr Piers Gooding have described supported decision making as an ethos that is characterised by support to strengthen self-determination, respecting dignity of risk and upholding the principles of equality, non-discrimination and human rights.[189] Ms Indigo Daya, Consumer Academic, Centre for Psychiatric Nursing at the University of Melbourne giving evidence in a personal capacity told the Commission that 'best practice for recovery-oriented and trauma informed practice is for people to be fully informed and then be supported to make their own decisions about treatment and care'.[190]

Substituted decision making occurs when another person makes a decision in place of the person to whom the decision relates. This can either be a person appointed by the consumer (for example, a medical treatment decision-maker or attorney) or appointed by a court (for example, a guardian or administrator). It can also occur without a specific appointment in certain situations (for example, by an authorised psychiatrist when a person is subject to compulsory treatment).

Dr Lynne Coulson Barr OAM, Victoria's Mental Health Complaints Commissioner at the time of giving evidence, noted that many complaints she received related to concerns about consumer views and preferences not being considered. Dr Barr said that these factors, among others, had most likely contributed to feelings of lack of safety and lack of trust in services, and have impeded the realisation of supported decision making.[191]

Professor Amita Dhanda pointed out that the humanitarian impulse of helping people in distress or in life-endangering situations was not being questioned—what was being questioned was the procedures through which people are prevented from governing their own lives. Professor Dhanda said that:

> the imposition of dependence is a negation of human aspiration, respect and choice. It is for this recognition of human interdependence that supported decision-making needs to displace guardianship in legal constructions of capacity.[192]

While some argue that in providing a framework for compulsion the Mental Health Act is fundamentally incompatible with supported decision making, many contributors to the Commission considered it both possible and desirable for supported decision making to be implemented for consumers on, or at risk of being placed on, a compulsory treatment order.[193]

Embracing supported decision-making principles means giving consumers the power and support to decide for themselves. Shifting power to consumers in this way challenges what Ms Erandathie Jayakody, a witness before the Commission, described as 'the deeply ingrained belief that people with mental health challenges are incapable, therefore it is acceptable to have their treatment decisions taken away from them'.[194] Similarly, in his witness statement, Mr Corbett told the Commission that more compassionate and supportive treatment, care and support is needed:

> We need to break the pill-popping habits taught in medical schools and show them that there is an alternative to pills, which is talking to people, learning about their trauma and better empathising and understanding patients, before prescribing medication.[195]

Further, practice around treatment planning is not currently resourced or structured to enable supported decision making.[196]

In addition to this, another barrier to the routine use of supported decision making in treatment, care and support is that while there is broad support among psychiatrists about supported decision-making frameworks,[197] some are unsure about how far supported decision making should be taken. For example, some psychiatrists argue that substituted decision making is needed to uphold the legal and clinical duties of care.[198] Associate Professor Vine summarised this tension:

> The aims of supported decision-making, strengthening agency, and giving hope are excellent and I support these, but there is a conflict at times between these aims, and treatments that will have longer term benefits to the person and the wider community.[199]

Professor Brophy reflected that some mental health clinicians see removing substituted decision making and compulsory treatment as 'farfetched, unrealistic and potentially harmful'.[200]

The combination of these factors means that consumers are not getting access to a variety of support people, such as peer workers and non-legal advocates, to help them exercise their rights and have their needs and preferences respected. In this context it is not surprising that supported decision making has not thrived in Victoria.

Victoria's implementation of supported decision making is incomplete. A way forward is for people living with mental illness and psychological distress to be treated as 'rights holders'—that is, people who have the right to the dignity of risk and a high quality of care that respects and upholds their human rights.[201] The calls of the mental health workforce for resources, training and leadership to encourage supported decision-making practices must be met.[202]

No single strategy will ensure consumers are supported to make decisions; a concerted effort and multiple strategies are required to embed supported decision making in Victoria's future mental health and wellbeing system.

32.3.2 Non-legal advocacy and legal representation are valued

Both legal representation before the Mental Health Tribunal and non-legal advocacy regarding treatment are highly valued by consumers, although not all consumers are aware of or able to get them.[203] Defined in Box 32.3, they provide important support to promote the rights of consumers and the principles in the Mental Health Act.[204]

Access to advocacy services is effective at putting supported decision making into practice because both non-legal advocates and lawyers act on the instructions of consumers, rather than in their 'best interests'.[205] Further, '[e]nsuring consumers are heard facilitates their decision making capacities, ensuring they remain actors within their own lives and are able to work toward recovery.'[206]

Non-legal advocates and lawyers can also support consumers to respond to the power and information imbalance. As one consumer told the Commission:

> I was fortunate to get help from an advocate and lawyer ... the lawyer and advocates helped me to understand and speak up for my rights. It helped me make my stand.[207]

The Mental Health Tribunal set out how legal representation and non-legal advocacy can support consumers experiencing compulsory treatment:

> People experiencing severe mental illness often experience cumulative disadvantage and disempowerment attributable to a range of causes. Legal representation and advocacy more broadly (such as Victoria Legal Aid's Independent Mental Health Advocacy service) can reduce disempowerment both objectively, as well as in relation to individual consumers' subjective experience of various processes and discussions related to their treatment.[208]

Limited access to non-legal advocacy services

Non-legal advocacy is an important human rights protection.[209] Non-legal advocacy can reduce feelings of disempowerment among consumers[210] and is well regarded by consumers, even when they do not achieve their desired outcome.[211] Despite this, access to non-legal advocacy is limited.

The Victorian Mental Illness Awareness Council explained that its members 'view access to advocacy as being paramount to the protection of inpatients' rights, particularly for those under a compulsory treatment order', submitting:

> When faced with such restrictions it is vital that consumers receive appropriate advocacy, either through legal representation or through an independent advocate who can provide supported decision-making that is free and confidential.[212]

Some identified that processing information about the role of non-legal advocacy while in extreme distress can be difficult for some consumers.[213] This underscores the difficulties of access presented by the current opt-in model, which puts the onus on the individual to seek out advocacy services. Also, access to non-legal advocacy is even more difficult for those on Community Treatment Orders, who rely largely on their treating team to make referrals to non-legal advocacy services.[214]

Independent Mental Health Advocacy has no statutory powers to ensure eligible consumers can access it. Without this legislative framework, Independent Mental Health Advocacy relies on advocates connecting with service providers to facilitate access.[215]

Box 32.3: Legal representation and non-legal advocacy

Legal representation, in this context, refers to Australian legal practitioners providing legal advice to people who are subject to compulsory treatment regarding their impending Mental Health Tribunal hearing and acting on their instructions before the Tribunal.

This representation is generally provided without cost to the consumer, although some consumers choose to pay for private legal representation.

Although lawyers must act on the instructions of their clients, their paramount duty is to the court and the administration of justice. Lawyers provide advice on the law and hearing strategy but do not make decisions on behalf of their client, or substitute what the lawyer may consider to be in the consumer's 'best interests'. Rather, lawyers provide advice and then act on their client's instructions. Due to this, lawyers are unable to represent the small number of consumers who are unable to provide them with instructions to act.

Non-legal advocacy, in this context, refers to advocates taking instructions from individual consumers then representing them or supporting them in self-advocacy. Advocates listen to and communicate a person's preferences and wishes as expressed by them, regardless of whether or not the advocate considers that to be in their 'best interests'. In most instances this involves advocating to the treating team about treatment and discharge. Advocates provide consumers with information relevant to their circumstances and support them to make decisions. Most models, such as the Independent Mental Health Advocacy model of non-legal advocacy in Victoria, also seek to improve people's capacity to self-advocate. Independent Mental Health Advocacy supports eligible consumers (people who are placed on compulsory treatment orders, or at risk of being placed on compulsory treatment orders) across every designated mental health service in Victoria.[216]

Few consumers are legally represented

In Victoria, people are entitled to representation when appearing before the Mental Health Tribunal.[217] However, in 2018–19 consumers were legally represented in only 13 per cent of hearings.[218] This contrasts with legal representation rates in hearings before the New South Wales Mental Health Tribunal, where legal representation was provided in 83 per cent of hearings in 2018–19.[219] Funding limitations are a major reason for Victoria's low representation rate.[220]

Legal representation helps consumers to participate in hearings.[221] Ms Barker described how legal representation helped her:

> I found the experience at the Tribunal difficult and terrifying. I was so grateful to have a lawyer because I don't think I would have been able to do it otherwise.[222]

The Mental Health Legal Centre described the apprehension consumers often feel:

> It is important to understand that attending a … hearing is overwhelming and many consumers feel that there is a significant power imbalance … This is unquestionably intimidating particularly at a time of acute mental illness … The presence of a lawyer is very comforting for people, they feel that there is someone specifically there for them.[223]

Consistent with the *Convention on the Rights of Persons with Disabilities*, legal representation can support consumers to exercise their legal capacity[224] and is an effective way to ensure consumers are supported to participate in decisions.[225]

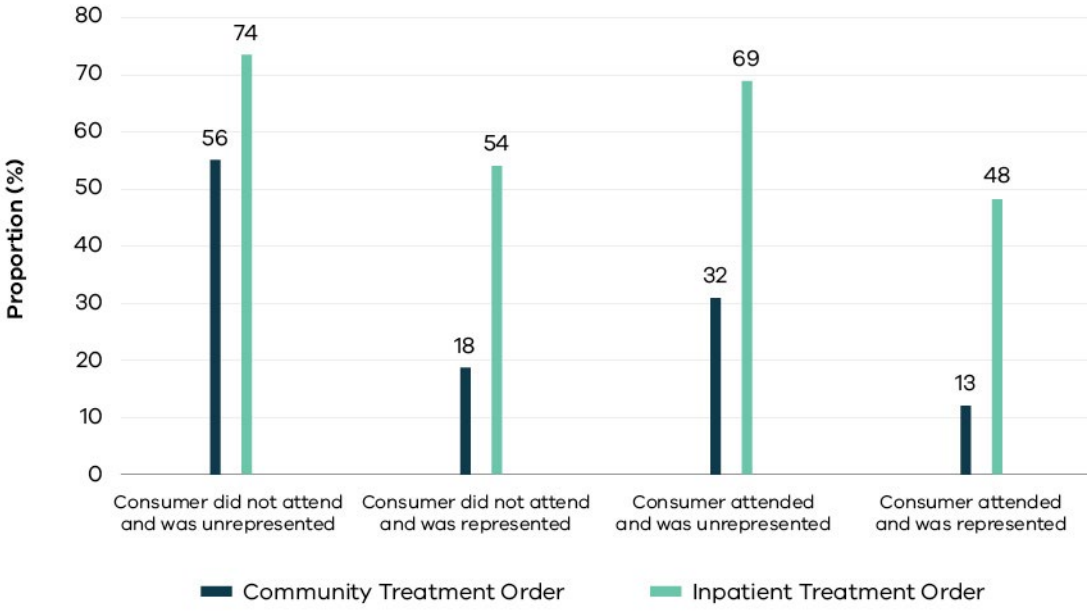
In addition, legal representation can have an impact on the outcome of a hearing. The Commission's analysis suggests consumers who are legally represented are more likely to receive shorter orders than those who appear unrepresented (who, in turn, obtain shorter orders than consumers who do not attend their hearings at all).[226] For example, as shown in Figure 32.7:

- 56 per cent of consumers who were unrepresented and did not attend their hearings received the maximum term for a Community Treatment Order, compared with 32 per cent of consumers who appeared unrepresented and only 13 per cent of those who were represented[227]
- regarding Inpatient Treatment Orders, 74 per cent of people who were unrepresented and did not attend their hearing were made subject to the maximum duration of an order, compared with 69 per cent who appeared unrepresented and 48 per cent of represented consumers.[228]

In hearings relating to electroconvulsive treatment, data indicate that the impact of legal representation is more pronounced than in other hearings. Commission analysis suggests the Tribunal refused to make an order allowing electroconvulsive treatment to be performed in 40 per cent of matters where the consumer attended and was legally represented compared with 12 per cent of matters where a consumer attended unrepresented. This indicates orders are more than three times more likely to be refused by the Mental Health Tribunal when a consumer is represented than if they attend their hearing without a lawyer.[229]

Although these outcomes may not only be due to legal representation, legal representation has both subjective and objective benefits to consumers, in a context in which their rights can be severely compromised. Despite the various benefits experienced by consumers, access to legal representation remains very restricted.

Figure 32.7: Proportion of people who received the maximum order duration by consumer attendance and legal representation status at hearing, 2014–15 to 2019–20



Source: Mental Health Tribunal, Case Management System 2014–15 to 2019–20.

Note: The maximum duration the Mental Health Tribunal can make a Treatment Order for a person over the age of 18 years is 12 months for a Community Treatment Order and six months for an Inpatient Treatment Order. If the person is under 18 years, the maximum duration the Mental Health Tribunal can make a Treatment Order for is three months (both community and inpatient).

32.3.3 Mixed views and low uptake of current safeguards

Several rights-related safeguards were strengthened or introduced with the 2014 Mental Health Act. The then Minister for Mental Health asserted that the new Act would establish 'a comprehensive and integrated suite of oversight mechanisms and safeguards to protect the rights of patients'.[230] The existence of safeguards in the Act is one of the reasons why it was deemed to be compatible with the Victorian Charter of Human Rights and Responsibilities.[231]

Despite the aspiration behind the introduction of these new statutory safeguards (refer to Table 32.2), there are mixed views and evidence about how well they uphold consumer rights and reduce compulsory treatment.

There is persistently low uptake of safeguards, with only 2.94 per cent of adult consumers having an advance statement recorded in 2019–20 (up from 2.85 per cent in 2018–19) and only 2.55 per cent having a nominated person recorded in 2019–20 (down from 2.60 per cent in 2018–19),[232] with considerable variation between age cohorts.[233]

Table 32.2: Summary of key safeguards

Statement of rights	Advance statements	Nominated persons	Second psychiatric opinions
The statement of rights sets out a person's rights and entitlements while they are being compulsorily assessed or treated under the Mental Health Act.[234] The statement of rights must be provided and adequately explained[235] to consumers at key points, including when Assessment Orders are made or varied,[236] when Temporary Treatment Orders are made or varied[237] or when Treatment Orders are varied.[238] Ensuring consumers understand the information provided to them is the priority. For example, reasonable attempts must be made to ensure information is provided at a time and in a way that the consumer is best able to understand it.[239]	Advance statements are documents that set out a person's preferences in relation to care and treatment[240] in the event that the person becomes a 'compulsory patient', 'security patient' or 'forensic patient'.[241] While advance statements are not binding, they must be considered by decision-makers at various points, including in the making of Temporary Treatment Orders,[242] in deciding whether Community or Inpatient Temporary Treatment Orders are to be made,[243] in the making of Treatment Orders,[244] and when a patient does not or cannot give consent to treatment.[245] The Mental Health Act also sets out the circumstances in which advance statements may be overridden.[246]	The Mental Health Act provides that consumers may nominate another person to: • provide them with support and to help represent their interests[247] • receive specified information[248] • be consulted at certain points[249] • assist the patient to exercise their rights.[250] The *Mental Health Services Annual Report 2015–16* explains that the intention of the nominated persons safeguard is to enable consumers to 'nominate someone to support them in the event they become unwell and need compulsory treatment'.[251]	The Mental Health Act provides that an entitled 'compulsory patient'[252] may seek a second psychiatric opinion at any time[253] from any psychiatrist[254] and, if the 'patient' seeks assistance in obtaining the second opinion, the authorised psychiatrist must take reasonable steps to assist the 'patient' in exercising this right.[255] Second psychiatrists must provide their opinion in writing regarding whether the criteria for the relevant order apply and whether any changes to treatment should be made.[256] If the second opinion recommends changes to treatment that the authorised psychiatrist does not adopt, the consumer may seek a review by the Chief Psychiatrist.[257] This rarely occurs.[258] In 2016–17 Melbourne Health and Monash Health started a funded second statewide psychiatric opinion service.[259]

Advance statements and nominated persons are intended to be safeguards taken up before starting compulsory treatment. Since the introduction of the current Mental Health Act, just under half of all new orders made were for consumers who had not had an order in the previous five years. That, along with the fact that more than 40 per cent of consumers being placed on new orders are not existing clients of a public specialist mental health service, means that many consumers subject to compulsory treatment would be unaware of, or would not have had an opportunity to take up, safeguards before being made subject to a compulsory order.[260]

A further reason for low take-up rates is that, similar to getting non-legal advocacy and legal representation, the onus to find, access and use safeguards falls on people living with mental illness or experiencing psychological distress, with limited assistance available.[261]

A 2018 survey exploring consumer attitudes, experiences and perspectives conducted by the Victorian Mental Illness Awareness Council suggested that more than 60 per cent of consumers agreed or strongly agreed that information about advance statements and nominated persons was hard to find and only 8–15 per cent were routinely provided with information about advance statements and nominated persons.[262]

Professor Brophy described how further work is required to support the uptake of safeguards:

> we should work on, and enable, supports to be put in place to increase the potential for uptake of these mechanisms. A key to this is to work is empowering consumers to gain access to the resources and information they need. Again, independent advocacy, support from consumer led organisations such as [the Victorian Mental Illness Awareness Council], peer support, as well as online resources and accessible information are essential. Expecting staff to provide rights information has already been established to be very unreliable.[263]

Similarly, there has been limited uptake of second psychiatric opinions. The Commission has been told of barriers preventing consumers from accessing a second psychiatric opinion, as well as features of the scheme that can deter consumers. Consumers are sometimes unable to get a second opinion[264] and there are often delays in consumers receiving the second opinion:[265]

> changes in mental state happen fast, there is no time for second opinions and even if you were to seek a second opinion the wait is ridiculously long.[266]

This is consistent with the evidence of the former Mental Health Complaints Commissioner, who advised that complaints about second psychiatric opinions related to lack of information, access, refusals regarding requests to see a different psychiatrist and delays.[267]

The Commission has been advised that in the context of compulsory treatment there is a significant power imbalance between consumers and clinicians, and consumers may find it challenging to assert their views and preferences. This can deter consumers from accessing safeguards.[268] Consumers living with disabilities or from culturally diverse communities can experience further barriers to communicating their views and preferences—for example, if they cannot get information about safeguards in the language or format they prefer.[269] A review of the uptake and use of advance statements and nominated persons undertaken by the Office of the Chief Mental Health Nurse in 2018 reported that several factors were contributing to low take-up rates, including poor promotion of consumer rights[270] and that an increasingly crisis-driven and reactive mental health system was limiting the ability of the mental health workforce to discuss the merits and limitations of safeguards with consumers.[271]

Whether the greater barrier is the lack of available resources or the poor promotion of existing resources is to some extent irrelevant; either way, consumers must receive the assistance they need to exercise their rights and to make use of safeguards.

32.3.4 Concerns about the effectiveness of safeguards

There are also concerns about the effectiveness of safeguards themselves, particularly advance statements.[272] Consumers, advocates and nominated persons advised of concerns that advance statements are not binding and the views of nominated persons were, in practice, often ignored:

> 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.[273]

> As a nominated person I have found myself frequently and actively excluded from key clinical decisions regarding the compulsory treatment of who I provided care for. This has made it exceptionally difficult for me to effectively fulfil my role as their advocate while they were under a compulsory order. Assessment orders and temporary treatment orders were frequently issued and revoked without any attempt to seek my input or inform me.[274]

Jill, shared her experiences of being a nominated person for her friend Lorraine, in a personal story.

Reflecting on poor implementation of safeguards, a participant at the workforce roundtable on compulsory treatment told the Commission:

> there's a lack of understanding and knowledge, especially around recovery practices, around the notion of dignity of risk around things like capacity and consent, and how they're applied in the Act. And even things around, you know, advance statements, nominated persons and those kind of things, which are poorly encouraged or poorly, really applied by mental health services.[275]

The Victorian Mental Illness Awareness Council's 2018 survey also highlighted consumer concerns about safeguards, noting that a high proportion (83 per cent) of consumers interviewed said that the views and preferences expressed in their advance statement were not upheld by the hospital, and 67 per cent said that requests made by nominated persons on behalf of consumers were not adhered to by the hospital.[276]

Similarly the Commission heard concerns about second psychiatric opinions, with many reporting the second psychiatric opinion did not provide a genuinely independent alternative perspective,[277] rarely offering a different view.[278]

In addition to poor promotion and education among the workforce,[279] other barriers to safeguards include 'an episodic model of care, which only allows a limited time' with consumers and a lack of system-wide support for use, including the absence of a database containing completed advance statements, meaning clinicians are sometimes unable to locate them.[280]

Further, while there is support among psychiatrists for supported decision making, there is evidence to suggest that, as noted previously, some psychiatrists hold reservations about advance statements and how far supported decision making should be taken.[281] For example, some argue that a legal framework providing for compulsory treatment, including the ability to override an advance statement, is needed to prevent poor mental health outcomes and to uphold legal and clinical duties of care.[282]

A culture that supports the effectiveness of safeguards must be considered in parallel with their increased uptake. For individual clinicians to support and promote consumer autonomy, practices need to be resourced and reconfigured to embed consumer participation, views and preferences. There must be ongoing resources, training and support for the workforce to understand and use safeguards and to put supported decision making into practice.

32.3.5 Challenges of being a nominated person

There is sometimes tension between the different roles of nominated persons and carers. While the nominated person's role is to represent the interests of the consumer, family members, carers and supporters may hold a different view or perspective from a consumer.

This tension may arise when the nominated person and carer are the same person. The Victorian Mental Illness Awareness Council consumer survey on advance statements and nominated persons suggested that this is not uncommon, with 45 per cent of nominated persons being carers or family members.[283]

The potential conflict in roles was also identified in the Chief Mental Health Nurse's Review, which suggests, first, that there was some confusion about the two roles;[284] and second, that the tension between the two roles could act as a barrier to consumers accessing the nominated person safeguard. The report quoted a mental health service worker:

> patients are not wanting to appoint a [nominated person] as they do not believe that their carer/support person would accurately represent their views and, vice versa, carers are reluctant, and some are refusing to be a [nominated person] as the main aim of the role (as they are led to believe) is that they are required to solely represent and uphold the consumer's views, therefore the carer cannot voice their own views about what they believe may be beneficial for the consumer, which at times may be different to those of the consumer.[285]

32.3.6 Lack of alignment of the Mental Health Act with other laws

International human rights frameworks informed the drafting of the Mental Health Act, but interpretations of the content of such human rights laws have evolved. For example, since the enactment of the Mental Health Act, there has been a focus on supported decision-making frameworks, as evident in the *Medical Treatment Planning and Decisions Act 2016* (Vic) and the *Guardianship and Administration Act 2019* (Vic).[286]

The principles in the Mental Health Act state that people should be supported to make or participate in decisions about their treatment.[287] In assessing whether a person is giving informed consent, the authorised psychiatrist must consider supports the person needs to make the decision.[288] Yet the Mental Health Act allows for a substituted decision to be made even when a person is deemed to have decision-making capacity, if the psychiatrist is satisfied there is no less restrictive way for the person to be treated.[289]

Personal story:

Jill

Jill* was asked by her friend Lorraine* to be her nominated person under the Mental Health Act. Lorraine has lived experience of mental illness and was caring for her elderly mother, whom she lives with. Jill and Lorraine have been friends for a long time and have the same cultural background. Jill was surprised one day to get a phone call from a clinician telling her that Lorraine had been involuntarily admitted to hospital. As Lorraine's nominated person, the clinician told Jill about the admission and an upcoming Mental Health Tribunal hearing.

It was difficult for Jill to get in touch with Lorraine while she was in hospital, but she was eventually able to speak to her. Lorraine told her that the police had come to her home and forcibly taken her to hospital. Jill was shocked that Lorraine could have her rights taken away from her so quickly.

> I was so angry and disappointed to hear Lorraine had been forcibly removed from her home. Is this the way we treat vulnerable people? Anyone would be traumatised. It was wrong.

Jill was surprised to find out she only had one week to prepare for Lorraine's upcoming Mental Health Tribunal hearing. The report from the treating team was received two days before the hearing (which is the mandated minimum timeframe), providing little time to review and obtain advice.

> I was stunned that they felt that two days was sufficient time for us to review and interpret a report that would impact Lorraine's life. Lorraine had been deemed incapable of looking after herself by the doctors, she had been forcibly taken to the hospital, was medicated against her wishes, and was distraught as she had no access to her mum. Yet was in a seemingly fit enough state to be able to interpret and respond to a report. How does that make sense?

Jill found the process confusing and difficult to navigate and said she wasn't offered any advice, just provided with a pamphlet and expected to figure it out herself. Jill said she didn't know who to listen to, receiving conflicting advice from the hospital and Lorraine's lawyer. Jill was also disappointed to see that her friend had lost any hope of the system listening to her.

> It was just like being in quicksand, trying to figure out how do I do the best for Lorraine. I walked a fine line, trying to help her get some control when her ability to have control had been taken away from her. Like, what do I do? How can we make this work for her because she was really defeated as well. Lorraine said, 'I know what's going to happen'.

Jill and Lorraine worked on a written response to the report, but Lorraine's lawyer advised them not to submit it. At the tribunal hearing, Jill felt that Lorraine was not really heard. Lorraine was put on a compulsory treatment order for 52 weeks.

> I definitely think that the process doesn't listen to the patient. You don't really have a voice. Let's just be real here.

During the hearing, Jill did not get asked about her opinion or get to speak as the nominated person. Although Lorraine did get to speak, Jill feels that the process should have listened to her as the nominated person.

> As a nominated person my experience was confronting, confusing and disappointing. We take these vulnerable people and expect them to be able to cope.

Jill says that a future mental health and wellbeing system will hopefully have a process for listening to the nominated person, and for the consumer's voice and the carer or nominated person's voice to be heard.

Source: RCVMHS, *Interview with 'Jill' (pseudonym)*, October 2020.
Note: *Names have been changed to protect privacy.

Conversely, both the Guardianship and Administration Act and Medical Treatment Planning and Decisions Act do not enable substituted decisions to be made for people with decision-making capacity. Both the Medical Treatment Planning and Decisions Act and the Guardianship and Administration Act prioritise supported decision making and obligate those exercising powers to support people to make decisions.[290] Substituted decisions can be made for people who are deemed to not have decision-making capacity for the relevant decisions under the both Acts.[291]

In enabling substituted decisions for people with decision-making capacity, the Mental Health Act is at odds with other legislation. Some clinicians, academics and Victoria Legal Aid argue this creates a discriminatory situation[292] in which people living with mental illness are among the few Victorians whose decision to refuse treatment can be overridden by doctors.[293]

In determining whether there is no less restrictive way for a consumer to be treated, regardless of whether or not a person has decision-making capacity, the authorised psychiatrist must consider the consumer's views and preferences about the proposed and alternative treatments, as well as the reasons for those views and preferences, including any recovery outcomes they would like to achieve.[294] Mental health services do not consistently record or report on what basis treatment decisions are made—for example, whether the person gave their informed consent, was deemed unable to consent or refused to provide informed consent.[295] Therefore, it is unclear to what extent authorised psychiatrists consider these provisions before administering treatment.

The Medical Treatment Planning and Decisions Act also enables people to make binding advance care directives[296] and to appoint a medical treatment decision-maker[297] to make decisions in the event that they no longer have decision-making capacity. Advance care directives and decisions made by appointed medical treatment decision-makers can only be overridden in very limited circumstances.[298] The Medical Treatment Planning and Decisions Act explicitly excludes mental health treatment from these provisions.[299]

The Mental Health Act enables consumers to appoint nominated persons and make advance statements, but these are not binding on clinicians.[300]

The Commission has heard that in failing to offer an equivalent level of autonomy and human rights protection as similar provisions for medical treatment, the Mental Health Act's advance statement and nominated persons safeguards discriminate against people living with mental illness or psychological distress.[301]

In the case of *PBU & NJE v Mental Health Tribunal* [2018] VSC 564, Justice Bell described 'personal identity and the dignity of recognition' in upholding consumer autonomy and decision making:

> **The principle of self-determination enables a person (including a person with mental disability) to exercise an individual choice to give or refuse consent to medical treatment. The choice is intensely personal because it is informed by the values, life experience and relationships of the individual. Some people make this choice as if it were the next note to sound in the song of their life. Choosing to consent to or refuse medical treatment is therefore a fundamental expression of the individual identity of the person … When respect is afforded to the choice of the person to consent to or refuse medical treatment, the person is recognised for who they are.[302]**

32.4 Challenges with oversight and accountability arrangements

As the use of compulsory treatment is a substantial infringement on human rights, oversight and accountability arrangements are critical. Several submissions to the Commission raised concerns with current oversight and accountability arrangements.[303] For example, the Victorian Mental Illness Awareness Council told the Commission that the current system fails to protect human rights and assure safety, and linked this to the lack of accountability in the system 'for practices that damage people'.[304]

There is currently limited oversight and no public reporting on how mental health services are complying with the principles of the Mental Health Act[305] or with its practical requirements such as seeking informed consent,[306] presuming capacity,[307] supporting consumers to make decisions,[308] providing statements of rights[309] or providing treatment consistent with a person's advance statement.[310] Mr Dan Nicholson, Executive Director of Criminal Law at Victoria Legal Aid, advised the Commission:

> **In my view, appropriate systems and oversight will help to ensure there is better understanding and implementation of the Mental Health Act and its safeguards, including supported decision-making, least restrictive assessment and treatment and a recovery focus. This should include embedding consumer leadership and self-advocacy as part of systems and services.[311]**

The Chief Psychiatrist and Mental Health Complaints Commissioner both undertake reviews and make reports regarding existing practice.[312] Stakeholders such as the Victorian Mental Illness Awareness Council and Victoria Legal Aid have also undertaken reports, surveys and snapshots of service practice.[313] Overall, however, oversight and accountability arrangements are fragmented[314] and ineffective in motivating service-level and system-wide improvement.

The current regulatory and oversight mechanisms are explored in further detail in Chapter 30: *Overseeing the safety and quality of services*. Here, the Commission sets out the existing mechanisms as they relate to oversight of compulsory treatment.

32.4.1 Role of authorised psychiatrists

Authorised psychiatrists hold substantial statutory power regarding the use of compulsory treatment, with the Mental Health Act conferring a number of functions, powers and duties on them. Only authorised psychiatrists and their delegates can make Temporary Treatment Orders, enabling people to be compulsorily treated for up to 28 days,[315] and can vary and revoke Temporary Treatment Orders and Treatment Orders.[316]

Under the Mental Health Act, each designated mental health service must have an authorised psychiatrist who is appointed by the governing board of that service.[317]

In 2019–20, authorised psychiatrists made 8,973 Temporary Treatment Orders and revoked 5,552 Temporary Treatment Orders (or 60 per cent of these orders made).[318] Five per cent of Temporary Treatment Orders and 9 per cent of Treatment Orders were revoked by the Tribunal.[319]

In this way, the administrative decisions made by authorised psychiatrists have significant bearing on the use and rates of compulsory treatment in Victoria. Changing the culture, policies and conditions in which authorised psychiatrists operate holds significant potential to reduce the rates of compulsory treatment, given their role in decision making about compulsory treatment use.

32.4.2 Role of the Mental Health Tribunal

As an independent statutory tribunal established under the Mental Health Act,[320] the Mental Health Tribunal determines whether the criteria for compulsory mental health treatment as set out in the Act apply to a person and makes (or varies or revokes) Treatment Orders.[321]

While the Tribunal provides independent scrutiny over the use of compulsory treatment, there is concern that the Tribunal uses the maximum duration of Treatment Orders as a default, therefore limiting the expected checks and balances on compulsory treatment. Victoria Legal Aid observed that there is 'an overuse of compulsory treatment orders, in both the number of orders made and the duration of these orders' and notes that the Tribunal continues to make most orders sought by mental health services, including of the duration and setting sought.[322]

In 2019–20, the Tribunal made 6,226 Treatment Orders and revoked 531 Temporary Treatment Orders and Treatment Orders.[323] Of the determinations for Treatment Orders, 3,866 (or 57 per cent) were for Community Treatment Orders and 2,360 (or 35 per cent) were for Inpatient Treatment Orders.[324]

The high rate at which the Tribunal makes the orders sought by authorised psychiatrists needs to be interpreted with caution. There is no way to know with certainty why the Tribunal rarely varies or denies Treatment Orders sought by authorised psychiatrists. For example, it is uncertain whether this means that the Tribunal is not open to persuasion by consumers and their representatives or whether public specialist mental health services rarely present someone at a hearing who does not meet the treatment criteria.

Around two-thirds (67 per cent) of Inpatient Treatment Orders were for 26 weeks in 2019–20, noting that a 26-week Inpatient Treatment Order is the longest, most restrictive order the Tribunal can make.[325] Regarding Community Treatment Orders, 45 per cent were for 16–26 weeks and a further 42 per cent were for 27–52 weeks.[326]

Victoria Legal Aid argues that Treatment Orders with long durations give the treating team wide discretion when it comes to discharge and reduces oversight of the person's experience of compulsory treatment.[327]

The Tribunal, however, states that the duration of an order is intended to reflect the circumstances of the individual.[328] Mr Carroll said the Tribunal seeks to change the mindsets of mental health services from one of 'make an Order for the maximum amount of time possible and cancel it if it is not needed' to a view that an order should only be made for the amount of time it appears needed, then, if the need arises, consider a further order at a later date.[329]

The rate of participation by consumers at Tribunal hearings in Victoria is low, with a wide range of barriers impeding attendance.[330] In 2019–20, consumers participated in 57 per cent of hearings.[331] Families, carers or nominated persons attended 24 per cent of hearings in that same year. [332] Comparatively, in 2018–19 consumers attended and participated in 86 per cent of all matters and reviews considered by the New South Wales Mental Health Review Tribunal within its civil jurisdiction.[333]

Low rates of attendance are concerning because one of the most important variables to influencing the outcome of a Tribunal hearing is consumer attendance.[334] For hearings where a Treatment Order was revoked since 2014–15, consumers who participated were approximately twice as likely to have their order revoked compared with those who did not.[335]

Despite aspirations behind the Mental Health Act and the introduction of the Mental Health Tribunal to reduce compulsory treatment, this has not been achieved.

32.4.3 Other key oversight roles

Both the Secretary of the Department of Health and the Chief Psychiatrist have roles in promoting continuous improvement in the quality and safety of mental health services.[336] In the context of compulsory treatment, the Chief Psychiatrist has further roles in promoting the rights of consumers and providing clinical leadership[337] and additional functions such as developing standards and guidelines on electroconvulsive treatment and neurosurgery for mental illness and receiving reports of their use.[338] The Chief Psychiatrist can also review treatment if an authorised psychiatrist does not adopt the recommendations of a second psychiatric opinion,[339] direct that a different designated mental health service provide assessment or treatment[340] and undertake audits, reviews[341] and investigations.[342] Some of these powers are rarely used, such as reviewing treatment after a second opinion.[343] The broader functions and powers of the Chief Psychiatrist, including powers to conduct investigations and make recommendations, are described in Chapter 30: *Overseeing the safety and quality of services*.

There is little transparency around use of these powers. For example, since the introduction of the current Mental Health Act, the Chief Psychiatrist has not reported on whether they have used their powers to direct a different designated mental health service to provide treatment or to review treatment after a second psychiatric opinion and has provided limited information on audits and investigations beyond those into reportable deaths and use of electroconvulsive treatment.[344]

The Mental Health Complaints Commissioner accepts, manages and investigates complaints relating to mental health service providers.[345] Although the Mental Health Complaints Commissioner can identify, analyse and review quality, safety and other matters arising out of complaints (and provide information and recommendations as appropriate), then Mental Health Complaints Commissioner, Dr Coulson Barr, noted that the powers afforded to the role are limited, and for example do not include powers to conduct own-motion investigations.[346]

The Auditor-General noted that despite developing and issuing guidelines on a wide range of topics, there is not enough support provided by either the Chief Psychiatrist or the department and, critically '[t]he [Office of the Chief Psychiatrist] does not monitor the implementation of guidelines.'[347]

The high level of demand for services, as well as gaps, duplication and lack of clarity between roles means there is little coordinated systemic oversight of compulsory treatment. Where problems are identified, there is limited capacity for the existing bodies to help improve practice beyond providing recommendations and guidelines.

The Victorian Government identified that the complexity of existing arrangements can lead to a lack of clarity about accountability and this may impede improvement efforts.[348]

32.4.4 Limited publicly available data about compulsory treatment

The Mental Health Tribunal publishes statewide information about the number and duration of Treatment Orders made by the Tribunal and the number of orders permitting electroconvulsive treatment; and the department publishes the rates of compulsory treatment use in its mental health services annual report.[349]

While some high-level data about compulsory treatment use is available, it is not separated to show variables such as demographics, geography, cultural background, service level or the rate or duration of Assessment Orders or Temporary Treatment Orders. There are also no key performance indicators or targets related to compulsory treatment use.

The publicly available data paints an incomplete picture. For example, it does not indicate how many consumers are subject to consecutive orders, how many orders are revoked immediately before their expiry or lapse on expiry, or how often authorised psychiatrists are seeking and being granted consecutive Treatment Orders.

Given the limited public data, it is difficult to ascertain how many people are subject to compulsory treatment at any given time in Victoria[350] and to observe trends among particular groups or services. Additionally, current publicly available data does not include consumer-completed outcome and experience measures.

Ms Jayakody told the Commission, '[i]f we are to have a person-centred system that respects the inherent dignity of people, data reporting needs to reflect this.'[351] Some research raised concerns that the 'invisibility' of compulsory community treatment can marginalise the people subject to such orders and their experiences, preferences and needs.[352]

The lack of data on how, why and in relation to whom compulsory treatment is being used, combined with significant variation of rates between services, presents difficulties in tackling the factors influencing the continued high rates of compulsory treatment.

32.4.5 Cross-border issues for compulsory treatment

Australian states and territories each have their own mental health legislation to cover their own jurisdictions. This means there are differences in how compulsory treatment orders operate between jurisdictions, including the criteria to receive compulsory assessment and treatment.

These variations can have important consequences for Victorian consumers. In Victoria's border regions with New South Wales and South Australia, there are not always health services available to people on both sides of the borders. This means people must travel into other states to get mental health services, or travel further within their own state.[353]

To ensure continuity of care across state lines, mental health laws in Victoria include provisions for the interstate application of mental health orders. These provisions facilitate the transfer of 'compulsory patients' to other states, allow Victorians to receive mental health treatment in bordering states, allow interstate people to receive mental health treatment in Victoria and enable 'compulsory patients' who are absent from mental health services without leave to be apprehended.[354] For these provisions to operate effectively, the legislation requires some similarities between how the mental health laws operate.

Victoria's mental health legislation also requires bilateral ministerial agreements between jurisdictions to recognise the other jurisdictions' corresponding laws and orders.[355] These ministerial agreements set out how these provisions should operate to ensure continuity of care.

Victoria currently only has ministerial agreements in place with New South Wales, South Australia and the Australian Capital Territory for 'compulsory patients'.[356] Given these agreements have not been updated since the 2014 Mental Health Act was enacted, they still reference the 1986 Act, making them difficult to interpret and understand.

Dr Coventry told the Commission:

> **Bilateral agreements have proven to be an unsatisfactory vehicle to support the interstate application of mental health laws. Bilateral agreements are resource intensive because they take time to negotiate and require resources to maintain their currency because an agreement will require revision whenever the parties' mental health laws are significantly revised.[357]**

Given the difficulties with the ministerial arrangements, factors relating to 'compulsory patients' transferring out or into Victoria are often dealt with via 'collaboration and cooperation' between jurisdictions, rather than through the formal processes envisaged under the legislation.[358]

All Australian jurisdictions should work together to find a more efficient way to deal with these problems, to help give people the benefit of uninterrupted care, such as through mutual recognition of mental health orders.[359]

32.5 A new service system where compulsory treatment is the last resort

Providing well-resourced, diverse and integrated mental health and wellbeing services is a pivotal step towards meeting Victoria's obligations under human rights frameworks and responding to the needs and preferences of consumers.

The Commission recognises that achieving a meaningful reduction in the use and duration of compulsory treatment depends on consumers having ready access to a diverse mix of voluntary treatment, care and support. This means that services that do not involve coercion must be uniformly available.

The Commission emphasises the need for greater adherence to supported decision-making principles and practices where consumers can exercise their rights, as well as readily accessible non-coercive options—in particular, through a diverse community mental health and wellbeing service offering.

A concurrent immediate priority of these reforms is to reduce the use and duration of compulsory treatment. The Commission is also recommending changes to strengthen monitoring and accountability for decisions relating to compulsory treatment. These changes are directed towards decision-makers at all levels of the system, including individual decision-makers.

The Commission considers there is a need to give regard to aligning mental health and wellbeing legislation with other legislation concerning decision making. This means that substituted decision making rules for both mental health and medical treatment decisions should be the same, with some limited exceptions.

The Commission notes that existing laws allow medical treatment (other than mental health treatment) to be administered without the person's consent in emergencies.[360] Appropriate provision may similarly be made in relation to mental health treatment. For example, Peru has removed most provisions permitting compulsory treatment and detention but has retained the ability to provide compulsory treatment in emergencies.[361]

Although alignment with mainstream laws regarding decision making around treatment represents a significant step in reducing discrimination on the basis of mental illness, this does retain a division between those who can be supported to make a decision and those who are deemed to be unable to be supported to make a decision at the time.

The Commission anticipates that full alignment with mainstream laws such as the Medical Treatment Planning and Decisions Act may not be possible for people who would be considered 'forensic or security patients' under current laws. Victoria Legal Aid's submission proposed that the Mental Health Act be amended to uphold the rights of consumers with decision-making capacity to refuse treatment, except where the treatment is least restrictive and necessary to prevent serious harm to others,[362] an approach also put forward by some scholars.[363] These provisions are relevant to the principle of proportionality, which is a key concept when limiting or balancing competing rights and interests under the Charter of Human Rights and Responsibilities[364] and internationally.[365]

The success of the Commission's reforms, and realising a future where consumers are supported to make decisions about their own lives, requires a significant cultural change across the Victorian community and the mental health system, with a redistribution of power.[366]

Providing targeted resources and ongoing training will be essential to support the workforce to meet the expectations of a reimagined mental health and wellbeing system in which the workforce is no longer constrained by the system within which it operates.

32.6 New system-wide expectations

Realising the Commission's aspiration to greatly reduce the rates and duration of compulsory treatment will require an ambitious objective that holds government, service providers, clinicians and other decision-makers to account.

32.6.1 A new system-wide commitment

As explored throughout this chapter, there is widespread support for a real reduction in compulsory treatment. This is a difficult ambition to achieve in the current system, but with the Commission's reforms, current constraints and power differentials can be overcome. Any lesser aspiration would run contrary to a future where human rights are upheld and consumers are listened to, understood and respected.

Achieving this ambition will require strong and committed system leadership. System leaders must drive cultural change and sector-wide reform, set expectations, equip services and individuals to meet those expectations, and hold those players to account. In turn, system leaders must be accountable for the objectives they set.

There must be no ambiguity about what the Victorian Government and the mental health and wellbeing system are collectively seeking to achieve—clear direction drives outcomes and strengthens accountability. The Commission was told there is merit to committing to reduction targets or developing a road map to reduce compulsory treatment, and that such approaches would support efforts to develop and make available services that do not involve compulsory treatment.[367]

Ms Daya called for a commitment to reduce and eventually end compulsory treatment. Ms Daya told the Commission that 'there is no motivation to reduce compulsory treatment' and:

> Until this occurs, the sector could benefit from [key performance indicators] on the maximum proportion of compulsory treatment orders, with an expectation that there will be a statewide annual decrease in the rate.[368]

The United Nations *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* set out concrete actions to move countries 'towards mental health systems that are based on and compliant with human rights'.[369] This included countries using indicators and benchmarks to monitor progress against these aims.[370] The Special Rapporteur also highlighted the importance of a road map as an immediate obligation:

> Core obligations include the elaboration of a national public health strategy and non-discriminatory access to services. In terms of the right to mental health, that translates into the development of a national mental health strategy with a road map leading away from coercive treatment and towards equal access to rights-based mental health services, including the equitable distribution of services in the community.[371]

Without a clear commitment and strong leadership, the system will continue to operate in a culture where avoiding risk is the dominant paradigm and continuous improvement is not fostered.[372] For example, at a workforce roundtable on compulsory treatment, a participant described how deeply ingrained cultures and attitudes among parts of the mental health workforce, and in society more broadly, skewed expectations about what constitutes quality service:

> I think there is a fundamental issue also with the philosophy of care. And that's both, I think, within the mental health system, but in a sense within the community as well. And I guess what I mean by that touches upon a couple of points … which is everybody's very risk averse, and the community has particular expectations about what good care looks like, and what derelict care or insufficient care looks like. And I think often that puts services in the conundrum around compulsive treatment and being seen to be doing everything that is necessary to prevent bad outcomes.[373]

Currently, there is no long-term target to reduce the use of compulsory treatment in Victoria. The system needs to move from one focused almost solely on risk, to one that equally focuses on continuous improvement and supporting people to attain good mental health and wellbeing. The Victorian Government, service providers, the workforce and those involved in oversight need to be accountable for achieving this.

To support a reset of the culture within the mental health and wellbeing system and its responsibilities to support and respond to the needs of individuals, the Commission recommends that the Department of Health set a system-wide performance improvement target to significantly reduce the use and duration of compulsory treatment. This target must be periodically reviewed and reduced every year. This aligns with the Commission's proposed aspirations for the new Mental Health and Wellbeing Act (refer to Chapter 26: *Rebalancing mental health laws—a new Mental Health and Wellbeing Act*).

As part of this target, a range of actors, including the Victorian Government, service providers, the workforce and those involved in oversight, must facilitate and commit to a culture where compulsory treatment is regarded as a measure of last resort. As reported in the World Psychiatric Association–Lancet Psychiatry Commission regarding the future of psychiatry:

> Use of compulsion needs to be seen as a system failure. Some mental health-care providers have started to implement this view for restraint and seclusion, through the No Force First principles. Expansion of this idea to compulsion generally—ie, no compulsion first—would be a good starting point.[374]

A new Mental Health Improvement Unit in Safer Care Victoria has been recommended by the Commission to drive service improvement. Among other things, the unit will set statewide improvement strategies and support services with guidance and expertise to reduce the use and duration of compulsory treatment.

Different expectations will be required to reduce compulsory treatment use in inpatient and community settings. Because the Commission has recommended extensive reforms to community-based mental health services, the reduction targets within inpatient and community settings will need to differ.

The new Mental Health and Wellbeing Commission will have a key role in holding the Victorian Government to account for the performance of the mental health and wellbeing system, including reductions in the use and duration of compulsory treatment and the uptake of supported decision-making practices.

Introducing an independent statutory body to monitor and publicly report on system-wide efforts to reduce the use and duration of compulsory treatment will support an enduring focus on this important area. This increase in accountability reflects evidence to the Commission that the current system lacks independent governance.[375] For example, Ms Louise Glanville, CEO of Victoria Legal Aid, said:

> **The responsibility for the mental health system in Victoria all falls within the oversight and supervision of [the department]. While there are a number of different bodies set up, collectively they are not providing sufficient oversight. One problem is the lack of independent governance, as all of the relevant bodies report into [the department] and this type of governance structure reduces the level of independence and accountability in the system.**[376]

Establishing the Mental Health and Wellbeing Commission responds to this criticism. In addition to the above monitoring and oversight functions, the Mental Health and Wellbeing Commission will also receive and investigate complaints about the mental health and wellbeing system, including complaints about the treatment, care and support provided to people subject to compulsory treatment and, where appropriate investigate, respond to and mediate mental health service delivery, including issuing compliance notices. The Commission will also have powers to conduct own-motion inquiries, publish reports and make recommendations, including on opportunities to reduce the use and duration of compulsory treatment.

While a target in and of itself will not reduce the use of compulsory treatment, it will signal that the system's collective focus should be on reducing the use and duration of compulsory treatment and improving consumer outcomes. Ensuring that the target is not just an 'aspirational slogan' will require system-wide reform,[377] as explored in the following sections.

32.6.2 The role of non-coercive options

The Commission has been consistently advised that reducing compulsory treatment requires a broad range of services with a focus on non-coercive options and the opportunity for people to connect with services early and in a way that is meaningful to them and that responds to their needs and preferences.[378]

For example, Ms Roper explained:

> One reason why alternative services are so important is that they do not engage in coercion. They instead rely on the development of connections among people who mutually share helpful techniques and support. The absence of coercive treatment engenders an extraordinary sense of trust. Often people who have been through traditional public mental health services have encountered coercive treatment. One of the benefits of having an alternative is that coercion does not happen. That means that there is a feeling of trust around people having walked similar paths. Relationships are prized. Alternative services are relational: things are negotiated and force is not present, and the research shows that they can be highly effective as well as decreasing use of mainstream mental health services. For example, alternatives to traditional in-patient services appear to be associated with a better experience of admission, greater service user satisfaction and less negative experiences.[379]

Dr Maylea shared this view and considered that there are many effective alternatives to compulsory treatment, including:

- adequate investment in mental health services and a refocus on choice, recovery-based treatment, early intervention and support[380]
- increasing the workforce and funding mental health nursing staff and peer-run services and workers[381]
- warm, approachable, safe and well-resourced voluntary services such as Prevention and Recovery Care Centres that consumers can approach directly[382]
- dealing with the social determinants of mental health, such as poverty, secure housing, adequate physical health care services and employment.[383]

Professor Newton stated that early access to services is pivotal to reducing compulsory treatment:

> Resourcing should be increased to help consumers to receive treatment early and avoid the need for compulsory treatment. Services should be patient-centred and develop an understanding of stigma and discrimination in order to reduce the use of unnecessary compulsory treatment. We need to take steps to reduce the risk of consumers being treated involuntarily and with a poor standard of care.[384]

Further, Professor Newton believes that, while they depend on resourcing, there are various alternatives to compulsory treatment that can be used particularly in community-based mental health services. He noted that 'a central component of these approaches is to engage the patient in a therapeutic relationship that focusses on what matters to the consumer and on working with them to deliver care'.[385]

Professor Brophy also suggested that there are many alternatives that hold promise for reducing compulsory treatment including: crisis homes or crisis respite houses; voluntary residential services that are often consumer managed; step-up/step-down residential programs, such as Prevention and Recovery Care Centres in Victoria, as well as non-residential alternatives (such as intensive home-based support for people who are experiencing a deterioration in their mental health or experiencing a difficult transition from inpatient services to the community); mental health peer support workers being included in emergency departments; and alternative crisis services such as the Safe Haven Café at St Vincent's Hospital.[386]

The Commission's recommendations support objectives to reduce the use and duration of compulsory treatment. For example, including peer workers in crisis outreach teams will help promote compassionate cultures and practices that focus on crisis resolution rather than whether consumers meet the criteria for compulsory assessment and treatment. Further, the Commission has proposed a contemporary adaptation of Assertive Community Treatment in Victoria, that brings together clinical care as well as wellbeing supports for people living with mental illness who require ongoing intensive treatment, care and support. Where a consumer has a compulsory treatment order, the support provided will aim to have the consumer resume decision-making autonomy about their treatment, care and support.

Importantly, improving and expanding alternatives to non-compulsory treatment must be consistent with the principles of supported decision making. To help people find and access treatment, care and support in line with their needs and preferences, the Commission has recommended a number of changes, including a new website that provides clear, up-to-date information about Victoria's mental health and wellbeing system. These changes are described further in Chapter 8: *Finding and accessing treatment, care and support*.

32.6.3 Encouraging system improvement

To support practice improvements, the Mental Health Improvement Unit will develop and make available training and guidance to reduce the use and duration of compulsory treatment. This includes support for embedding supported decision making practices and increasing the uptake and effectiveness of safeguards. The unit will also convene Communities of Practice and forums to share lessons among service providers or ways to reduce the use and duration of compulsory treatment.

The Mental Health Improvement Unit will coordinate with the Chief Psychiatrist, Chief Officer for Mental Health and Wellbeing and Mental Health and Wellbeing Commission to ensure its work on system improvement is informed by the knowledge and data that exists across these entities.

Alongside the Commission's service model reforms, new arrangements for planning, funding and monitoring services will create incentives for quality treatment, care and support and reduce compulsory treatment.

For example, commissioning bodies, namely the proposed new Regional Mental Health and Wellbeing Boards, will each be required to plan, resource and monitor services that do not use coercion (that is, alternatives to compulsory treatment) for delivery by service providers, operating in Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services. These approaches will mean consumers will be able to get services where they are supported to make choices about the types of treatment, care and support that are most responsive to their needs, without compulsory treatment.

Further, the Department of Health, in the long term, will introduce pricing and funding reforms that signal to mental health and wellbeing services the need to reduce compulsory treatment.

In time, people on or at risk of being placed on a Treatment Order will have a choice to register with a service provider who would be responsible for funding and coordinating all of the consumer's treatment, care and support in line with their needs and preferences for an extended time period, preferably for at least a year. Principles and practices of supported decision making will be at the foundation of this approach and people will have access to independent non-legal advocacy services if they wish. Under this arrangement, the service provider will be paid a 'capitated payment'—a fixed amount per consumer for the extended time period. Using this funding, the service provider could either deliver services directly or engage another provider; for example, the provider could use subcontracting arrangements to meet consumers' needs and preferences.

The service provider will be accountable for all of the consumer's health outcomes and will be paid the full amount when agreed benchmarks, which will be centred on reducing the use and duration of compulsory treatment, are achieved. This approach aims to ensure funding is going towards delivering services that are valued by consumers and is used to motivate service providers to improve outcomes and experiences.

Mental health and wellbeing services will also receive additional funding to implement initiatives that reduce the use and duration of compulsory treatment. Given the diverse needs of communities and local factors that can contribute to compulsory treatment use, service-level initiatives that are locally driven will also be important to reducing compulsory treatment use. The Mental Health Improvement Unit will support mental health and wellbeing services in these efforts to significantly reduce the use and duration of compulsory treatment.

32.6.4 Taking advantage of research

Research is also an important aspect of supporting the system to significantly reduce the use and duration of compulsory treatment. It is important in identifying trends in compulsory treatment and which, if any, groups are more likely to be compulsorily treated.[387] Research may assist in identifying how to effectively prevent the use of compulsory treatment, intervene earlier, provide non-coercive treatment, care and support, and also to improve understanding about the effectiveness and experiences of compulsory treatment.[388]

The Commission has heard that Victoria currently lacks empirical evidence about which social groups are more likely to be treated compulsorily. Professor Brophy told the Commission:

> We need more research in Victoria and nationally to establish the social drivers that underpin compulsion. This research may help us to shift thinking around how we respond to compulsory treatment order rates if they affect certain population types more than others.[389]

Recent analysis suggests that, internationally, the people most likely to be treated compulsorily are from socioeconomically disadvantaged, marginalised or culturally diverse backgrounds.[390] Research in Queensland indicates that Aboriginal people are more likely to be compulsorily detained than non-Aboriginal people, and people from culturally diverse backgrounds who required interpreters were placed on Community Treatment Orders at nearly triple the rate of Australian-born, English-speaking people.[391]

Efforts to reduce the rates of compulsory treatment use cannot be made in the absence of an understanding of the social determinants of compulsory treatment, nor the varied influences on clinicians' and services' decision making. But with limited data and research, this is difficult to achieve.

Research may also be of benefit with respect to understanding the use and utility of compulsory electroconvulsive treatment, given the negative impacts reported by consumers to the Commission and the Mental Health Tribunal refusing a much higher proportion of applications for compulsory electroconvulsive treatment than applications for Treatment Orders.

Given the importance of research to implementing practice changes, the Commission's reforms for an innovative and adaptive mental health system should be used to support these efforts. The Victorian Collaborative Centre for Mental Health and Wellbeing will be tasked with progressing research into ways to reduce the use of compulsory treatment as a priority, as set out in Chapter 36: *Research, innovation and system learning*.

32.7 The role of consumer leadership

Involving consumer expertise in efforts to reduce compulsory treatment is critical in policy development, practice change and the development and delivery of responsive services. For example, Dr Tricia Szirom, the then CEO of the Victorian Mental Illness Awareness Council, reflected that:

> Listening to people with lived experience of mental health challenges is essential in considering the many and complex issues of responsive mental health service provision, and a way to filter and assess the many options for reform. It is also the best way to uphold and safeguard human rights, prevent serious harms, learn about the social determinants that led to mental health crisis and further develop community led responses.[392]

Including consumer expertise can assist service improvements and support the development of initiatives that better reflect consumers' needs. For example, submissions explained:

> Any good service, no matter the industry, will improve by listening to the people that it serves. But mental health services have a very particular obligation to elevate and privilege consumer/survivor voices—precisely because of the many rights restrictions and breaches we experience in services. Mental health services are still a long way from being rights-based, respectful services … Ensuring that consumers/survivors can speak about every issue that affects our lives is a critical part of driving change.[393]
>
> If people with lived experience are involved in the development of policy, practice and research, then the services that result from that work will become more reflective of what consumers think and need.[394]

The value of including consumer expertise in initiatives to reduce compulsory treatment and promote supported decision making has already been demonstrated. For example, Victoria Legal Aid highlighted how consumer leadership and co-production was central to the establishment and success of Independent Mental Health Advocacy, which provides a non-legal advocacy service:

> From the outset, consumer leadership and co-production was central for [Independent Mental Health Advocacy], and people with lived experience of the mental health system advised on its development, including co-production of [the] program logic and evaluation framework. Consumers are part of [the service's] work, and they are also part of its workforce. As part of [the service, Victoria Legal Aid] employs a Senior Consumer Consultant to oversee and promote consumer leadership, and two-thirds of [the service's] advocacy workforce identify as having a lived experience of mental health issues.[395]

The Commission considers that consumer leadership and participation is critical to the success of system-wide and local efforts to reduce the use and duration of compulsory treatment. The new Mental Health Improvement Unit will work with mental health services to actively increase consumer leadership and participation in all activities to reduce compulsory treatment.

32.8 Improving publicly available data about compulsory treatment

As established earlier in this chapter, there is limited data that is publicly available on the numbers of compulsory treatment orders made. There is no separation of data by variables such as demographics, and there is no data about the rates or duration of Assessment Orders or Temporary Treatment Orders.

It has been reiterated to the Commission that in a system where a person's human rights can be compromised, there must be strong accountability and transparency.[396] Public and meaningful data are central to this. Achieving the Commission's objective to greatly reduce the rates and duration of compulsory treatment depends on access to high-quality data. There must be timely access to data to encourage system-wide behaviour change and to hold services and government to account.

Currently, without meaningful public data, there is limited oversight of the rates of compulsory treatment use among services, and without comparative data, there is little incentive to reduce the rates of use.[397] Ms Jayakody told the Commission that mental health services need to be held to account through mandatory public sharing of data.[398] Several submissions identified the potential of public reporting and benchmarking between services to reduce rates of compulsory treatment and enable services to learn from each other.[399]

Improved data reporting is also important to building the evidence base about why and how compulsory treatment is used, which groups are disproportionately affected, including any social determinants. Professor Brophy explained:

> We need a detailed understanding of the demographic and clinical characteristics of those who are subjected to community treatment orders and the rationales for their use. If we had this data, we would likely be able to identify social determinants of compulsory treatment which could open up opportunities for preventative interventions. Data of this type would also identify what mental health services use or rely on compulsory treatment orders more frequently, enabling us to examine the reasons behind this increased use and the microcultures in those services. Conversely, examining the reasons why a mental health service may have low rates of compulsory treatment may also be of utility.[400]

Victoria Legal Aid submitted that this type of information would assist in determining why there is variation between services.[401] Similarly, Dr Maylea told the Commission that the current lack of available data prevents researchers and advocacy organisations 'being able to properly analyse data to identify trends and advocate for changes and improvements and impedes a form of oversight over the [Mental Health] Tribunal's decision making powers'.[402] Data is also important to understanding the effectiveness of compulsory treatment orders and the services and supports people are accessing. Dr Maylea found that currently, 'mental health service provision is opaque'.[403]

While its merits are clear, the collection and public reporting of data must be undertaken in a considered way. There are systemic reasons why a mental health service may have comparatively higher rates of compulsory treatment use. For example, different services work with different populations, have varying resources available to them, and are based in different catchments, which may affect demand and demographics. Associate Professor Vine told the Commission that clinical variation must also be considered, such as services with very experienced staff compared with services with more 'junior and risk averse staff' and a greater staff turnover.[404] This is influenced by a lack of funding and unattractive infrastructure.[405] Data must be collected and reported in a way that recognises the circumstances and efforts of individual mental health services.[406]

The Commission recommends that the Department of Health regularly publish meaningful, service-level and system-wide data on the use and duration of compulsory treatment. This data would enable an understanding of the system's performance as a whole, enable services and hospitals to understand how their service provision compares, and enable an understanding of the Mental Health Tribunal's role and impact. For the purposes of transparency, the Commission, as a first step, has published in this chapter, data on the use of compulsory treatment at each public health service. The Commission considers that this level of data analysis to be the minimum, and expects the department to publish a range of information that continues to expand over time.

Service delivery improvements will depend on timely access to data on practice, processes and outcomes, with measures that are meaningful and credible. *Targeting Zero*, the review of hospital safety and quality assurance in Victoria, suggested that:

> **Such measures must make it easier for clinical teams to develop a detailed understanding of the specific problems and opportunities for improvement in the way they are delivering care, and observe the effect of improvement strategies when they are implemented.**[407]

This approach would also support the Commission's recommendations for a new approach to performance monitoring and accountability to hold service providers to account and improve the outcomes and experiences of consumers, families, carers and supporters. This approach is described further in Chapter 28: *Commissioning for responsive services*.

As part of this approach, the department will set measures and monitor the use and duration of compulsory treatment with an expectation placed on service providers to achieve yearly reductions in the use and duration of compulsory treatment that contribute to accomplishing the system-wide improvement goals described above.

Without data, there is no public accountability to ensure services and the department are significantly reducing the rate and duration of compulsory treatment.

32.9 Supporting people to exercise their rights

Human rights are often conceived of through a 'protection lens', that is, a person's rights need to be protected through providing for various safeguards, such as legal and non-legal advocacy and advance statements. Equally important, however, is promoting people's human rights, that is, creating an environment where consumers, families, carers and supporters, as well as the mental health workforce, understand their responsibilities and are enabled to exercise their rights.

To reduce the use of compulsory treatment, the mental health system must focus on promoting the good mental health and wellbeing of all people. The Commission's recommendation to enact a new Mental Health and Wellbeing Act that has as its purpose the promotion of good mental health and wellbeing is one important element of putting in place such a system, as described in Chapter 26: *Rebalancing mental health laws—a new Mental Health and Wellbeing Act*. While on its own, a new Act will not deliver accessible and high-quality mental health services, it can help enable the Commission's aspirations for a mental health and wellbeing system that is equitable, responsive and adaptive, to be realised.

The new Act can enable good practice, encourage a human rights-based culture to flourish and support efforts to reduce compulsory treatment. Putting in place a mental health and wellbeing system that enables people to get the help they seek in line with their needs and preferences will minimise the use of compulsory assessment and treatment.

Strong and transparent accountability mechanisms will mean that decision-makers under the new Mental Health and Wellbeing Act will need to not only consider and promote good mental health and wellbeing when developing policies and programs and when delivering services but to demonstrate how this has been done. For example, rights can be promoted through ensuring information about rights and accessing services is available in different languages and formats. These initiatives would promote rights under the Charter of Human Rights and Responsibilities, including the right to equality before the law, the right to life, freedom of expression, the right to receive information and cultural rights.[408]

Other recommendations made by the Commission directed towards reducing stigma and discrimination, strengthening quality, safety and oversight arrangements, and developing workforce capabilities, including through human rights training, will also contribute to a mental health system that promotes good mental health and wellbeing.

32.9.1 An opt-out approach to non-legal advocacy

The Commission has received a range of evidence about the benefits of non-legal advocacy for people who are subject to, or at risk of, compulsory treatment.[409] An evaluation report of the work undertaken by Independent Mental Health Advocacy identified the following benefits:

> As a result of contact with [Independent Mental Health Advocacy], consumers identified an improvement in their self-advocacy skills, an increased sense of having their views and preferences respected, a greater sense of control over treatment and recovery, and generally felt they had received less restrictive treatment.[410]

The evaluation report found consumers feel having an advocate enables them to be heard by clinicians,[411] with one consumer telling the Commission, 'I've now had to get my advocate from [Independent Mental Health Advocacy] to help me, because the clinicians don't care what you have to say.'[412]

Increased access to non-legal advocacy may also improve the relationship between consumers and clinicians[413] and drive down coercive practices.[414]

Despite the positive and empowering experiences consumers have with non-legal advocates, matters of accessibility remain.[415] International experience suggests that those with the clearest understanding of their rights are the most likely to use advocacy services and, conversely, those with the least understanding, who need advocacy the most, access it the least.[416]

The Commission recommends an opt-out mechanism, established in legislation, be implemented to ensure all eligible consumers can connect with non-legal advocacy services. This must be accompanied by adequate funding to ensure effective implementation, guaranteeing that all consumers can experience the benefits of non-legal advocacy services if they wish.

The Commission recommends a stepped approach, starting with an increase in funding to make enough non-legal advocates available to meet demand. The Department of Health will work with non-legal advocacy service providers and mental health service providers to develop policies and protocols to ensure non-legal advocates can contact consumers to advise them about the service, including any mechanisms to coordinate efforts among non-legacy advocacy service providers.

Over time, eligibility for non-legal advocacy services may be extended to consumers who are not experiencing or imminently at risk of compulsory treatment, informed by evaluation and research.

The Commission considers the approach of increasing funding, broadening the scope of eligibility and embedding an opt-out mechanism to be the most effective way to expand access and remove existing barriers, particularly for consumers in the community with limited access to or awareness of non-legal advocacy.

32.9.2 Increasing access to legal representation before the Mental Health Tribunal

Well-trained specialist mental health lawyers can ensure consumers can participate in their hearings and assist the Tribunal to understand a consumer's views and preferences, supporting the Tribunal's inquisitorial approach.[417]

Despite the Tribunal's efforts to create a non-adversarial environment and to create accessible hearing processes for unrepresented people,[418] many consumers feel vulnerable when attending their hearings and unprepared to attend their hearings alone, describing the presence of a lawyer as reassuring, or even essential.[419] One consumer reflected on their experience before the Mental Health Tribunal:

> If I hadn't had a solicitor I wouldn't have been prepared, I wouldn't have known my rights, and I wouldn't have known the process. I was nervous as it was, without guidance you don't know what you're walking into. Being unwell and with where you're at, it's a very intimidating process, to go into a room of strangers, it's an incredibly intimidating process, and it would be very frightening if you had to defend yourself on your own.[420]

As stated earlier, consumers who attend their hearings, and who are legally represented, are more likely than other consumers to obtain a less restrictive outcome. Tribunal data from 2018–19 indicate that only 2 per cent of orders were revoked where consumers did not attend their hearings, compared with 7 per cent where consumers attended unrepresented and 12 per cent where consumers attended and were legally represented.[421]

Reflecting current service provision models, legal representation rates fall the longer the duration of compulsory treatment, as depicted in Figure 32.8. Given current funding constraints and models of legal service provision, people on Community Treatment Orders are currently unlikely to be able to access legal representation.[422]

The Productivity Commission's *Mental Health Inquiry Report* recommended that state and territory governments ensure consumers have a right to access legal representation, forming the view that:

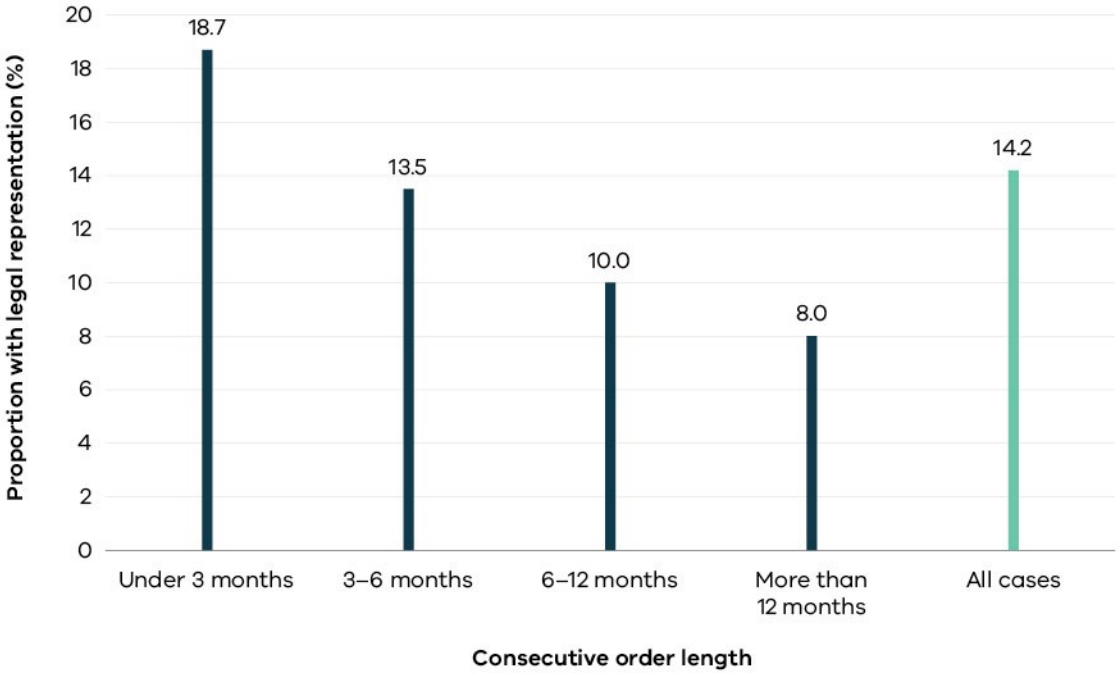
> individuals appearing before mental health tribunals should have the right to access legal representation if they choose. Mental health tribunals make decisions that can affect some of the most fundamental rights of individuals.[423]

The importance of legal representation before the Tribunal was echoed by Ms Barker, who told the Commission how grateful she was to have a lawyer:

> because I don't think I would have been able to do it otherwise. I have been in Court before and I honestly don't know which was worse—maybe the Tribunal, because I knew that the ramifications were more restrictive.[424]

The Commission is especially concerned about consumers who experience long consecutive periods under Community Treatment Orders given the long-term restrictions on their autonomy. Legal representation can bring particular benefits to this group who, in light of current funding constraints and models of legal service provision, are unlikely to obtain legal representation.[425]

Figure 32.8: Proportion of people with legal representation before the Mental Health Tribunal for a hearing about a Treatment Order, by consecutive order length at the time of hearing, Victoria, 2019–20



Sources: Department of Health and Human Services, Client Management Information/Operational Data Store 2019–20; Mental Health Tribunal, Case Management System 2019–20.

As noted previously, the Productivity Commission made recommendations to adequately resource legal assistance services to assist people with hearings before mental health tribunals.[426]

The Commission supports this approach, with a specific focus on people subject to extended periods of compulsory treatment.

32.9.3 Upholding consumer autonomy

Safeguards that are well known and well respected by consumers, as well as families, carers and supporters, and the workforce, have the potential to deliver better outcomes and experiences for consumers. For example, they can highlight consumer views and preferences regarding treatment, care and support in Tribunal hearings.[427]

The Commission aspires to a mental health system that upholds consumer autonomy and rights and is aligned with other laws relating to personal and treatment decision making, such as the Medical Treatment Planning and Decisions Act and Guardianship and Administration Act.

To achieve this goal, the Commission sets out a stepped approach to:

- first, increase uptake of safeguards, supported decision-making practices and monitoring in the short term
- second, reduce the circumstances in which substituted decision making can occur in the medium term
- third, increase legislative alignment with other laws related to personal treatment decision making, such as Guardianship and Administration Act and Medical Treatment Planning and Decisions Act, in the long term.

In the short term, to improve the uptake of existing safeguards among consumers and to foster greater understanding of safeguards and supported decision making among consumers and clinicians, the Mental Health Improvement Unit will:

- make available ongoing education and training programs on safeguards and supported decision making for consumers, families, carers and supporters, as well as the mental health workforce
- make available support materials and practical tools for consumers, families, carers and supporters, as well as the workforce
- provide for advance statements and nominated persons registers
- support service providers to implement initiatives to ensure consumers receive a statement of rights on entry to the service and that the statement is provided in different languages and formats.

To increase supported decision-making practices, there needs to be an understanding of the extent to which substituted decision making is occurring. This understanding will also support future efforts to improve how safeguards are considered in practice and efforts to continuously improve the ways in which consumers are supported to exercise their rights.

The department will require services to document that they have sought a consumer's informed consent to provide treatment, that either the person provided informed consent or that an assessment was made that they could not provide informed consent. Services will be required to document efforts to support the consumer to make a decision.[428]

To further promote supported decision-making, the department will require service providers to document discussions about the use of other safeguards such as confirming statements of rights have been provided and explained and that nominated persons have been informed and consulted as required. Services will also be required to document decisions by authorised psychiatrists to act against a person's views and preferences as expressed by them at the time, or through their advance statement or nominated person. As part of this, authorised psychiatrists will need to record:

- how they considered the consumer's views and preferences about the proposed treatment and any alternatives that were reasonably available
- a consumer's reasons for those views and preferences, including any recovery outcomes that they would like to achieve (as well as the other views the psychiatrist must consider).[429]

Data systems should support services to make reporting efficient and practicable. These measures can be swiftly implemented in a cost-effective way.

As part of performance monitoring and accountability arrangements, the department and Regional Mental Health and Wellbeing Boards will use this information to improve practices among service providers, in conjunction with the Mental Health Improvement Unit. The Mental Health and Wellbeing Commission will also consider these matters as part of its role in system-wide oversight.

To strengthen the framework for upholding consumer autonomy, the Commission advises the Victorian Government to consider, when reviewing mental health legislation in the future, including provisions that allow consumers to appoint a nominated decision-maker to make a substituted decision in the event that the consumer does not have the capacity to make that decision. This would be in addition to existing nominated person appointments, which function as nominated support persons. Witness before the Commission, Professor Neil Rees explained the benefit of consumers being able to appoint a trusted person to make decisions if they do not have decision-making capacity to make those decisions for themselves:

> **if I ever needed psychiatric treatment and I was not in a position to provide consent to it myself, I would much prefer that my wife made that decision than another person who I had never met before in my life. It is astounding that in the current system, we do not allow people to appoint others close to them to make these decisions for them when they are incapable of doing so themselves.**[430]

When reviewing mental health legislation, the Commission encourages the Victorian Government to consider aligning requirements for nominated decision-makers with decision-making requirements under related legislation, for example, by enabling nominated decision-makers to make decisions that they believe the consumer would have made if they had decision-making capacity. Similarly, nominated decision-makers could be required to make decisions in line with the principles in the Guardianship and Administration Act—only overriding the person's will and preferences where it is necessary to do so to prevent serious harm. The Commission suggests the Victorian Government consider amendments to mental health legislation that provide for nominated decision-makers' decisions to only be overridden in limited circumstances. Such provisions are included in the Medical Treatment Planning and Decisions Act.

To entrench the importance of respecting consumers' wishes and preferences, the Commission encourages the Victorian Government when reviewing mental health legislation, to consider making advance statements binding, in all but very limited circumstances. This would mean that clinicians would generally be bound by law to respect consumers' wishes and preferences as set out in advance statements.

Possible legislative amendments could then be monitored by the Mental Health and Wellbeing Commission to ensure they are understood and applied appropriately and consistently. The Mental Health and Wellbeing Improvement Unit and Mental Health and Wellbeing Commission could coordinate to benchmark and provide targeted training and assistance to services.

As a further step to aligning mental health laws with other decision-making laws and strengthening supported decision-making principles and practices, the Commission advises that, as part of reviewing mental health legislation, the government consider amending laws so that substituted decision-making frameworks for both mental health and medical health treatment decisions are aligned. Such amendments would minimise the circumstances in which consumers with decision-making capacity could have decisions about their treatment, care and support, made by someone else.

As described by Ms Daya:

> I can think of no reasonable justification whatsoever as to why mental health consumers/survivors should not have equal rights to decide for or against treatments in advance ...[431]

Bringing these laws into alignment will reduce discrimination against people living with mental illness or experiencing psychological distress and the unequal access barriers that consumers face.

32.10 Updating oversight arrangements

While the reforms in this report focus extensively on preventing the use of compulsory treatment, the Commission recognises that oversight and accountability for decisions that relate to compulsory treatment requires constant attention.

Achieving the Commission's aspiration to reduce compulsory treatment such that it is used only as a last resort requires a concerted and ongoing effort from a range individuals and organisations. Entities involved in governance, oversight and quality improvement across the future mental health and wellbeing system will have a critical role.

The Commission has recommended a suite of new and updated arrangements to achieve contemporary governance as well as stronger oversight and quality improvement across the mental health system. These bodies and their respective responsibilities as they relate to compulsory treatment are described throughout this chapter and outlined in Table 32.3. These bodies will need to work effectively with existing bodies with related roles, including the Mental Health Tribunal and Chief Psychiatrist.

As described in Chapter 30: *Overseeing the safety and quality of services*, the role of the Chief Psychiatrist will be reviewed as the system evolves, with any adjustments to be included as part of future legislative reforms. In this context, the role of the Chief Psychiatrist in relation to compulsory treatment will also be reviewed.

32.10.1 The Mental Health Tribunal

Mechanisms to review the use of compulsory treatment in one form or another—whether that be a judicial review, tribunal review or review by fellow professionals through schemes such as the second psychiatric opinion service—feature strongly in the regulatory landscape of various jurisdictions. For example, dedicated mental health tribunals to review compulsory treatment exist in most Australian states and territories, including Queensland and New South Wales, and in other countries such as New Zealand, Scotland and Wales.[432] Also, the *Convention on the Rights of Persons with Disabilities* requires that measures that relate to the exercise of legal capacity be 'subject to regular review by a competent, independent and impartial authority or judicial body'.[433]

Some literature suggests that each of the above models can contribute to protecting rights but none deliver a completely satisfactory level of protection.[434] In her evaluation of different review models, Professor Mary Donnelly concluded that tribunal reviews hold the most potential to protect rights, ensure appropriate treatment and provide 'accessible, fair and participative process'.[435]

Table 32.3: Roles and responsibilities for the oversight of compulsory treatment

Mental Health and Wellbeing Division, Department of Health	Chief Psychiatrist, Mental Health and Wellbeing Division, Department of Health	Mental Health Improvement Unit, Safer Care Victoria	Mental Health and Wellbeing Commission
• Sets the broad vision for the mental health and wellbeing system, including reductions in compulsory treatment • Sets performance targets for service providers to support reductions in the use and duration of compulsory treatment • Monitors service provider performance against the compulsory treatment reduction targets • Takes action, through performance and accountability arrangements, if services to do not meet targets • Develops meaningful measures on the use of compulsory treatment and collects and shares relevant data • Regularly publishes statewide and service level data on the use of compulsory treatment	• Provides direction to services on the use of compulsory treatment (such as when it can and cannot be used) • Reports on specific practices and incidents related to compulsory treatment, such as electroconvulsive treatment at the system level • Where a problem relates to specific practices or serious incidents, conducts an investigation, makes recommendations or directs service providers	• Sets annual improvement strategies for the system • Develops guidance and tools for service providers • Works with consumers and services to identify quality improvement activities that will help reduce compulsory treatment and increase supported decision making • Develops or coordinates resources, tools and forums to support services (such as Communities of Practice to share information about strategies) • Provides advice to the Chief Officer for Mental Health and Wellbeing on any emerging issues (such as areas where a policy reset may be required)	• Monitors and reports on system-wide efforts to reduce compulsory treatment • Identifies current trends in the use and duration of compulsory treatment, supported decision making and safeguards and (via reporting) highlights achievements and areas of concern • Receives and responds to complaints about the use of supported decision-making mechanisms and compulsory treatment and, where appropriate, conducts investigations • Based on complaints, investigations, and monitoring of use, provides advice to the Chief Officer for Mental Health and Wellbeing on opportunities to reduce compulsory treatment and increase supported decision making

Professor Rees said it has been beneficial for the Mental Health Tribunal to be a dedicated, standalone body, rather than incorporated into the Victorian Civil and Administrative Tribunal, advising:

> the expertise that people build on mental health review tribunals is incredibly important in terms of [knowing things such as] what relevant facilities are available in the community … In a standalone tribunal people tend to build up appropriate expertise faster. My view is that there are no disadvantages, and distinct advantages, of having a separate Tribunal to make decisions on the use of compulsory treatment.[436]

The rationale behind establishing the Mental Health Tribunal to make Treatment Orders remains relevant and sound. While having a dedicated and independent review body was not extensively challenged in the evidence received by the Commission, a number of submissions and contributions advocated for changes to the role and operations of the Tribunal.[437]

The Tribunal itself acknowledged that as the entity making Treatment Orders, it shares some of the responsibility for high rates of compulsory treatment.[438]

Consumers pushed for changes to confront the power imbalances that mean they have difficulty accessing meaningful ways to participate and respond to the information that is presented and discussed at Tribunal hearings.[439] For example, Ms Barker characterised her experience as 'difficult and terrifying'.[440] Ms Wilson described supporting her son at his Tribunal hearings as 'extremely traumatic' for both of them.[441]

Clinicians also report difficulties in engaging with Tribunal processes, reporting that the time needed for staff to prepare documentation, arrange logistics and attend hearings can be considerable.[442] There are also reports from some clinicians of a 'mismatch between practice and the regulatory framework'; that is, clinicians and the Tribunal may disagree about how the Mental Health Act should be interpreted.[443]

Some submissions cited limited oversight and transparency of Tribunal processes and decisions as a concern. This included that hearings are not recorded, appeals are rare and conducted de novo (where the Victorian Civil and Administrative Tribunal will consider all evidence, including new evidence, afresh) and the onus is on consumers to seek a written statement of reasons from the Tribunal for making a Treatment Order.[444]

There are also questions as to whether the Tribunal has an over-reliance on medical opinion, which can weaken the intentions of oversight. The dominance of the medical domain and its potential to undermine hearings is a limitation that is often associated with mental health tribunals.[445]

An inquisitorial approach can support the conduct of fair and participatory hearings.[446] The more inquisitorial the Tribunal is, the less legalistic and adversarial the proceedings become. This is because the Tribunal displays a level of scrutiny that is considered sufficient to the person, their lawyer or advocate.[447]

Some submissions suggested transferring governance for the Mental Health Tribunal, reflecting on the experience in the England with administrative changes that resulted in the Tribunal moving from within the Department of Health to be part of the First-tier Tribunal (Health, Education and Social Care Chamber) alongside other tribunals within the Ministry of Justice.[448] Reports suggest that this move supported improvements to the quality of decision making as a result of training and resources and the exposure of Tribunal members to more judicial and inquisitorial approaches to conducting hearings and making decisions.[449]

The Commission reflected on a number of proposals to significantly reform the Tribunal, but on balance concluded that large-scale reform of the Tribunal's role and operations occurring in parallel with system-wide reforms could detract from efforts to prevent the use of compulsory treatment and reduce its use and duration.

Nonetheless, the Commission does consider that there are significant opportunities to improve—and, in particular, streamline—the operations of the Tribunal. However, the precise opportunities that are to be implemented need to be identified when system-wide reforms have sufficiently progressed. For example, more data collection and analysis will allow an improved understanding about how to improve and target oversight arrangements.

The Commission advises the department to commission an independent review of the Tribunal's operations to inform the ways in which the role and operations of the Tribunal should be revised. This review will build on the matters that have been raised with the Commission. This includes considering ways to improve participation in hearings by consumers, families, carers and supporters, the adoption of a more inquisitorial approach and streamlining operations to ensure oversight is well targeted.

32.10.2 An ongoing focus on reducing compulsory treatment

In a contemporary mental health system, where the preferences of consumers are respected and consumers are supported to make decisions about their treatment, care and support, the use and duration of compulsory treatment must be significantly reduced. Ultimately, as the Commission's ambition to transform the mental health system is successively realised, compulsory treatment will be used as a last resort. Reducing compulsory treatment will be a marker of the Commission's success—where a future system is centred on community-based services, with a diverse mix of treatment, care and support.

The reform efforts will require substantive structural and cultural change. The Commission has set out a range of recommendations to support its ambition, focusing on consumer leadership and enhancing consumer rights, and strengthened oversight, monitoring and accountability arrangements. This is within the context of the Commission's broader reform agenda to expand the availability of accessible services that do not involve coercion.

Central to these reforms is strong system leadership and ongoing effort. The Department of Health must set a system-wide target to significantly reduce the use and duration of compulsory treatment that is successively reduced over time. Public reporting against this target coupled with renewed oversight through the new Mental Health and Wellbeing Commission will hold the system to account.

Where human rights are impinged, there must be transparency and accountability to build community confidence in the system and to create incentives for reducing compulsory treatment. System leaders must work collectively to stay true to the Commission's aspirations. Research, public data and evaluation must drive widespread practice change.

Systemic cultural change will not occur quickly, but with collective will, effective leadership, ongoing commitment and genuine consumer leadership and participation, compulsory treatment can be reduced so it is only used as a last resort.

1 Maria Rodrigues and others, *Implementing Alternatives to Coercion: A Key Component of Improving Mental Health Care Position Statement*, 2017, p. 1.

2 *Witness Statement of 'Elizabeth Porter' (pseudonym)*, 27 April 2020, para. 30; Elijah-rei Onekawa, *Submission to the RCVMHS: SUB.0002.0027.0037*, 2019, p. 1; Anonymous 236, *Submission to the RCVMHS: SUB.0002.0021.0007*, 2019, p. 1.

3 *Witness Statement of 'Lucy Barker' (pseudonym)*, 29 June 2020, para. 31.

4 *Witness Statement of Cath Roper*, 2 June 2020, para. 65.

5 M. B. Simmons and P. M. Gooding, 'Spot the Difference: Shared Decision-Making and Supported Decision-Making in Mental Health', *Irish Journal of Psychological Medicine*, 34.4 (2017), 1–12 (p. 1); *Witness Statement of Dan Nicholson*, 22 May 2020, para. 103; *Witness Statement of Louise Glanville*, 8 July 2019, para. 36(b).

6 *Personal Story Number 7, Collected by Victoria Legal Aid*, 2020; *Personal Story of Susan Mahomet, Collected by Victoria Legal Aid*, 2020; 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. 10; *Witness Statement of Cath Roper*, para. 81.

7 *Joint Witness Statement of 'Mary Corbett' and 'Jacob Corbett' (pseudonyms)*, 25 June 2020, para. 7.

8 *Evidence of Matthew Carroll*, 20 May 2020, p. 12; *Witness Statement of Dr Neil Coventry*, 28 June 2019, paras. 72–73.

9 *Witness Statement of Professor Richard Newton*, 7 May 2020, paras. 45, 46 and 48; *Witness Statement of Dr Christopher Maylea*, 30 April 2020, para. 16; *Witness Statement of Associate Professor Ruth Vine*, 29 April 2020, para. 25.

10 Anonymous 294, *Submission to the RCVMHS: SUB.0002.0001.0290*, 2019, p. 2.

11 *Witness Statement of 'Elizabeth Porter' (pseudonym)*, para. 69.

12 Scottish Recovery Network, Mary O'Hagan—Legal Coercion: The Elephant in the Recovery Room, <www.scottishrecovery.net/resource/legal-coercion-the-elephant-in-the-recovery-room/>, [accessed 28 January 2020]; *Witness Statement of Dr Christopher Maylea*, para. 8(c); *Witness Statement of Cath Roper*, para. 69.

13 Scottish Recovery Network.

14 *Mental Health Act 2014* (Vic), secs. 19, 46(2)(a)(ii), 48(2)(b) and 55(2)(b).

15 *Mental Health Act 2014* (Vic), sec. 28.

16 *Mental Health Act 2014* (Vic), sec. 1(a); *Crimes (Mental Impairment and Unfitness to Be Tried) Act 1997* (Vic), sec. 3; *Sentencing Act 1991* (Vic), sec. 94A.

17 *Mental Health Act 2014* (Vic), sec. 3.

18 *Mental Health Act 2014* (Vic), sec. 23–24.

19 *Mental Health Act 2014* (Vic), sec. 79.

20 *Mental Health Act 2014* (Vic), secs. 12 and 50(b).

21 *Mental Health Act 2014* (Vic), sec. 45.

22 *Mental Health Act 2014* (Vic), sec. 5.

23 *Mental Health Act 2014* (Vic), sec. 52.

24 *Human Rights Act 2004* (ACT); *Human Rights Act 2019* (Qld).

25 *Charter of Human Rights and Responsibilities Act 2006* (Vic), sec. 38(1).

26 *Charter of Human Rights and Responsibilities Act 2006* (Vic), sec. 28.

27 Parliament of Victoria, *The Mental Health Act Statement of Compatibility*, 2014, p. 461.

28 Parliament of Victoria, *The Mental Health Act Statement of Compatibility,* pp. 458–461.

29 Parliament of Victoria, *The Mental Health Act Statement of Compatibility*, pp. 436–467.

30 United Nations, *Convention on the Rights of Persons with Disabilities*, 6 December 2006, Article 25.

31 United Nations, *Convention on the Rights of Persons with Disabilities*, Article 1.

32 United Nations, *Convention on the Rights of Persons with Disabilities: General Comment No.1 (2014), Eleventh Session*, 19 May 2014, p. 6.

33 United Nations, Committee on the Rights of Persons with Disabilities: Concluding Observations on the Initial Report of Australia, Adopted by the Committee at Its Tenth Session, 2013, p. 5.

34 United Nations, Human Rights Council, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, 2017, p. 15.

35 United Nations, Human Rights Council, p. 15.

36 *Rethinking Rights-Based Mental Health Laws*, ed. by Bernadette McSherry and Penelope Weller (Oxford and Portland, Oregon: Hart Publishing, 2010), p. 177; Neeraj S Gill, 'Human Rights Framework: An Ethical Imperative for Psychiatry', *Australian and New Zealand Journal of Psychiatry*, 53.1 (2019), 8–10 (p. 8); Roberto Mezzina and others, Chapter 30: The Practice of Freedom: Human Rights and the Global Mental Health Agenda, in *Advances in Psychiatry* (Cham: Springer International Publishing, 2019), pp. 483–515 (p. 511).

37 Martin Zinkler and Sebastian von Peter, 'End Coercion in Mental Health Services—Toward a System Based on Support Only', *Laws*, 8.3 (2019), 1–10 (p. 8).

38 United Nations, *Convention on the Rights of Persons with Disabilities*, p. 3.

39 *Witness Statement of Dr Neil Coventry*, 29 July 2020, para. 403.

40 John Dawson, 'A Realistic Approach to Assessing Mental Health Laws' Compliance with the UNCRPD', *International Journal of Law and Psychiatry*, 40 (2015), 70–79 (p. 70).

41 *Witness Statement of Associate Professor Ruth Vine*, 2020, para. 30.

42 United Nations, *Convention on the Rights of Persons with Disabilities*, Articles 1, 12 and 25.

43 RCVMHS, *Sale Community Consultation—May 2019*.

44 Onekawa, p. 4.

45 Anonymous 236, p. 5.

46 Department of Health and Human Services, Client Management Interface/Operational Data Store 2019–20.

47 Department of Health and Human Services, *Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework 2017–2027*, 2017, p. 2.

48 *Witness Statement of Dr Christopher Maylea*, para. 45; Anonymous 280, *Submission to the RCVMHS: SUB.0002.0032.0126*, 2019, p. 8; Lucia MacNamara, *Submission to the RCVMHS: SUB.0002.0025.0107*, 2019, p. 7.

49 *Witness Statement of Julie Dempsey*, 23 July 2019, para. 17.

50 *Mental Health Act 2014* (Vic), sec. 351(1).

51 Indigo Daya, *Submission to the RCVMHS: SUB.0002.0032.0159*, 2019, p. 5; RCVMHS, *Melbourne Community Consultation—May 2019*; Anonymous, *Brief Comments to the RCVMHS: SUB.0001.0024.0001*, 2019, p. 4.

52 *Evidence of Julie Dempsey*, 26 July 2019, p. 1850.

53 RCVMHS, *Preston Community Consultation—May 2019*.

54 RCVMHS, *Melbourne Community Consultation—May 2019*.

55 RCVMHS, *Melbourne Community Consultation—May 2019*.

56 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 236.

57 *Witness Statement of Cath Roper*, para. 85.

58 *Witness Statement of Indigo Daya*, 12 May 2020, para. 68.

59 *Evidence of Dr Christopher Maylea*, 20 May 2020, p. 77.

60 *Witness Statement of Professor Penelope Weller*, 27 August 2020, paras. 24–25; Mezzina and others, pp. 510–511; Zinkler and von Peter, p. 1.

61 Tina Minkowitz, 'Prohibition of Compulsory Mental Health Treatment and Detention Under the CRPD', *SSRN Electronic Journal*, 2011, 1–22 (p.11).

62 *Joint Witness Statement of 'Mary Corbett' and 'Jacob Corbett' (pseudonyms)*, para. 77; Anonymous 269, *Submission to the RCVMHS: SUB.3000.0001.0356*, 2019, p. 1; Anonymous 570, *Submission to the RCVMHS: SUB.3000.0001.0421*, 2019, p. 1.

63 *Witness Statement of the Honourable Professor Kevin Bell AM QC*, 26 August 2020, para. 7.

64 Anonymous 265, *Submission to the RCVMHS: SUB.3000.0001.1105*, 2019, p. 1.

65 *Joint Witness Statement of 'Mary Corbett' and 'Jacob Corbett' (pseudonyms)*, para. 77.

66 *Witness Statement of Dr Christopher Ryan*, 21 May 2020, para. 20; *Witness Statement of Dr Christopher Maylea*, paras. 38–40; *Witness Statement of Professor Lisa Brophy*, 29 April 2020, paras. 39–40; Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, 2019, p. 3.

67 *Witness Statement of Richard (Rick) Corney*, 3 May 2020, para. 38.

68 *Witness Statement of 'Lucy Barker' (pseudonym)*, paras. 23–24.

69 Penelope Lewisohn, *Submission to the RCVMHS: SUB.0002.0028.0391*, 2019, p. 3.

70 RCVMHS, *Warragul Community Consultation—May 2019*.

71 RCVMHS, *Warragul Community Consultation—May 2019*.

72 Ruth Vine and Angela Komiti, 'Carer Experience of Community Treatment Orders: Implications for Rights Based/Recovery-Oriented Mental Health Legislation', *Australasian Psychiatry*, 23.2 (2015), 154–157 (p. 154).

73 *Witness Statement of Dr Neil Coventry*, 2020, para. 383; *Witness Statement of Dr Christopher Ryan*, paras. 16–17.

74 *Witness Statement of Associate Professor Ruth Vine*, 2020, para. 10.

75 *Witness Statement of Peter Kelly*, 29 May 2020, paras. 98–99; *Witness Statement of Professor Suresh Sundram*, 19 May 2020, paras. 135–136; *Witness Statement of Dr Neil Coventry*, 2020, para. 377.

76 *Witness Statement of Professor Richard Newton*, para. 50.

77 Lewisohn, p. 6; RCVMHS, *Warragul Community Consultation—May 2019*.

78 Melissa Bardell-Williams and others, 'Rates, Determinants and Outcomes Associated with the Use of Community Treatment Orders in Young People Experiencing First Episode Psychosis', *International Journal of Law and Psychiatry*, 62 (2019), 85–89 (p. 86).

79 Kay E Wilson, 'The Abolition or Reform of Mental Health Law: How Should the Law Recognise and Respond to the Vulnerability of Persons with Mental Impairment?', *Medical Law Review*, 28.1 (2019), 30–64 (pp. 47 and 54–62); Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws Final Report*, 2014, pp. 11–13; Victoria Legal Aid, *Correspondence to the RCVMHS: CSP.0001.0001.0151, Paving the Roads to Recovery: Building a Better System for People Experiencing Mental Health Issues in Victoria*, May 2020, pp. 20–21; Sascha Mira Callaghan and Christopher Ryan, 'Is There a Future for Involuntary Treatment in Rights-Based Mental Health Law?', *Psychiatry, Psychology and Law*, 21.5 (2014), 747–766 (p. 760).

80 Bardell-Williams and others, p. 86; *Witness Statement of Professor Richard Newton*, para. 44.

81 *Witness Statement of Peter Kelly*, para. 101.

82 *Witness Statement of Professor Suresh Sundram*, para. 138.

83 *Witness Statement of Dr Neil Coventry*, 2020, para. 378.

84 Giles Newton-Howes and Christopher James Ryan, 'The Use of Community Treatment Orders in Competent Patients Is Not Justified', *British Journal of Psychiatry*, 210.5 (2017), 311–312 (p. 311); Edwina Light, 'Rates of Use of Community Treatment Orders in Australia', *International Journal of Law and Psychiatry*, 64 (2019), 83–87 (p. 83).

85 *Witness Statement of Professor Lisa Brophy*, para. 14.

86 Steven P. Segal, Stephania L. Hayes and Lachlan Rimes, 'The Utility of Outpatient Commitment: I. A Need for Treatment and a Least Restrictive Alternative to Psychiatric Hospitalization', *Psychiatric Services*, 68.12 (2017), 1247–1254 (p. 1247).

87 Steven P. Segal and Philip M. Burgess, 'Use of Community Treatment Orders to Prevent Psychiatric Hospitalization', *Australian and New Zealand Journal of Psychiatry*, 42.8 (2008), 732–739 (p. 732).

88 Segal and Burgess, 'Use of Community Treatment Orders to Prevent Psychiatric Hospitalization', p. 738; Segal, Hayes, and Rimes, p. 1252.

89 *Mental Health Act 2014* (Vic), sec. 57.

90 Anthony Harris and others, 'Community Treatment Orders Increase Community Care and Delay Readmission While in Force: Results from a Large Population-Based Study', *Australian and New Zealand Journal of Psychiatry*, 53.3 (2019), 228–235 (p. 228).

91 Rachel Churchill and others, *International Experiences of Using Community Treatment Orders*, 2006, p. 178.

92 Steve Kisely and Katharine Hall, 'An Updated Meta-Analysis of Randomized Controlled Evidence for the Effectiveness of Community Treatment Orders', *The Canadian Journal of Psychiatry*, 59.10 (2014), 561–564 (p. 564).

93 Steve R Kisely, Leslie A Campbell, and Richard O'Reilly, *Compulsory Community and Involuntary Outpatient Treatment for People with Severe Mental Disorders (Review)*, 2017, p. 2.

94 Marvin S Swartz and others, 'Assessing Outcomes for Consumers in New York's Assisted Outpatient Treatment Program', *Psychiatric Services*, 61.10 (2010), 976–981 (p. 976).

95 Jorun Rugkåsa, 'Effectiveness of Community Treatment Orders: The International Evidence', *The Canadian Journal of Psychiatry*, 61.1 (2016), 15–24 (p. 22).

96 Simon Lawton-Smith, John Dawson, and Tom Burns, 'Community Treatment Orders Are Not a Good Thing', *British Journal of Psychiatry*, 193.2 (2008), 96–100 (p. 96).

97 Steven P. Segal and Philip M. Burgess, 'Factors in the Selection of Patients for Conditional Release From Their First Psychiatric Hospitalization', *Psychiatric Services*, 57.11 (2006), 1614–1622 (p. 1614).

98 Stefan Priebe and others, 'Predictors of Clinical and Social Outcomes Following Involuntary Hospital Admission: A Prospective Observational Study', *European Archives of Psychiatry and Clinical Neuroscience*, 261.5 (2011), 377–386 (p. 384).

99 Isis F.F.M. Elzakkers and others, 'Compulsory Treatment in Anorexia Nervosa: A Review', *International Journal of Eating Disorders*, 47.8 (2014), 845–852 (p. 849).

100 *Witness Statement of Dr Christopher Maylea*, para. 10.

101 *Witness Statement of Associate Professor Ruth Vine*, 2020, para. 18; *Witness Statement of Professor Richard Newton*, para. 42; *Witness Statement of Professor Lisa Brophy*, para. 23; *Witness Statement of Dr Christopher Ryan*, para. 21; *Witness Statement of Professor Suresh Sundram*, para. 148.

102 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 92.

103 Neil Rees, 'Learning from the Past, Looking to the Future: Is Victorian Mental Health Law Ripe for Reform?', *Psychiatry, Psychology and Law*, 16.1 (2009), 69–89 (pp. 71–73).

104 *Mental Health Bill 1985, Explanatory Memorandum*, p. 1.

105 *Mental Health Act 2014* (Vic), sec. 1(a).

106 Parliament of Victoria, Mental Health Bill 2014, Legislative Assembly Second Reading Speech, 20 February 2014, p. 471, <hansard.parliament.vic.gov.au/?IW_DATABASE=*&IW_FIELD_TEXT=HOUSENAME%20CONTAINS%20

(ASSEMBLY)%20AND%20SPEECHID%20CONTAINS%20(50355)%20AND%20SITTINGDATE%20CONTAINS%20(20%20February%202014)&Title=MENTAL%20HEALTH%20BILL%202014&IW_SORT=n:OrderId&LDMS=Y>, [accessed 5 March 2020].

107 Parliament of Victoria, Mental Health Bill 2014, Legislative Assembly Second Reading Speech, p. 473.

108 Parliament of Victoria, Mental Health Bill 2014, Legislative Assembly Second Reading Speech, p. 473; *Mental Health Act 2014* (Vic), sec. 57.

109 *Mental Health Act 2014* (Vic), sec. 53.

110 *Mental Health Act 2014* (Vic), secs. 53–54.

111 *Mental Health Act 2014* (Vic), sec. 55(1)(b).

112 *Mental Health Act 2014* (Vic), Part 5, Division 5.

113 *Mental Health Act 2014* (Vic), sec. 100.

114 Victorian Mental Health Tribunal, *Submission to the RCVMHS: SUB.1000.0001.0979*, 2019, p. 28; *Evidence of Professor Lisa Brophy*, 20 May 2020, p. 36; *Witness Statement of Dr Christopher Ryan*, para. 36.

115 Department of Health and Human Services, Client Management Interface/Operational Data Store 2015–16 to 2019–20.

116 Note: For the purposes of the data in this section, we have excluded forensic patients and security patients and have focused solely on compulsory patients.

117 Department of Health and Human Services, Client Management Interface/Operational Data Store 2019–20.

118 Department of Health and Human Services, Client Management Interface/Operational Data Store 2019–20.

119 Department of Health and Human Services, Client Management Interface/Operational Data Store 2015–16 to 2019–20.

120 Department of Health and Human Services, Client Management Interface/Operational Data Store.

121 Department of Health and Human Services, Client Management Interface/Operational Data Store.

122 Department of Health and Human Services, Client Management Interface/Operational Data Store.

123 Department of Health and Human Services, Client Management Interface/Operational Data Store.

124 Department of Health and Human Services, Client Management Interface/Operational Data Store.

125 Department of Health and Human Services, Client Management Interface/Operational Data Store.

126 Department of Health and Human Services, Client Management Interface/Operational Data Store.

127 Department of Health and Human Services, Client Management Interface/Operational Data Store.

128 Mental Health Tribunal, Victoria, *Annual Report 2019–20*, 2020, pp. 4 and 18.

129 Department of Health and Human Services, Client Management Interface/Operational Data Store 2009–10 to 2019–20; Australian Bureau of Statistics, Australian Demographic Statistics, June 2020, cat. no. 3101.0, Canberra.

130 Department of Health and Human Services, Client Management Interface/Operational Data Store 2019–20.

131 Department of Health and Human Services, Client Management Interface/Operational Data Store 2019–20.

132 Department of Health and Human Services, Client Management Interface/Operational Data Store 2018–19.

133 Department of Health and Human Services, Client Management Interface/Operational Data Store 2015–16 to 2019–20; Mental Health Tribunal, Case Management System 2019–20.

134 *Mental Health Act 2014* (Vic), sec. 54.

135 Department of Health and Human Services, Client Management Interface/Operational Data Store 2015–16 to 2019–20.

136 Department of Health and Human Services, Client Management Interface/Operational Data Store 2019–20.

137 Department of Health and Human Services, Client Management Interface/Operational Data Store 2019–20.

138 Department of Health and Human Services, Client Management Interface/Operational Data Store 2019–20.

139 *Witness Statement of Professor Lisa Brophy*, para. 72; *Witness Statement of Associate Professor Ruth Vine*, 2020, para. 49.

140 Excluding Forensicare. Excludes any consecutive Order that had a non-civil order component.

141 Light, p. 85, Table 1.

142 Light, p. 85.

143 Light, p. 85.

144 Department of Health and Human Services, Client Management Interface/Operational Data Store 2019–20. Note: This does not include any time the person may have spent in the inpatient unit and their contact with the consultant psychiatrist in that setting.

145 Department of Health and Human Services, Client Management Interface/Operational Data Store 2019–20.

146 Victorian Government, *Submission to the RCVMHS: SUB.5000.0001.0001*, 2019, p. 24.

147 Australian Institute of Health and Welfare, *Mental Health Services in Australia, State and Territory Community Mental Health Care Services, 2018–19*, Table CMHC.3.

148 *Witness Statement of Dr Neil Coventry*, 2020, para. 195.

149 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 409; *Witness Statement of Professor Dan Lubman*, 28 May 2020, para. 99; Lee Bull, *Brief Comments to the RCVMHS: SUB.0001.0031.0150*, 2019, pp. 4–5.

150 Victorian Mental Illness Awareness Council, *Submission to the RCVMHS: SUB.0002.0028.0645*, 2019, p. 5; Anonymous 236, p. 1; *Witness Statement of 'Elizabeth Porter' (pseudonym)*, para. 69.

151 *Witness Statement of 'Lucy Barker' (pseudonym)*, para. 28.

152 Anonymous 236, p. 1.

153 RCVMHS, *Warragul Community Consultation—May 2019*; Victoria Legal Aid, *Productivity Commission's Public Hearing into Mental Health: Response to Question on Notice Regarding Community Treatment Orders*, 2019, p. 4.

154 *Witness Statement of Dr Christopher Maylea*, para. 10.

155 *Witness Statement of Professor Richard Newton*, paras. 47–48; Damien Hurrell, *Submission to the RCVMHS: SUB.0002.0032.0054*, 2019, pp. 1–2; *Witness Statement of Dr Neil Coventry*, 2020, para. 447.

156 *Witness Statement of Dr Neil Coventry*, 2020, pp. 72–73.

157 *Witness Statement of 'Anna Wilson' (pseudonym)*, 3 August 2020, para. 80(h).

158 *Mental Health Act 2014* (Vic), sec. 11(1)(a).

159 *Witness Statement of Professor Lisa Brophy*, para. 39; *Witness Statement of Dr Christopher Maylea*, para. 40.

160 *Witness Statement of Professor Richard Newton*, para. 48.

161 *Witness Statement of Professor Lisa Brophy*, para. 14.

162 *Witness Statement of Professor Richard Newton*, para. 43.

163 *Witness Statement of Associate Professor Ruth Vine*, 2020, para. 18.

164 *Witness Statement of Dr Neil Coventry*, 2020, para. 444.

165 *Witness Statement of Matthew Carroll*, 27 April 2020, para. 45; RCVMHS, *Compulsory Treatment Roundtable: Record of Proceedings*, 2020.

166 *Witness Statement of Matthew Carroll*, para. 15; *Witness Statement of Professor Lisa Brophy*, para. 61.

167 *Witness Statement of Dr Paul Denborough*, 11 May 2020, paras. 87–89 and 92.

168 RCVMHS, *Compulsory Treatment Roundtable: Record of Proceedings*.

169 *Witness Statement of Matthew Carroll*, para. 15.

170 Lisa Brophy and others, 'Community Treatment Orders and Supported Decision-Making', *Frontiers in Psychiatry*, 10 (2019), 1–12 (p. 4); Vrinda Edan and others, 'The Experience of the Use of Community Treatment Orders Following Recovery-Oriented Practice Training', *International Journal of Law and Psychiatry*, 64 (2019), 178–183 (p. 181).

171 *Evidence of Professor Dan Lubman*, 18 June 2020, p. 9.

172 Dr Anna Arstein-Kerslake and Dr Yvette Maker, *Submission to the RCVMHS: SUB.0002.0017.0022*, 2019, p. 11.

173 *Witness Statement of Professor Richard Newton*, para. 43.

174 *Mental Health Act 2014* (Vic), sec. 11(1)(d).

175 *Witness Statement of Peter Kelly*, para. 108.

176 Department of Health, Victoria, *Framework for Recovery-Oriented Practice*, 2011, p. 10.

177 *Witness Statement of 'Elizabeth Porter' (pseudonym)*, paras. 23–28.

178 *Witness Statement of Associate Professor Simon Stafrace*, 14 August 2020, para. 55(b).

179 The Royal Australian and New Zealand College of Psychiatrists, *RANZCP Victorian Branch Position Paper: Enabling Supported Decision-Making*, 2018, p. 5.

180 *Witness Statement of Dan Nicholson*, paras. 90–91 and 117; Dr Chris Maylea, Susan Alvarez-Vasquez, and others, *Evaluation of the Independent Mental Health Advocacy Service (IMHA)*, 2019, pp. 15 and 23–20; *Witness Statement of Louise Glanville*, para. 21; Mental Health Legal Centre, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, 2020, pp. 21–22; Lyn Edith Sarah Roberts Burt, *Submission to the RCVMHS: SUB.0002.0006.0089*, 2019, pp. 1–2; Productivity Commission, *Mental Health Inquiry Report, Volume 3*, 2020, pp. 1063–1066, 1068 and 1070–1071; Victorian Mental Illness Awareness Council, *VMIAC Consumer Survey: Advance Statements and Nominated Persons*, 2018, pp. 5–6, 8 and 12–13.

181 RCVMHS, *Compulsory Treatment Roundtable: Record of Proceedings*.

182 *Mental Health Act 2014* (Vic), sec. 11(1)(c).

183 *Witness Statement of Matthew Carroll*, para. 25; *Witness Statement of Louise Glanville*, para. 59(a); Mental Health Victoria and Mental Health Legal Centre, *Submission to the RCVMHS: SUB.0002.0029.0006*, 2019, p. 24.

184 *Witness Statement of Professor Lisa Brophy*, para. 63; *Witness Statement of Professor Penelope Weller*, para. 18; Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, pp. 15–16; RCVMHS, *Compulsory Treatment Roundtable: Record of Proceedings*.

185 Simmons and Gooding, pp. 7–8; *Witness Statement of Professor Lisa Brophy*, para. 47; Mental Health Complaints Commissioner, *Submission to the RCVMHS: SUB.4000.0001.0179*, 2019, p. 41.

186 *Witness Statement of Julie Anderson*, 28 May 2020, para. 42.

187 Soumitra Pathare and Laura S. Shields, 'Supported Decision-Making for Persons with Mental Illness: A Review', *Public Health Reviews*, 34.2 (2012), 1–40 (p. 4).

188 General Assembly, United Nations, *Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary-General, Human Rights Council, Tenth Session, Agenda Item 2*, 26 January 2009, p. 15.

189 Simmons and Gooding, p. 7.

190 *Witness Statement of Indigo Daya*, para. 85.

191 *Witness Statement of Dr Lynne Coulson Barr OAM*, 4 June 2020, p 74.

192 Professor Amita Dhanda, Advocacy Note on Legal Capacity, 2009, p. 2.

193 The Royal Australian and New Zealand College of Psychiatrists, pp. 1–2; Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, p. 3; *Witness Statement of Professor Lisa Brophy*, para. 47; *Witness Statement of Indigo Daya*, para. 67.

194 *Witness Statement of Erandathie Jayakody*, 4 June 2020, para. 129.

195 *Joint Witness Statement of 'Mary Corbett' and 'Jacob Corbett' (pseudonyms)*, para. 93.

196 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'*, p. 10; *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 175.

197 The Royal Australian and New Zealand College of Psychiatrists, p. 1; Alfred Health, *Submission to the RCVMHS: SUB:0002.0028.0157 (Addendum)*, 2019, p. 16; Piers Gooding, 'Psychiatrists' Perceptions of Supported Decision-Making: A Victorian Empirical Study', *Psychiatry, Psychology and Law*, 22.5 (2015), 701–722 (p. 719).

198 *Witness Statement of Dr Christopher Ryan*, para. 16; Marcus Sellars and others, 'Australian Psychiatrists' Support for Psychiatric Advance Directives: Responses to a Hypothetical Vignette', *Psychiatry, Psychology and Law*, 24.1 (2017), 61–73 (p. 70); Simmons and Gooding, p. 7.

199 *Witness Statement of Associate Professor Ruth Vine*, 27 June 2019, para. 93.

200 *Witness Statement of Professor Lisa Brophy*, para. 54.

201 *Witness Statement of Professor Lisa Brophy*, para. 54; Bernadette McSherry and Yvette Maker, 'International Human Rights and Mental Health: Challenges for Law and Practice', *Journal Law and Medicine*, 25 (2018), 315–319 (p. 319); United Nations, Human Rights Council, p. 14.

202 *Evidence of Dr Neil Coventry*, 8 July 2019, p. 460; RCVMHS, *Compulsory Treatment Roundtable: Record of Proceedings*.

203 *Witness Statement of Dan Nicholson*, paras. 90 and 117; Maylea, Alvarez-Vasquez, and others, p. ix; Productivity Commission, *Draft Report on Mental Health, Volume 1*, 2019, pp. 641–644; *Witness Statement of Louise Glanville*, para. 19; Mental Health Legal Centre, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, p. 21; Roberts Burt, pp. 1–2.

204 *Witness Statement of Louise Glanville*, para. 66; Anonymous; Mental Health Legal Centre, *Submission to the RCVMHS: SUB.0002.0032.0106 (Submission 1)*, 2019, p. 33.

205 United Nations, *Convention on the Rights of Persons with Disabilities* Article 12.

206 Penelope Weller and others, 'The Need for Independent Advocacy for People Subject to Mental Health Community Treatment Orders', *International Journal of Law and Psychiatry*, 66 (2019), 1–9 (p. 8).

207 *Personal Story Number 16, Collected by Victoria Legal Aid*, 2020.

208 Mental Health Tribunal, Victoria, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, 2020, p. 3.

209 *Witness Statement of Indigo Daya*, para. 68(c); Karen Newbigging, Julie Ridley and others, '"When You Haven't Got Much of a Voice": An Evaluation of the Quality of Independent Mental Health Advocate (IMHA) Services in England', *Health and Social Care in the Community*, 23.3 (2015), 313–324 (p. 313); Wanda Bennetts and others, 'The "Tricky Dance" of Advocacy: A Study of Non-Legal Mental Health Advocacy', *International Journal of Mental Health and Capacity Law*, 24.2018 (2018), 12–31 (p. 14); Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1065.

210 Mental Health Tribunal, Victoria, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, p. 3; Office of the Public Advocate, *Submission to the RCVMHS: SUB.0002.0029.0448 (Submission 1)*, 2019, pp. 16–17; *Witness Statement of Indigo Daya*, para. 42(f); Karen Newbigging, Dr Julie Ridley, and others, *The Right to Be Heard: Review of the Quality of Independent Mental Health Advocate (IMHA) Services in England*, 2012, p. 192.

211 Maylea, Alvarez-Vasquez and others, p. 15; Newbigging, Julie Ridley and others, p. 321.

212 Victorian Mental Illness Awareness Council, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, 2020, p. 7.

213 Bennetts and others, p. 26; Maylea, Alvarez-Vasquez, and others, p. 22; Newbigging, Dr Julie Ridley, and others, p. 92.

214 Weller and others, p. 5; Newbigging, Julie Ridley and others, p. 322.

215 Maylea, Alvarez-Vasquez and others, p. ix.

216 Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, p. 8.

217 *Mental Health Act 2014* (Vic), sec. 184(3).

218 Mental Health Tribunal, Victoria, *Annual Report 2018–19*, 2019, p. 27, Table 30.

219 Mental Health Review Tribunal, New South Wales, *Annual Report 2018–19*, 2019, p. 25.

220 Louise Glanville, *Response to Question on Notice at Public Hearing*, 30 July 2019, p. 7.

221 *Witness Statement of Matthew Carroll*, para. 18; *Witness Statement of Dan Nicholson*, para. 91.

222 *Witness Statement of 'Lucy Barker' (pseudonym)*, para. 44.

223 Mental Health Legal Centre, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, pp. 21–22.

224 Aisha Macgregor, Michael Brown, and Jill Stavert, 'Are Mental Health Tribunals Operating in Accordance with International Human Rights Standards? A Systematic Review of the International Literature', *Health and Social Care in the Community*, 27.4 (2019), e494–e513 (p. e509); United Nations, *Convention on the Rights of Persons with Disabilities: General Comment No.1 (2014), Eleventh Session*, p. 10.

225 *Witness Statement of Dan Nicholson*, para. 90; Mental Health Legal Centre, *Submission to the RCVMHS: SUB.0002.0032.0106 (Submission 1)*, p. 33; *Witness Statement of 'Lucy Barker' (pseudonym)*, para. 44.

226 Mental Health Tribunal, Case Management System 2014–15 to 2019–20.

227 Mental Health Tribunal, Case Management System 2014–15 to 2019–20.

228 Mental Health Tribunal, Case Management System 2014–15 to 2019–20.

229 Mental Health Tribunal, Case Management System 2014–15 to 2019–20.

230 Parliament of Victoria, Mental Health Bill 2014, Legislative Assembly Second Reading Speech.

231 Parliament of Victoria, *The Mental Health Act Statement of Compatibility*.

232 Department of Health and Human Services, *Victoria's Mental Health Services Annual Report 2019–20*, 2020, p. 72.

233 Department of Health and Human Services, *Review of the Take Up and Use of Advance Statements and Nominated Persons*, 2018, p. 50.

234 *Mental Health Act 2014* (Vic), sec. 12.

235 *Mental Health Act 2014* (Vic), secs. 8 and 13.

236 *Mental Health Act 2014* (Vic), sec. 32(1)(b) and 35(3)(c)(ii).

237 *Mental Health Act 2014* (Vic), sec. 50(1)(b) and 59(b).

238 *Mental Health Act 2014* (Vic), sec. 59(b).

239 *Mental Health Act 2014* (Vic), secs. 8 and 13(3).

240 *Mental Health Act 2014* (Vic), sec. 19.

241 *Mental Health Act 2014* (Vic), sec. 19.

242 *Mental Health Act 2014* (Vic), sec. 46(2)(a)(ii).

243 *Mental Health Act 2014* (Vic), sec. 48(2)(b).

244 *Mental Health Act 2014* (Vic), sec. 55(2)(b).

245 *Mental Health Act 2014* (Vic), sec. 71(4)(b).

246 *Mental Health Act 2014* (Vic), sec. 73.

247 *Mental Health Act 2014* (Vic), sec. 23(a).

248 *Mental Health Act 2014* (Vic), sec. 23(b).

249 *Mental Health Act 2014* (Vic), sec. 23(c).

250 *Mental Health Act 2014* (Vic), sec. 23(d).

251 Department of Health and Human Services, *Victoria's Mental Health Services Annual Report 2015–16*, 2016, p. 64.

252 *Mental Health Act 2014* (Vic), sec. 78.

253 *Mental Health Act 2014* (Vic), sec. 79(1).

254 *Mental Health Act 2014* (Vic), sec. 80.

255 *Mental Health Act 2014* (Vic), sec. 79(3).

256 *Mental Health Act 2014* (Vic), sec. 81(1).

257 *Mental Health Act 2014* (Vic), sec. 87.

258 *Witness Statement of Dr Neil Coventry*, 2020, para. 157.

259 Department of Health and Human Services, *Victoria's Mental Health Services Annual Report 2015–16*, p. 64.

260 Department of Health and Human Services, Client Management Interface/Operational Data Store 2014–15 to 2019–20. Note: 'New order' refers to a new order being initiated so that an occasion of compulsory treatment involving an Assessment Order, Temporary Treatment Order and Treatment Order is considered a single 'new order', rather than three separate orders.

261 Mental Health Legal Centre, *Submission to the RCVMHS: SUB.0002.0032.0106 (Submission 1)*, pp. 14–15; *Witness Statement of Erandathie Jayakody*, para. 126; *Witness Statement of Dr Christopher Maylea*, para. 47.

262 Victorian Mental Illness Awareness Council, *VMIAC Consumer Survey: Advance Statements and Nominated Persons*, p. 8.

263 *Witness Statement of Professor Lisa Brophy*, para. 48.

264 RCVMHS, *Ballarat Community Consultation—April 2019*; *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 206.

265 *Witness Statement of Professor Lisa Brophy*, para. 49; Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, p. 16.

266 *Witness Statement of Erandathie Jayakody*, para. 66.

267 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 206.

268 *Witness Statement of Dr Christopher Maylea*, para. 47; *Witness Statement of Professor Lisa Brophy*, para. 49.

269 Mental Health Complaints Commissioner, *Submission to the RCVMHS: SUB.4000.0001.0179*, p. 63; Department of Health and Human Services, *Review of the Take Up and Use of Advance Statements and Nominated Persons*, p. 36.

270 Department of Health and Human Services, *Review of the Take Up and Use of Advance Statements and Nominated Persons*, p. 6.

271 Department of Health and Human Services, *Review of the Take Up and Use of Advance Statements and Nominated Persons*, p. 24.

272 Paige Lerman, *Submission to the RCVMHS: SUB.0002.0030.0032*, 2019, p. 4; *Witness Statement of Julie Dempsey*, para. 35.

273 *Witness Statement of 'Elizabeth Porter' (pseudonym)*, para. 56.

274 Brendan Gillespie, *Submission to the RCVMHS: SUB.0002.0028.0521*, 2019, p. 5.

275 RCVMHS, *Compulsory Treatment Roundtable: Record of Proceedings*.

276 Victorian Mental Illness Awareness Council, *VMIAC Consumer Survey: Advance Statements and Nominated Persons*, p. 9.

277 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 206.

278 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 206; Terry Carney and David Tait, 'Mental Health Tribunals—Rights, Protection, or Treatment? Lessons from the ARC Linkage Grant Study?', *Psychiatry, Psychology and Law*, 18.1 (2011), 137–159 (p. 142); Department of Health and Human Services, *Victoria's Mental Health Services Annual Report 2015–16*, p. 64; *Personal Story of Jodie Ballagh, Collected by Victoria Legal Aid*, 2020.

279 Gooding, pp. 705–707; Mimi M. Kim and others, 'Understanding the Personal and Clinical Utility of Psychiatric Advance Directives: A Qualitative Perspective', *Psychiatry: Interpersonal and Biological Processes*, 70.1 (2007), 19–29 (p. 28); P. Nicaise and others, 'Users' and Health Professionals' Values in Relation to a Psychiatric Intervention: The Case of Psychiatric Advance Directives', *Administration and Policy in Mental Health and Mental Health Services Research*, 42.4 (2015), 384–393 (pp. 389–390); *Witness Statement of Professor Penelope Weller*, para. 56.

280 Kim and others, p. 20; Nicaise and others, p. 389; Fiona Kumar, *Submission to the RCVMHS: SUB.0002.0019.0033*, 2019, p. 3; RCVMHS, *Box Hill Community Consultation—May 2019*.

281 Gooding, p. 702; Sellars and others, p. 72; Dr Chris Maylea, Sara Matta, and others, *Preliminary Finding Report—Advance Statements Under the Mental Health Act 2014*, 2018, p. 4.

282 Sellars and others, pp. 70–71; *Witness Statement of Associate Professor Ruth Vine*, 2020, para. 9; *Witness Statement of Dr Christopher Ryan*, para. 16.

283 Victorian Mental Illness Awareness Council, *VMIAC Consumer Survey: Advance Statements and Nominated Persons*, p. 27.

284 Department of Health and Human Services, *Review of the Take Up and Use of Advance Statements and Nominated Persons*, p. 20.

285 Department of Health and Human Services, *Review of the Take Up and Use of Advance Statements and Nominated Persons*, p. 23.

286 Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, p. 52; Victoria Legal Aid, *Correspondence to the RCVMHS: CSP.0001.0001.0151, Paving the Roads to Recovery: Building a Better System for People Experiencing Mental Health Issues in Victoria*, p. 21.

287 *Mental Health Act 2014* (Vic), sec. 11(1)(c).

288 *Mental Health Act 2014* (Vic), sec. 69(3)(c).

289 *Mental Health Act 2014* (Vic), sec. 71(1)(a)(ii) and 71(3).

290 *Medical Treatment Planning Decisions Act 2016* (Vic), sec. 7(1)(e); *Guardianship and Administration Act 2019* (Vic), secs. 8(1)(a) and 41(1)(c).

291 *Guardianship and Administration Act 2019* (Vic), sec. 30; *Medical Treatment Planning Decisions Act 2016* (Vic), secs. 50, 58 and 63.

292 George Szmukler, 'Involuntary Detention and Treatment: Are We Edging Toward a "Paradigm Shift"?', *Schizophrenia Bulletin*, 46.2 (2020), 231–235 (p. 232); Victoria Legal Aid, *Correspondence to the RCVMHS: CSP.0001.0001.0151, Paving the Roads to Recovery: Building a Better System for People Experiencing Mental Health Issues in Victoria*, pp. 20–21; Newton-Howes and Ryan, p. 311.

293 Other Victorian legislation enables treatment to be compelled on people without their consent in limited circumstances. For example, section 8(2)(b) of the *Severe Substance Dependent Treatment Act 2010* (Vic) enables people to be detained and treated against their will if immediate treatment is necessary as a matter of urgency to save the person's life or prevent serious damage to their health. The Chief Health Officer may make public health orders under section 117 of the *Public Health and Wellbeing Act 2008* (Vic) for a person to be detained, isolated and treated where it is necessary to eliminate or reduce the risk of the person causing a serious risk to public health. These decisions must be made by the Magistrates' Court and Chief Health Officer respectively and are rarely used. The 'double standard' in how coercive treatment is used in relation to mental illness compared to infectious diseases is discussed in Christopher James Ryan, 'One Flu Over The Cuckoo's Nest: Comparing Legislated Coercive Treatment for Mental Illness with That for Other Illness', *Journal of Bioethical Inquiry*, 8 (2011), 87–93.

294 *Mental Health Act 2014* (Vic), sec. 71(4)(a).

295 Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, p. 17.

296 *Medical Treatment Planning Decisions Act 2016* (Vic), sec. 13.

297 *Medical Treatment Planning Decisions Act 2016* (Vic), sec. 26.

298 *Medical Treatment Planning Decisions Act 2016* (Vic), secs. 8, 22, 51 and 60.

299 *Medical Treatment Planning Decisions Act 2016* (Vic), sec. 48.

300 *Mental Health Act 2014* (Vic), sec. 73(1)(a).

301 Victorian Mental Illness Awareness Council, *Submission to the RCVMHS: SUB.0002.0028.0645*, p. 9; *Witness Statement of Dr Christopher Maylea*, para. 52; *Witness Statement of Professor Penelope Weller*, para. 60; *Witness Statement of Indigo Daya*, para. 69(b); United Nations, *Convention on the Rights of Persons with Disabilities: General Comment No.1 (2014), Eleventh Session*, pp. 4–5.

302 *PBU and NJE v Mental Health Tribunal*, 2018, para. 199.

303 Victoria Legal Aid, *Correspondence to the RCVMHS: CSP.0001.0001.0151, Paving the Roads to Recovery: Building a Better System for People Experiencing Mental Health Issues in Victoria*, pp. 19 and 26; Victorian Mental Illness Awareness Council, *Submission to the RCVMHS: SUB.0002.0028.0645*, p. 4; *Witness Statement of Dr Christopher Maylea*, paras. 21, 57 and 60; *Witness Statement of Matthew Carroll*, para. 22; *Witness Statement of Professor Lisa Brophy*, para. 51.

304 Victorian Mental Illness Awareness Council, *Correspondence to the RCVMHS: Governance in Mental Health*, 2020, p. 3.

305 Peninsula Health, *Submission to the RCVMHS: SUB.0002.0028.0109*, 2019, p. 7; Victoria Legal Aid, *Correspondence to the RCVMHS: CSP.0001.0001.0151, Paving the Roads to Recovery: Building a Better System for People Experiencing Mental Health Issues in Victoria*, p. 3.

306 *Mental Health Act 2014* (Vic), sec. 70(1).

307 *Mental Health Act 2014* (Vic), sec. 70.

308 *Mental Health Act 2014* (Vic), secs. 11(1)(c) and 69.

309 *Mental Health Act 2014* (Vic), sec. 13.

310 *Mental Health Act 2014* (Vic), sec. 71(4)(b).

311 *Witness Statement of Dan Nicholson*, para. 113.

312 Mental Health Complaints Commissioner, *The Right to Be Safe: Ensuring Sexual Safety in Acute Mental Health Inpatient Units: Sexual Safety Project Report*, 2018; Department of Health and Human Services, *Review of the Take Up and Use of Advance Statements and Nominated Persons*.

313 Victorian Mental Illness Awareness Council, *Seclusion Report*, 2019; Victorian Mental Illness Awareness Council, *Seclusion Report #2*, 2020; Victorian Mental Illness Awareness Council, *VMIAC Consumer Survey: Advance Statements and Nominated Persons*; Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, p. 19.

314 *Witness Statement of Kym Peake*, 4 October 2020, para. 117.

315 *Mental Health Act 2014* (Vic), secs. 45 and 51.

316 *Mental Health Act 2014* (Vic), secs. 58 and 61.

317 *Mental Health Act 2014* (Vic), sec. 150(1).

318 Department of Health and Human Services, Client Management Interface/Operational Data Store 2019–20.

319 Department of Health and Human Services, Client Management Interface/Operational Data Store 2019–20.

320 *Mental Health Act 2014* (Vic), sec. 152.

321 *Mental Health Act 2014* (Vic), sec. 153.

322 Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, p. 14.

323 Mental Health Tribunal, Victoria, *Annual Report 2019–20*, p. 20.

324 Mental Health Tribunal, Victoria, *Annual Report 2019–20*, p. 21.

325 Mental Health Tribunal, Victoria, *Annual Report 2019–20*, p. 22.

326 Mental Health Tribunal, Victoria, *Annual Report 2019–20*, p. 22.

327 Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, p. 14.

328 Victorian Mental Health Tribunal, p. 9.

329 *Witness Statement of Matthew Carroll*, para. 29b.

330 Mental Health Tribunal, *Mental Health Tribunal Hearing Experience Survey: Report*, 2020, p. 3.

331 Mental Health Tribunal, Victoria, *Annual Report 2019–20*, p. 20.

332 Mental Health Tribunal, Victoria, *Annual Report 2019–20*, p. 20.

333 Mental Health Review Tribunal, New South Wales, p. 32.

334 Mental Health Tribunal, Victoria, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, p. 7; *Witness Statement of Emeritus Professor Terry Carney AO*, 17 July 2020, paras. 37–38 and 40.

335 Mental Health Tribunal, Victoria, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, p. 10.

336 *Mental Health Act 2014* (Vic), secs. 118(1)(c) and 120(b).

337 *Mental Health Act 2014* (Vic), secs. 120(a) and 120(c).

338 *Mental Health Act 2014* (Vic), secs. 99, 104, and 121(1).

339 *Mental Health Act 2014* (Vic), secs 84, 87 and 88.

340 *Mental Health Act 2014* (Vic), sec. 65.

341 *Mental Health Act 2014* (Vic), sec. 121(1)(f).

342 *Mental Health Act 2014* (Vic), sec. 122.

343 *Witness Statement of Dr Neil Coventry*, 2020, para. 157.

344 Department of Health and Human Services, *Chief Psychiatrist's Annual Report 2014–15*, 2015, pp. 14–21; Department of Health and Human Services, *Chief Psychiatrist's Annual Report 2015–16*, 2016, pp. 7–10 and 21–27; Department of Health and Human Services, *Chief Psychiatrist's Annual Report 2016–17*, 2017, pp. 10–12; Department of Health and Human Services, *Chief Psychiatrist's Annual Report 2017–18*, 2018, pp. 19–21.

345 *Mental Health Act 2014* (Vic), sec. 228.

346 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 145.

347 Victorian Auditor-General's Office, *Child and Youth Mental Health*, 2019, p. 67.

348 Victorian Government, pp. 26–27.

349 Mental Health Tribunal, Victoria, *Annual Report 2019–20*, pp. 20–22; Department of Health and Human Services, *Victoria's Mental Health Services Annual Report 2019–20*, p. 64.

350 *Witness Statement of Erandathie Jayakody*, para. 120; Victoria Legal Aid, *Correspondence to the RCVMHS: CSP.0001.0001.0151, Paving the Roads to Recovery: Building a Better System for People Experiencing Mental Health Issues in Victoria*, p. 24; Graham Rodda, *Submission to the RCVMHS: SUB.0002.0025.0083*, 2019, p. 2.

351 *Witness Statement of Erandathie Jayakody*, para. 122.

352 Light, p. 86; Edwina Light and others, 'Community Treatment Orders in Australia: Rates and Patterns of Use', *Australasian Psychiatry*, 20.6 (2012), 478–482 (p. 481); Edwina M Light and others, 'Out of Sight, out of Mind: Making Involuntary Community Treatment Visible in the Mental Health System', *Medical Journal of Australia*, 196.9 (2012), 591–593 (pp. 591–592).

353 Albury Wodonga Health, *Submission to the RCVMHS: SUB.0002.0032.0088*, 2019, p. 15; Legal Aid New South Wales and Victoria Legal Aid, *Cross-Border Justice: Exploring Ways to Improve Access to Legal Assistance Along the NSW / Victorian Border*, 2018, p. 13.

354 *Mental Health Act 2014* (Vic), Part 13.

355 *Mental Health Act 2014* (Vic), Part 13.

356 *Witness Statement of Dr Neil Coventry*, 2020, para. 437.

357 *Witness Statement of Dr Neil Coventry*, 2020, para. 437.

358 *Witness Statement of Dr Neil Coventry*, 2020, para. 439.

359 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1073; Anonymous 110, *Submission to the RCVMHS: SUB.0002.0024.0068*, 2019, p. 1.

360 *Medical Treatment Planning Decisions Act 2016* (Vic), sec. 53.

361 International Disability Alliance, *Report on IDA's Follow-up Mission to Peru*, 2017, p. 29; Tina Minkowitz, Peruvian Legal Capacity Reform—Celebration and Analysis, *Mad In America*, 19 October 2018, <www.madinamerica.com/2018/10/peruvian-legal-capacity-reform-celebration-and-analysis/>, [accessed 4 December 2020].

362 Victoria Legal Aid, *Correspondence to the RCVMHS: CSP.0001.0001.0151, Paving the Roads to Recovery: Building a Better System for People Experiencing Mental Health Issues in Victoria*, pp. 20–21.

363 Kay E Wilson, pp. 47 and 58; Sascha Callaghan and Christopher James Ryan, 'An Evolving Revolution: Evaluating Australia's Compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law', *UNSW Law Journal*, 39.2 (2016), 596–624 (p. 610).

364 *Charter of Human Rights and Responsibilities Act 2006* (Vic), sec. 7(2).

365 United Nations, *Convention on the Rights of Persons with Disabilities*, Article 12(4); McSherry and Weller, pp. 330–338.

366 Jeremy Heimans and Henry Timms, 'Understanding "New Power"', *Harvard Business Review*, December 2014, pp. 1–2; *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 37; *Witness Statement of Dr Neil Coventry*, 2020, para. 74.

367 *Witness Statement of Dr Christopher Maylea*, para. 29; *Witness Statement of Professor Penelope Weller*, paras. 24–25; *Witness Statement of Indigo Daya*, para. 67; Victorian Mental Illness Awareness Council, *Submission to the RCVMHS: SUB.0002.0028.0645*, p. 9.

368 *Witness Statement of Indigo Daya*, para. 67.

369 United Nations, Human Rights Council, p. 1.

370 United Nations, Human Rights Council, p. 9.

371 United Nations, Human Rights Council, p. 10.

372 Victorian Mental Health Tribunal, p. 28; Monash Health, *Submission to the RCVMHS: SUB.7000.0003.0001*, 2019, p. 10; *Witness Statement of Dr Paul Denborough*, 2020, para. 88.

373 RCVMHS, *Compulsory Treatment Roundtable: Record of Proceedings*.

374 Dinesh Bhugra and others, 'The WPA—Lancet Psychiatry Commission on the Future of Psychiatry', *The Lancet Psychiatry*, 4.10 (2017), 775–818 (p. 793).

375 *Witness Statement of Dr Christopher Maylea*, para. 21; *Witness Statement of Angus Clelland*, 5 June 2020, para. 39; Victorian Mental Illness Awareness Council, pp. 3, 11 and 14.

376 *Witness Statement of Louise Glanville*, para. 63.

377 Gill, p. 9.

378 *Witness Statement of Dr Neil Coventry*, 2020, paras. 444–447; *Witness Statement of Associate Professor Ruth Vine*, 2020, para. 18; *Witness Statement of 'Elizabeth Porter' (pseudonym)*, para. 69; The Centre for Psychiatric Nursing, *Submission to the RCVMHS: SUB.0002.0028.0284*, 2019, pp. 1–2.

379 *Witness Statement of Cath Roper*, para. 46 citing Grey and O'Hagan, 2015 and Gooding et al, 2018.

380 *Witness Statement of Dr Christopher Maylea*, para. 10.

381 *Witness Statement of Dr Christopher Maylea*, para. 12.

382 *Witness Statement of Dr Christopher Maylea*, para. 13.

383 *Witness Statement of Dr Christopher Maylea*, para. 14.

384 *Witness Statement of Professor Richard Newton*, para. 53.

385 *Witness Statement of Professor Richard Newton*, para. 42.

386 *Witness Statement of Professor Lisa Brophy*, paras. 30, 37 and 68.

387 *Witness Statement of Professor Lisa Brophy*, para. 25; Susan Walker and others, 'Clinical and Social Factors Associated with Increased Risk for Involuntary Psychiatric Hospitalisation: A Systematic Review, Meta-Analysis, and Narrative Synthesis', *The Lancet Psychiatry*, 6.12 (2019), 1039–1053 (p. 1040).

388 *Witness Statement of Dr Neil Coventry*, 2020, para. 456; Walker and others, p. 1039; Anonymous 408, *Submission to the RCVMHS: SUB.0002.0032.0019*, 2019, p. 4; *Witness Statement of Professor Penelope Weller*, para. 50.

389 *Witness Statement of Professor Lisa Brophy*, para. 75.

390 Walker and others, p. 1050; Lisa Brophy, Cath Roper, and Kellie Grant, 'Risk Factors for Involuntary Psychiatric Hospitalisation', *The Lancet Psychiatry*, 6.12 (2019), 974–975 (p. 974); *Witness Statement of Professor Lisa Brophy*, para. 25; Phoebe Barnett and others, 'Ethnic Variations in Compulsory Detention under the Mental Health Act: A Systematic Review and Meta-Analysis of International Data', *The Lancet Psychiatry*, 6.4 (2019), 305–317 (p. 305).

391 *Witness Statement of Professor Lisa Brophy*, para. 25; Steve Kisely and others, 'Efficacy of Compulsory Community Treatment and Use in Minority Ethnic Populations: A Statewide Cohort Study', *Australian and New Zealand Journal of Psychiatry*, 54.1 (2020), 76–88 (p. 76).

392 *Witness Statement of Dr Tricia Szirom*, 12 May 2020, para. 18.

393 *Witness Statement of Indigo Daya*, para. 104.

394 *Witness Statement of 'Rachel Bateman' (pseudonym)*, 16 June 2020, para. 165.

395 Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, pp. 27–28.

396 Victoria Legal Aid, *Correspondence to the RCVMHS: CSP.0001.0001.0151, Paving the Roads to Recovery: Building a Better System for People Experiencing Mental Health Issues in Victoria*, p. 24; Mental Health Legal Centre, *Submission to the RCVMHS: SUB.0002.0032.0106 (Submission 1)*, p. 36; Victorian Mental Illness Awareness Council, *Submission to the RCVMHS: SUB.0002.0028.0645*, p. 4.

397 *Witness Statement of Dr Christopher Ryan*, para. 42.

398 *Witness Statement of Erandathie Jayakody*, para. 116.

399 *Witness Statement of Associate Professor Ruth Vine*, 2020, para. 47; *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 200; *Witness Statement of Professor Richard Newton*, para. 27; Victoria Legal Aid, *Correspondence to the RCVMHS: CSP.0001.0001.0151, Paving the Roads to Recovery: Building a Better System for People Experiencing Mental Health Issues in Victoria*, p. 26; Light, p. 87.

400 *Witness Statement of Professor Lisa Brophy*, para. 72.

401 Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, p. 69.

402 *Witness Statement of Dr Christopher Maylea*, para. 61.

403 *Witness Statement of Dr Christopher Maylea*, paras. 63–64.

404 *Witness Statement of Associate Professor Ruth Vine*, 2020, para. 70.

405 *Witness Statement of Associate Professor Ruth Vine*, 2020, para. 70.

406 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 202; Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, p. 69; *Witness Statement of Associate Professor Ruth Vine*, 2020, paras. 70–71.

407 Department of Health and Human Services, *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality of Care. Report of the Review of Hospital Safety and Quality Assurance in Victoria*, 2016, p. 179.

408 *Charter of Human Rights and Responsibilities Act 2006* (Vic), secs. 5, 8–9, and 19.

409 Office of the Public Advocate, p. 16; *Witness Statement of Professor Penelope Weller*, para. 22(c); *Personal Story Number 16, Collected by Victoria Legal Aid*.

410 Maylea, Alvarez-Vasquez and others, p. 13.

411 Maylea, Alvarez-Vasquez and others, p. 27.

412 *Personal Story of Jodie Ballagh, Collected by Victoria Legal Aid*.

413 Newbigging, Dr Julie Ridley and others, p. 202; *Witness Statement of Professor Lisa Brophy*, para. 28; Stephen Rosenman, Ailsa Korten and Leigh Newman, 'Efficacy of Continuing Advocacy in Involuntary Treatment', *Psychiatric Services*, 51.8 (2000), 1029–1033 (p. 1029).

414 *Witness Statement of Dr Christopher Maylea*, para. 82; Newbigging, Dr Julie Ridley and others, p. 200.

415 Maylea, Alvarez-Vasquez and others, p. 23; *Personal Story Number 2, Collected by Victoria Legal Aid*, 2020; *Personal Story Number 3, Collected by Victoria Legal Aid*, 2020; *Personal Story of Jodie Ballagh, Collected by Victoria Legal Aid*; *Witness Statement of Dan Nicholson*, para. 117(c).

416 Newbigging, Dr Julie Ridley and others, p. 4.

417 Eleanore Fritze, *Shining a Light Behind Closed Doors*, 2015, pp. xiv and 42; Mental Health Tribunal, Victoria, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, p. 6; Victoria Legal Aid, *Answers to Questions on Notice in Response to the Productivity Commission Public Hearing into Mental Health: Is There Evidence of Systematically Different Outcomes Before Mental Health Tribunals Depending on Whether There Is Legal Representation?*, 2020, pp. 4–5; Macgregor, Brown and Stavert, p. 509; Dr Penelope Weller, 'Taking a Reflexive Turn: Non-Adversarial Justice and Mental Health Review Tribunals', *Monash University Law Review*, 37.1 (2011), 81–101 (p. 97).

418 Mental Health Tribunal, Victoria, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, p. 6.

419 Victorian Mental Illness Awareness Council, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, p. 7; *Personal Story Number 16, Collected by Victoria Legal Aid*; Vivienne Topp, Martin Thomas and Mim Ingvarson, Lacking Insight: Involuntary Patient Experience and the Victorian Mental

Health Review Board, <www.yumpu.com/en/document/read/41539411/lacking-insight-community-law>, [accessed 8 December 2020].

420 Victoria Legal Aid, *Productivity Commission's Public Hearing into Mental Health: Response to Question on Notice Regarding Legal Representation Before Mental Health Tribunals*, 2019, p. 2.

421 Mental Health Tribunal, Victoria, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, p. 10.

422 Glanville, p. 7; Victoria Legal Aid, *Productivity Commission's Public Hearing into Mental Health: Response to Question on Notice Regarding Community Treatment Orders*, p. 2; Mental Health Legal Centre, *Submission to the RCVMHS: SUB.0002.0032.0106 (Submission 1)*, pp. 33–34.

423 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1063.

424 *Witness Statement of 'Lucy Barker' (pseudonym)*, para. 44.

425 *Witness Statement of Dr Christopher Ryan*, para. 31; Glanville, p. 7; Victoria Legal Aid, *Productivity Commission's Public Hearing into Mental Health: Response to Question on Notice Regarding Community Treatment Orders*, pp. 6–7; Mental Health Legal Centre, *Submission to the RCVMHS: SUB.0002.0032.0106 (Submission 1)*, pp. 32–34.

426 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1064, Action 21.8.

427 *Witness Statement of Matthew Carroll*, para. 17; *Witness Statement of Professor Lisa Brophy*, para. 47; *Witness Statement of Professor Suresh Sundram*, para. 142; Department of Health and Human Services, *Review of the Take Up and Use of Advance Statements and Nominated Persons*, pp. 24 and 26.

428 These records will reference how services considered sections 11 and 68 to 71.

429 *Mental Health Act 2014* (Vic), sec. 71(4).

430 *Witness Statement of Professor Neil Rees*, 15 June 2020, para. 34.

431 *Witness Statement of Indigo Daya*, para. 69(b).

432 *Mental Health Act 2007* (NSW), sec. 140; *Mental Health Act 2016* (Qld), sec. 704; *Mental Health Act 1983* (United Kingdom), sec. 65, <www.legislation.gov.uk/ukpga/1983/20/part/VIII/crossheading/functions-of-the-secretary-of-state>, [accessed 8 July 2020]; *Mental Health Compulsory Assessment and Treatment Act 1992* (NZ), sec. 101; *Mental Health (Care and Treatment) (Scotland) Act 2003*, sec. 21.

433 United Nations, *Convention on the Rights of Persons with Disabilities*, Article 12(4).

434 McSherry and Weller, pp. 276–277; Macgregor, Brown, and Stavert, p. 494; Katey Thom and Ivana Nakarada-Kordic, 'Mental Health Review Tribunals in Action: A Systematic Review of the Empirical Literature', *Psychiatry, Psychology and Law*, 21.1 (2014), 112–126 (p. 112).

435 Mary Donnelly, 'Chapter 12: Reviews of Treatment Decisions: Legalism, Process and the Protection of Rights', in *Rethinking Rights-Based Mental Health Laws* (Oxford and Portland, Oregon: Hart Publishing, 2010), pp. 275–298 (p. 295).

436 *Witness Statement of Professor Neil Rees*, para. 55.

437 *Witness Statement of Associate Professor Ruth Vine*, 2020, para. 40; Rees, pp. 80–81; *Witness Statement of Peter Kelly*, para. 160; *Witness Statement of Emeritus Professor Terry Carney AO*, para. 49; Mental Health Legal Centre, *Submission to the RCVMHS: SUB.0002.0032.0106 (Submission 1)*, p. 34; RCVMHS, *Compulsory Treatment Roundtable: Record of Proceedings*.

438 Mental Health Tribunal, Victoria, *Correspondence to the RCVMHS: CSP.0001.0001.0122*, 2020, p. 6.

439 *Personal Story Number 9, Collected by Victoria Legal Aid*, 2020; *Personal Story Number 16, Collected by Victoria Legal Aid*; *Personal Story Number 22, Collected by Victoria Legal Aid*, 2020.

440 *Witness Statement of 'Lucy Barker' (pseudonym)*, para. 44.

441 *Witness Statement of 'Anna Wilson' (pseudonym)*, para. 37.

442 *Witness Statement of Associate Professor Ruth Vine*, 2020, para. 60; RCVMHS, *Compulsory Treatment Roundtable: Record of Proceedings*; Alfred Health, p. 16.

443 RCVMHS, *Compulsory Treatment Roundtable: Record of Proceedings*; *Witness Statement of Professor Suresh Sundram*, para. 132.

444 Victoria Legal Aid, *Correspondence to the RCVMHS: CSP.0001.0001.0151, Paving the Roads to Recovery: Building a Better System for People Experiencing Mental Health Issues in Victoria*, pp. 23–24; *Witness Statement of Dr Christopher Maylea*, para. 57; *Witness Statement of Erandathie Jayakody*, paras. 117–118; Anonymous 408, p. 20.

445 Macgregor, Brown and Stavert, p. 506; Thom and Nakarada-Kordic, pp. 116–117.

446 Mental Health Tribunal, Victoria, *A Guide to Solution-Focused Hearings in the Mental Health Tribunal*, 2014, p. 21; Weller, pp. 88–89.

447 Fritze, p. xiv.

448 Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, p. 71; Mental Health Legal Centre, *Submission to the RCVMHS: SUB.0002.0032.0106 (Submission 1)*, p. 34.

449 Fritze, p. 59.

Chapter 33

A sustainable workforce for the future

Recommendation 57:

Workforce strategy, planning and structural reform

The Royal Commission recommends that the Victorian Government:

1. ensure that the range of expanded mental health and wellbeing services is delivered by a diverse, multidisciplinary mental health and wellbeing workforce of the necessary size and composition across Victoria.
2. by the end of 2023, implement and support structural workforce reforms to:
    - **a.** attract, train and transition staff to deliver the core functions of services across Local, Area and Statewide Mental Health and Wellbeing Services (refer to recommendation 5); and
    - **b.** develop new and enhanced workforce roles as described by the Royal Commission in its final report.
3. develop, implement and maintain a Workforce Strategy and Implementation Plan and, by the end of 2021, enable the Department of Health to:
    - **a.** conduct ongoing workforce data collection, analysis and planning;
    - **b.** establish a dedicated workforce planning and strategy function; and
    - **c.** encourage collaborative engagement and partnerships with relevant workforce stakeholders in implementing recommendations.

Recommendation 58:

Workforce capabilities and professional development

The Royal Commission recommends that the Victorian Government:

1. through the Department of Health, by the end of 2021, define the knowledge, skills and attributes required of a diverse, multidisciplinary mental health and wellbeing workforce, starting with the priorities as described by the Royal Commission.
2. develop a Victorian Mental Health and Wellbeing Workforce Capability Framework as a component of this.
3. detail the approach to capability development across the mental health and wellbeing workforce as part of the workforce strategy and implementation plan.
4. build on the interim report's recommendation 1 and enable the Collaborative Centre for Mental Health and Wellbeing, in collaboration with training providers, mental health and wellbeing services and people with lived experience, to coordinate learning and professional development activities across the whole mental health and wellbeing workforce.

Recommendation 59:

Workforce safety and wellbeing

The Royal Commission recommends that the Victorian Government:

1. by the end of 2021, establish an ongoing Mental Health Workforce Wellbeing Committee to address occupational health and safety needs, co-chaired by the Department of Health and WorkSafe Victoria that will:
   - **a.** identify, monitor and address existing physical safety and wellbeing risks as well as those that may emerge throughout the reform process; and
   - **b.** develop tailored monitoring approaches for the psychological health and safety of staff in the mental health and wellbeing workforce.
2. work with service providers, workers (including lived experience workers), unions, representative and professional bodies to set clear expectations and implement a range of measures to support the professional wellbeing of the mental health and wellbeing workforce, as described by the Royal Commission in its final report.
3. beginning in 2021, work with the Mental Health Workforce Wellbeing Committee to monitor workforce wellbeing outcomes at least once a year.

33.1 The heart of the future mental health and wellbeing system

The workforce is the heart of the Victorian mental health and wellbeing system. It will play a crucial role in realising the Commission's vision for reform and in leading continuous improvement into the future.

The Commission's interim report emphasised that an adequately resourced, engaged, skilled and motivated mental health and wellbeing workforce is essential to delivering high-quality, safe and effective treatment, care and support to people living with mental illness or psychological distress, and to families, carers and supporters.[1] The report proposed several foundational reforms to begin addressing workforce shortages, including increasing lived experience workforces. It also committed to defining the new roles, composition, skills and values of the workforce in the future mental health and wellbeing system.

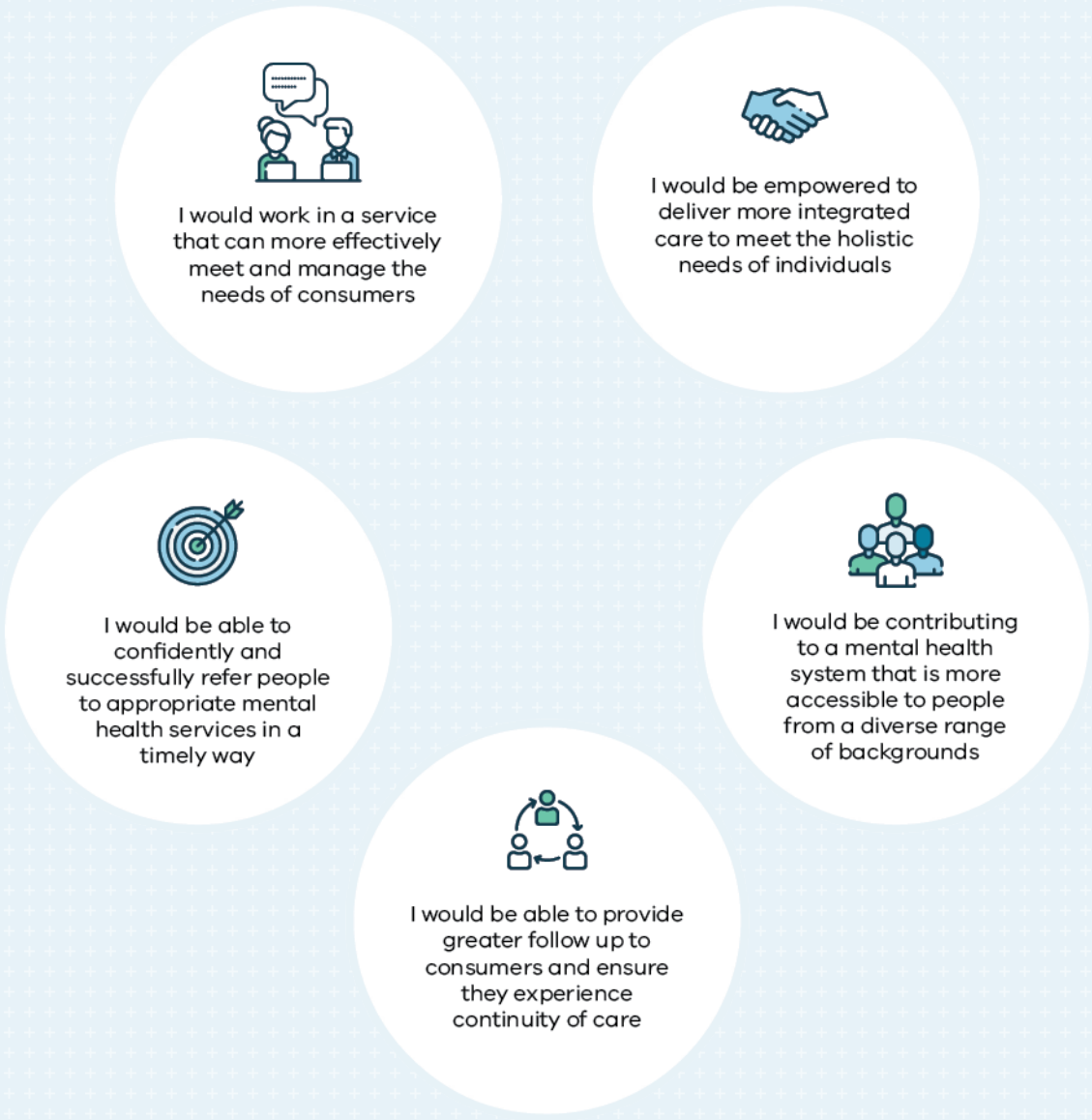
A responsive and integrated mental health and wellbeing system will deliver services in new ways to support the mental health and wellbeing of people throughout Victoria. To achieve this, the Commission's vision for the future mental health and wellbeing system sees a workforce that is supported to thrive in rewarding and engaging environments that value cultures of 'collaboration, curiosity and care'.[2]

It is critical that system reforms harness the collective strengths of the workforce. The system must provide better support for the workforce by:

- encouraging and supporting excellence and valuing all types of expertise in delivering mental health and wellbeing services
- enabling the workforce to use their existing capabilities (knowledge, skills and attributes) effectively and to develop their skills and knowledge to continually improve the quality of treatment, care and support they provide
- ensuring the workforce feels safe, trusted, respected and valued
- ensuring the Victorian mental health and wellbeing system is an attractive, contemporary and sustainable place to work by supporting workforce wellbeing and career progression.

Thousands of members of the workforce have shared their vision for the future system with the Commission.[3] Mental health and wellbeing workers are driven by values and motivated to make a difference to the lives of those living with mental illness or psychological distress. They want to deliver services that are holistic, integrated and responsive to diversity and to be part of a mental health and wellbeing system that centres on developing positive therapeutic relationships,[4] continuity of care and collaboration across services.[5] They want to work in environments that enable them to take the time to understand the needs and unique circumstances of the people they see, and to work with consumers, families, carers and supporters to help them make informed decisions about what support is right for them.[6] They want services to be more accessible to a diverse range of backgrounds, and they want people to be able to seamlessly and easily move around the system. Figure 33.1 highlights the workforce's aspirations for the future system.

Figure 33.1: An ideal mental health and wellbeing system, as described by the workforce



Source: ORIMA Research, Mental Health Workforce Survey, 2020.

As one mental health professional told the Commission:

> My aspiration, I think, would be around a greater focus within the workforce of 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.[7]

While many aspirations were shared across professional groups, some particular areas of focus were notable. While psychologists and psychiatrists emphasised the desire to feel better supported to manage complex caseloads when needed,[8] nurses highlighted their desire to have more time to focus on establishing and developing therapeutic rapport and working in a service that can more effectively meet and manage the needs of consumers.[9] Lived experience workers stressed the importance of being part of a highly developed lived experience workforce in the design, leadership and delivery of mental health and wellbeing services.[10]

The workforce's ability to engage effectively with consumers, families, carers and supporters, and collaborate with their colleagues is affected by a number of complex matters including workforce shortages, a lack of support for professional development and the need to better support their own mental health and wellbeing.[11] These matters need to be resolved to build the sustainable workforce necessary to realise system reforms.

The Commission's vision and recommended workforce reforms will ensure the workforce has sufficient size and diversity and is properly distributed throughout the state to respond to supply gaps and shortages. The reforms will also improve specific capabilities across professions, roles and settings that are aligned to future service-delivery approaches. Better supports will also ensure workers feel safe, valued and confident at work, wherever they work.

33.2 Profile of the mental health and wellbeing workforce

The current Victorian mental health and wellbeing workforce includes people from many different professions, disciplines, backgrounds and experiences who work together across public, community and private mental health service settings. Collectively, the workforce draws on a wide range of capabilities and expertise to deliver services to Victorians in order to support their recovery, mental health and wellbeing.

The Commission defines the Victorian mental health and wellbeing workforce as people whose primary professional role is in delivering treatment, care and support to consumers experiencing mental illness or psychological distress, and working with families, carers and supporters or other social and professional supports. The Commission takes a broader view of the professional diversity of the workforce than the *Mental Health Act 2014* (Vic), which provides a narrower definition of 'mental health practitioner' for the specific purposes of that Act.[12] The workforce includes professions registered under the National Registration and Accreditation Scheme (such as psychologists, psychiatrists, nurses and occupational therapists), self-regulated professions (such as social workers, counsellors and art therapists) and a diverse range of other workforce groups (including lived experience workers, wellbeing support workers—sometimes referred to as 'psychosocial support' workers—and other mental health and wellbeing treatment, care and support workers in a variety of organisational settings).[13]

The term 'lived experience workforces' broadly represents two distinct professional groups working in roles that focus on their lived expertise—people with personal lived experience of mental illness or psychological distress ('consumers') and families, carers and supporters with lived experience of supporting a family member or friend.[14] The lived experience workforces undertake a diverse range of roles including providing support directly to consumers, families, carers and supporters through peer support or advocacy, or indirectly through leadership, consultation, system advocacy, education, training or research.[15] Each of these roles has a distinct value and purpose that should be clearly articulated and delineated within services and the broader system.[16]

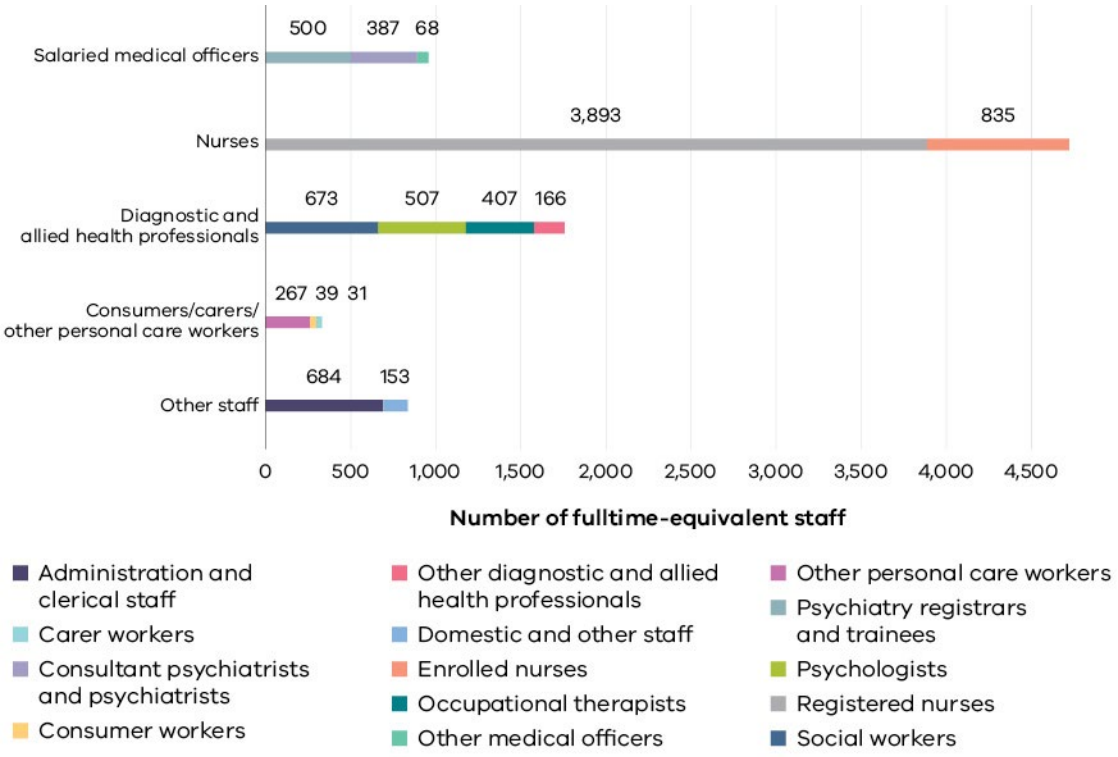
This chapter focuses primarily on the paid mental health and wellbeing workforce, including lived experience workers. Volunteers also play an important role in the mental health and wellbeing system in a range of roles and settings. It is estimated that more than 2.3 million Victorians volunteered in 2019 across diverse sectors and activities, and many mental health and wellbeing services, such as crisis helplines, rely on formal volunteer programs for their service delivery.[17] Other professions also regularly interact with the mental health system and play an important role in supporting people living with mental illness or psychological distress. These professionals include GPs, pharmacists, dietitians, paramedics and police, as well as those working in other sectors or settings such as in education, family violence and aged care. In addition to the workforce, the Commission also recognises the important and substantial work of families, carers, supporters and other community supports in caring for people living with mental illness or psychological distress.

33.2.1 Profile and distribution

The Victorian mental health and wellbeing workforce includes people from diverse backgrounds and with a range of life experiences, professional qualifications, skills and capabilities. The Commission's interim report noted the difficulties in comprehensively profiling the mental health workforce in Victoria. There is no consolidated dataset that sufficiently captures detailed workforce data. Neither the Victorian Government, Commonwealth Government nor private organisations are responsible for keeping a detailed and up-to-date repository of workforce information.[18]

Some aggregated data help provide a basic picture of the Victorian mental health workforce. The Australian Institute of Health and Welfare collects data on fulltime-equivalent staff working in state and territory specialised mental healthcare facilities.[19] As Figure 33.2 indicates, several professions work in these services.[20] From 2016–17 to 2018–19, Victoria was below the national average rate of professionals per 100,000 people. However, over the past two years the average rate per 100,000 people has increased for some professions such as salaried medical officers, nurses and diagnostic and allied health professionals.[21] This is a positive development, however, as outlined throughout this chapter, shortages in many professions remain or are anticipated to arise in the near future.

Figure 33.2: Fulltime-equivalent staff in specialised mental health care facilities, by staffing category, Victoria, 2018–19



Source: Australian Institute of Health and Welfare, Mental Health Services in Australia: Specialised mental health care facilities 2018–19, Table FAC.34 <www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/specialised-mental-health-care-facilities> [accessed 6 December 2020].

The mental health and wellbeing workforce also appears to be unevenly distributed across Victoria, which can lead to a lack of service offerings in some communities. Workforce shortages are particularly pronounced in rural and regional areas.[22] For example, in 2017–18 there were 15.6 psychiatrists per 100,000 people in metropolitan Melbourne, in contrast to 8.4 in peri-urban and regional areas and 5.6 in rural areas.[23] There are also a number of mental health professionals, in particular, psychiatrists and psychologists, working exclusively in the private sector[24] for a variety of reasons.[25]

Apart from these settings, there are many workers in community-based services, including non-government organisations, who deliver mental health and wellbeing services to consumers, families, carers and supporters. As noted by the Productivity Commission, accurately profiling the mental health professionals working in these settings is even more constrained by data inadequacies.[26] Overall, there is a lack of data about community health services—particularly non-government organisations—and the mental health professionals and wellbeing support workers they employ.[27]

New insights into workforce profiles

The lack of detailed workforce data limited the Commission's ability to better understand the Victorian workforce, its makeup, experiences and motivations. This information is critical to determine workforce priorities and capability needs and to develop targeted workforce supports.

In response to the shortfall in information, the Commission undertook additional data analysis and engaged ORIMA Research to undertake a mental health workforce survey.[28] The information gathered from the workforce survey is useful for understanding the profile of the workforce. The survey gathered responses from 2,920 professionals from a wide range of roles and settings across the state.[29]

In addition to gathering insights from members of the current workforce into the design of the future mental health and wellbeing system, the purpose of the survey was to create a broader and more detailed picture of the diversity and experiences of the workforce in Victoria. This aided the Commission's assessment of future workforce needs and opportunities. To this end, the survey posed a range of questions on demographic characteristics, background and experience, as well as workforce roles and settings.

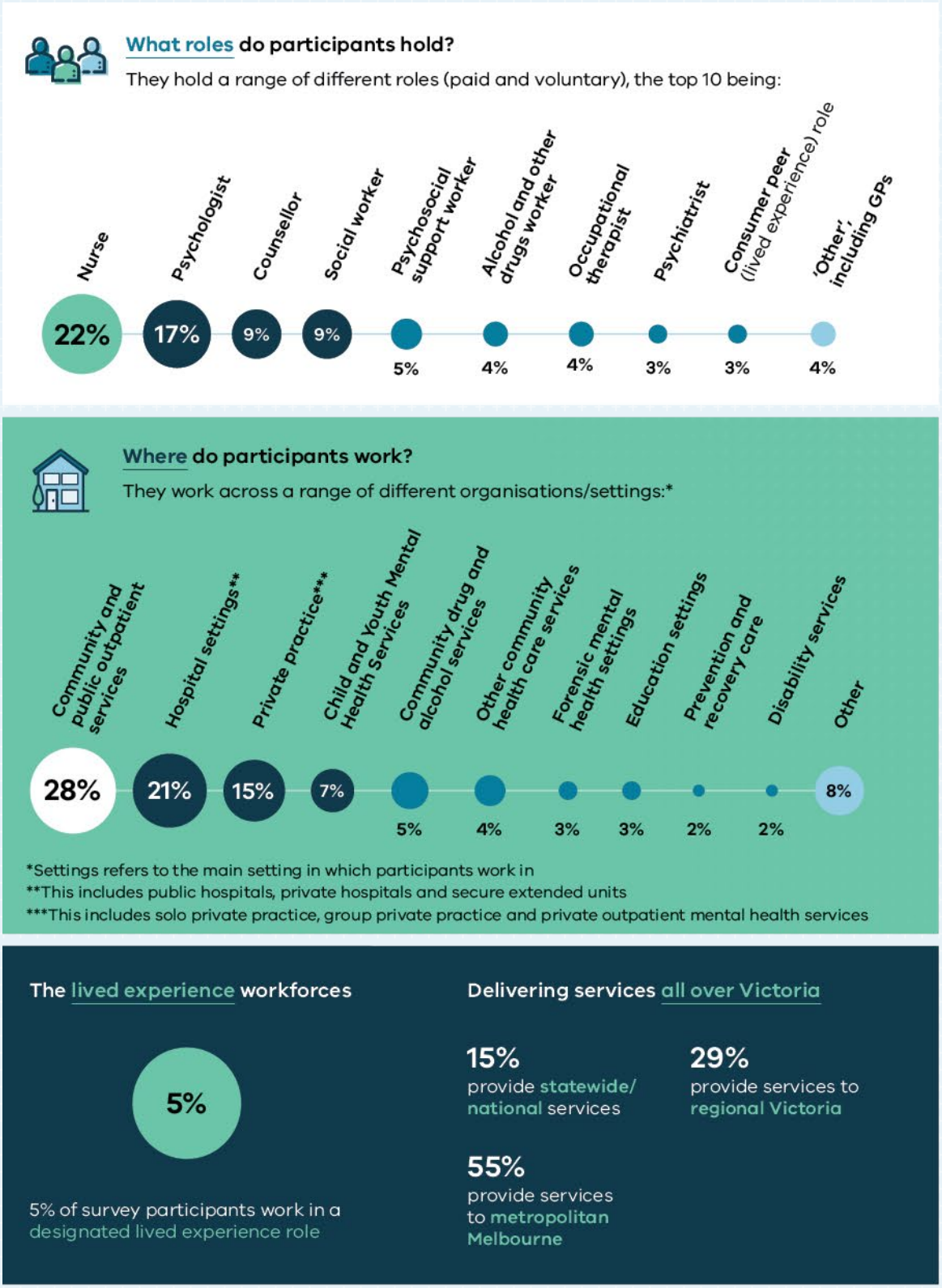
Given existing data limitations—particularly for community mental health workers, wellbeing support workers and lived experience workers—the Commission took a deliberately broad and inclusive approach in designing and distributing the workforce survey. The workforce survey was open to professionals working across all roles (both paid and voluntary) and the full range of settings that comprise Victoria's mental health system (including public settings, private settings, community and non-government settings). Although the settings described in the National Mental Health Workforce Data Tool were used to compare data, ORIMA Research pursued a breakdown based on workforce roles—including lived experience workers, community workers and wellbeing support workers—to derive insights into the experiences, wishes, aspirations and professional support needs of professional groups that are not adequately represented in current state and national datasets. Aggregate figures throughout this chapter, such as Figures 33.3 and 33.4, include mental health professionals working across public, private, community and non-government settings.

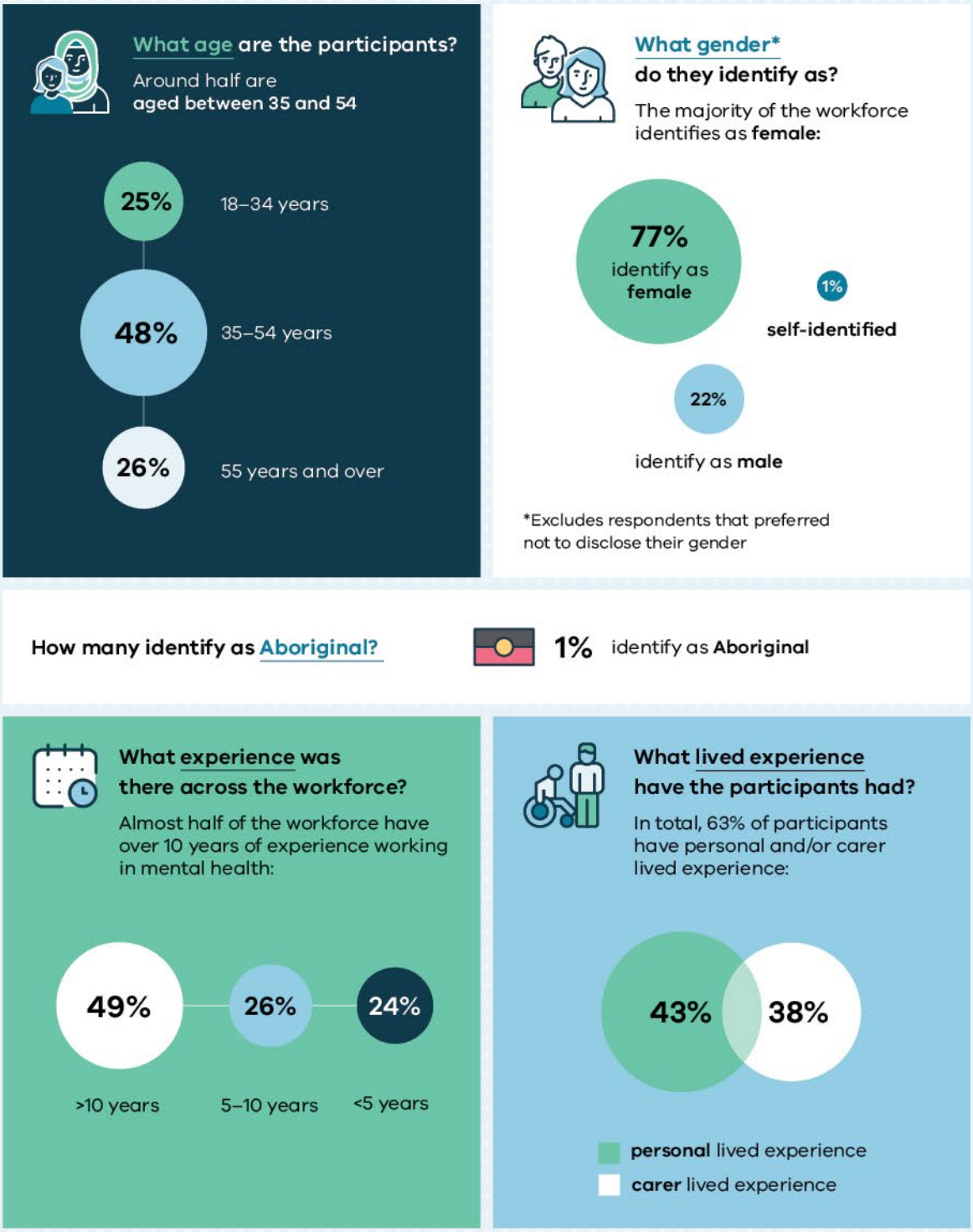
Figure 33.3 summarises the survey responses that shed light on the profile of the Victorian workforce. Findings indicated considerable diversity within the current workforce.[30] Many different professions are delivering mental health services to consumers, including nurses, psychologists, psychotherapists, counsellors, telephone counsellors, creative arts therapists, community and psychosocial support workers, case managers, team leaders, personal care assistants/aides, managers, directors, crisis workers, alcohol and other drug workers, lived experience workers, social workers, occupational therapists, psychiatrists, medical officers, registrars and GPs.

The workforce is also working in a variety of service settings, but more than half of participants work in settings that provide metropolitan services only. While more services are important wherever there are large populations of people, the Commission understands there are critical workforce shortages in rural and regional areas—discussed later in the chapter and in more detail in Chapter 24: *Supporting the mental health and wellbeing of people in rural and regional Victoria*.

Approximately half of the participants had less than 10 years of experience in the mental health sector, which may be an indicator of retention problems, particularly in public mental health settings.[31]

Figure 33.3: Profile of mental health workforce survey participants





Source: ORIMA Research, *Mental Health Workforce Survey*, 2020.

Note: Only includes participants that have answered each question.

33.2.2 Lived experience workforces

Lived experience workforces are critical to the contemporary mental health and wellbeing system. Victoria has small but growing lived experience workforces.[32] In 2017 there were 341 lived experience positions occupied in the public mental health system, and two-thirds of these were consumer lived experience roles. The remaining positions were carer lived experience roles. These positions were operating across a range of clinical and community settings.[33]

The workforce survey provided further insights into the profile of Victoria's lived experience workforces. Approximately 5 per cent of participants reported working mainly in a designated lived experience position, and just over half of these roles were from a consumer perspective. The Commission was encouraged to see that lived experience workers are employed across a broad range of settings in metropolitan, regional and statewide service delivery areas. But more can be done to enhance the role of lived experience workforces. Figure 33.4 summarises some of the key insights gleaned about Victoria's lived experience workforces.

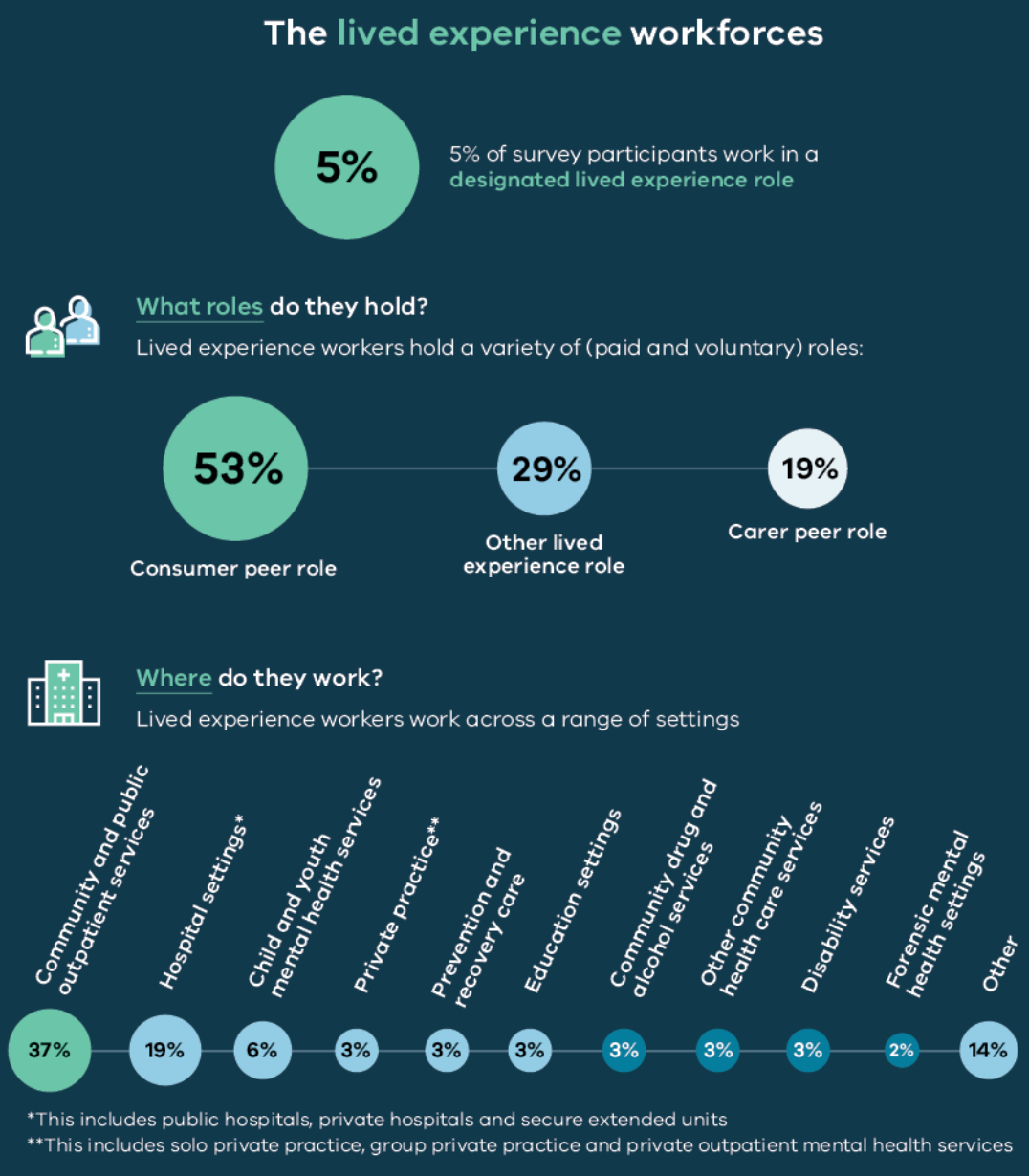
33.2.3 Lived experience across the broader workforce

As shown in Figure 33.3, the workforce survey also indicated that approximately 66 per cent of participants across broader professional roles and settings reported having lived experience of mental illness or psychological distress (43 per cent) and/or lived experience of caring for a friend or family member with mental illness (38 per cent). The large proportion of the workforce with some form of lived experience could indicate a trend in attracting people with a personal as well as professional desire to work in the sector. Over time this could be harnessed to combat the stigma of mental illness or psychological distress in mental health–related and other workplaces.

But there is concern that this same stigma continues to prevent mental health and other professionals from talking about their lived experiences publicly.

> at least 1 in 3 students surveyed reported previously not seeking help for mental illness when they needed to … [one of] [t]he most predominant reasons cited by students were feeling … concern about the impact on their career.[34]
>
> Effectively, attracting, retaining and supporting ambulance workers requires employers to ensure and promote the fact that there will be adequate support for employees … if they experience poor mental health. … One paramedic … stated that … "there are still minimal known stories of lived experience and recovery among … employees. This is presumably due to people not recovering enough to come back to work or an unwillingness to divulge this information among colleagues…"[35]

Figure 33.4: Profile of the workforce survey participants in designated lived experience roles



Source: ORIMA Research, *Mental Health Workforce Survey*, 2020.

Note: Only includes participants that have answered each question.

Personal story:

Dr Kieran Allen

Dr Kieran Allen first experienced mental health challenges and recurrent mood episodes during adolescence, but he started becoming more unwell during his time at university while studying medicine. Kieran reflected on the self-stigma that came with talking about his lived experience as a psychiatric trainee.

> I didn't want to talk about it because I felt ashamed of having a mental illness.
>
> The biggest challenge was from myself—and it was about fear—fear about how people would react. Would they accept my illness without pre-judging my capability or safety? This fear prevented me from being open.

Initially Kieran tried to keep his professional life as a psychiatry registrar and his personal life separate. But, this created a divide that eventually led to another period of poor mental health. After this time, Kieran said he made a critical decision to be more open about his experiences so he did not need to 'pretend' at work and could be more authentic.

> I initially opened up to a wellbeing officer who was wonderful and supportive. Then I started opening up to senior staff who were very understanding and now I'm fully open across the board.

Kieran explained that this process took a number of years and was difficult and confronting. He emphasised the importance of his workplace and colleagues being incredibly supportive and proactive in promoting awareness of clinicians with lived experience of mental illness.

Kieran said that while he chooses not to share his personal experience with patients in clinical contexts, his lived experience informs his practice and has helped him become a more skilled and empathetic clinician.

> It helps me to be a little bit more caring, a little bit more understanding of where they're coming from and to try to offer them some insights and alleviate some of their own self-stigma as well.
>
> It gives me an insight into the little things people value that might be missed.

Since sharing his lived experience, Kieran said he has had a lot of clinical professionals share their own personal stories with him. He said while this was not an intended outcome, he is proud his openness is helping others.

> Just as having had surgery makes you understand what the operation is about … it makes you empathise with the pain. Having experience of mental illness can help you to empathise with the pain of going through that in a different way.
>
> I have found it has added to my skillset as a clinician and meant that I can bring a different perspective to my work … to help my colleagues to see how our patients are experiencing things in a unique way and to challenge some of the pre-existing ideas that might be underlying their beliefs toward patients.

Kieran was clear that his role as a psychiatry registrar is different from a professional working in a designated lived experience role. He said there is a need to move beyond unhelpful distinctions that can exist between 'clinical professionals' and 'those with lived experience'. He thinks there is an opportunity to break down these barriers, but it needs to start from the top.

> Ideally, I see a world where clinicians can feel as comfortable talking about having had an episode of mental illness as they do about having had the flu.
>
> I hope in the future we are able to talk about things as if they're just another medical condition and without that stigma that we continue to perpetuate, particularly in the mental health professions.

Kieran is also hopeful that consumers, families, carers and supporters can be part of this paradigm shift, by being given the opportunity to say they would like to be treated by mental health professionals who have lived experience of mental illness.

Source: RCVMHS, *Interview with Dr Kieran Allen*, November 2020.

Dr Tricia Szirom, CEO of the Victorian Mental Illness Awareness Council at the time of her evidence, told the Commission:

> The consumer movement holds incredibly bright, intelligent, thoughtful people including heads of departments and judges who are afraid to speak out because they feel it may affect their career. I was a senior executive in the health department and I didn't tell people about my mental illness for ten years. I felt that if people knew … I had depression and contemplated suicide I would never have been promoted. There is a real issue of stigma. If we can overcome this and encourage successful people in the industry to speak out, that would be a very powerful perspective to obtain system change … It comes down to bravery and leadership … We need a cohort of strong leaders who are willing to say I know how to do this, I know how to change things, I know the processes, and I'm willing to say I have had mental health challenges.[36]

Acknowledging that lived experience is found across the system across a variety of professional roles and service settings—regardless of whether it is disclosed—can help create a strong foundation for a compassionate and collaborative mental health and wellbeing system.

33.2.4 Motivations and aspirations of the workforce

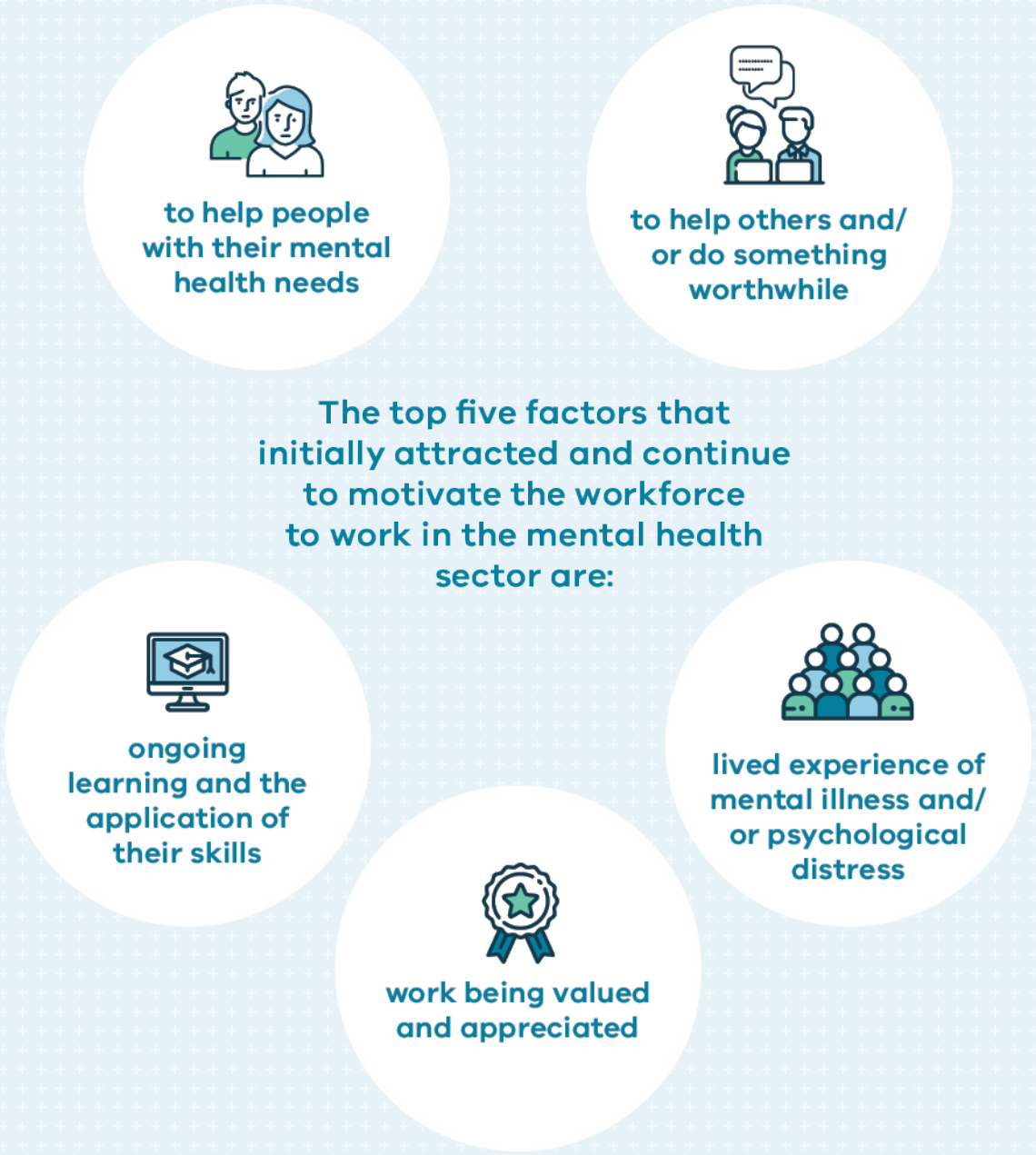
Mental health and wellbeing workers have a strong desire to contribute to real and positive change for consumers.[37] Many frontline workers shared with the Commission their commitment to and passion for building therapeutic relationships with consumers, families, carers and supporters. For example, mental health professionals who participated in Commission-led focus groups described what motivates them in their work including:

> Building social trust [and] collaborative relationships over time is very rewarding …[38]

> [having] that feeling of real change in a client's life, that I felt that I contributed to through some of the work we're doing.[39]

The results of the workforce survey further confirmed the positive motivations of the workforce. Personal lived experience of mental illness or psychological distress, or that of a family member or friend, may also have motivated workers to want to help others.[40] As illustrated in Figure 33.5, participants ranked the top five factors that initially attracted them to work in mental health, and that continue to motivate them in their current roles, as: the desire to help others, to do something worthwhile, to develop their skills in supporting people with their mental health needs, personal lived experience and feeling that their work is valued and appreciated. Supporting the workforce to realise these motivations is vital to their own wellbeing, to workforce retention and, ultimately, to better consumer outcomes.

Figure 33.5: Motivations for working in the mental health sector



Source: ORIMA Research. *Mental Health Workforce Survey*, 2020.

Note: Participants were asked to rank the top three factors that (i) initially motivated them to work in the mental health sector and (ii) continue to motivate them in their current role in the mental health system. Above includes the most common responses across both questions.

33.3 The challenge of meeting workforce supply needs

The Commission's interim report recognised that workforce shortages are affecting the system's ability to meet service demand and deliver high-quality treatment, care and support to consumers, families, carers and supporters.[41]

The mental health and wellbeing workforce is facing substantial and enduring staff resourcing challenges, particularly in public mental health services:[42]

> **The reasons for psychiatrists leaving the public sector are multifactorial, yet can also simply be attributed to the excessive demands being placed on them in an under-resourced sector.[43]**

Associate Professor Alessandra Radovini, Director of Mindful at the University of Melbourne and Consultant Psychiatrist at Orygen, told the Commission in a personal capacity about the relationship between demand pressures and persistent challenges in recruiting and retaining staff:

> **There is insufficient staffing levels to meet the mental health needs of the community … which means current staff have extremely high caseloads and are put under substantial pressure (particularly where there are waiting lists and waiting times for new clients). A culture of 'do more with less' has permeated the sector based on this under resourcing which can result in difficulty recruiting and retaining staff in tertiary mental health services (particularly in rural areas further compounding the problem).[44]**

As outlined in section 33.7.4, the Commission undertook comprehensive analysis of the Victorian mental health workforce. This analysis—using a range of datasets and the *National Mental Health Service Planning Framework*—indicates that major fulltime-equivalent shortfalls are already apparent across most professional groups in specialist public mental health services. Over time, these shortfalls are likely to worsen as shortages emerge for other professional groups within the next five years.

Even professional groups where supply currently appears stable will only remain so where there are sufficient pipelines (a ready pool of potential qualified candidates), coupled with long-term recruitment and retention strategies to support public mental health service workforce needs in the future integrated and responsive mental health and wellbeing system.

The analysis of projected supply gaps does not take into consideration the need for a revised approach to modelling, including new workforce composition requirements and adjustments to assumptions that the Commission has discussed in Chapter 28: *Commissioning for responsive services*. The Commission takes the view that the risks identified using the current *National Mental Health Service Planning Framework* are reliable, but the Department of Health must continue to analyse and project needs as new approaches to modelling service and system demands are introduced.

While pressures on workforce demand have been known for some time, the Commission understands there has been limited action to deal with the causal factors across the mental health system.[45] Despite decades of state and federal mental health workforce strategies and reviews,[46] recruiting and retaining enough mental health workers remains an obstacle to providing consumers with appropriate access to services.[47]

The Commission heard that public mental health services experience difficulties in recruiting and retaining skilled mental health nurses,[48] psychiatrists,[49] psychologists,[50] social workers[51] and occupational therapists.[52] In 2019 the Victorian Auditor-General's Office found that recruiting, retaining and managing the workforce was a major obstacle to service provision in area mental health services.[53]

Workforce shortages are more pronounced in certain regions, service settings, professional disciplines and specialist roles.[54] Recruitment and retention factors can result in reduced service delivery, less effective responses to consumers, and risks to staff wellbeing and burnout:

> In hospital-based settings, mental health nurse staffing shortages impact on … bed closures, consumer experience of health service delivery, increased acuity, consumer and staff safety, critical incidents (including suicide) and the use of restrictive practices (e.g. seclusion, restraint).[55]

Dr Neil Coventry, Victoria's Chief Psychiatrist, told the Commission:

> In my role, I … observe the difficulties experienced by mental health services in retaining their workforces. Recruitment and retention difficulties result in a less experienced clinician group in acute mental health units, and less effective management of consumer distress. This in turn contributes to higher rates of staff attrition. For psychiatry in particular, workforce retention can pose more of an issue than supply, with clinicians leaving the public system for the private system.[56]

Retention challenges may also be replicated in mental health services in the non-government sector. The workforce survey showed that mental health support workers are the most likely to cite career prospects as a reason for considering leaving their current role in the next 12 months.[57]

As discussed in Chapter 24: *Supporting the mental health and wellbeing of people in rural and regional Victoria*, rural and regional communities face even greater challenges with workforce shortages:[58]

> [Australian Association of Social Workers] members have identified that the difficulties being experienced in metropolitan areas of Melbourne and in major regional centres [are] compounded in rural and remote areas by distance and lack of staff to meet demand.[59]
>
> The difficulty in recruiting and retaining psychologists to rural and remote Victoria is not surprising given the limited incentives for rural practice … there has been no investment in developing a rural [workforce] pipeline in Victoria …[60]

Mr Angus Clelland, CEO of Mental Health Victoria, emphasised the poor geographical distribution of the Victorian mental health workforce and the problems this causes:

> One of the key challenges we face in Victoria and across the country is workforce distribution. Trying to get professional staff outside the inner suburbs of Melbourne is particularly challenging and results in a mal-distribution of the workforce across the State. Regional and rural Victoria really suffer from this inability to attract psychiatrists, psychologists, general practitioners (GPs), nurses, and other community mental health workers.[61]

There are multiple complex barriers to ensuring adequate supply and appropriate geographic distribution of the mental health and wellbeing workforce in Victoria. Health services have emphasised low morale and an ageing, overstretched workforce, coupled with stigma and negative community perceptions, as key challenges to recruitment and retention.[62]

The following factors make it difficult to retain experienced and skilled health professionals:

- excessive, unsustainable or increasingly complex workloads[63]
- experiences of occupational violence, including physical and verbal aggression[64]
- fatigue, vicarious trauma[65] and burnout[66]
- high administrative burden contributing to a loss of meaningful clinical time spent with consumers, families, carers and supporters[67]
- a lack of professional development and career progression opportunities[68]
- the attraction of private practice.[69]

Workforce shortages can result in a heavy reliance on agency staff, particularly in acute inpatient units. As early as 2002, the then Department of Human Services documented the overuse of agency staff in these settings. For example, *Revitalising Acute Inpatient Services: Department of Human Services Response and Report of the Review of Adult Acute Inpatient Mental Health Services,* noted that nursing shortages in acute inpatient units had resulted in 'an excessive reliance of casual agency staff to cope with regular shortages'.[70]

This can bring risks to the quality and safety of treatment, care and support. Agency staff may not receive adequate induction into service policies, procedures and requirements under the relevant legislation. They may not have accessed appropriate training in mental health to ensure their approach to delivering treatment, care and support is aligned with contemporary values and approaches to practice, such as trauma-informed care.[71] Dr Lynne Coulson Barr OAM, Victoria's former Mental Health Complaints Commissioner, explained to the Commission that using agency staff may compromise quality of treatment, care and support:

> Agency or bank staff are unlikely to be familiar with service policies and procedures. They are unlikely to have received the same access to training as permanent staff, and may be unaware of all options within the service that would enable them to respond to a consumer's individual needs.[72]

In its submission to the Commission, Maurice Blackburn Lawyers echoed this sentiment:

> We note particular concerns in relation to the engagement of agency staff in public inpatient units, where the patient care needs are complex, and there are differences across facilities and Health Service providers that can impact on patient safety.[73]

International recruitment of overseas-trained practitioners is a common practice to respond to workforce shortages. In Victoria, international recruitment is used by public and private hospitals, as well as metropolitan and rural area mental health services. The Commission understands that there are many Victorian mental health nurses who have trained overseas, and that some health services have run successful recruitment campaigns attracting mental health nurses from the United Kingdom.[74] Both metropolitan and rural area mental health services use international recruitment to attract medical graduates and psychiatric registrars.[75] However, the Commission has heard that Victorian mental health services face significant challenges in retaining overseas-trained psychiatrists in the public system once they gain full registration, particularly in rural and regional services.[76] While the Australian Government has a '10-year moratorium' policy that means that any overseas-trained psychiatrist who has gained registration in Australia, or gained fellowship, must work for 10 years before receiving access to Medicare benefits, attrition to private practice remains a challenge.[77]

The Productivity Commission emphasised that Australia 'relies heavily' on overseas-trained psychiatrists, noting that between 2013 and 2018, the proportion of psychiatrists trained overseas (excluding New Zealand) grew from about 30 per cent to over 36 per cent.[78] As articulated in Chapter 24: *Supporting the mental health of people in rural and regional Victoria*, the Productivity Commission outlined the significant limitations of expanding international recruitment programs to address workforce shortages via rural and regional medical incentive programs. The Productivity Commission concluded that the recruitment of overseas-trained mental health nurses is not a long-term solution, noting that 'recruitment overseas is unlikely to be a sustainable basis for resolving shortages'.[79] In the context of the COVID-19 pandemic, relying on international recruitment strategies to address workforce shortages for the duration of the pandemic may be challenging. Even beyond the pandemic, returning to the same level of reliance on international recruitment is not viable.

The importance of pursuing domestic strategies for sustained solutions to workforce supply gaps is noted in the World Health Organization's *Global Code of Practice on the International Recruitment of Health Personnel*, to which Australia is a signatory:

> Member States should strive, to the extent possible, to create a sustainable health workforce and work towards establishing effective health workforce planning, education and training, and retention strategies that will reduce their need to recruit migrant health personnel … All Member States should strive to meet their health personnel needs with their own human resources for health, as far as possible.[80]

The Commission remains of the view that '[a]lthough the objective is to expand the mental health workforce by attracting qualified and high-quality recruits, the Commission notes that [international recruitment] is complementary to—and does not replace—domestic workforce growth strategies.'[81]

Given the complexity of recruiting and retaining workers in the mental health system, the Commission considers that a multipronged approach to tackling workforce supply issues is required.

> The Royal Australian and New Zealand College of Psychiatrists Victorian Branch submits its profound concern about the future of Victoria's public mental health system, due to the significant challenges facing the recruitment and retention of psychiatrists. Without a strategy to address this, any recommendations from the Royal Commission about increasing service capacity will be unable to be met.[82]
>
> [Occupational Therapy Australia] believes individual mental health services require a strategic workforce plan that addresses recruitment, retention and succession planning for the workforce. This strategy should include a career structure in mental health practice, education, research, management and strategy.[83]

The Commonwealth Department of Health echoed this view in correspondence to the Commission:

> Because Australia's health system and its health workforce activities are so complex, most reforms attempt to tackle the issues through several mechanisms. This includes the use of financial incentives, outreach programs, through education and training levers and also through regulatory means. There is no workforce cure-all, and the system must be considered as a whole when developing policy.[84]

33.4 The pressures of working in the current mental health system

The Commission has heard extensive evidence indicating the positive motivation and commitment of the mental health and wellbeing workforce to help those in need of support.[85] While it is rewarding work, the Commission also acknowledges that working in mental health and delivering high-quality services to consumers can often be complex and emotionally draining.[86] Despite the fact that the workforce is made up of committed and resilient people,[87] mental health and wellbeing workers face a number of challenges that affect their ability to work effectively.

33.4.1 Impacts on the wellbeing of the workforce

The Commission recognises that supply and demand pressures, workforce shortages and a focus on crisis have a negative effect on the ability of mental health and wellbeing workers to deliver compassionate and person-centred care.[88] Workers need to have not only the right combination of skills and motivation but also enough supports in the workplace to effectively provide treatment, care and support to a wide range of consumers. However, the current service delivery environment has created a culture focused on risk and has reduced the capacity of workers to use their skills to deliver therapeutic care.[89]

People working in mental health contexts report experiencing low morale[90] and limitations on their ability to fully apply their professional skills.[91] This can lead to staff burnout and poor wellbeing.[92]

> those working in the mental health system, including psychiatrists, are being traumatised by an under-resourced system. Psychiatrists 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.[93]
>
> People who are often in extreme distress or behaviourally disturbed regularly wait for hours and often days in [emergency departments] ... Emergency physicians are profoundly frustrated and demoralised by trying to provide safe, quality care for people in this environment.[94]

This poor wellbeing and low sense of achievement has major impacts on attracting, recruiting and retaining staff, as well as on workforce stability more generally. As one contributor to the Commission commented:

> There are many sources of demoralisation for clinicians, many of whom report limited respect for clinical expertise, and frustration over ongoing barriers to quality care. This contributes to increasing staff burn-out, and many experienced clinicians are leaving the public sector ...[95]

Teams and individual practitioners often find themselves overworked and under-resourced.[96] A range of practitioners and professional or industrial bodies reported these issues to the Commission.

> In my workplace … the team [is] very burnt out and mentally exhausted and we will talk about how when we have our days [off], no one has energy to do anything … and people keep turning up to work because of not letting the team down.[97]
>
> To combat attrition rates within the sector employees need to feel valued, engaged, supported and be allocated reasonable workloads where they are given the time and resources to give patients the care that they need and deserve.[98]
>
> Trainees are an important part of the psychiatry workforce, they are often on the front-line of services and first point of contact for families and carers. There has been increasing concern about trainees being overworked in under-resourced environments.[99]

The Commission was told that the impact of supply challenges and staff shortages can lead to staff having increased workloads, having to work extra hours and being unable to provide people with the intensive treatment, care and support they would like to offer them, particularly in rural and regional areas.[100]

Poorly supported professional practice not only contributes to lower workforce retention but also poses direct risks to workers' own mental health. Vicarious or secondary trauma and professional burnout have all been described as common experiences in the current system.[101]

> Students [undertaking placements] are exposed to clinical environments where violence … occurs as a part of day-to-day work. Patients are, not infrequently, subjected to … interventions against their wishes. These experiences may … lead to burnout and mental health symptoms [of] their own … Although clinical mental health education is important, it should not have to occur to the detriment of personal mental wellbeing.[102]

The Australian Services Union told the Commission:

> the nature of the work can have significant impacts on their own mental health and wellbeing if appropriate work conditions are not available, if they are overloaded with work, or if they have insufficient ongoing training and development.
>
> This is a workforce with high mental health literacy; they know being under-resourced in this work will have poor outcomes for their own wellbeing and result in poor service delivery for consumers.[103]

To improve workforce wellbeing in the future system there is a need to embed appropriate supports to help the workforce to build their skills, to use all their capabilities for the benefit of consumers and to better manage emotional stress and prevent burnout.

33.4.2 Limited practice supports

The Commission understands that limited access to professional practice supports can have a negative impact on skill development and workforce wellbeing. There are well-established practice supports that can help to build workforce resilience and support wellbeing: reflective practice; professional and clinical practice supervision; and formal and informal debriefing (particularly after critical, challenging or psychologically distressing experiences)—refer to Box 33.1 for a brief overview of these terms.[104]

The then Department of Health and Human Services acknowledged the importance of including these key practice supports in mental health services through a range of mental health workforce strategies and related policies.[105] For example, *Victoria's 10-Year Mental Health Plan* emphasised that reflective practice is important 'to support worker safety and satisfaction [and to c]reate better learning and working environments'.[106]

However, these critical workforce wellbeing and professional practice supports are not consistently embedded into services in meaningful ways across roles and settings.[107] Frontline mental health professionals participating in a Commission-led focus group confirmed that not having access to professional practice supervision and reflective practice contributes to a range of negative outcomes for the workforce, including reduced empathy, burnout, poor mental health and poor decision making, and has a negative impact on interpersonal relationships in the workplace.[108] In turn, this can compromise the quality of services being provided to consumers. One mental health practitioner who participated in a focus group told the Commission, '[when] staff [are] not having that reflective space or not feeling heard … their capacity to hear and understand the consumer is impacted enormously'.[109]

Box 33.1: Key terms—workforce wellbeing and professional practice supports

Reflective practice

The Commission uses the term 'reflective practice' to refer to a collaborative process between mental health professionals to support learning through and from experience and to gain new insights. This can be done between individuals or in groups by:

- reflecting on experiences of delivering treatment, care and support to consumers, families, carers and supporters
- examining and critically reflecting on assumptions underlying everyday practices
- reflecting on challenging interpersonal dynamics.

Professional and clinical practice supervision

The Commission uses the term 'professional practice supervision' to refer to a formal professional relationship between two mental health and wellbeing workers that is designed to enable reflective practice, support professional self-care, maintain standards of professional practice, refine therapeutic and clinical competencies, and explore ethical matters. It is distinct from line management and performance management and is not a form of therapy.

The term 'clinical supervision' is typically used in policy literature to refer to this form of practice supervision because it is a common part of formal continuing professional development and regulatory requirements for disciplines such as psychology, nursing, psychiatry, social work and occupational therapy. However, the Commission's use of the term 'professional practice supervision' emphasises that this workforce wellbeing and professional development support is relevant to a wider range of professionals, including those in lived experience roles.

While professional and clinical practice supervision can be cross-professional (conducted by a member of another discipline), the Commission has heard evidence from a range of professionals that intraprofessional supervision (conducted by a member of the same discipline) is optimal and has particular advantages for both:

- workforces that come under discipline-specific regulatory schemes (such as psychologists)[110]
- workforces that are not currently regulated in this way (such as consumer and carer workers).[111]

Formal and informal debriefing

The Commission uses the term 'formal debriefing' to refer to voluntary, structured discussions provided by trained debriefing or professional practice supervision staff (who are distinct from line management). These discussions aim to give support to a mental health and wellbeing worker and reduce psychological distress following a challenging, overwhelming or critical incident in the workplace.

In contrast, the Commission uses the term 'informal debriefing' to refer to peers supporting and debriefing each other and sharing their daily working experiences to help manage the cumulative impact of the emotional challenges of working in mental health. One participant told the Commission:

> Especially in mental health there's a lot of times where you have a rough day or a rough appointment and … peer-to-peer debriefing is probably the most powerful thing.[112]

33.4.3 Risks of poor workplace safety

Occupational violence and safety concerns have a negative effect on the experiences of workers and consumers and are a major contributor to workforce turnover, retention problems and low morale.[113] As noted in the Commission's interim report, safety is a major concern for the workforce and must be addressed.

The risk of exposure to violence can lead to poor mental health and psychological trauma for the workforce.[114] Mr Colin Radford, CEO of the Victorian WorkCover Authority, advised that in addition to physical harm, work-related violence can result in stress, vicarious trauma and mental injuries.[115] NorthWestern Mental Health told the Commission that staff exposed to the 'risk of occupational violence are traumatised and disenfranchised'.[116]

The impact of such workplace experiences, both individual and collective, may also contribute to workplaces where fear and a sense of risk are prominent. This may result in reliance on practices such as seclusion and restraint:[117]

> Enhancing actual and perceived safety of nurses is essential to achieving further reductions in seclusion and restraint in mental health settings, which is not safe for all involved.[118]
>
> Under-reporting [of occupational violence and aggression] is also a system-wide problem, due in part to concern among nurses that reporting won't help change the environment while a culture of acceptance and shared responsibility for violence persists.[119]

One mental health practitioner told the Commission:

> [Where] I work, when the staff get really burnt out, and there's lots of violence and assault happening, the staff become more controlling, or they [have lost] that capacity for empathy. Just trying to keep everything kind of operational.[120]

The Commission heard that many workers experience poor safety at work.[121] As noted in the Commission's interim report, in a 2019 Health and Community Services Union survey of 464 of their members, approximately 31 per cent said they had been physically attacked in the workplace in the 12 months preceding the survey; and 64 per cent said they had witnessed physical violence in the workplace.[122]

In 2019 NorthWestern Mental Health recorded 350 incidents of occupational violence during a 90-day period, with 84 of these incidents resulting in physical harm to staff.[123] Eastern Health also told the Commission:

> Staff are frequently injured during the admission process or when caring for a consumer during their stay. At any one time … [multiple mental health team members] are on long-term personal leave directly related to safety and harm in the workplace.[124]

As outlined in Chapter 30: *Overseeing the safety and quality of services*, mental health services report safety incidents to multiple agencies and databases, including the Victorian Agency for Health Information. Current limitations of the data collected mean there is minimal meaningful or comprehensive information about occupational incidents on a service-by-service basis.[125] It also makes it difficult to analyse the scale of the problem across the system.

A range of factors contribute to the lack of workplace safety, including under-resourcing, poorly designed physical infrastructure, suboptimal system design and leadership shortcomings.[126]

Given the impact of occupational violence on consumers and staff, the system cannot provide high-quality treatment, care and support while accepting the current level of incidents within the system. It is imperative that appropriate mechanisms and structures are in place to reduce instances of occupational violence or safety risks and to appropriately respond to them if they arise. Building a culture—both at the service and system levels—where both consumer and staff safety are valued as a 'central tenet' of treatment, care and support will be critical to reducing the number of incidents.[127]

Tackling contributing factors will require changes across the mental health and wellbeing system. It will require a system characterised by early intervention, with services provided in community settings, home-based services and hospital-based mental health units that provide high-quality and safe treatment, care and support. It will require leadership in services and teams that ensures appropriate staffing levels, management support and other resources are in place. It also requires staff to have the necessary skills, capacity and resources to support consumers who are distressed and agitated, or who exhibit aggressive or violent behaviours, without using restrictive practices.[128]

In addition, system-level reporting, monitoring and analysis of occupational violence must be improved to enable system and service leaders to identify and respond to factors that contribute to a lack of safety for staff at work. Dr Coventry noted that this capacity should be available by 2022.[129] This will provide an important measure of how well the mental health and wellbeing system is functioning—ongoing high levels of occupational violence will indicate the need for further action.

Failure to deal with current levels of occupational violence risks will see a further decline of the mental health and wellbeing system.

> Workplace safety for nurses is a significant issue in building a mental health nursing workforce, nurses are frightened given the stigma of mental health to enter the mental health nursing workforce. It is also likely that improving mental health nurse safety at work will support increased retention of existing workforce and further recruitment into the specialty.[130]
>
> Health services quickly earn a reputation among staff and prospective staff for the way they care for their employees, and any failure to do so undermines recruitment and retention efforts.[131]

The Health and Community Services Union highlighted the importance of responding to these current negative experiences and outcomes in the workplace:

> While additional funding and more workers will alleviate this pressure, the long-term neglect of the Victorian mental health system by policymakers has resulted in a toxic workplace culture taking root. Reforming this culture will require more than simply dollars and bodies, it will require sustained and sophisticated strategies and is something the Commission must have front-of-mind when considering its recommendations.[132]

33.5 A workforce with unrealised potential

The Victorian mental health and wellbeing workforce will play a critical role in realising the Commission's recommended reforms. Despite the current diversity and breadth of skills and experience that already exist across Victoria's mental health and wellbeing workforce, the system is not supporting the workforce to realise its full potential.

33.5.1 Optimising scopes of practice in multidisciplinary teams

Members of the current workforce want to deliver services that align with their vision for the future mental health and wellbeing system, including working in collaborative, multidisciplinary teams to deliver a continuity of care that responds to consumers' needs.[133] Genuine multidisciplinary treatment, care and support aims to optimise a range of generalist and specialist skill sets within teams and across professional groups to give consumers a holistic and targeted service response.[134] However, the Commission has heard that increased service demand, coupled with insufficient resourcing and funding pressures, has often not allowed the workforce to deliver multidisciplinary care effectively.[135] Over time, an emphasis on more generic roles, and the employment of skilled specialist professionals into them, appears to have limited the ability of those professionals to meaningfully apply their skills as part of multidisciplinary approaches.[136]

> As social workers are increasingly employed in generic positions … there is a fear that the social work focus on structural, systemic, wholistic, and psychosocial supports is being lost. This removes the truly 'multidisciplinary team' where there are a variety of positions each with a specific focus, to generic teams of multidisciplinary background, who all perform the same role and lose the specialized focus of their discipline.[137]

> Community teams require an occupational therapy workforce that has a mix of equivalent full-time funded positions to allow for both case management functions and discipline specific positions that enable occupational therapy specific assessment and intervention work.[138]

Dr Coventry told the Commission:

> we really need multidisciplinary input from clinicians who are well trained in a lot of different disciplines: nursing, social work, occupational therapy, speech and language therapy, clinical psychology, neuropsychology, et cetera, et cetera. We have lost that capacity I think with employing what we call generic clinicians, which doesn't acknowledge that every discipline has a specialty background that they can offer for our consumers.[139]

Dr Ravi Bhat, Divisional Clinical Director of Goulburn Valley Health's Goulburn Valley Area Mental Health Service, noted that a heavy focus on case management roles, at the expense of specialist or therapeutic roles, has been an unforeseen negative effect of deinstitutionalisation:[140]

> There were clear roles not just for doctors and nurses but also for allied health staff such as psychologists, occupational therapists and social workers … while I think de-institutionalisation was a radical reform in many ways, and especially in the fact that it brought into focus the fundamental human rights of people with mental illnesses, I think [one] of the effects that it's had is that the focus became on providing what's known as case management, which is mostly coordination of care. This, in my opinion, left out a highly specific discipline skill set, such as psychology and occupational therapy and so on, which has affected Victoria-wide in my view, but has affected rural services even more.[141]

As articulated in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults,* care planning and coordination is a core function of the future integrated and responsive service system. Integrated approaches to case coordination and care planning are critical functions in multidisciplinary teams, particularly for consumers with complex needs.[142] Effective case coordination and care planning requires a range of skills, including deep system literacy and advanced interpersonal skills such as the ability to build therapeutic rapport.

The Commission is concerned that in the current system, an absence of discipline-specific roles has meant that opportunities for some allied health professionals to deliver best practice therapeutic treatment are at times limited. Dr Bhat indicated that this leads to poorer service outcomes for consumers, families, carers and supporters across the system.[143] Having their skills underused and being unable to work to their full scope of practice (refer to Box 33.2) can leave workers feeling undervalued, with a loss of professional identity.[144]

> Given speech pathology is often not recognised as a core allied health discipline in mental health, it can be challenging for speech pathologists working in this field to have their role understood and accepted, particularly when working in a newly created role, or with colleagues who have not previously worked with speech pathologists … Challenges to clinicians' professional identity and integrity undoubtedly increases the stress of working within an often already stressful setting.[145]

Box 33.2: Key terms—full and optimal scopes of practice

In this final report, the Commission uses the term 'full scope of practice' to talk about the full range of skills that a mental health professional has been trained in and is competent to perform.

The Commission uses 'optimal scope of practice' to talk about the most effective configuration of professional roles and responsibilities within a team or service. This is determined by considering other team members' relative competencies and the skills they are trained and competent to perform.[146]

When professional roles and scopes of practice are not optimised across teams and services, it can affect the quality, breadth and continuity of care available to consumers, families, carers and supporters.[147]

The South Australian Department for Health and Wellbeing's *Mental Health Services Plan 2020–2025* explains a number of barriers to a desirable future mental health and wellbeing system based on optimal scopes of practice; these may equally apply to the Victorian context:

> There is a difference between the therapeutic interventions that ideally could be available and those that are available within the capability of the system. The workforce has the opportunity to diversify and provide a broad range of care options but the system needs to support clinicians to do this … Clinical disciplines can operate within a broad scope of practice, and the allocation of roles and responsibilities within multidisciplinary teams need to reflect the opportunity and benefits of clinicians working to the top of their scope of practice.[148]

For allied health professions, opportunities for leadership and clinical progression appear limited to management positions, which may contribute to a loss of skills and professional identity.[149] Demand pressures have required practitioners to undertake increasingly heavy clinical workloads and administrative tasks.

> Clinicians are time poor as a result of high caseloads and burdensome administration [and] reporting requirements.[150]
>
> Members [of the Australian Nursing and Midwifery Federation] consistently, insistently and persistently raise concerns about the time required to meet administrative and documentation requirements and the time this takes away from direct patient care.[151]

This has contributed to people leaving for the private sector. As one clinical psychologist and private practice clinical director told the Commission:

> I guess my reasons for leaving working in public for private [are] that sense that you spend so much time doing the bureaucratic paperwork to demonstrate that you are doing work, that you can't actually have the time to do the work you want to do with people. So it ties into all of those aspects of human control and that we're actually doing what we're setting out to do, which is to make a difference.[152]

Professionals representing a range of disciplines, including social work, occupational therapy, nursing, speech pathology, psychology and psychiatry, have told the Commission that the current configuration of roles and responsibilities in public mental health settings does not always support them to use their unique knowledge and skills to deliver reflective, person-centred approaches to treatment, care and support.[153] To ensure that consumers receive genuine multidisciplinary treatment, care and support, the contemporary system will need to increase its support for mental health and wellbeing workers to be able to use their diverse skillsets, by optimising scopes of practice across a broad range of professions.

33.5.2 Professional development

Limited access to professional development or career pathways is also constraining the workforce's ability to apply its full range of professional capabilities for the benefit of consumers, families, carers and supporters.

> GPs must have access to ongoing training and education in order to competently, confidently and safely address the mental health needs of their community. The provision of ongoing GP training means more mental health conditions can be managed locally at significantly less cost to government. This would allow patients to access mental health closer to home with their GP ...[154]

A lack of professional progression pathways can be a disincentive for young graduate nurses compared with other areas of medicine.[155] For psychologists, a lack of meaningful career pathways may drive them to leave the public system for private sector work.[156]

> [Australian Psychological Society] members report being dissatisfied with career structures in the mental health system and the level of support they receive from their employer. They also cite insufficient employment flexibility that causes more experienced senior psychologists to exit to the private sector. As a consequence, early career psychologists are not sufficiently exposed to senior colleagues and there is a lack of internal supervisors (or the provision of time to attend external supervisors), resulting in the lack of professional guidance and development.[157]

Across the allied health disciplines, clinical leadership pathways are also limited.[158] As a relatively new professional discipline, the lived experience workforces similarly lack career development and progression supports.[159]

In its interim report, the Commission acknowledged that the availability of quality professional development varies greatly, and there is no collective, workforce-wide approach to developing workers' capabilities in areas of priority focus.[160] Access to continued learning and professional development opportunities—including structured training and education, reflective practice, professional practice or clinical supervision, and workplace mentoring and skill development—are also inconsistent across professions and services.[161]

As a result, core skills, knowledge and attributes are no longer consistently developed across the workforce. Tertiary education and early working experiences are also 'siloed'; that is, education and professional development pathways for various professions are separate, rather than integrated or collaborative where relevant. This means professionals are not equipped with the knowledge, understanding and skills they need to work effectively with other professions in a range of settings.[162] Although there are notable exceptions, the Commission is also concerned that interprofessional learning and practice are not common, especially in tertiary settings and early career training.

> **Given the deeply embedded multidisciplinary nature of team-based work, it seems appropriate to model collaborative and collegial working together by creating opportunities for people from different disciplinary backgrounds to learn together.[163]**

The siloed nature of skills and knowledge development has negatively affected the delivery of integrated, multidisciplinary approaches to care.[164]

Limitations in access to high-quality professional practice supervision, mentoring and support can also hinder professional growth and development, including when translating learning into practice.[165] The Commission has heard that early career professionals do not often get enough exposure to more senior colleagues in professional development or mentoring contexts, including through professional practice supervision.[166]

Professional development opportunities are essential to ensure staff have the capabilities and skills to deliver treatment, care and support effectively. Appropriate opportunities for professional development will be critical to sustaining the contemporary mental health and wellbeing system over time.

33.6 Supporting the workforce through change

Achieving the Commission's vision for the future responsive and integrated mental health and wellbeing system will require major workforce reform. The newly designed system will require a larger, more diverse and differently structured workforce.

> Achieving anything in relation to improved mental health outcomes depends on the provision of best practice services staffed by a skilled and available workforce.[167]

> An appropriate and sustainable workforce is absolutely fundamental to being able to boost the capacity of the mental health system, and to enable the roll-out of any reform agenda.[168]

In the future system, consumers should receive recovery-oriented support tailored to their context and needs. The workforce should be given high-quality wellbeing and professional practice supports, in addition to clearly defined, purposeful and sustainable roles, as well as career progression pathways.

The Commission investigated whether the mental health and wellbeing workforce believes that the mental health system needs to—and is ready for—change, and what would be most important in implementing the necessary changes. One source of this evidence was the workforce survey. As illustrated in Figure 33.6, almost all survey participants agreed with the need for change and reported readiness for change among their colleagues.

Despite this clear appetite for change, only 56 per cent of participants felt they would have the necessary support to manage changes that will affect their role.[169] Figure 33.7 summarises the most important types of support participants felt would help them prepare for reform and throughout the change process. Professionals emphasised the importance of clear communication that keeps them informed throughout the transformation process; access to relevant training and professional development supports; strong and supportive change management within their workplace setting; dedicated time and resources allocated to change activities; and the importance of strong leadership in the change management process across the sector.

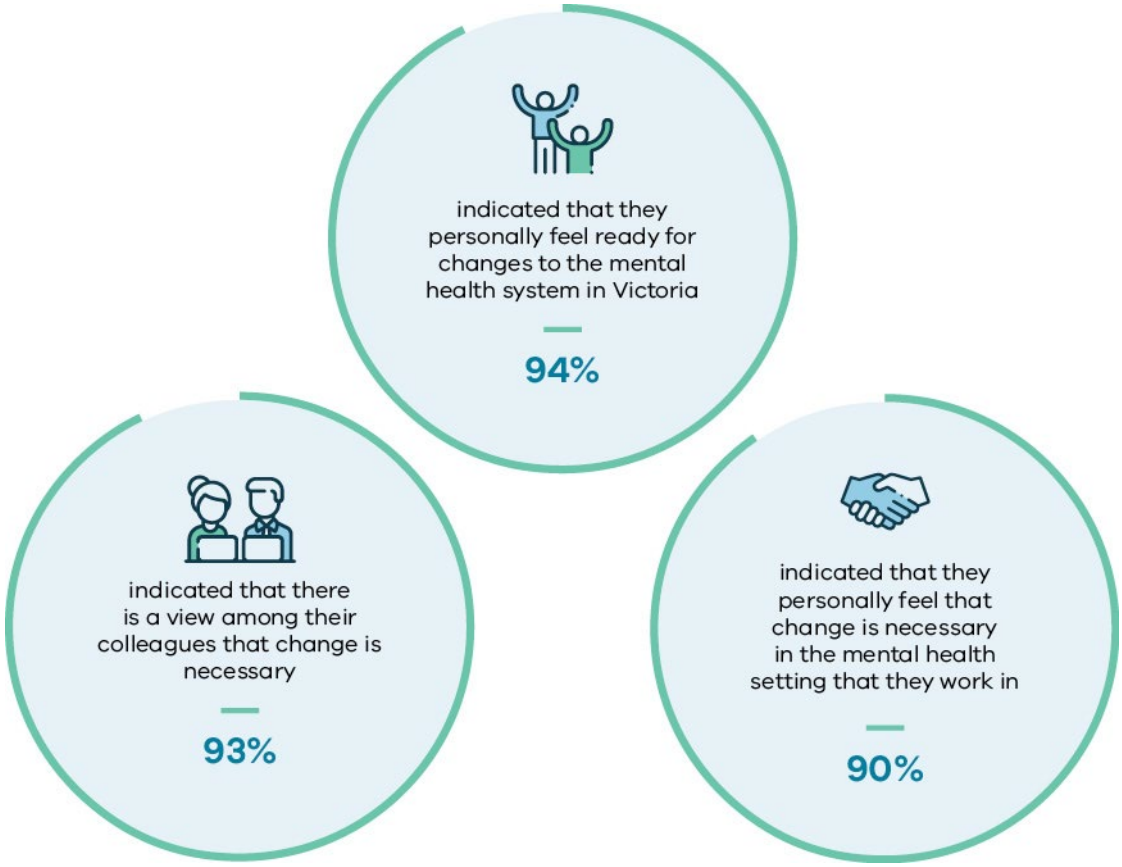
When asked in focus groups about what would support the workforce through the system changes, participants told the Commission:

> Being really clear on why we're wanting to change so it's really meaningful for those people that are involved.[170]

> In 10 years, I would like to be moving from feeling that I'm doing good [therapeutic] work in the room with someone, to using the things that we're doing on an individual basis to shape bigger systems in society—that society, I guess, is treating each other in the way that we are working individually with people.[171]

The Commission acknowledges that members of the workforce often find themselves trying to do their best in a system that constrains them.[172] The Commission recognises that for existing and future workforces to consistently deliver high-quality treatment, care and support in sustainable ways, systemic pressures on them—such as workforce shortages—need to be urgently resolved. Otherwise, such constraints may undermine future reforms and make it more difficult for consumers to get the treatment, care and support they need through genuine multidisciplinary services.[173]

Figure 33.6: Readiness for change among the mental health and wellbeing workforce



Source: ORIMA Research, *Mental Health Workforce Survey*, 2020.

In its interim report, the Commission outlined recommendations for workforce readiness to prepare for workforce reforms and to begin to deal with workforce shortages. The Commission's final recommended workforce reforms set a pathway for the future. Supporting the workforce through the reform process and beyond will be necessary to implement and sustain positive change. The approach to workforce reforms should tackle identified needs and gaps but also build on the positive motivation and commitment of the workforce, as illustrated by a respondent to the workforce survey:

> Looking forward to the opportunities that lay ahead. A great time to be part of a positive reform. Love working in a sector with such a strong commitment to improving outcomes for people.[174]

The Commission considers there are three major focus areas for workforce reform: workforce strategy and planning; workforce capability development; and support for the safety and wellbeing of the workforce to sustain them into the future.

Figure 33.7: Factors that would help mental health and wellbeing workers prepare for reform

Source: ORIMA Research, *Mental Health Workforce Survey*, 2020.

33.7 Reforms and workforce implications

Implementing a responsive and integrated mental health and wellbeing system will introduce considerable changes to the way services are organised and delivered. This will require substantial and essential work to ensure the mental health and wellbeing workforce is of the necessary size and configuration and has the required support and capabilities.

The Victorian Government will need to implement a range of structural workforce reforms to deliver on the objectives of the responsive and integrated mental health and wellbeing system. This will include a particular focus on the size, diversity and distribution of the workforce across the state and the way the workforce works together, regardless of funder or provider, to respond to a person's whole needs.

33.7.1 Overview of system and service reforms

The Commission's vision is founded on the idea that most people will receive services in the community, with access to a diverse mix of treatment, care and support options. As outlined in Chapter 5: *A responsive and integrated system*, the new system will see people access different levels of treatment, care and support depending on the intensity of their needs.

Major reforms will deliver a range of mental health and wellbeing services and holistic treatment, care and support options to consumers through:

- **Local Mental Health and Wellbeing Services**—these will be delivered in a variety of settings where most people will 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 except crisis services and some specialised forms of treatment, care and support. 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 partnerships between public health services (or public hospitals) and non government organisations that provide 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 will respond to people with higher levels of need, and their expertise will be shared with Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services so that as many service providers as possible can deliver treatment, care and support to people close to home. Statewide services, Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services may work together to deliver treatment, care and support through shared-care arrangements. They may also provide services to people directly. In some instances, statewide services may undertake more than one of these roles simultaneously. These are where highly specialised services will be concentrated for high-quality and safe service provision.

Age and developmentally appropriate treatment, care and support will be provided, and strict age-based eligibility will be removed. There will be two parallel systems. One will be a system for infants, children and young people with two streams of services, the first for infants, children and families (from birth to 11 years old), and the second for young people (12–25 years old). The other system, for adults and older adults, will have a service stream specifically for people needing treatment, care and support for mental health needs related to or compounded by ageing.

All community-based mental health and wellbeing services will be expected to deliver a suite of core functions consistently across age groups, with some tailoring, for example, to provide developmentally appropriate services to children and young people. These core functions are outlined 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* and Chapter 13: *Supporting the mental health and wellbeing of young people*. The core functions are summarised in Figure 33.8.

Figure 33.8: Community mental health and wellbeing services: core functions

While community-based services will be the backbone of the mental health and wellbeing system, the Commission's reforms recognise that there is still an important role for bed-based and residential services across the care continuum. These services will be delivered in a range of settings, including at home, in the community and in hospitals, and will include alternatives to inpatient care—such as peer-led services and short-term residential respite services as outlined in Chapter 10: *Adult bed-based services and alternatives* and Chapter 13: *Supporting the mental health and wellbeing of young people*, also recommends new bed-based services for young people delivered in a range of settings.

Better integration of services through structured partnership approaches will be a prominent feature of the new system. As outlined earlier, Area Mental Health and Wellbeing Services will be delivered in partnerships between public health services (or public hospitals) and non government organisations that provide wellbeing supports to deliver the full range of core functions recommended by the Commission. Local Mental Health and Wellbeing Services will also receive inreach support from some staff from Area Mental Health and Wellbeing Services, as well as from statewide service professionals. In addition to more formal partnership structures, cross-service collaboration and support will be an important feature, with better supported referral and transition processes for consumers.

The introduction of Local Mental Health and Wellbeing Services, Area Mental Health and Wellbeing Services and statewide services creates considerable structural change that has major implications for the size, structure and composition of the mental health and wellbeing workforce, as well as its collective and specific capabilities.

33.7.2 Indicative workforce impacts

At a minimum, the size of some workforce groups will need to increase to meet demand. In other instances, new roles will be required to deliver a range of new services and initiatives, and team composition will also need to reflect the new system's requirements. Additional capacity will also need to be built into the workforce to ensure supportive and sustainable working environments and to enable new ways of working. The new system will also alter the distribution of demand for mental health and wellbeing services, with most people using Local Mental Health and Wellbeing Services and more intensive needs being met through Area Mental Health and Wellbeing Services and statewide services.

These structural changes will have a different workforce impact at each level of the system. For example, many Local Mental Health and Wellbeing Services, particularly for adults and older adults do not yet exist or are not yet ready to deliver the full scope of core functions recommended by the Commission. In some instances new services will need to be established, and in other instances the size and scope of services will need to increase (for example, to deliver wellbeing supports). Different team and professional compositions will also be required to deliver the functions successfully.

The multidisciplinary approach required from each Area Mental Health and Wellbeing Service will also need a highly skilled, experienced and diverse workforce comprising a broad range of professions and disciplines including lived experience expertise. These services will deliver a range of offerings that will require new roles, capabilities and ways of working. Where services are supporting older adults, infants and children, or young people, they will require appropriately trained staff. For example, the Infant, Child and Family Area Mental Health and Wellbeing Services, discussed in Chapter 12: *Supporting perinatal, infant, child and family mental health and wellbeing*, will need professional disciplines that support cohort-specific services. This may include psychologists, occupational therapists, social workers, family therapists, child psychiatrists, child psychotherapists, paediatricians, speech therapists and maternal and child health nurses.

The reforms to statewide services will require an increase in the number of specialised professionals in the public mental health and wellbeing system, as well as new partnerships and ways of working to deliver on their expanded functions, including consultation and education, training and professional development.

While the size and scope of the reforms require considerable frontline workforce change, implementation and realisation of the new system will not be achievable without ensuring other workforces that support the system to function (such as in public administration and system oversight) are also enabled to make their contribution to the reform. The Commission has recommended a range of governance and oversight changes, including new functions within the Department of Health and a new Mental Health and Wellbeing Commission as described in Chapter 27: *Effective leadership and accountability for the mental health and wellbeing system—new system-level governance*, new consumer leadership functions as described in Chapter 18: *The leadership of people with lived experience of mental illness or psychological distress*, as well as improved research and innovation functions to drive continuous improvement, as outlined in Chapter 36: *Research, innovation and system learning*. These functions will require capabilities that may not be adequately supplied in the current system.

33.7.3 Implications for workforce reform

Every changed approach to treatment, care and support, a service delivery setting or anticipated reach of a service offering brings with it a range of specific workforce requirements. In aggregate—at the local, area, statewide and system-wide levels—there are major implications for the task of structural workforce reform and ongoing workforce strategy. Across the reforms, workforce implications take on several forms that could require changes to supply, configuration and the introduction of new roles.

The move to the new system necessitates early changes including:

- enabling the employment and transition of staff to Local Mental Health and Wellbeing Services, and the redistribution of staff to under-resourced areas across the state
- providing guidance and incentives to encourage services to create more diverse workforces that reflect the makeup and needs of the communities they serve
- attracting and developing staff to deliver the core functions of the community mental health and wellbeing system
- expanding therapeutic approaches in all core functions across all settings, including bed-based services—this includes new and expanded workforce roles as described by the Commission (for example, peer workers, wellbeing support workers, specialist trauma practitioners, alcohol and other drug support workers, access and navigation workers and professional practice supervisors).

Based on the Commission's analysis, there are a number of implications in terms of the size, diversity and distribution of the workforce across the system. Implications that need to be dealt with include supply risks relating to particular professional disciplines, dedicated action to boost the supply of specific workforce segments and ensuring the approach to workforce reform generates the new ways of working needed in the contemporary system.

The creation of additional and new types of treatment, care and support will generate workforce profiles that will look different to some of those that operate within the existing system. The mental health and wellbeing workforce is expected to expand in size overall to meet the needs of future service delivery, but there will also be additional capacity created to increase the diversity of professions delivering services.

These changes will reflect a greater emphasis on community-based service delivery and a greater variety in the types of services offered. Over time, workforce profiles will also be influenced by provider partnerships and models of care that bring new organisations and service settings into the system (such as treatment, care and support within the home).

The Commission acknowledges that these changes will bring industrial considerations that must be carefully responded to. These are discussed further in section 33.8.5.

Increasing overall supply

Where services are operating in a similar way but will be servicing more consumers to meet demand, the Victorian Government will need to grow the supply of relevant professionals to meet that demand. Several recommendations throughout this report will require considerable increases to the size of the existing workforce. Examples include:

- **shifting the focus of service delivery to the community as recommended in Chapter 5**: ***A responsive and integrated system***, this will require an increased supply of a range of professional disciplines. In particular, Local Mental Health and Wellbeing Services—which are the foundational feature of the new system—will require a sizable increase in workforce supply. This may include psychiatric and clinical psychology roles, allied health and lived experience roles
- **introducing a centrally coordinated 24/7 telephone and telehealth crisis response service within each Adult and Older Adult Area Mental Health and Wellbeing Service**. As described in Chapter 9: *Crisis and emergency responses*, this will require an additional supply of adequately skilled crisis response workers to provide immediate support and crisis assessment, and to mobilise a response where necessary.

Shifting to new workforce profiles and team compositions

Where there are changed ways of working, new workforce profiles and compositions may be required. This could result in an increase in the number of existing professions within a particular service and the inclusion and integration of additional capabilities by adding new roles and disciplines. The result will be overall growth with a shift in makeup.

Many of the Commission's service reforms will have this impact, with examples including:

- **introducing new bed-based models of care.** As recommended in Chapter 10: *Adult bed-based services and alternatives*, these will provide people with multidisciplinary treatment, care and support and a broad range of services, therapies and wellbeing supports, as well as alternative models of treatment, care and support. These reforms will require more peer support roles and clinical roles (including allied health roles) across bed-based services. For example, access to therapeutic and other supports in these settings (and community settings more broadly) may see a need for more art therapists and occupational therapists to work alongside existing staff
- **new crisis response teams.** As recommended in Chapter 9: *Crisis and emergency responses*, this will require experienced, highly skilled clinicians and workers who can support existing emergency services workers through telehealth or onsite consultations

- **expanding Forensicare's community forensic mental health services and transitional support services for people needing ongoing intensive treatment, care and support on their release from correctional settings.** As recommended in Chapter 23: *Improving mental health outcomes across the criminal justice, forensic mental health and youth justice systems*, this will require multidisciplinary teams able to offer psychological treatment combined with appropriate wellbeing support for people living with mental illness exiting prison, supports in the community adapted to a person's presentation and needs, and outreach visits to promote continuing involvement and connection
- **introducing the statewide specialist substance use or addiction service.** As outlined in Chapter 22: *Integrated approach to treatment, care and support for people living with mental illness and substance use or addiction*, these will support greater service integration of mental health and alcohol and other drug responses for consumers. This will require mental health specialist practitioners, substance use or addiction specialist practitioners and addiction medicine specialists with a combination of clinical and research capabilities.

Building in new supports and creating new workforce cohorts

Some of the Commission's reforms will create a need to introduce entirely new supports and workforce cohorts into the system. For example:

- the greatly expanded role for wellbeing supports in Local Mental Health and Wellbeing Services and in Area Mental Health and Wellbeing Services
- introducing new specialist trauma practitioners into Area Mental Health and Wellbeing Services, as articulated in Chapter 15: *Responding to trauma*, which will require services to ensure highly skilled and experienced specialist practitioners are recruited and retained in these positions
- expanding lived experience-led services, which will require more lived experience professionals and experts in roles beyond direct service delivery. For example, introducing peer-led and consumer-designed dedicated 'safe space' facilities, including respite services, for supporting mental health and suicidal crises, as recommended in Chapter 9: *Crisis and emergency responses.* These safe spaces, which will include both adult and youth-focused facilities, will require a considerable increase in the number of adequately skilled and experienced lived experience workers for both management and peer support roles. Roles able to offer lived experience professional practice supervision will also need to be integrated to provide tailored support for these workers.

Facilitating new ways of working across services

The Commission's vision means the future workforce will work in different disciplinary configurations across different settings and in new ways, requiring a shift in workforce culture and norms.

Professional roles and team composition need to reflect the value of bringing different types of expertise together—including lived experience expertise—and the unique contributions that different professional disciplines can offer in truly multidisciplinary teams. However, simply transforming the composition of multidisciplinary teams across local, area and statewide services will not be enough. To realise the full potential of genuine multidisciplinary, integrated and collaborative practice, new ways of working should be established, developed and maintained within and across services.

Several structural changes will support intended new ways of working in the future system. For example, Area Mental Health and Wellbeing Services will be delivered in a partnership between a public health service (or public hospital) and a non-government organisation that provides wellbeing supports. Due to this structured partnership model, the workforce will be required and facilitated to work in more integrated ways across a range of organisations and providers.

Area Mental Health and Wellbeing Services will also play a new and expanded role in providing inreach support and consultation liaison services across the system. For each of the new and/or expanded service functions described above, new commissioning arrangements should ensure the specialist multidisciplinary teams delivering these services have the appropriate size, specialist skills and capacity. Examples of new roles and functions in the reformed mental health and wellbeing system include:

- dedicated inreach support to Local Mental Health and Wellbeing Services, including primary consultation for consumers with ongoing or higher intensity support needs
- functions to help consumers, families, carers and supporters to navigate the mental health and wellbeing system
- consultation services to local primary and secondary care services; and collaboration with local GPs to provide a model of comprehensive shared care for people living with mental illness and complex support needs relating to their mental health and wellbeing, including for example substance use or addiction
- support functions for both primary and aged care services, as well as other mental health and wellbeing services (via consultation liaison, secondary consultation and shared-care activities) to assist these workforces in identifying and supporting older Victorians with complex and compounding mental health needs related to ageing.

The Department of Health should introduce relevant strategies to help implement these changes in the workforce. These strategies should consider:

- identifying size and role needs in workforce planning to ensure the capacity to work in new ways is embedded in workforce structures and resourcing for services and providers
- any employment or industrial matters that may need to be considered, in consultation with relevant stakeholders
- developing guides, resources and skill development programs to model and support these approaches—the capability entity recommended later in this chapter could be responsible for leading this work
- enabling more diverse education placements and rotations in services to improve shared understanding of practices across professional disciplines
- enabling more integrated cross-professional education and learning, including through the capability entity, as well as through educational institutions
- Victorian Government funding and commissioning of services to enable and promote more collaborative practices across services, rather than competition, as outlined in Chapter 28: *Commissioning for responsive services*.

To deliver the recommended outcomes for consumers, families, carers and supporters in the future mental health and wellbeing system, there is a need for different types of team, organisational and cross-service ways of working that can: deliver desired future system service outcomes; develop high-performing teams and services; and create the working environments that will attract and retain the necessary workforce to meet service demand.

In increasing overall capacity and adjusting composition, the Victorian Government should take into account the Commission's priorities for the new system including:

- more collaborative, person-centred approaches to working with consumers, families, carers and supporters and time for positive, therapeutic connection
- approaches to supported decision-making practices and human rights frameworks
- enhanced service delivery approaches including mental health and wellbeing services led by people with lived experience of mental illness or psychological distress
- enhanced service delivery approaches such as work that involves consumers' families, carers and supporters; as articulated in Chapter 19*: Valuing and supporting families, carers and supporters*, positions will be funded so there is capacity to deliver intensive therapy models that involve consumers' families, carers and supporters in each mental health and wellbeing service area
- increasing the role of workforce development and wellbeing through reflective practice, professional practice and clinical supervision and professional development.

Workforce diversity

Treatment, care and support should be delivered by a more diverse workforce. This diversity relates to professional disciplines and specialisation, including diverse lived experience expertise. For consumers to be provided with high-quality and genuinely therapeutic treatment, care and support, multidisciplinary teams made up of diverse professions will need to be supported to maximise the impact of their individual and collective capabilities. A range of evidence put before the Commission has emphasised the importance of this approach:

> I really don't think that we've done enough in terms of focusing on how to understand the unique contribution of each profession.[175]
>
> Myths and perceptions about different disciplines continue to raise barriers to effective collaboration. There continues to be a lack of awareness and understanding of the types of roles in mental health.[176]
>
> It is vital to ensure that state-funded mental health services are truly multidisciplinary. Discipline specific roles need to be clearly articulated.[177]
>
> Workforce development and retention is important, but it's even MORE important to think about what the right mental health workforce should actually look like … consider what an ideal mental health workforce would look like—there is no point in trying to keep and train a workforce that is not the right one … we could easily see a very different workforce, one that includes a much higher percentage of therapists and counsellors, peer workers and other allied health.[178]

The diversity of the workforce also relates to individual backgrounds and minority representation within teams, services and across the system. This means that people from diverse backgrounds—including Aboriginal, LGBTIQ+ and culturally diverse workers—need to be better represented across professional disciplines, roles and settings. As articulated in Chapter 21: *Responding to the mental health and wellbeing needs of a diverse population,* the Commission acknowledges that employing representative workforces is a critical enabler of cultural safety for consumers, families, carers and supporters and professionals themselves.[179] The workforce needs to be more representative of the diversity of the communities, families and individuals it serves across the state.

To ensure greater representation of the communities they work with, services should also be supported to:

- increase the number of Koori mental health liaison officers across each service setting, as well as consumer and carer peer workers in Aboriginal community-controlled health organisations
- expand 'liaison' or 'peer support' roles to support LGBTIQ+ and culturally diverse communities
- ensure access to appropriate interpreter and translation services.

Lived experience workforces

In its interim report, the Commission committed to lived experience workforces being a core part of the new mental health and wellbeing system.[180] The Commission recommended that consumer and family, carer and supporter lived experience workforces be expanded and underpinned by enhanced workplace supports for their practice.[181] The Commission continues to recognise the vital role lived experience workforces play in service delivery, leadership and advocacy. Expanding and supporting lived experience workforces will enable them to better contribute to the leadership and implementation of change.

Recommendations throughout this final report identify ways in which lived experience expertise and dedicated peer worker roles should be increased and enhanced in the future system. For example, *Chapter 7: Integrated treatment, care and support in the community for adults and older adults* discusses the important role of peer support as a core function of the future mental health and wellbeing system. The Commission's recommendations also call for employing people with lived experience—including personal, family and carer lived experience—in multiple and substantive leadership positions.

Personal story:

Bianca Childs

Bianca has worked in various lived experience roles for over 16 years. She is currently a Senior Lived Experience Advisor at Mind Australia, a community mental health service in Victoria. In her six years at Mind Australia, she has seen its dedicated peer workforce grow, and peer work become more highly valued and recognised as a professional discipline.

> In the last two years, 10 non-lived experience mental health workers have moved into peer roles because they've seen how supported our peer workers are, and how valued they are by the organisation. People are being drawn to that, and to use their lived experience.

Mind Australia has developed systems and training to support staff in doing peer support work. As part of her capacity-building role, Bianca has been involved in developing a new framework for peer workers that helps define their role.

> Being aware of what the peer role is, and that the peer model is less about the tasks and more about how they approached the work or how they do their work. I think that's what makes it a discipline.

Bianca said that by using their lived experience, peer workers can engage with consumers and achieve outcomes that may not otherwise have been possible. She explains how it can break down the power imbalance that can be felt between consumers and mental health practitioners and helps develop consumers' trust.

> Partially it comes down to that permanent state of disclosure of having 'peer' in the title. So just introducing yourself to somebody as a peer worker, automatically, you are seen as more equal. Peer workers also have the tools to build their knowledge of different power imbalances and the impact these can have as well as working towards minimising these imbalances.
>
> It could be that the peer worker might have shared something about themselves, which then made the client trust them more or that they feel safe to share something.

Over the years, many staff at Mind Australia have moved from peer worker roles into team leader and management positions, which has had a positive impact on the workplace culture. Bianca says that having people with lived experience in both peer roles and management positions has been important in bringing lived experience perspectives to the organisation more broadly.

> Now, in those team leader meetings and the service manager meetings, where they come together, there are people who have lived experience, but who also have the skills and the framework to use that in how they work and bringing that to the table and the decisions that are made at that higher level as well.

Bianca says that peer workers at Mind Australia draw on their lived experience knowledge and peer work values in all aspects of their work. This contributes to a positive culture within the team, a culture that recognises and values diversity and is open to learning about and sharing other experiences.

> It's more than just that one to one relationship and conversations with clients. It's having those conversations all the time in our work that makes a huge difference.

Bianca has found her work very rewarding, including the opportunities to train and support peer workers and work with managers and teams to ensure the organisational and service culture values and centres lived experience.

> Feeling like I'm making a difference, that's why I do this work.

Source: RCVMHS, *Interview with Bianca Childs*, November 2020.

This includes:

- in the Mental Health and Wellbeing Division in the Department of Health, as described in Chapter 27: *Effective leadership and accountability for the mental health system—new system-level governance*
- in the Mental Health and Wellbeing Commission, as described in Chapter 27
- on Regional Mental Health and Wellbeing Boards to support a more responsive approach to the planning and organisation of mental health and wellbeing services based on community needs, as discussed in Chapter 5: *A responsive and integrated system*
- in the agency led by people with lived experience of mental illness or psychological distress that will inform development of organisations and services, as discussed in Chapter 18: *The leadership of people with lived experience of mental illness or psychological distress*
- in research and innovation roles, including within the dedicated innovation support function, as described in Chapter 36: *Research, innovation and system learning*.

In addition, Chapter 19: *Valuing and supporting families, carers and supporters,* recommends establishing carer-led family and carer centres across the state. Support worker positions will be funded in each centre and, over time, most of these positions will be filled by family or carer lived experience workers. The support workers in the centres should be supported by a statewide coordinator who is a family or carer lived experience worker. Workers in the centres will require the skills to conduct needs assessments, to support older carers with transition planning and to provide peer support, education and help with system navigation. Chapter 19 also recommends establishing a peer call-back service delivered by families, carers and supporters with lived experience of caring for someone experiencing suicidal thoughts.

Chapter 19 also recommends that Area Mental Health and Wellbeing Services focus on the mental health and other support needs of young carers. The scope of the existing Families where a Parent has a Mental Illness program will be broadened, including by adding new young carer support worker positions. This will require targeted recruitment of adequately skilled young carer support practitioners with the right skills and system navigation literacy to provide support to young carers, including through supported referral. These workers will have a strong connection to a funded non-government organisation that will creatively co-design and deliver a range of supports for young carers and children and young people who have a family member experiencing mental illness or psychological distress.

Locally embedded trauma-informed peer support workers will also provide a critical, recovery-oriented support role for consumers, helping to validate the meaning and impact of trauma through shared, lived experience. Working with specialist trauma practitioners, peer support workers will also help consumers to use social and or peer support networks, including a range of digital peer support platforms hosted and supported by the Statewide Trauma Service as recommended in Chapter 15: *Responding to trauma*.

33.7.4 Indicative workforce reform challenges

As discussed, the major structural changes to the service system bring with them a considerable degree of change to workforce size, profile and capabilities. An appropriate workforce strategy and plan will be needed to ensure an adequate pipeline and transition (refer to section 33.8).

Meeting the workforce pipeline challenge

The Commission recognises that the Victorian Government does not control all the strategic and operational levers needed to manage the workforce pipeline. These levers include:

- **attraction and training**—promotion and marketing, education and training pathways, student places, and curriculum
- **accreditation and employment**—accreditation functions, registration, recruitment, workplace conditions and industrial relations
- **development and retention**—ongoing professional development career pathways, incentives and credentialling.

A considerable number of parties influence the many workforce supply levers in the mental health and wellbeing system. These include multiple layers of government, training providers, colleges and accreditation bodies, service providers and unions. As discussed above, at a minimum, some system reforms may require a far greater supply of professionals, but most service reforms may also bring a need for new capabilities that could require new training and potentially accreditation changes.

Establishing and expanding access to locally delivered, integrated treatment, care and support for consumers will represent an important service delivery and workforce composition shift. But for many other professionals—particularly clinical practitioners—the Victorian Government is not solely responsible for entry pathways, training curricula, regulatory settings or industrial arrangements. It is also challenging to influence accreditation processes and conditions that determine who enters the workforce and the functions they are approved to perform.

Given these challenges, it will be essential that the Victorian Government works closely and in partnership with the Commonwealth Government, professional bodies, unions, employers and other organisations to secure the appropriate pipeline and ensure workforce reforms can be achieved. The Commission has outlined the importance of such an approach as a requirement of the functions responsible for workforce strategy and planning discussed in section 33.8. The Victorian Government should also endeavour to make sure education pathways complement the ongoing professional development approaches discussed later in this chapter.

Understanding and responding to critical shortages

Given the above challenges, the Victorian Government should, in the first instance, consider the disciplines that are most at risk of workforce shortages in different settings. However, workforce reform risks will need to be interrogated in much more detail as part of the workforce strategy and the Victorian Government will need to monitor the supply of all disciplines because new risks may continue to emerge.

As emphasised in the interim report, the Commission found it difficult to accurately profile the mental health workforce because there is no consolidated source of data held by state or Commonwealth governments across all disciplines.[182] In response to this challenge the Commission undertook further analysis, drawing on two primary data sources that capture different information about the mental health workforce:

- the national Mental Health Establishment Dataset—data for all staffing categories working in public mental health services across most of the disciplines, based on the *National Mental Health Service Planning Framework*
- the National Health Workforce Data Tool—data for professions that are required to register with the Australian Health Practitioner Regulation Agency (under the National Registration and Accreditation Scheme) including a range of demographic variables such as years of experience, age, gender, workplace roles and public, private and various community settings.

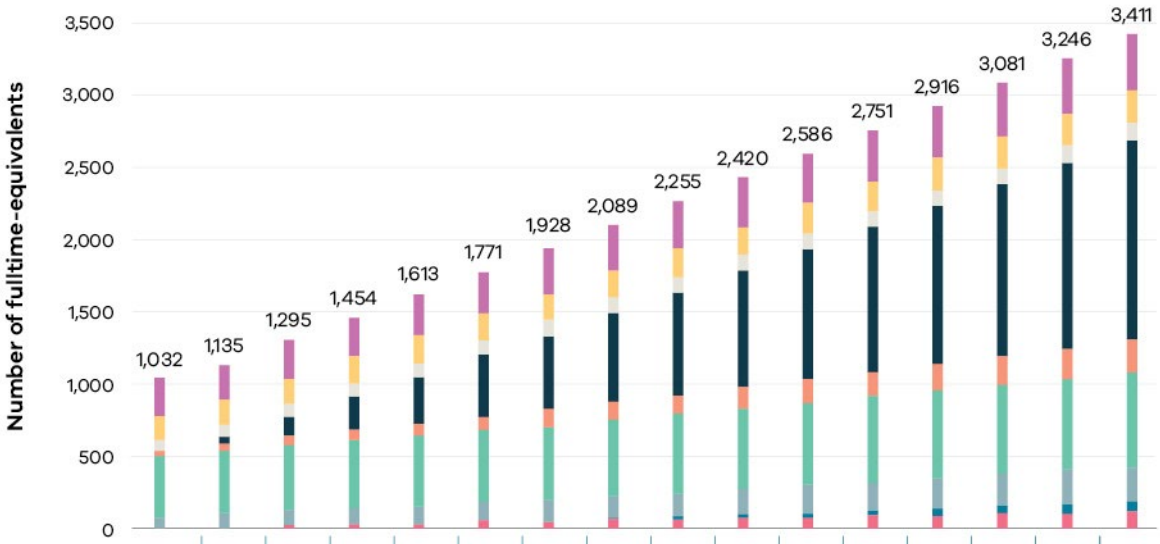
Understanding the supply problems that the mental health workforce currently faces (as best as the data allows) enabled the Commission to form a baseline view of the 'starting line' supply problems in the system. It was crucial that the Commission considered and understood the supply problems facing these key professions to identify workforce implications, risks and urgent areas for consideration arising from the reforms. Given the nature of current workforce shortages (and the various professional disciplines which they apply to) will continue to evolve over time, work of this kind will need to continue, as discussed in section 33.8.

This demand forecast identifies when there will be a shortfall in fulltime-equivalent numbers for each discipline by financial year, in addition to how large the deficit in fulltime-equivalent staff across various professional groups will be as defined by the staffing targets predicted by the *National Mental Health Service Planning Framework* in public mental health services.

It is important to note that these projections are based on the workforce composition and distribution assumptions of the *National Mental Health Service Planning Framework*, which may differ in the future Victorian mental health and wellbeing system.[183] Current shortages in the public mental health and wellbeing system include consumer and carer peer workers, social workers, psychologists and occupational therapists.[184] Fulltime-equivalent worker shortfalls are predicted for psychiatrists and nurses in 2021–22.[185] As noted above, current projections estimating positive supply numbers for some disciplines are not necessarily indicative of a stable trend over time. Close monitoring will be essential.

Figure 33.9 depicts the estimated current and future workforce shortfalls at the state level between 2020–21 and 2035–36.

Figure 33.9: Estimated workforce supply gaps in the public specialist mental health system, by workforce discipline, Victoria, 2020–21 to 2035–36



	2020–21	2021–22	2022–23	2023–24	2024–25	2025–26	2026–27	2027–28	2028–29	2029–30	2030–31	2031–32	2032–33	2033–34	2034–35	2035–36
Other Workforce	251	260	270	279	288	297	307	316	325	334	344	353	362	372	381	390
Consumer Peer Worker	166	170	174	178	182	187	191	195	199	203	207	211	215	219	223	227
Carer Peer Worker	81	83	85	87	89	91	94	96	98	100	102	104	106	108	110	112
Nursing	-	41	137	233	330	427	523	619	715	811	907	1,003	1,099	1,195	1,291	1,387
Social Worker	30	43	57	70	82	95	108	120	132	145	157	170	182	195	207	219
Occupational Therapist	426	442	457	472	487	502	517	532	547	562	577	592	607	622	637	652
Psychologist	79	91	103	114	125	136	146	157	167	178	188	199	209	220	230	241
Registrar	-	-	-	-	-	-	-	4	13	21	30	38	47	55	64	72
Psychiatrist	-	5	13	20	28	35	43	50	58	65	73	80	88	95	102	110
Junior Medical Officer	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

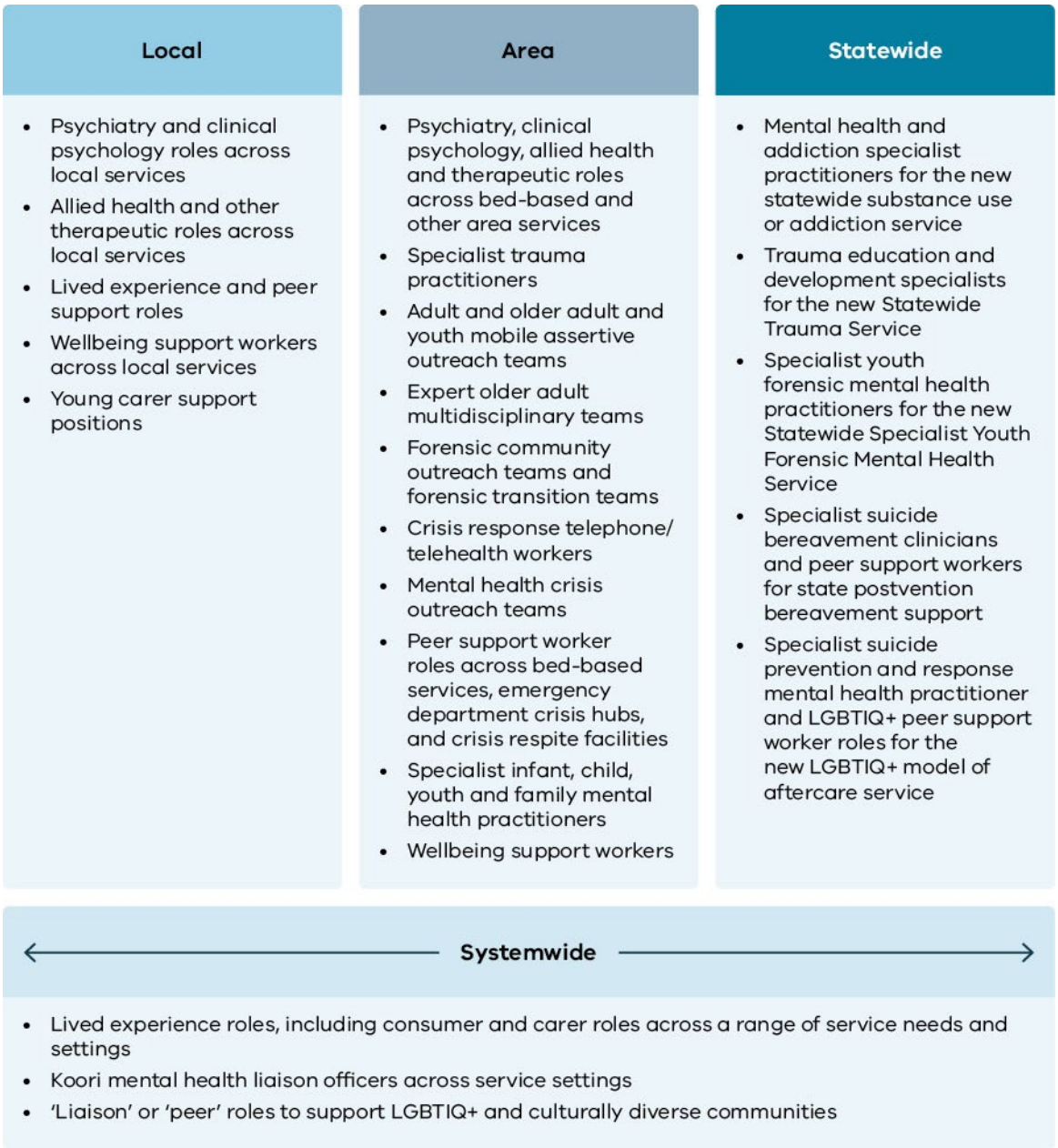
Sources: Commission analysis of the Department of Health (Commonwealth), *National Mental Health Service Planning Framework*; Department of Environment, Land, Water and Planning. Victoria in the Future 2019; Australian Institute of Health and Welfare, Mental Health Services in Australia: Specialised Mental Health Care Facilities 2018–19. Table FAC.34.

Notes: For the purpose of this analysis, it is assumed there is no growth in the workforce from 2018–19, the most recently available data.

For the workforce category Registrar, there is a surplus in the current workforce until 2027–28. The surplus in 2020–21 is 57 fulltime equivalents. For the workforce category Junior Medical Officer, there is a surplus in the current workforce beyond 2035–36. The surplus in 2020–21 is 19 fulltime equivalents. For the workforce category Psychiatrist, there is a surplus in the current workforce until 2021–22. The surplus is three fulltime equivalents in 2020–21. For the workforce category Nursing, there is a surplus in the current workforce until 2021–22. The surplus in 2020–21 is 56 fulltime-equivalents.

The *National Mental Health Service Planning Framework* workforce category Medical unspecified has been grouped to Psychiatrists. The workforce category Tertiary Qualified unspecified is split evenly across Social Workers, Psychologists and Occupational Therapists. The workforce category Nursing includes all enrolled nurses, registered nurses and nurse practitioners. The workforce category Other Tertiary Qualified, including pharmacists, has been excluded due to limitations in workforce data available.

Figure 33.10: Indicative workforce supply considerations



The Commission's analysis based on the national Health Workforce Dataset[186] also provides additional evidence that the workforce is poorly distributed across rural and regional areas, and that the workforce average age is increasing across many core professions.[187] Victorian public mental health services also face notable challenges in retaining Victoria's most experienced psychiatrists and psychologists, with more professionals working in private practice than in any other job setting in Victoria.[188] Also, the psychology workforce in public mental health services is greatly underutilised given the attrition to the private sector,[189] as substantiated by a range of evidence put before the Commission.[190]

Many services will also need an adequate supply of professionals with expertise beyond providing clinical mental health treatment, care and support. There are major supply challenges for the workforces in non-government and community organisations that will be delivering a range of therapeutic services, including wellbeing supports (formerly known as 'psychosocial supports'). As Mind Australia told the Commission:

> Mind is concerned by the significant workplace challenges facing [non-government organisations] working in the community mental health space, which threaten the provision of vital psychosocial and social support services.[191]

The transition of many psychosocial supports to the National Disability Insurance Scheme has had a considerable impact on the workforce delivering services to people with a disability or people living with mental illness or psychological distress.[192]

> [For the community services workforce] the NDIS and a trend towards shorter funding contract[s] has had a devastating effect on workforce retention. Redundancies are common, many others are leaving because of uncertain futures or being discouraged by the directions of the sector, or not being willing to work for what is increasingly lower pay and shorter term or casual positions.[193]

In a joint submission in response to the Productivity Commission, Mind, Wellways, Neami National and Sane Australia emphasised that the introduction of the National Disability Insurance Scheme has contributed to higher turnover rates and increased job insecurity.[194] The Commission understands that the changes have caused a loss of skilled and experienced workers, and generated concerns about job security and being able to work to the full extent of their capability.[195]

The increase in the need for more wellbeing professionals is noteworthy. There may be opportunities for attraction, recruitment and partnership in the context of other evolving sectors, and the Victorian Government is well positioned to control many of the levers that will drive desired change within and across sectors, and how they impact and support each other. Many of these professionals will hold vocational or diploma-level qualifications, and as a result, the Victorian Government can consider strategies relating to funding of training, attraction strategies and worker accreditation.

In terms of immediate priorities, assessing workforce requirements should be undertaken based on factors including (refer also to Figure 33.10):

- professional roles that have critical undersupply in the current system
- professional roles that have known or existing attraction and retention challenges for particular professional groups in public mental health and wellbeing settings
- professional roles that have known or existing rural and regional supply gaps
- professional roles that have known or existing attraction and retention challenges in rural and regional settings
- an expansion of service functions and activities associated with a considerable staffing increase or a service function associated with specialist capabilities.

33.8 Workforce strategy and planning

Given the degree of change required, a clear plan with identified priorities, timelines and responsibilities for transforming the future workforce is needed. Effective strategic planning, monitoring and continued leadership will be required to grow, develop and support the mental health and wellbeing workforce to deliver the level of treatment, care and support the Commission envisions.

33.8.1 A strategic plan for workforce reform

The Victorian Government should develop and publicly release a new workforce strategy and implementation plan by the end of 2021 to support workforce reform and ongoing workforce planning and monitoring. The plan should:

- ensure effective sequencing, milestones and implementation of planned phases of reform
- define key actions, resourcing and capability requirements across local, area and statewide services
- keep the Victorian Government accountable for what it has committed to delivering. (As part of this, the plan should assign responsibilities, deliverables and key activities across agencies, and support alignment across government)
- guide those with responsibilities to implement activities effectively and at the right time
- enable the Department of Health to effectively monitor implementation, manage risk and to allow oversight bodies to monitor progress against commitments
- enable work with the non-government sector to ensure strategic workforce planning and development for that sector with the reforms in mind.[196]

The workforce strategy and implementation plan should be reviewed and updated as required but at least once every two years.

Priorities for tackling future supply needs, and the strategies needed to respond to them through various educational and other pathways, should be based on expected additional workforce needs, how long it takes for staff to become qualified and join the workforce and known supply shortfalls.

In developing the plan, the Department of Health should consider:

- alignment with the Commission's vision for an appropriately skilled, diverse, multidisciplinary workforce, including more lived experience and diverse professional roles
- the workforce capacity necessary to accommodate new ways of working, such as more time for family, carer and supporter consultation, more collaborative and consultative approaches including supported decision making, providing support for improved system navigation, and consideration of overall case and administrative load
- the workforce capacity necessary to accommodate allocated time for professional development and improving skills
- the workforce capacity necessary to accommodate access to and the provision of workforce wellbeing and practice supports.

A range of early workforce priorities should be considered. As recommended in Chapter 24: *Supporting the mental health and wellbeing of people in rural and regional Victoria*, establishing a new incentive scheme to attract and retain workers in rural and regional areas will respond to maldistribution challenges, providing incentives to move to and work in rural and regional locations.[197]

In addition to this scheme, other strategies should be considered to deal with current and future workforce distribution needs. They may include:

- providing opportunities for part-time training positions[198]
- providing opportunities for flexible work conditions and career progression[199]
- incentivising rural and regional training opportunities such as scholarships, rural and regional placements, supported internships and fellowships[200]
- establishing specialist training and internship programs located in rural and regional settings.[201]

A further priority for the immediate workforce strategy should be tackling the lack of meaningful professional pathways and clarity of roles across professional disciplines and lived experience experts in the workforce, particularly in public mental health and wellbeing services.[202] To improve workforce supply in the mental health and wellbeing system, clearer pathways into and between professional roles should be identified and supported.

This work should reflect the unique contribution and technical skills each profession has to offer while allowing for flexibility in relation to the needs of different services and settings. The importance of creating, supporting and maintaining well-articulated career and learning pathways has been emphasised to the Commission.

> we've got the right ingredients, but we're not putting them together right.[203]
>
> By ensuring a strong career structure from graduate entry to advanced practice, leadership, education and research positions for occupational therapists working in the mental health sector, the Victorian Government can achieve sustainable workforce recruitment, retention and development, while also ensuring the generation and use of best evidence-based practice.[204]

Participants at one roundtable discussed the opportunity of providing Victorians with new, accessible pathways to join the mental health and wellbeing workforce of the future:[205]

> [What is important is] helping people with their career path … It's the career pathways, it's thinking about lifelong learning pathways.[206]

33.8.2 A dedicated workforce strategy and planning function

The Department of Health will require the ongoing policy, planning and technical capacity to identify, drive and respond to workforce reforms of this magnitude. To determine the workforce composition, role and pathway requirements for the new responsive and integrated service system, it is crucial that the Victorian Government establishes a dedicated mental health and wellbeing workforce policy, planning and strategy function to undertake this role.

This function should sit within the Department of Health. Initially, the function should focus on the workforce makeup, risks and immediate considerations outlined above, as well as the capability priorities identified by the Commission in section 33.9. These priorities should be tested and built on in collaboration with relevant stakeholders. The function should demonstrate an ongoing capacity to:

- conduct ongoing workforce data collection and analysis to map current and future workforce needs and supply risks
- connect the workforce supply and composition strategy to overall service and system modelling and planning
- identify and facilitate strategic approaches to workforce planning and development, including identifying and managing industrial implications
- work in partnership with relevant organisations to develop effective professional pathways into and within the workforce, including any use of international recruitment
- work with Regional Mental Health and Wellbeing Boards to tailor workforce planning, strategy and implementation to geographic and service needs
- encourage collaborations and partnerships (public, private and non-government) to review and adjust approaches as required through the reform process.

33.8.3 A data-driven approach

The Commission's interim report emphasised the need to regularly collect, collate and publish workforce data across Victoria's mental health and wellbeing system to ensure accountability, transparency and innovation.[207]

This chapter has articulated the difficulties associated with accurately profiling the mental health and wellbeing workforce, given state and Commonwealth governments do not have a consolidated source of data covering all service settings, professional disciplines and workforce cohorts.[208] This is particularly the case for community mental health and support workers.[209]

The Productivity Commission recommended that known data and information gaps should be prioritised, including data on non-government organisations that provide mental health services.[210] As emphasised by the Productivity Commission, neither national nor state datasets adequately capture 'the size, composition and roles of the community mental health and support workforce'.[211]

The Productivity Commission concluded that:

> **There is accordingly inadequate information about mental health community workers, their occupational categories, scope of practice, education, and demographic characteristics. This is a data vacuum that Australian governments should fill …**[212]

The Productivity Commission recommended that the Commonwealth, state and territory governments should ensure a nationally consistent dataset of non-government organisations that provide mental health services is established in all states and territories.[213] In doing so, the Productivity Commission also recommended that governments should 'adequately fund and provide ongoing support to non-government organisations to collect this data, to ensure the data is of high quality'.[214]

Noting the constraints associated with data sources and survey methodologies, the Commission has investigated current and future supply risks to determine growth and distribution priorities in the short and medium term. As outlined in sections 33.3 and 33.7.4, work of this kind must continue as the reforms are implemented. The Department of Health will need ongoing capacity to map and respond to workforce supply and distribution needs and risks into the future. Approaches to this must be informed by adjustments to modelling service and system demand over time—including using the *National Mental Health Service Planning Framework*, as articulated in Chapter 28: *Commissioning for responsive services*.

Workforce supply pressures are expected to change over time in line with workforce entry and attrition rates and the different phases of workforce reforms. Ongoing data analysis and reporting will be necessary to:

- identify and respond to supply, composition and distribution demands and gaps
- monitor progress according to the workforce strategy and implementation plan
- maintain the capacity to continue workforce planning and strategy into the future.

The department should ensure it has the capacity to undertake ongoing mental health and wellbeing workforce data analysis, planning and reporting. This includes:

- developing and maintaining ongoing workforce data collection, analysis and modelling ability by improving workforce data and analytical capabilities
- the ability to consider professional discipline-specific insights together with global workforce trends to regularly map workforce composition needs, geographic distribution and resourcing requirements before and during the implementation of reforms.

Taking a data-informed approach, the Department of Health will need to map in detail the initial composition and capability priorities the Commission has identified. Risk-informed strategies will need to be developed and tested with relevant stakeholders. Mapping workforce requirements across the system should take into consideration:

- what is being delivered—service delivery functions and activities required to deliver the new system's treatment, care and support offerings
- who will deliver these service delivery elements—which capabilities and aligned professions will be required in various roles, within and across services
- where they will deliver it—in local, area and statewide services, as required to meet demand across the state
- when they will deliver it—hours of service to meet consumer needs including crisis responses
- how they will deliver it—modes of delivery and ways of working to provide integrated services and a continuity of care across the system.

Mapping of this kind must consider the challenges in meeting current service demands as a result of poor geographic workforce distribution, particularly in rural and regional areas. In addition, this work should include the diversity of services and professions envisaged for the future mental health and wellbeing system across public, non-government and private settings.

In developing this capability the department should consider ways to understand both supply and demand drivers at the local, area and statewide levels. The department should pursue data-informed approaches that support Regional Mental Health and Wellbeing Boards, Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services to meet their workforce requirements quickly. In keeping with a community-led approach to mental health and wellbeing, services should also seek to increasingly fulfil local workforce needs from local communities.

Jobs Victoria's Working for Victoria program is an example of an initiative that draws on this approach. In responding to the economic impacts of the COVID-19 pandemic, the Victorian Government established the initiative to support and connect jobseekers and employers.[215] The approach involves helping jobseekers to get 'job ready' and working closely with employers to help them identify the skills and experience they are looking for in their workers. The program then connects employers with appropriate candidates.[216] Jobs Victoria established a digital platform and database to support the initiative. The platform can identify candidates and workforces with specific skills or characteristics in specific locations. Working for Victoria has created more than 1,100 roles in community sector organisations.[217] As well as providing employment, this has enabled jobseekers to gain experience in an area of workforce demand and embark on a potential new career. This 'real-time' data on jobseekers and their interests provides an opportunity to fill immediate workforce gaps while also creating pathways into new roles as they are established—for example, new wellbeing support workers.

The Commission considers that initiatives of this kind can be leveraged to support data-informed workforce planning as part of workforce transformation, and practically support localised workforce initiatives with real-time information on candidates.

33.8.4 Fostering collaboration and partnerships

As discussed, the Victorian Government does not hold all the levers that influence workforce supply, distribution, retention or experience. To create sustainable workforce reforms, the Department of Health will need to make collaboration and partnerships a priority, both during the initial waves of reform and into the future.

Diverse and targeted partnerships are needed with many parties including the Commonwealth Government, professional regulatory and worker representative bodies, and education and training providers, as well as services and peak bodies. These partnerships and collaborative relationships should be fostered at the central, regional and statewide levels.

The Productivity Commission emphasised the importance of consulting a more diverse range of mental health services and professionals in workforce strategy and planning processes. The Productivity Commission recommended that the forthcoming *National Mental Health Workforce Strategy* and the *National Medical Workforce Strategy* should pursue greater consultation with community mental health service employers and practitioners who 'tend to be given less of a voice'.[218]

The Commission has also identified a range of specific opportunities for the department to work closely with the Commonwealth Government and associated federal entities. For example, the *National Mental Health Workforce Strategy* will identify key workforce challenges and will consider the supply, distribution and structure of the mental health workforce, including lived experience workforces.[219] It will also identify 'practical approaches that could be implemented by Australian governments to attract, train and retain the workforce'.[220] The Productivity Commission has recommended that the Commonwealth Government ensures that the strategy 'aligns the skills, costs, cultural capability, substitutability, availability and location of mental health practitioners with consumer needs … by integrating the workforce strategy with service and infrastructure planning'.[221] In the context of the *National Mental Health Workforce Strategy*, Victoria should ensure the proposed mental health workforce strategy and implementation plan is aligned with national efforts and places Victoria in a position to benefit from national initiatives and areas of focus.[222]

The department should work with the Commonwealth Government and relevant professional bodies and regulators on ways to formally recognise training and skills for workers from broad professional backgrounds who have the necessary qualifications and clinical experiences (for example, from alcohol and other drug services and emergency medicine). This may include pursuing options for areas of practice endorsement—for example, a mental health area of practice endorsement for GPs.[223]

Other opportunities for national collaboration include the Commonwealth Government partnering with professional bodies in relation to training approaches. For example, the national Specialist Training Program provides vocational training for specialist registrars in settings outside metropolitan teaching hospitals, including regional, rural and remote and private health services. The program 'aims to improve the quality of the future specialist workforce by providing registrars with exposure to a broader range of healthcare settings'.[224] The Specialist Training Program also 'aims to have a positive influence on future workforce distribution'.[225]

Currently, medical registrars conduct psychiatry rotations in public specialist clinical mental health services, and the Commission has heard how these experiences can discourage entry to the psychiatry discipline.[226] One psychiatry registrar said:

> Our interns don't enjoy their psychiatry rotations and find them stressful when they are not supported. Our registrar workforce gets exhausted and burnt out. Our consultants similarly so ...[227]

The Commission considers there could be opportunity through a partnership with the Commonwealth Government and The Royal Australian and New Zealand College of Psychiatrists to establish rotations in private health or other appropriate settings to provide a greater diversity of early career experiences. Such opportunities might extend to clinical placements for medical students:

> The majority of clinical placements typically occur in the inpatient setting. In the context of mental health education, this is potentially problematic as the majority of patients with mental illness and poor mental health are seen in community settings ... [inpatient placements provide] limited or no exposure to patients with high prevalence illnesses ... As a result some students feel ill-equipped to diagnose and manage more common mental health complaints ... This is a particular issue when students conduct mental health consultations and are not taught how to interview patients appropriately or complete a mental health care plan. Multiple students expressed that they feel unprepared in these circumstances.[228]

The department will need to work with many stakeholders to ensure the mental health and wellbeing system develops a sufficiently diverse workforce, particularly in rural and regional areas. It will be important to build regional workforce planning functions into formal structures and mechanisms including Regional Mental Health and Wellbeing Boards and other structures such as the current regional coordinator roles at the existing Centre for Mental Health Learning.

There is also an opportunity for the department to work alongside universities and TAFEs to increase rural and regional placement opportunities across a range of settings. The department should work with professional colleges and other relevant bodies to plan and implement recruitment, training and retention activities for professional groups that are facing critical shortages such as consumer and carer peer workers, social workers, psychologists and occupational therapists, or underutilisation such as psychologists. Together with the capability entity (refer to section 33.9), the department should work with professional colleges and associations to ensure capability development needs and professional development programs can be credited appropriately wherever possible (for example, as part of continuing professional development requirements).

The department should also facilitate clear and consistent communication and stakeholder participation processes as part of the planning and implementation of workforce reforms. This should include an inclusive process in workforce planning, including with lived experience experts, as well as clear communication with services and the wider workforce about implementing system reforms and continuous improvement. Participants to the workforce survey rated 'receiving clear communication and being kept informed through the change process' as the most important factor they felt would help them prepare for changes to the system.[229]

The Productivity Commission's *Mental Health Inquiry Report* recommended that, in developing a new workforce strategy, the Commonwealth Government should ensure 'planning consultations give weight to the perspectives of consumers, carers, mental health workers and service providers, including the non-clinical community mental health sector'.[230]

33.8.5 Industrial considerations

The Commission's reforms call for major workforce change to ensure the range of expanded mental health and wellbeing services is delivered by a diverse, multidisciplinary mental health workforce of the necessary size and composition across Victoria.

In addition to boosting supply, workforce profiles and team compositions will change and new roles will be introduced. As the reforms proceed and new providers take on new functions, it may also be necessary for existing members of the mental health and wellbeing workforce to work in new ways, across different settings and organisations. These changes bring important industrial considerations and potential implications.

It will be critical for the Department of Health to take a strategic, data-informed and collaborative approach to workforce reform. The Commission anticipates that this approach to implementation will be informed by a thorough and collaborative assessment of industrial implications led by the department. This work should be done in collaboration with unions and other industrial or representative stakeholders, including lived experience workforces. These stakeholders have considerable expertise and experience with workforce change and have deep insight into workforce experiences, needs and hopes for the future. Lessons learnt from workforce reforms in other sectors should also be considered. As is the case with the Commission's broader reforms, addressing these workforce implications should be overseen by the Mental Health and Wellbeing Secretaries' Board and Mental Health and Wellbeing Cabinet Subcommittee outlined in Chapter 27: *Effective leadership and accountability for the mental health and wellbeing system—new system-level governance*.

33.9 Approach to developing workforce capabilities and professional development

To effectively implement the future system, specific new and enhanced capabilities will need to be developed across professions, roles and settings to deliver the intended service delivery components and approaches.

Capability development should be made a priority and should include tiered requirements ranging from core whole-of-workforce skills, knowledge and attributes, through to specialist and technical capabilities. These activities should complement other professional discipline- or service-specific requirements such as those necessary to maintain professional accreditation. Capability development should also occur through a coordinated, networked approach to ensure the workforce develops the collective values, knowledge, skills and attributes it needs to provide consumer-focused, recovery-oriented treatment, care and support. To achieve this, the Commission considers that the Victorian Government should:

- provide a central capability entity with the responsibilities to lead a whole-of-mental-health workforce approach to capability development and training
- work with relevant stakeholders to develop a Victorian Mental Health Workforce Capability Framework that defines the knowledge, skills and attributes required to meet the needs of consumers, families, carers and supporters.

33.9.1 A whole-of-workforce approach to workforce capability development

The Commission recognises the need for clear and dedicated responsibilities to support workforce capability development and training in a more coordinated and consistent way across the mental health and wellbeing system. The Commission's interim report recommended that the Collaborative Centre for Mental Health and Wellbeing 'educate the mental health workforce through practice improvement, training and professional development programs'.[231] Building on this, the Department of Health should implement a whole-of-workforce approach to capability development by:

- enabling a comprehensive and networked approach to building capability across the whole workforce by coordinating and supporting access to priority learning and professional development activities and educational resources in collaboration with training providers, statewide services and others
- developing approaches that ensure access to professional development tools and resources in subject areas of high priority and areas of greatest need, starting with those the Commission has identified
- supporting the delivery of a change management approach (as part of the workforce strategy and implementation plan) across the mental health and wellbeing workforce with a focus on priority capability development reforms
- encouraging the workforce to participate in the innovation and knowledge dissemination opportunities described in Chapter 36: *Research, innovation and system learning*.

The Commission considers that a whole-of-workforce approach is needed to define the core generalist and specialist capabilities required across the workforce. This will support more effective multidisciplinary and collaborative practice across teams and services and ensure the necessary knowledge, skills and attributes are developed across the diverse mental health and wellbeing workforce in more consistent ways. A coordinated and collaborative approach to develop and enhance these capabilities is also necessary. There are important benefits in taking a collaborative and coordinated approach:

> in the workforce … [professionals] work alongside each other, many of them have to have some basic core competencies that are shared. There are some specific competencies; competencies that different disciplines need. But we have a strong sense that … it seems reasonable to train those people alongside each other because they will work alongside each other. And there's a common base that they all need to know, particularly at the beginning of their careers.[232]

> the opportunity to be engaged in multidisciplinary learning or combined education sessions are greatly valued by pharmacy (and other) students. We believe the education of tertiary students in mental health care would be an ideal time to invest in multidisciplinary learning opportunities.[233]

There is also a need for professional learning and development to be implemented through a range of approaches that are integrated into workplace professional practice, rather than into only designated training or external professional development. The Commission was told that embedding cultures of learning into services is important to help workers to implement what they have learnt:[234]

> when we get into talking about capabilities, we slip into talking about training. Whereas in my experience of doing training with people … you can do a one-day [course], a five-day [course], … you know, several week[s] [of] training, whatever it may be. But then the challenge those people experience is not in learning in the training context. It's in how do I implement what I've learned in my practice? And sustain that too.[235]

While a whole-of-workforce approach is needed, the Commission also recognises the need to develop tailored approaches to professional learning and development for the mental health and wellbeing workforce in rural and regional locations and other specific areas, both geographical and cohort specific. One workforce member emphasised the importance of tailoring:

> I think it's really easy for us to think about all the opportunities that we can create [in metropolitan areas], particularly around training and skills. [But] there are particular challenges to accessing that … when people are in regional and rural environments … [We need to] think about how we can ensure that the … [development of] workforce capabilities and competencies … are accessible … [t]o be able to benefit the group of people using services in those parts of the state.[236]

As submitted to the Commission by Mental Health Victoria and the Victorian Healthcare Association, '[t]here is a need for the systematic incorporation of learning into everyday practice.'[237] Submissions have outlined a range of strategies to improve capability development, including regular professional practice rotations across diverse settings and fellowships and training scholarships.[238]

Case study:

Health Education and Training Institute (NSW)

NSW's Health Education and Training Institute (HETI) provides education and training to support more than 110,000 clinical and non-clinical staff, trainers and leaders across New South Wales' health system. HETI was established in 2012 as a statutory health corporation and reports to the Ministry of Health (NSW Health).

HETI works closely with local health districts and specialty networks and other public health organisations across New South Wales to ensure programs are relevant and responsive to the needs of health professionals. Annette Solman, the Chief Executive of HETI, said:

> We also work with the Ministry of Health, to identify what are the emerging and critical workforce needs now and into the future, to ensure that we have a highly skilled and capable workforce in the delivery of quality and timely care to our patients.

Dr Roderick McKay, from HETI's Mental Health Portfolio, said the education and training programs are designed to build skills that could be effectively applied in practice.

> HETI provides education and training that people can actually integrate into their workplace and see a difference. We are able to use experts from across NSW Health to achieve this.

HETI's offering includes professional development and training networks. It is also an accredited provider of higher education and currently delivers Postgraduate Certificate, Diploma and Masters-level qualifications in Psychiatric Medicine and Applied Mental Health Studies. Its training is delivered through customised learning experiences via multiple modes including in-person sessions, e-learning, work placements and mentoring. Some of the modalities have been more limited recently due to the COVID-19 pandemic. Importantly, the training HETI provides is guided by the lived experience of people with mental illness or psychological distress, families, carers and supporters.

HETI also undertakes educational research with a focus on embedding evidence-informed practice, and publishes the peer-reviewed *Health Education in Practice: Journal of Research for Professional Learning*. HETI has a dedicated research capacity building program for healthcare workers in rural and remote settings.

As part of its offering, HETI provides mental health education and training for the NSW Health mental health workforce, as well as for the wider health workforce. It works with sector partners to support improved mental health and wellbeing of the health workforce.

An example of the mental health professional development provided by HETI is the GP Mental Health Assessment and Management Skills workshop. It is a two-day workshop that aims to develop GPs' skills in mental health assessment and management planning and is based on a recovery-focused model. Participants are trained by experts from psychiatry, general practice, trauma-focused care and addiction medicine, along with people with lived experience.

Source: HETI, <heti.nsw.gov.au>, [accessed 19 November 2020]; HETI, 2018–2020 *Health Education and Training Institute Strategic Plan,* <heti.nsw.gov.au/__data/assets/pdf_file/0017/431450/HETI_StrategicPlan.pdf>, [accessed 19 November 2020].

Other jurisdictions have created specific entities to support the workforce to build capability—for example, the Health Education and Training Institute in New South Wales. Another example is the Evidence-Based Practices Resource Center, opened in 2018 by the Substance Abuse and Mental Health Services Administration in the United States. This facility provides communities, clinicians, policymakers and others in the field with evidence-based resources, including treatment improvement protocols, toolkits, resource guides and clinical practice guidelines.[239] Such models provide good examples from which the Victorian Government can draw inspiration and practical guidance.

A whole-of-workforce capability entity

The Victorian Government should provide a central capability entity with the responsibility to lead a whole-of-mental-health workforce approach to capability development and training. The Victorian Government currently commissions the Centre for Mental Health Learning as the central agency for public mental health workforce development. It supports access to quality, contemporary workforce training and development and works with organisations across the state that provide workforce training.

The Commission suggests that the work of the existing Centre for Mental Health Learning[240] could be auspiced by the Collaborative Centre for Mental Health and Wellbeing and extended to undertake a range of statewide workforce capability functions. To avoid delays in actioning the Commission's recommendations, the Centre for Mental Health Learning could take on responsibility for a number of additional functions aligned to its existing responsibilities, and work with the Department of Health and the Collaborative Centre for Mental Health and Wellbeing through an establishment and transition period.

The capability entity should ensure professional development and learning is designed to encourage development of cultures of reflective, career-long learning within teams and services, and across the system, in a way that is consistent with current research and system priorities. Professional learning resources and programs should also be designed, developed, delivered and evaluated based on principles of effective adult learning and should engage participants in real-life, practice-related content.

A coordinated approach to mental health workforce capability development should support professional development across core competencies in the whole-of-workforce capability framework proposed in this chapter. The capability entity should be responsible for working collaboratively with the department and educational, academic and specialist service organisations to:

- help the workforce make the most of high-quality professional learning opportunities to strengthen priority capabilities and support career and leadership pathways
- integrate lived experience expertise in the design and delivery of professional learning opportunities
- coordinate learning and development activities and access to specialist knowledge and expertise across services, professions and geographic areas
- increase the availability of learning and development, including expanding regional training, supervision and internships, diversifying clinical placement opportunities, and expanding online delivery and practice supports

- in partnership with service providers and education providers, increase rural and regional access to learning and development, including expanding regional placement, training, supervision and professional pathway supports
- help create learning, development and professional supports (including digitally enabled communities of practice and reflective practice groups) for senior clinical and specialist educator roles in the new service system—this should have an emphasis on allied health professions (including psychology, occupational therapy and social work), and lived experience experts
- develop resources and professional supports for priority workforce groups (in particular lived experience workforces, rural and regional professionals, Aboriginal practitioners, LGBTIQ+ practitioners and culturally diverse practitioners).[241]

Working with the department, the capability entity should develop a workforce capability strategy and associated workplan. This would form a component of the overall workforce strategy and implementation plan, and would focus on actions to build the capabilities required in the short-, medium- and long-term phases of the system reform.

In doing so, the department and the capability entity should work with relevant groups—including professional colleges and associations, relevant statewide services, lived experience workforce bodies and training and education providers—to ensure the implementation of capability development complements professional development requirements across settings and professional disciplines.

Statewide specialist training and development

As outlined in Chapter 5: *A responsive and integrated system*, the Collaborative Centre for Mental Health and Wellbeing will auspice statewide services and play a critical role in helping statewide services to build the capability of Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services. The Commission envisages that the capability entity (as an arm of the Collaborative Centre) will work closely with various statewide specialist services that play key roles in training and professional development.

Taking a networked approach, the capability entity will support and facilitate access to specialist training and development in existing, enhanced and new areas of focus including:

- **Targeted strategies for developing, attracting and retaining specialist clinical professionals.** For example, as articulated in Chapter 22*: Integrated approach to treatment, care and support for people living with mental illness and substance use or addiction*, a new statewide specialist substance use or addiction service will support the capability of the mental health and alcohol and other drug sectors to provide integrated approaches to treatment, care and support and to increase the number of addiction medicine specialists (addiction medicine physicians and addiction psychiatrists) in Victoria's mental health and wellbeing system. Chapter 23: *Improving mental health outcomes across the criminal justice, forensic mental health and youth justice systems* recommends a new specialist Youth Forensic Mental Health Service that will run a youth forensic clinical specialist program to build forensic capability within Infant, Child and Youth Area Mental Health and Wellbeing Services.

- **Models for specialist mental health practitioner training, education and ongoing development through specialist communities of practice.** For example, as articulated in Chapter 15: *Responding to trauma*, the new statewide Specialist Trauma Service will design and deliver a system-wide approach to trauma and recovery workforce capability development across the mental health and wellbeing workforce, developing an education, training and development program for specialist trauma practitioners, including resourcing communities of practice. The statewide specialist substance use or addiction service recommended in Chapter 22 will also deliver training and education to a broad range of practitioners and clinicians across the state with a focus on optimal delivery of integrated care.
- **Specialist outreach models of support and capability development.** For example, as articulated in Chapter 23: *Improving mental health outcomes across the criminal justice, forensic mental health and youth justice systems* and *Chapter 10: Adult bed-based services and alternatives*, Forensicare will deliver the specialist behaviour response team, with specialists from Forensicare regularly outposted to Area Mental Health and Wellbeing Services. The team will assist in building specialist capabilities across regions and services, particularly in relation to consumers with complex needs who may be a risk to themselves or others.

Supporting broader workforce capability building

While the capability entity's primary role will focus on building the capability of the mental health and wellbeing workforce, it could also play a coordination role to help build the capability of the general health workforce and other workforces that respond to people living with mental illness or psychological distress.

For example, the Commission's reforms will see many general health worker roles integrate more closely with the mental health and wellbeing system to support physical health recovery and wellbeing. Outside of general health, Victoria Police, Ambulance Victoria and the Department of Justice and Community Safety will also be required to form much stronger partnerships with the mental health and wellbeing system to support continuity of care and effective responses. A range of other services and professions, including education, housing and child protection, will also interface more closely with mental health and wellbeing services to provide wellbeing supports and/or connected services.

The capability entity could actively collaborate with relevant organisations and bodies to ensure consistency in approach and incorporation of good practice. The capability entity may also facilitate access to mental health training and education programs.

The Commission also anticipates that GPs will take on an even more active role in mental health and wellbeing treatment, care and support. This includes as primary referrers into Area Mental Health and Wellbeing Services, formalising mental health care plans and referring people to relevant services under the Better Access scheme. It also includes delivering mental health treatment, care and support, such as focused psychological strategies, especially in rural and regional areas. GPs currently have a range of formal training requirements that enable them to undertake assessment and diagnosis of mental illness and are required to complete additional training to deliver focused psychological strategies under the Better Access scheme. Given the considerable role that GPs will play in the future mental health and wellbeing system, there is opportunity for the Commonwealth Government and professional bodies to consider developing a 'mental health area of practice endorsement' for GPs. Such an endorsement would not only support GPs to build their capability in mental health but would also provide them with greater access to incentives under the Medicare Benefits Schedule.

Priority capabilities for development

The Commission has identified several areas as priorities for capability development, as outlined in Box 33.3.

These priorities are informed by the skills needed to deliver the specific service and system reforms recommended in this report, as well as to realise the overall shift in workforce culture, practice and approaches. They are also informed by feedback from members of the workforce, who highlighted several priorities:

- delivering holistic treatment, care and support to consumers across mental health, social and other needs
- working collaboratively with consumers to understand their current circumstances, relationships, background, identity and past experiences, including trauma
- capabilities to respond to the specific effects of major or complex trauma
- delivering services in ways that can actively respond to diverse consumer backgrounds in meaningful ways (for example, cultural/language backgrounds, gender diversity)
- working collaboratively with other colleagues, services or parts of the system in delivering care.

Participants from specific professions also emphasised additional capabilities. For example, psychologists emphasised the need for capability development in terms of working with challenging interpersonal dynamics within their current role/setting.[242] Lived experience workers emphasised the importance of actively engaging with consumers, families, carers and supporters in the design and delivery of services, in addition to interpersonal skills such as active listening and rapport building within their current role/setting.[243]

The priorities in Box 33.3 should be further considered in developing the Victorian Mental Health and Wellbeing Workforce Capability Framework.

Box 33.3: Priority capabilities for the future system

- **Mental health legislation and human rights**: understanding mental health legislative frameworks and practice implications related to the new Mental Health and Wellbeing Act and relevant human rights responsibilities, including advocacy related to compulsory treatment and supported decision making for people placed on compulsory treatment.
- **Specialist clinical assessment, therapeutic interventions and other specialist treatment, care and support**: this includes in specialist trauma, substance use or addiction and forensic capability, as well as collaborative formulation and comprehensive assessment.
- **Cohort-specific clinical assessment, therapeutic interventions and other specialist treatment, care and support**: this includes in perinatal mental health, infant, child and youth mental health (including family therapies) and older adult mental health.
- **Reflective practice and professional practice supervision**: this includes facilitating interprofessional reflective practice groups, professional practice supervision and tailored professional practice supervision for specific workforce groups (peer workers, crisis response workers, specialist trauma practitioners and those working in forensic contexts).
- **Working effectively with people demonstrating threatening behaviour**: preventing escalating distress or agitation, and responding least restrictively to threatening behaviour, violence or aggression while maintaining safety, including de-escalation and communication skills.
- **Working effectively with complexity**: working compassionately and effectively with complex behavioural presentations (including chronic suicidality and non-suicidal self-harm) and advanced interpersonal skills to effectively manage challenging interpersonal dynamics (including identifying attachment challenges and trauma-based coping mechanisms).
- **Understanding, preventing and responding to mental health crisis and suicide**: this includes risk assessment and care planning, crisis and suicide response and intervention, intensive psychological and suicidal distress support, and specialist bereavement and aftercare support.
- **System navigation and literacy**: this includes understanding the reformed responsive and integrated mental health and wellbeing system, service and referral options and pathways, and approaches to support continuity of care and consumer choice.
- **Working with families, carers and supporters across the workforce**: this includes collaborative formulation, family and carer communication, liaison and information sharing, family-based therapies and interventions, and family and carer and wellbeing supports.

- **Understanding and responding to trauma across the workforce**: understanding of prevalence and different types of trauma (including acute, chronic and complex trauma); understanding and identifying the biopsychosocial effects and common indicators of trauma; responding effectively to disclosures of trauma and aligning practice with trauma-informed treatment approaches.
- **Digital capabilities**: skill development and system knowledge in technology-enabled service delivery and consumer involvement, including secure and appropriate use of digital tools and services, electronic messaging systems, risk management and crisis response.
- **Information use and sharing**: understanding of and practice alignment with new expectations in information collection, use and sharing and practice, including approaches to support and respond to consumer consent to share information with other service providers, families, carers and supporters. In addition, competency in using the new Mental Health Record and Mental Health Information and Data Exchange.
- **Cultural responsiveness**: this includes understanding and responding to the needs of Victoria's diverse population and of specific social cohorts.
- **Innovation and evaluation capability**: supporting the mental health workforce to develop evaluation mindsets and encourage the use of innovative and evidence-based approaches.

33.9.2 Victorian Mental Health and Wellbeing Workforce Capability Framework

The Commission recommends the Victorian Government develop a whole-of-workforce capability framework based on the Commission's preliminary work by the end of 2021. Services and training providers have advocated for a framework that describes a set of observable skills and behaviours for workers.[244] Such frameworks have been used to grow, strengthen and support workforces in other mental health systems,[245] in other health and public service sectors, and as part of implementing other system reforms such as the National Disability Insurance Scheme and family violence reforms in Victoria.[246]

Using the Commission's identified priority capabilities as a starting point, the framework should describe the desired knowledge, skills and attributes within the workforce to meet the needs of consumers, families, carers and supporters. It should:

- be inclusive and developed collaboratively with the workforce, people with lived experience as consumers, families, carers and supporters, and other subject matter experts to ensure a consistent understanding and use of language across professions, and to maintain a lived experience and frontline workforce perspective
- be used to inform priorities for training and professional development at the service and system levels
- deal with the core skills that all treatment, care and support practitioners need, and the specialist professional disciplinary skills needed to be distributed across the new system[247]
- be tied to clear and measurable actions at the individual, team, service and system levels
- be reviewed and updated at appropriate intervals in line with the emerging needs of the system in future waves of reform.

The framework should also articulate the leadership and organisational capabilities that the workforce requires to practice effectively and provide the greatest benefit to consumers, families, carers and supporters. Box 33.4 sets out the proposed purpose and structure of the framework.

Box 33.4: The purpose and structure of the Victorian Mental Health and Wellbeing Workforce Capability Framework

The framework should provide a common language to describe the knowledge, skills and attributes needed to perform work across all settings and services. These capabilities will complement the context and professional discipline-specific capabilities that will continue to be required and developed. It also supports the transformation to a more cohesive and collaborative future workforce by generating a sense of collective identity and reciprocal responsibility for how treatment, care and support is delivered.

The framework should set out the core capabilities and associated behaviours that are required by:

- the whole workforce in any service setting or role so all who engage with any part of the mental health and wellbeing system will receive an empathetic response that responds to their needs in all interactions
- those directly providing treatment, care and support so all consumers receive an appropriate, effective and cohesive service response to their unique needs and circumstances
- those who provide more specialist and technical interventions to support delivery of high-quality clinical and specialist treatment, care and support.

As the workforce grows and diversifies, the framework will be an inclusive and unifying approach that is shared and owned across professions, disciplines, specialties and roles. It will help individuals in any role to understand what capabilities they need to develop to meet the responsibilities of their role. It will empower teams to consider their collective skills and expertise, and how best to use them. It will help employers and training providers to plan and develop professional learning and practice across the system.

As well as determining the workforce capability development priorities into the future, the Department of Health, the capability entity, professional bodies, training providers and employers should use the framework to:

- inform strategic workforce planning, including integrating new skills, capabilities and workforces
- help monitor activities designed to embed and develop core workforce capabilities
- support a strategic and clear approach to investment in—and planning, design and delivery of—professional learning, supported by the capability entity to assist in developing career and leadership pathways within the mental health and wellbeing system, and support individual career and development planning
- design multidisciplinary teams and plan optimal use of team skills and expertise to meet consumer needs within service settings and contexts
- recruit and induct staff, manage performance and support development.

The Commission understands that the Department of Health has given responsibility to the Centre for Mental Health Learning to develop a mental health workforce capability framework,[248] which could be further developed. The framework should be informed by exemplar equivalents and be aligned wherever necessary with existing relevant capability frameworks.

In consolidating the evidence it has received about the universal, core capabilities required to deliver treatment, care and support in the future mental health and wellbeing system, the Commission has identified a set of core values and approaches to underpin the framework. These are summarised in Table 33.1.

The content in the framework should not relate only to a specific profession, discipline, role or setting, except where these are part of specialist and technical capabilities. It should include comprehensive but succinct statements of consumer expectations, needs and experiences, and outline the workforce capabilities that enable these.

The department should lead an inclusive and collaborative approach to keeping the framework and training priorities up to date in line with phases of reform, emergent workforce needs and contemporary research. Colleges and training providers will share responsibility for integrating evolving priorities into training and development. The framework should not be an exhaustive articulation of existing professional practice standards and requirements.

Table 33.1: Victorian Mental Health Workforce Capability Framework—core values and approaches

Core values and approaches	Consumer and carer experience outcomes	Workforce experience outcomes
Holistic, person-centred and recovery-oriented: Services, teams and practitioners work collaboratively with consumers to identify personal strengths and goals, and to empower individuals to actively participate in decision making about their own care and recovery through human rights–informed approaches. System literacy at all stages of service delivery supports a holistic approach to care.	*I feel heard and understood as an individual with my own needs and experiences. My strengths and goals are taken into account and I am supported to understand and make choices about the treatment and support that I receive, and to access it when and where I need it.*	*We work as part of a collaborative, coordinated mental health system. We share responsibility for ensuring every person receives treatment, care and support that is appropriate to their needs and preferences. We will support consumers to identify personal goals, make decisions about their health and to exercise choice and control.*
All forms of expertise are valued: Services, teams and practitioners actively involve, value and respect all types of expertise—including lived experience expertise—in all functions and levels of the system.	*I am supported by a system, teams and people who value and respect all types of expertise, to provide a diverse and responsive range of services, informed by lived experience. The team that supports me works collaboratively and respectfully.*	*We have mutual respect and openness to different perspectives, experience and expertise. We value all types of expertise brought to service leadership, treatment, care and support.*
Quality professional relationships: The quality of interactions and professional relationships strongly influences consumer experience, recovery and wellbeing. Establishing, developing and maintaining therapeutic connection, positive rapport and collaborative ways of working are prioritised in how treatment, care and support are delivered.	*I can trust that at every point of care I will be supported to establish and develop respectful, trusting and collaborative therapeutic relationships.*	*We strive to establish, develop and maintain respectful, trusting, collaborative therapeutic relationships at every point of care.*
Diversity-responsive: Services, teams and practitioners seek to understand and respond to each person's needs regarding personal and cultural identity, values and circumstances, incorporating principles of diversity, inclusion, equity and compassion.	*The treatment, care and support that I receive respects and responds to my identity and cultural needs, which may change over time.*	*We are committed to providing inclusive and personalised care. We seek to understand and respect every person's individual values and identity, and to provide treatment and support that is safe, appropriate and compassionate.*

Core values and approaches	Consumer and carer experience outcomes	Workforce experience outcomes
Family-, carer- and community-inclusive: Services, teams and practitioners seek to understand the relational context of the individual, recognising that families, significant others, forms of kinship and social networks can support mental wellbeing. Social supports are involved in delivering treatment, care and support. The needs of families, carers, supporters and the broader social network are recognised.	*The people who are important to me are involved in my treatment, care and support. I am supported to establish and develop relationships and connections to my community in ways that are meaningful to me. As a family member, carer or supporter, my needs for treatment, care and support are recognised and responded to in their own right.*	*We involve a person's family, carers and supporters in their treatment, care and support. We understand that the relational context and social supports of the person can support mental wellbeing. We support people to establish or develop meaningful relationships and connections in their communities. We recognise and respond to the needs of carers and families in their own right.*
Trauma-informed and responsive: Services, teams and practitioners seek to understand, acknowledge and actively respond to a person's experiences of trauma and to ensure their care does not inflict further trauma.	*I am treated in ways that recognise and respond to my experiences, in particular those that have affected me in traumatic ways.*	*We are trauma-informed and trauma-responsive in the way we deliver treatment, care and support. We are supported to respond skilfully and compassionately to people experiencing mental distress, in therapeutic environments of least-restrictive care.*

Implementing the framework

Colleges, professional associations, educators and employers should be encouraged to implement structured processes to integrate the framework into their workforce training and development practices. The importance of ensuring the framework is meaningfully integrated was emphasised by a psychiatrist in the Commission's Future Mental Health Workforce Capabilities Roundtable:

> I think if you are thinking from a registrar's perspective, unless it is something that links in with their ultimate journey to be a psychiatrist … I don't want this to be another tick and flick, which is, you know, you do some work-based experience or something and you take it and, you know, you spend one day [doing training] and you tick it or whatever. That's not how it should be.[249]

Attendees at the roundtable emphasised the importance of measurable actions related to the framework at the individual, team and service levels:[250]

> There's got to be a commitment, there has got to be leadership, there has to be some sort of monitoring and reporting around how these capabilities are embedded, and the resources that it takes.[251]

> We know from education and training research that … we put most of our efforts … say 70 to 80 per cent of resources, into training people, when actually, we all know that only 10 or 20 per cent is spent on embedding those things in practice. And so, until we change that shift, and it's monitored, and it has to be reported on, then, you know, the first thing that goes in services really is, people are pulled from professional development, they're pulled from training.[252]

Personal story:

Dr Ravi Bhat and Melissa Metcalf

Dr Ravi Bhat and Ms Melissa Metcalf, Adult Mental Health Service Divisional Clinical Director and Senior Mental Health Nurse at Goulburn Valley Health respectively, reflected on their roles as leaders working in the mental health sector and consider it a journey of life-long learning.

They believe that a culture of collaborative interprofessional leadership, where people are valued and lived experience is central, is the key to a strong workforce.

They said reflective practice and clinical supervision are an important part of fostering positive, supportive environments, including for managers and senior leadership teams. However, this can be difficult to make a priority, with high patient numbers and budget constraints.

> Supervision is of critical importance, not just for clinicians working on ground level but for us too. Mental health professionals are required to draw from considerable emotional and cognitive reserves. On top of that there are constant pressures and limitations. At the moment there isn't dedicated funding for regular reflective supervision for the Senior Leadership Team.
>
> In an ideal world clinical supervision for nurses, particularly mental health nurses would be a mandatory requirement for ongoing registration as it is for a number of other disciplines. Nursing is fundamentally an interpersonal profession and at times this can be not only demanding but it can take an emotional toll. For managers this can be compounded by balancing the role that they have in overseeing service delivery while supporting their workforce. If this was to ever occur there needs to be an acknowledgment that this is part of the 'work day', not an add on. Time and resources would need to be invested.

Dr Bhat and Ms Metcalf noted that fostering cultures of learning and reflective practice are important to sustain and develop the workforce.

> There are challenges in retaining high quality staff in a role and environment that has inherent emotional load and complexity.

According to Dr Bhat and Ms Metcalf, staff need to feel supported in their role and see opportunities for growth, development and variety in the work they are doing. Collaborative leadership creates opportunities to build shared capabilities across workstreams and specialisations.

> We have put a lot of time and effort into developing pathways in our training programs for mental health professionals, including nurses and doctors, who we see as a source of our future leaders. We have been very intentional in building space into these programs to focus on development of leadership skills as well as allowing staff to develop in their areas of interest.

Dr Bhat and Ms Metcalf believe good leaders care about their staff; they show interest in their wellbeing and their professional development. This type of leadership facilitates sustainable, supportive working environments where people can fulfill their potential and have good work–life balance over the long haul.

> It is about caring and kindness. How is goodwill and trust built? It's built by developing relationships in a psychologically safe space. It is showing that being in a position of authority isn't just about accountability but equally about caring.

Dr Bhat and Ms Metcalf note that positive workforce outcomes lead to better outcomes for consumers.

Source: Dr Ravi Bhat and Melissa Metcalf, *Correspondence to the RCVMHS*, 2020.

33.10 Supporting the wellbeing of the mental health workforce

Providing the workforce with sustainable and supportive working environments is critical in delivering better experiences and outcomes for consumers, families, carers and supporters.[253] The Commission understands that a truly recovery-focused, empathic consumer experience requires a similar experience for the workforce—namely, an experience that values staff by helping them be and feel safe, and supporting and protecting their wellbeing.[254] Multiple professionals who participated in the Commission's frontline workforce focus groups emphasised this point:

> I just think if you as a worker actually feel supported and valued, and you feel like you're actually contributing to the decision making, you're more likely to practice in that way with your clients and their families. So, I think a well-supported worker is one that actually supports their clientele well.[255]

> I think what it comes down to is a parallel process about supporting each other in the same way that we support the consumer.[256]

> If the system wants recovery-oriented practice across the whole system … people talk a lot about empathy and how it's gone missing in certain parts of the system. Then you have to create that link to supporting your workforce through a reflective approach.[257]

There are a range of known supports that can minimise the impact of challenges faced by the mental health workforce. They include debriefing in the face of critical incidents,[258] collaborative reflective practice,[259] clinical or professional practice supervision,[260] Communities of Practice[261] and a supportive organisational culture.[262] In the Commission's workforce survey, 97 per cent of participants rated having 'adequate time for reflective practices and clinical or other relevant supervision' as important or very important in the future mental health system.[263] The frontline workforce,[264] unions[265] and consumers[266] have consistently emphasised to the Commission the importance of these supports.

Specific workforce groups face additional wellbeing and practice support challenges. For example, professional isolation is a factor regional services face when recruiting and retaining experienced mental health clinicians, as well as lived experience workforces.[267] Practitioners with diverse identities—including Aboriginal practitioners, LGBTIQ+ practitioners and culturally diverse practitioners—also face additional mental health risks and wellbeing challenges. Ms Lisa Annese (CEO) and Mr David Morrison AO (Chair) of the Diversity Council Australia told the Commission:

> there may be unique mental health challenges for particular communities who have experienced a history of oppression or exclusion.[268]

To ensure the future mental health and wellbeing system can attract and retain a more diverse workforce that represents the Victorian community, minority workforce groups should be provided with tailored wellbeing and practice supports.

While in some service settings and among certain professional groups the full range of necessary workforce supports are already in place, the Commission understands they are not always provided in high-quality or consistent ways.[269] For example, the impacts of inconsistent service-level approaches may be differentially experienced across professional groups, due to varying professional disciplinary requirements for ongoing professional development, supervision and reflective practice, in addition to variations across professions regarding regulation and accreditation standards.[270]

33.10.1 Ensuring access to the full range of necessary and effective supports

The Victorian Government should work with service providers, colleges, representative/professional bodies, unions and other relevant parties to set clear expectations and implement a range of measures to support the wellbeing and occupational health and safety of the mental health workforce more consistently across professional cohorts, settings and services.

The Commission acknowledges the importance of considering the wellbeing and occupational health and safety of any workforce, and the range of legislative and other measures in place to protect these core requirements. The Commission also acknowledges that the nature of different workplace settings, professions and roles at times bring specific challenges and risks. The mental health and wellbeing workforce faces the particular impacts of work that can be emotionally and interpersonally demanding. While there are recognised strategies to assist in managing these impacts, in the absence of such strategies, workers can experience negative effects. As highlighted in one submission to the Commission, '[b]eing part of the mental health workforce can be draining on one's own mental health.'[271]

While system reforms will go some way to tackling these concerns, the Commission acknowledges the emotional and interpersonal complexity of working in mental health to deliver high-quality services to consumers.[272] The Victorian Psychologists Association highlighted the inherent emotional load of consistently working in genuinely therapeutic ways:

> **Engaging emotionally with patients, with empathy … requires the clinician to engage with the deepest levels of fear, anxiety, sadness, and despair that human beings can experience … Engaging with patients and their distress repeatedly across the course of every day requires the clinician to develop appropriate methods of self-care.**[273]

Work pressures at times prevent professions from engaging in professional supports such as reflective practice and professional practice supervision.[274] This not only has an impact on wellbeing but may also contribute to the loss of skills and expertise. Associate Professor Simon Stafrace, Program Director of Alfred Mental and Addiction Health, Alfred Health at the time of giving evidence, emphasised that '[t]ime for supervision and reflective practice is as important to achieving proficiency and expertise as is training itself.'[275]

Personal story:

Dr Catharine McNab

Catharine is a clinical psychologist who has worked in the mental health system for almost 20 years. She has had a number of roles across public and private practice, and is currently a lecturer at Mindful, the Centre for Research and Training in Developmental Health at the University of Melbourne.

Previously, Catharine worked in a public tertiary mental health service, in a senior role that included supporting acute parts of the service. She emphasised the need for formal structures to create space for professionals to stop, step back and reflect on the best way forward when working with consumers, particularly in stressful and complex situations.

> When we're very stressed, or our work evokes other strong feelings in us as clinicians, our capacity to think clearly is often understandably affected. Having somebody to support those background functions, in whatever way this can happen, creates better outcomes for people accessing care, because there's more support, more scaffolding, to stop and think.

Catharine also noted the importance of workplaces having a framework in place to support and facilitate effective collaborative reflective practice, and believes that public mental health services have an opportunity to foster this more as a way to retain staff. One thing she misses about working in the public sector is the team-based environment in a clinical setting. She spoke about the benefits of interprofessional teams who get together to review clients and work through complexity in collaborative, reflective ways.

> A team is at its absolute best when it can think together about the work we are all doing.

According to Catharine, the incidental peer support that can be fostered in team environments is also critical to staff wellbeing and the creation of reflective, supportive workplace cultures.

> It is coming out of a session and being able to use another colleague, just in the moment, and say, 'This is how I feel right now. Do you have five minutes when we can just stop and think about that together?'

Catharine noted this is something that is more difficult in private practice. She also noted that the public sector may have difficulties in retaining professionals such as clinical psychologists, who may be attracted to the private system later in their careers. She believes the public sector may be able to retain staff by offering flexible working conditions and roles that combine consultation, training, supervision and clinical support, while also explicitly capitalising on the support that is offered to practitioners in public health that is less often offered in the private practice context.

Catharine also spoke about the opportunities to better support clinicians to combine clinical practice with translational research in the future system. As someone who completed her PhD in a clinical service, she reflected on the importance of service leadership encouraging her to use her clinical practice to inform her research and undertake practice translation activities. She reflected on how valuable this was, but also on the challenges that services might sometimes face in helping their staff work across these domains.

> It is reasonably unusual, particularly for non-psychiatrists, to have positions which span clinical and research practice, especially early in your career. You might be a clinician who dabbles in a bit of research, but you have to fit that into your clinical time. So that happens because you stay later or you work weekends. Or you're a researcher who, who does a bit of clinical work often as part of your research. It is often hard to combine all of that in the current system.

Source: RCVMHS, *Interview with Catharine McNab*, October 2020.

In turn, workplace cultures may be compromised and team functioning undermined, with particularly negative impacts for younger, less experienced professionals.[276] Ultimately, this affects the quality and continuity of treatment, care and support consumers receive. Professor David Castle, Consultant Psychiatrist at St Vincent's Hospital Melbourne and Professor of Psychiatry at the University of Melbourne, told the Commission in a personal capacity:

> Every service has struggled from time to time to recruit and retain well-trained and skilled staff. There is often a high turnover of staff which is not consistent with optimal care … One of the biggest problems has been insufficient action from governments in acknowledging the critical role that staff play in the quality of care for consumers and ensuring staff are adequately supported to remain engaged and incentivised to work in these services.[277]

Participants to the workforce survey said they want to work in a system that makes them feel empowered, trusted, respected, safe and supported.[278] Participants in a workforce focus group emphasised the importance of leaders who prioritise high-quality supervision, reflective practice and applying learning to practice.[279] Participants in the Commission's roundtables also emphasised the importance of moving from risk-focused, reactive cultures to cultures of reflective practice as part of the reform process.[280]

As illustrated in Figure 33.11, participants to the workforce survey confirmed these views and consistently emphasised the desire to work in diverse, cohesive and supportive teams. They also stressed the importance of feeling empowered, trusted and respected in their daily work; the importance of feeling safe and supported in their role; having adequate time for reflective practice and clinical and/or professional practice supervision; and having the right balance of time with consumers and administrative or other tasks.

System, service and clinical leaders need to prioritise and implement culture change to create the best possible service contexts for consumers, families, carers, supporters and the workforce. The Commission's interim report emphasised the importance of a strong workforce culture that is 'reflective and accountable, and emboldened by strong leaders who are open to change and new ideas'.[281] Leaders have a vital role in fostering workplace cultures that are supportive, sustainable and aligned with the values of the reimagined service system. One mental health practitioner who participated in a focus group told the Commission:

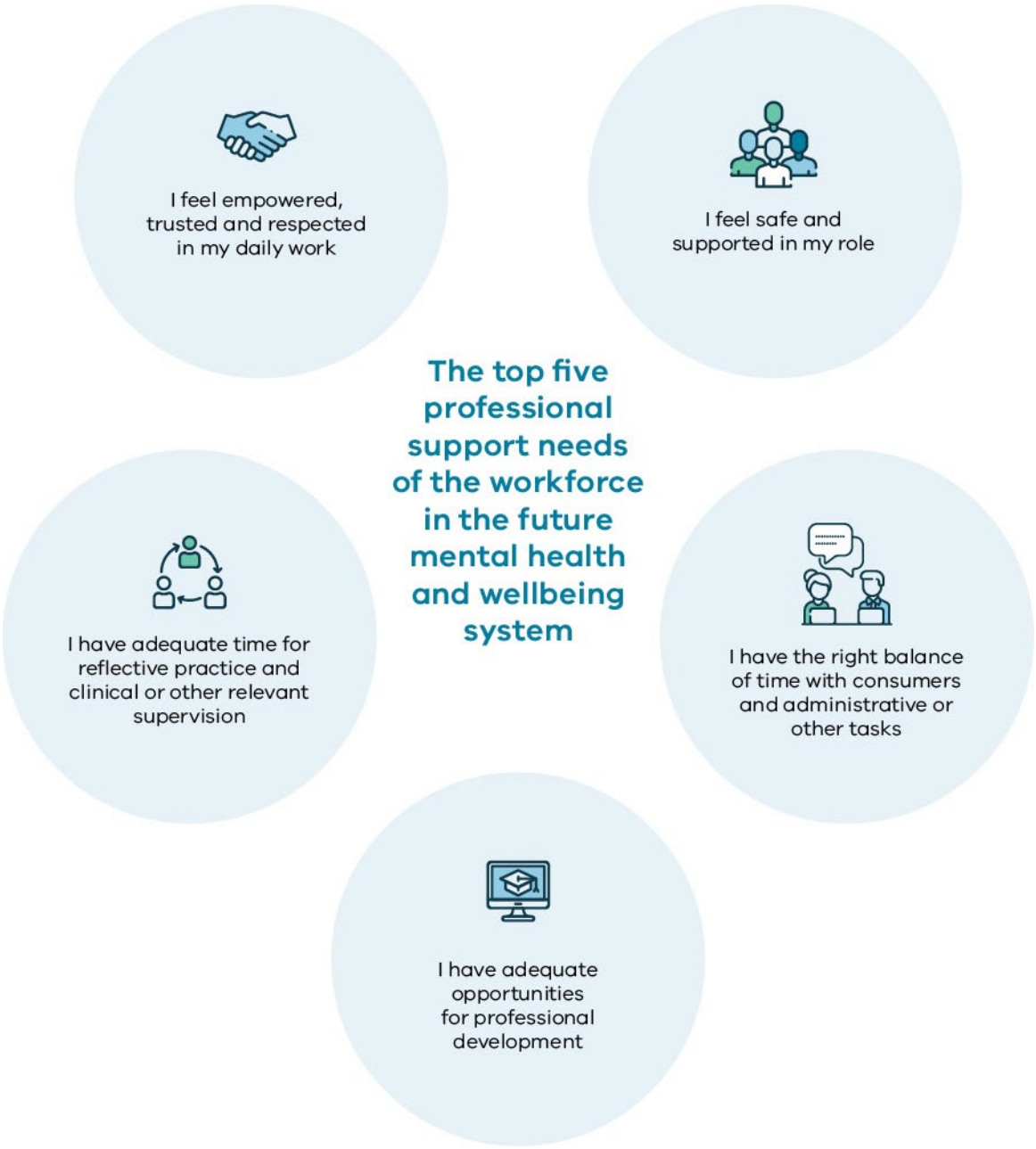
> I really think that we need that reflective space to be valued from every level. It needs to be valued by our management and leadership as much as our on the ground staff.[282]

The Commission has also heard about the importance of leaders enabling the broader workforce to engage in new ways of working together and encourage reflective, relational cultures, as illustrated in the following examples:

> I would like to be able to, going into the future, be able to lift staff morale and get more recognition when they go above and beyond.[283]

> To have capacity to create an environment for … the members of the multidisciplinary team, which should be a true multidisciplinary team and trainees where they feel like they've got access to what they need to provide the sort of care they know they should be providing.[284]

Figure 33.11: Workforce professional support needs



Source: ORIMA Research, *Mental Health Workforce Survey*, 2020.

While the Commission affirms that individual employers should retain direct responsibility for the wellbeing and occupational health and safety of their workforces, others—such as unions, professional associations, industrial bodies and the Department of Health—have a role to play. Given the presence of poor wellbeing outcomes for the mental health and wellbeing workforce, and the essential role this workforce will play in making system reforms a reality, the department and others should partner with relevant stakeholders to ensure high-quality, comprehensive wellbeing and practice supports are provided across the broader mental health workforce.

These supports should be meaningfully integrated into the service system to ensure the mental health and wellbeing workforce can provide high standards of treatment, care and support in sustainable ways.

> effective clinical supervision plays a key role in supporting nurses in their practice and helping them feel positive about, and connected to, their workplace.[285]

When implementing such supports, it is critical they are delivered through high-quality, meaningful processes and facilitated by adequately experienced practitioners. These staff should be skilled in delivering professional practice supervision and collaborative reflective practice. An allied health professional reflected on what it is like when reflective practice and supervision is not well facilitated:

> I think it can occasionally feel like you're just going through the motions and wasting time if it's not skilled or if it's not well done or if it is done in the team context and the team isn't functioning properly, that sort of thing. It can just be kind of excruciating, and can be quite meaningless. So, it has to be done properly, it has to be done by somebody who knows what they're doing.[286]

The workforce needs a culture that promotes best practice in a safe, sustainable, engaging and rewarding environment. Clear expectations will ensure wellbeing and professional practice supports are provided consistently across professional groups, settings and services.

33.10.2 Responding to occupational health and safety challenges

Responding to the occupational health, safety and wellbeing risks for the mental health and wellbeing workforce is paramount to ensuring the workforce can thrive and deliver high-quality treatment, care and support to consumers, families, carers and supporters. The workforce faces a number of specific physical health and safety risks in the workplace, with some service settings presenting higher risks than other workplaces. Workplace safety risks are particularly high for mental health professionals, alongside emergency response workers and other health professionals, as well as when delivering treatment, care and support in hospital emergency departments.[287] One study has indicated that nurses working in emergency department triage roles are particularly at risk of aggression or violence from people with drug or alcohol intoxication, and escalating distress or agitation associated with mental illness.[288] There is a relationship between physical health risks, such as exposure to violence and aggression in the workplace, and developing psychological injuries.[289]

As articulated in section 33.4, psychological health and safety is a major concern for the mental health and wellbeing workforce, particularly in the public mental health system.[290] A 2018 study of psychiatrists found high rates of concerns about burnout for those working in the public sector, with more than 80 per cent of survey participants citing this as a negative aspect of their working experience.[291] However, levels of burnout, disengagement and exhaustion appear to be very similar across the professions of medicine, nursing, psychology, social work and occupational therapy.[292]

The Victorian Faculty of Psychotherapy (Royal Australian and New Zealand College of Psychiatrists) told the Commission:

> [There is] escalating workforce dissatisfaction, increasing vicarious traumatisation of the workforce and burnout. When the 'person' of the patient and the therapeutic treatment relationship are lost from the system, it becomes a dehumanised and dehumanising system, both for patient and clinician.[293]

Employers are already obligated to protect and support the physical and psychological health and safety of their employees under workplace health and safety legislation.[294] However, the Productivity Commission found that levels of burnout, disengagement and exhaustion appear to be very high across professionals working in mental health settings, including medicine, nursing, psychology, social work and occupational therapy.[295] Emergency service workers, such as paramedics, ambulance workers and police also report high levels of burnout.[296] In its *Mental Health Inquiry Report*, the Productivity Commission made several recommendations for protecting psychological health and safety in workplace health and safety legislation.[297] The Productivity Commission's recommendations, if implemented, will introduce a clearer duty of care for all employers, including mental health services, to protect both the physical and psychological safety of their staff. These include recommendations related to workplace health and safety legislation specifying protecting psychological health and safety, additional codes of practice and advice to and monitoring of employers.[298]

The Productivity Commission did not recommend relying on guidelines alone to ensure the psychological health and safety of workers:

> Given that employers are legally required to protect their workers' psychological health and safety and there is greater complexity involved in identifying, eliminating and reducing psychological risks in the workforce compared to physical risks, [workplace health and safety] arrangements should provide more than just guidance to employers.[299]

The Commission recognises the good work already proposed or underway to help improve worker occupational health and safety, but considers that further targeted measures are required to sustain a strong focus on mental health worker safety in the new system. To this end, the Victorian Government should, by the end of 2021, establish a Mental Health Workforce Wellbeing Committee that is accountable to the Mental Health and Wellbeing Secretaries' Board as part of new system governance structures. Aligning the committee within the broader governance framework will ensure its agenda remains a priority and that measures proposed by the committee are fully aligned with and complementary to other system reform priorities.

The committee should comprise senior representatives from the Department of Health, Safer Care Victoria, WorkSafe Victoria and the Mental Health and Wellbeing Commission. The committee's responsibilities should be to deal with, as an urgent priority, the occupational health and safety concerns identified by the Commission and provide an ongoing monitoring role throughout the reform process.

The committee should also include representatives from professional colleges, unions, mental health service employers and other relevant bodies, and work to:

- identify, monitor and respond to existing physical safety and wellbeing risks, as well as those that may emerge throughout the reform process
- develop tailored approaches for monitoring and supporting the psychological health and safety of staff in the mental health and wellbeing workforce.

As outlined in Chapter 31: *Reducing seclusion and restraint*, the Commission is recommending that the Victorian Government acts to reduce the use of seclusion and restraint with the aim of eliminating these practices within 10 years. The workforce overwhelmingly does not want to use restrictive practices, but the drivers of their use are complex and they are sometimes necessary to protect the safety of the consumer or others. The Commission is recommending a range of measures to ensure that in working towards elimination, services are supported to understand the drivers in specific settings and to protect workforce safety while ensuring these interventions reduce over time. These efforts should be a priority area of focus for the committee.

33.10.3 Priority measures to improve overall workforce wellbeing outcomes

More active efforts are needed to improve the wellbeing of the workforce, given its crucial role in enabling a contemporary mental health and wellbeing system to thrive. Better workforce practice supports and wellbeing outcomes will help retain a highly skilled workforce, encourage new talent into the sector and provide the valued members of the workforce with more and better opportunities.

The Commission understands that supporting better wellbeing outcomes requires a multifaceted approach because no one solution will fully meet the wellbeing needs of the workforce. The Commission suggests that the Department of Health:

- ensures, as a priority, that service funding and commissioning approaches support the resourcing requirements for implementing comprehensive workforce wellbeing and professional supports
- through relevant public policy documents and strategies, outlines expectations and good practice guidance for providing workforce wellbeing supports
- in collaboration with the capability entity:
  - enables development of support structures within and across services, such as communities of practice, and resources and training strategies relating to reflective practice and professional practice supervision
  - facilitates a community of practice for senior educators and professional practice supervisors
- monitors wellbeing outcomes for the entire mental health workforce at least every two years—for example, through a whole-of-workforce 'pulse' survey. The Commission recommends this starts in 2021.

Measures should also include developing associated practice resources and capabilities to support delivery by services of high-quality wellbeing and practice supports for the workforce. This could be achieved by giving responsibility and funding to the capability entity for:

- developing, delivering and evaluating reflective practice resources (for example, toolkits, interactive learning materials and practice guides) for professionals, teams and services in collaboration with relevant stakeholders, including those with lived experience expertise
- developing, delivering and evaluating training and professional development in clinical and service leadership capabilities, reflective practice facilitation and clinical or professional practice supervision, with a focus on dedicated senior educator, senior clinician and professional practice supervisor roles
- coordinating development and delivery of tailored resources, professional supports and communities of practice for priority workforce cohorts, including lived experience workforces (through a co-design approach), rural and regional clinical professionals, Aboriginal practitioners, LGBTIQ+ practitioners and culturally diverse practitioners.

To sustain the workforce into the future, the Commission also recognises the importance of developing, supporting and retaining experienced practitioners in the mental health and wellbeing system to build workplace capabilities and cultures that focus on professional practice support and continuous learning.

The department should work with service providers and the capability entity to develop, implement and evaluate incentives for experienced professionals to take on supervision, mentoring and leadership of collaborative learning, with a particular focus on public mental health and wellbeing services, as well as rural and regional settings. Measures should also include developing, implementing and evaluating stronger system and service-level incentives to attract, develop and retain diverse and experienced mental health professionals across the system.

33.10.4 The importance of supporting lived experience workforces

In its interim report the Commission outlined the criticality of lived experience workforces being a core part of the new mental health and wellbeing system.[300] As outlined in section 33.7.3, the Commission's overall reforms will require growth and development of lived experience workforces to reflect their vital role in service delivery, leadership, strategy, policy, advocacy, research, evaluation, innovation and system oversight. Underpinning this must be a transition to better supported, recognised and expanded lived experience workforces.[301]

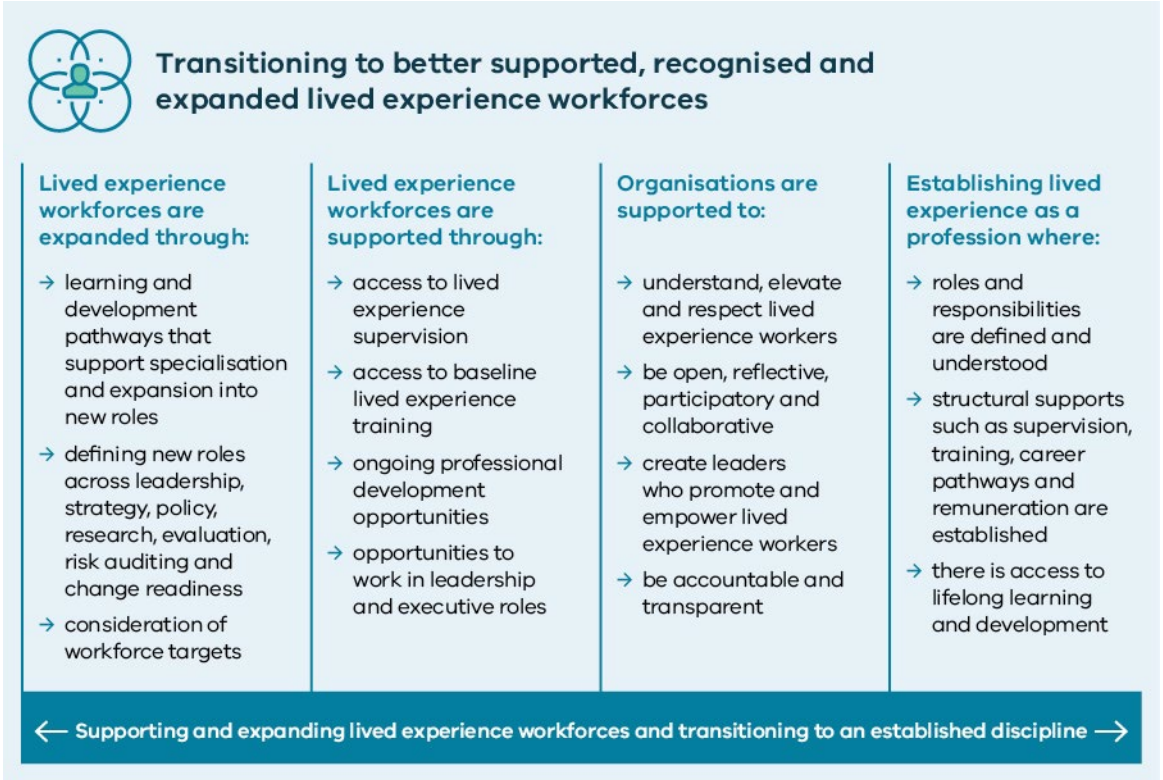
This includes access to high-quality lived experience training, access to learning and development that supports specialisation, movement into new roles and career pathways, and improving organisational and workforce awareness of the value of lived experience expertise.[302]

[The lived experience workforce] report that support for [lived experience] learning and development needs (e.g. paid study leave, payment of course fees, approval to take time off to attend training) varies from service to service and is often dependant on the value that managers place on [the lived experience workforce], on training and on the interpretation of the [enterprise bargaining agreement].[303]

> career progression must be developed in order to retain lived experience workers so that they may be able to share their expertise and provide supervision to more junior lived experience workers as well as develop their own careers.[304]
>
> Systematic development and implementation of the lived experience workforce as a discipline with a diversity of roles and career structure requires careful planning and dedicated resourcing … There are significant roles and opportunities at all levels for the Lived Experience workforce, including in community agencies to combat the stigma of mental illness and to foster hope, encourage social inclusion and recovery at a grass roots level.[305]

Figure 33.12 shows the major initiatives needed to better support current lived experience workforces, and expand those workforces over time.

Figure 33.12: Transitioning to better supported, recognised and expanded lived experience workforces



Since the publication of the interim report, the Commission has continued to engage with lived experience workforces through focus groups, the workforce survey and consultations.[306] The Commission acknowledges that as a relatively new professional discipline, lived experience workforces lack career development and ongoing professional practice supports such as tailored lived experience professional practice supervision.[307]

While many mental health professionals and services understand the value of highly developed lived experience workforces, there is still progress to be made in ensuring the value of lived experience is not only made visible but is deeply understood, respected and elevated across the system.[308]

The Productivity Commission recommended that the Commonwealth Government 'strengthen the peer workforce', including through the establishment of a professional association to represent lived experience peer workforces.[309] In addition, the Productivity Commission recommended that state and territory governments work with the Commonwealth to 'develop a program to educate health professionals about the role and value of peer workers in improving outcomes'.[310] Such an approach aligns to the Royal Commission's recommendation in its interim report regarding an organisational readiness and staff awareness program to support lived experience workforces to expand and succeed.[311]

The Commission supports all efforts to raise the profile of this emerging but rapidly expanding professional discipline. Mechanisms to promote professional recognition of lived experience workforces are valuable in their own right and also provide opportunities for professional coordination and input into efforts combating professional isolation through networking, professional development and communities of practice.

The importance of these supports is not limited to lived experience professionals working in direct service delivery roles with consumers, families, carers and supporters. As noted in Chapter 18: *The leadership of people with lived experience of mental illness or psychological distress,* the Commission recommends the establishment of a new non-government agency, overseen by a skills-based board chaired by and consisting of a majority of people with lived experience of mental illness or psychological distress. This organisation will deliver accredited training and organisational supports. It will also facilitate the co-location, shared resourcing, learning opportunities and the creation of new partnerships and networks between people with lived experience and the organisations they lead.

To perform its functions the agency will establish itself as a registered training organisation. This will enable it to deliver accredited training focused on developing the capabilities of people with lived experience to lead and manage their own organisations and services.

These actions will be pivotal to increasing the reach and influence of lived experience expertise. People with lived experience in leadership, research and executive roles across the system need to be supported to thrive through access to professional development opportunities in strategic leadership, governance and policy development. Professional supports such as mentorship and executive coaching may further support the expansion of lived experience roles in leadership and the implementation of system reforms.[312]

1 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 129.

2 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 129; RCVMHS, Psychiatrist and Psychologist Workforce Human-Centred Design Focus Group: Record of Proceedings, 2020.

3 ORIMA Research, Mental Health Workforce Survey, 2020, p. 4; RCVMHS, Nursing Roundtable: Record of Proceedings, 2019; RCVMHS, Doctors Roundtable: Record of Proceedings, 2019; RCVMHS, Lived Experience Workforce Roundtable: Record of Proceedings, 2019; RCVMHS, Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings, 2020; RCVMHS, Psychiatrist and Psychologist Workforce Human-Centred Design Focus Group: Record of Proceedings; RCVMHS, Nurses Workforce Human-Centred Design Focus Group: Record of Proceedings, 2020; RCVMHS, Lived Experience Workforce Human-Centred Design Focus Group: Record of Proceedings, 2020.

4 The development of positive therapeutic relationships between consumers, carers and mental health workers relies on establishing trust and developing therapeutic rapport or engagement based on relational qualities that demonstrate, for example, kindness, empathy, trust, reassurance, helpfulness, calmness and humour. Angela Sweeney and others, 'The Relationship between Therapeutic Alliance and Service User Satisfaction in Mental Health Inpatient Wards and Crisis House Alternatives: A Cross-Sectional Study', ed. by Melvin G. McInnis, *PLoS ONE*, 9.7 (2014), 1–13 (p. 6).

5 ORIMA Research, pp. 8–9.

6 RCVMHS, Psychiatrist and Psychologist Workforce Human-Centred Design Focus Group: Record of Proceedings; RCVMHS, Nurses Workforce Human-Centred Design Focus Group: Record of Proceedings; RCVMHS, Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings.

7 RCVMHS, Psychiatrist and Psychologist Workforce Human-Centred Design Focus Group: Record of Proceedings.

8 ORIMA Research, p. 18.

9 ORIMA Research, p. 18.

10 ORIMA Research, p. 18.

11 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 129.

12 The *Mental Health Act 2014* (Vic) defines 'mental health practitioner' for the purposes of making an Assessment Order under the Act as a person who is employed or engaged by a designated mental health service and is a registered psychologist, registered nurse, social worker or registered occupational therapist (*Mental Health Act 2014* (Vic), sec. 3.)

13 The National Registration and Accreditation Scheme is a single national registration scheme for health professionals established under the Health Practitioner Regulation National Law Act in 2010. Currently, there are 16 regulated professions with more than 750,000 registered health practitioners under the scheme. These include medicine (including general practice and psychiatry), nursing, occupational therapy, pharmacy and psychology. Although nursing, occupational therapy and general practice are regulated under the scheme, these professions do not have a mental health–specific area of practice endorsement or specialisation under the scheme. Social work, art therapy, music therapy, counselling and lived experience workforces are not currently regulated under the scheme (*Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic).

14 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 131.

15 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 131.

16 RCVMHS, Lived Experience Workforce Human-Centred Design Focus Group: Record of Proceedings.

17 Engage Victoria, Victorian Volunteer Strategy, <engage.vic.gov.au/victorian-volunteer-strategy>, [accessed 21 December 2020].

18 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 132.

19 These facilities are defined as public psychiatric hospitals, psychiatric units, wards in public acute hospitals, community mental healthcare services and government-operated and non–government operated residential mental health services.

20 Australian Institute of Health and Welfare, *Mental Health Services in Australia: Specialised Mental Healthcare Facilities 2018–19,* Table FAC.34.

21 Australian Institute of Health and Welfare, *Mental Health Services in Australia: Specialised Mental Healthcare Facilities 2016–17 to 2018–19,* Table FAC.36.

22 Commission analysis of Australian Government Services Australia, Medicare Benefits Schedule 2017–18.

23 Commission analysis of Australian Government Services Australia, Medicare Benefits Schedule 2017–18; Australian Bureau of Statistics, Australian Demographic Statistics, June 2020, cat.no. 3101.0, Canberra.

24 The Royal Australian and New Zealand College of Psychiatrists, Victorian Psychiatry Workforce: Executive Summary, 2017, pp. 5 and 11; Australian Psychological Society, Submission to the RCVMHS: SUB.0002.0029.0349, 2019, p. 32; Commission Analysis of Commonwealth Department of Health.

25 These reasons include unsustainable and/or increasingly complex workloads, burnout and vicarious trauma, administrative burden, a lack of professional development and career progression opportunities. Refer to: Australian Psychological Society, Submission to the RCVMHS: SUB.0002.0029.0349, p. 32; Department of Health and Human Services, Psychology Workforce Report, 2018, p. 59; RCVMHS, Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings; The Royal Australian and New Zealand College of Psychiatrists, Submission to the RCVMHS: SUB.0002.0029.0227, 2019, p. 31; Australian Psychological Society, Submission in Response to the

Draft Report from the Productivity Commission Inquiry into Mental Health, 2020, p. 16; *Witness Statement of Dr Neil Coventry*, 29 July 2020, paras. 335–356; Victorian Auditor-General's Office, Access to Mental Health Services, 2019, p. 35; RCVMHS, Psychiatrist and Psychologist Workforce Human-Centred Design Focus Group: Record of Proceedings.

26 Productivity Commission, Mental Health Inquiry Report, Volume 2, 2020, p. 737.

27 Productivity Commission, Mental Health Inquiry Report, Volume 2, p. 737.

28 ORIMA Research, p. 3.

29 ORIMA Research, p. 5.

30 When interpreting the results of the workforce survey the reader should note that the findings do not necessarily represent the whole Victorian mental health workforce. However, the sample was large (n = 2,920) so allows for robust overall statistical analysis plus detailed analysis of various subgroups of interest. Because detailed population proportions are not available for this workforce, the Commission cannot confidently assess the representativeness of the sample. However, the sample does contain responses from people working across diverse roles and settings. Some comparisons have been made against the limited population statistics information available. These comparisons suggest that the responding sample is broadly aligned with that of the population in terms of the predominant groups of professionals that exist within the workforce. ORIMA Research, pp. 4–5.

31 The workforce survey identified that some professions with more than 10 years of experience are more likely to be in private practice, while those with under 10 years of experience are more likely to be in public mental health services. *Commission Analysis of ORIMA Research, Mental Health Workforce Survey, 2020*.

32 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 136.

33 Department of Health and Human Services, Lived Experience Workforce Positions in Victorian Public Mental Health Services, 2017, p. 15.

34 Medical Student Council of Victoria, *Submission to the RCVMHS: SUB.0002.0028.0163*, 2019, p.9

35 Victorian Ambulance Union, *Submission to the RCVMHS: SUB.0002.0028.0277*, 2019, p. 17.

36 *Witness Statement of Dr Tricia Szirom*, 12 May 2020, paras. 85–87.

37 RCVMHS, Whittlesea Community Consultation—April 2019; Dr Ben Samuel, Submission to the RCVMHS: SUB.0002.0019.0030, 2019, p. 5; Brendan Cox, Submission to the RCVMHS: SUB.0002.0021.0022, 2019, pp. 4–5; *Evidence of Erica Williams*, 8 July 2019, pp. 443–444.

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

39 RCVMHS, Psychiatrist and Psychologist Workforce Human-Centred Design Focus Group: Record of Proceedings.

40 ORIMA Research, Mental Health Workforce Survey, 2020, pp. 44–45.

41 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 137 and 528.

42 *Witness Statement of Professor David Castle*, 29 May 2020, para. 47; *Witness Statement of Associate Professor Alessandra Radovini*, 10 June 2020, para. 32; *Witness Statement of Dr Neil Coventry*, 2020, paras. 355–356; Australian Psychological Society, Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health, p. 16.

43 The Royal Australian and New Zealand College of Psychiatrists, *Submission to the RCVMHS: SUB.0002.0029.0227*, 2019, p.30.

44 *Witness Statement of Associate Professor Alessandra Radovini*, para. 32.

45 Victorian Auditor-General's Office, p. 8.

46 See, for example: Virginia Trotter Betts and Graham Thornicroft, International Mid-Term Review of the Second National Mental Health Plan for Australia, <www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-i-midrev2-toc>, [accessed 14 November 2019]; Commonwealth Department of Health, *The Fifth National Mental Health and Suicide Prevention Plan*, 2017; Department of Human Services, *Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009–2019*, 2009; Department of Human Services, *New Directions for Victoria's Mental Health Services: The Next Five Years*, 2002, p. 1; Department of Health and Human Services, *Victoria's 10–Year Health Plan: Mental Health Workforce Strategy*, 2016, p. 2.

47 Victorian Auditor-General's Office, *Access to Mental Health Services*, 2019, p. 35.

48 Office of the Chief Mental Health Nurse, Department of Health and Human Services, *Mental Health Nursing Workforce: Current Supply and Demand Issues Within Victorian Mental Health Services*, 2017, pp. 6 and 8.

49 The Royal Australian and New Zealand College of Psychiatrists, *Submission to the RCVMHS: SUB.0002.0029.0227*, p. 30; Australian Psychological Society, *Submission to the RCVMHS: SUB.0002.0029.0349*, p. 32; Victorian Government, *Submission to the RCVMHS: SUB.5000.0001.0001*, 2019, p. 28.

50 Victorian Government, *Submission to the RCVMHS: SUB.5000.0001.0001*, p. 28; Victorian Psychologists Association, *Submission to the RCVMHS: SUB.1000.0001.2905*, 2019, p. 41; Australian Psychological Society, *Submission to the RCVMHS: SUB.0002.0029.0349*, pp. 8 and 32.

51 Victorian Government, Submission to the RCVMHS: SUB.5000.0001.0001, p. 28.

52 Victorian Government, Submission to the RCVMHS: SUB.5000.0001.0001, p. 28.

53 Victorian Auditor-General's Office, p. 35.

54 Victorian Government, Submission to the RCVMHS: SUB.5000.0001.0001, p. 28.

55 The Australian College of Mental Health Nurses, *Submission to the RCVMHS: SUB.0002.0013.0020, 2019*, p. 9.

56 *Witness Statement of Dr Neil Coventry*, 2020, paras. 355–356.

57 ORIMA Research, p. 55.

58 *Witness Statement of Professor Malcolm Hopwood*, 27 June 2019, paras. 42–44; Barwon Health, *Submission to the RCVMHS: SUB.0002.0029.0222*, 2019, p. 5; Department of General Practice, The University of Melbourne, *Submission to the RCVMHS: SUB.0002.0028.0609*, 2019, pp. 10–11; Cobaw Community Health, *Submission to the RCVMHS: SUB.0002.0029.0361*, 2019, p. 8; Productivity Commission, *Draft Report on Mental Health, Volume 1*, 2019, p. 371; Australian Association of Social Workers, *Submission to the RCVMHS: SUB.1000.0001.0031*, 2019, p. 11; *Witness Statement of Angus Clelland*, 5 June 2020, para. 18; The Royal Australian and New Zealand College of Psychiatrists, *Submission to the RCVMHS: SUB.0002.0029.0227*, p. 31.

59 Australian Association of Social Workers, *Submission to the RCVMHS: SUB.1000.0001.0031*, 2019, p. 11.

60 Australian Psychological Society, *Submission to the RCVMHS: SUB.0002.0029.0349*, 2019, p. 32.

61 *Witness Statement of Angus Clelland*, para. 18.

62 Victorian Auditor-General's Office, p. 35.

63 Australian Psychological Society, *Submission to the RCVMHS: SUB.0002.0029.0349*, p. 8; Department of Health and Human Services, *Psychology Workforce Report*, p. 59; RCVMHS, *Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings*; The Royal Australian and New Zealand College of Psychiatrists, *Submission to the RCVMHS: SUB.0002.0029.0227*, p. 31; Australian Psychological Society, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, p. 16.

64 Australian Nursing and Midwifery Federation, Victoria, *Submission to the RCVMHS: SUB.2000.0001.0002*, 2019, pp. 121–122; *Witness Statement of Dr Neil Coventry*, 2020, para. 358.

65 Vicarious or secondary trauma can be defined as psychological distress for a mental health professional due to interactions with consumers, families and carers, particularly when engaging with the traumatic or overwhelming experiences of others. Common symptoms may include physical symptoms (such as sleep disturbance), emotional symptoms (such as compassion fatigue, irritation, anxiety or guilt) and re-experiencing content from a consumer's story. This may contribute to burnout. Brittany S Sansbury, Kelly Graves and Wendy Scott, 'Managing Traumatic Stress Responses among Clinicians: Individual and Organizational Tools for Self-Care', *Trauma*, 17.2 (2015), 114–122 (pp. 115–116); Hannah M McCormack and others, 'The Prevalence and Cause(s) of Burnout Among Applied Psychologists: A Systematic Review', *Frontiers in Psychology*, 9:1897 (2018), 1–19 (p. 2).

66 Australian Services Union, *Submission to the RCVMHS: SUB.0002.0030.0025*, 2019, p. 25; *Witness Statement of Lynne Allison*, 25 August 2020, para. 160; *Witness Statement of Professor Patrick McGorry AO*, 22 June 2020, para. 132; The Adult Psychiatry Imperative, *Submission to the RCVMHS: SUB.3000.0001.0070*, 2019, p. 37; Australian Nursing and Midwifery Federation, Victoria, *Submission to the RCVMHS: SUB.2000.0001.0002*, 2019, p. 44 and 59; Victorian Ambulance Union, *Submission to the RCVMHS: SUB.0002.0028.0277*, 2019, p. 17.

Burnout is conceptualised by long-term chronic stress in response to caring professions characterised by high demands and little professional practice support. Burnout comprises three domains: mental and emotional exhaustion (also known as compassion fatigue); negative feelings and perceptions about the people one works with (also known as depersonalisation) and a decrease in feelings of personal efficacy and accomplishment (also known as low self-efficacy). McCormack and others, p. 2.

67 Australian Medical Association, Victoria, *Submission to the RCVMHS: SUB.4000.0001.0008*, 2019, p. 88; Australian Psychological Society, *Submission to the RCVMHS: SUB.0002.0029.0349*, 2019, p. 32.

68 Victorian Auditor-General's Office, p. 35; Australian Psychological Society, Submission to the RCVMHS: SUB.0002.0029.0349, p. 32.

69 *Witness Statement of Dr Neil Coventry*, 29 July 2020, para. 356; RCVMHS, *Psychiatrist and Psychologist Workforce Human-Centred Design Focus Group: Record of Proceedings*, 2020; Australian Psychological Society, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, 2020, p. 16.

70 *Witness Statement of Dr Ravi Bhat*, 4 July 2019, p. 313.

71 *Witness Statement of Dr Lynne Coulson Barr OAM*, 4 June 2020, para. 260.

72 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 170.

73 Maurice Blackburn, *Submission to the RCVMHS: SUB.1000.0001.3667*, 2019, p. 7.

74 The Australian College of Mental Health Nurses, *Submission to the RCVMHS: SUB.0002.0013.0020, 2019*, p. 4; Peninsula Health, *Submission to the RCVMHS: SUB.0002.0028.0109, 2019*, p. 11.

75 NorthWestern Mental Health (A Division of Melbourne Health), *Submission to the RCVMHS: SUB.0002.0030.0061*, 2019, p. 43; Barwon Health, *Submission to the RCVMHS: SUB.0002.0029.0222, 2019*, p. 6.

76 *Evidence of Professor Malcolm Hopwood*, 10 July 2019, pp. 632–633.

77 *Witness Statement of Professor Malcolm Hopwood, 27 June 2019, para. 37; Barwon Health, p. 6.*

78 Productivity Commission*, Mental Health Inquiry Report, Volume 2, 2020, p. 709.*

79 Productivity Commission*, p. 721.*

80 World Health Organisation. 2010. *Global Code of Practice on the International Recruitment of Health Personnel*, pp. 5 and 7.

81 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 543.

82 The Royal Australian and New Zealand College of Psychiatrists, p. 29.

83 Occupational Therapy Australia, *Submission to the RCVMHS: SUB.3000.0001.1264*, 2019, p.11.

84 Commonwealth Department of Health, *Correspondence to the RCVMHS: CSP.0001.0001.0093*, p. 25.

85 RCVMHS, Workforce Human-Centred Design Focus Group: Record of Proceedings; *Witness Statement of 'Nina Edwards' (pseudonym)*, 26 July 2019, paras. 21–22; *Witness Statement of Catherine White*, 2 July 2020, para. 27; RCVMHS, Whittlesea Community Consultation—April 2019; RCVMHS, Geelong Community Consultation—April 2019; Samuel, p. 5; Cox, pp. 6–7.

86 Victorian Psychologists Association Inc, *Submission to the RCVMHS: SUB.0002.0030.0262*, 2019, p. 44; Australian Services Union, p. 25.

87 RCVMHS, Workforce Human-Centred Design Focus Group: Record of Proceedings; *Witness Statement of 'Nina Edwards' (pseudonym)*, paras. 19–21; *Witness Statement of Catherine White*, para. 27; RCVMHS, Whittlesea Community Consultation—April 2019; RCVMHS, Geelong Community Consultation—April 2019; Samuel, p. 5; Cox, pp. 6–7.

88 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 129 and 140.

89 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 140.

90 Orygen, The National Centre of Excellence in Youth Mental Health, Submission to the RCVMHS: SUB.2000.0001.0741, 2019, p. 24.

91 Canberra Times, Mental Illness: The Health Crisis We're Happy to Turn a Blind Eye To, 29 November 2017.

92 Banyule Community Health, Submission to the RCVMHS: SUB.2000.0001.0501, 2019, p. 8.

93 The Royal Australian and New Zealand College of Psychiatrists , p. 29 citing Oliver D (2018) Moral Distress in Hospital doctors, British Medical Journal 360.

94 Australasian College for Emergency Medicine, *Submission to the RCVMHS: SUB.1000.0001.0051*, 2019, p. 6.

95 The Adult Psychiatry Imperative, p. 75.

96 *Witness Statement of Sue Williams*, 7 July 2020, para. 74.

97 RCVMHS, Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings.

98 Victorian Ambulance Union, *Submission to the RCVMHS: SUB.0002.0028.0277, 2019*, p. 17.

99 Ref: The Royal Australian and New Zealand College of Psychiatrists, p. 31..

100 *Witness Statement of Karyn Cook*, 21 May 2020, paras. 142–144.

101 Australian Services Union, p. 25; *Witness Statement of Lynne Allison*, para. 160; *Witness Statement of Professor Patrick McGorry AO*, para. 132; The Adult Psychiatry Imperative, p. 37.

102 Medical Student Council of Victoria, *Submission to the RCVMHS: SUB.0002.0028.0163*, 2019, pp. 2-3 .

103 Australian Services Union, p. 25.

104 See, for example: Department of Health and Human Services, Victoria's 10–Year Health Plan: Mental Health Workforce Strategy, p. 19; Commonwealth Department of Health and Ageing, A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers, 2013, p. 71; *Witness Statement of Nicole Bartholomeusz,* 9 June 2020, para. 124; *Witness Statement of Sandra Keppich-Arnold*, 18 May 2020, para. 111; Susan Glassburn, Lisa E McGuire, and Kathy Lay, 'Reflection as Self-Care: Models for Facilitative Supervision', Reflective Practice, 20.6 (2019), 692–704 (p. 692).

105 Department of Health and Human Services, Social Work Workforce Report, 2018, p. 8; Department of Health and Human Services, Victoria's 10–Year Health Plan: Mental Health Workforce Strategy, p. 19; Department of Health and Human Services, Clinical Supervision for Mental Health Nurses: A Framework for Victoria, 2018, p. 13.

106 Department of Health and Human Services, Victoria's 10–Year Health Plan: Mental Health Workforce Strategy, p. 19.

107 *Witness Statement of Sue Williams*, paras. 13–14; RCVMHS, Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings; Australian Psychological Society, Submission to the RCVMHS: SUB.0002.0029.0349, p. 32.

108 RCVMHS, Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings.

109 RCVMHS, Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings.

110 Victorian Psychologists Association Inc, p. 24.

111 RCVMHS, Lived Experience Workforce Human-Centred Design Focus Group: Record of Proceedings; RCVMHS, Workforce Needs of the Future and Enabling Transformation Roundtable: Record of Proceedings.

112 Australian Services Union, p. 25.

113 Eastern Health, *Submission to the RCVMHS: SUB.0002.0028.0585*, 2019, pp. 24–25; RCVMHS, *Nursing Roundtable: Record of Proceedings*; RCVMHS, *Doctors Roundtable: Record of Proceedings*; Health and Community Services Union, *Submission to the RCVMHS: SUB.0002.0030.0180*, 2019, p. 13; NorthWestern Mental Health (A Division of

Melbourne Health), *Submission to the RCVMHS: SUB.0002.0030.0061*, 2019, p. 29; *Witness Statement of Sue Williams*, para. 76; RCVMHS, *Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings*.

114 *Witness Statement of Gail Bradley*, 26 June 2019, para. 104(b); Eastern Health, p. 25; *Witness Statement of Professor Lisa Brophy*, 29 April 2020, para. 86; *Witness Statement of Peter Kelly*, 29 May 2020, para. 218; *Witness Statement of Sandra Keppich-Arnold*, para. 115.

115 *Witness Statement of Colin Radford*, 26 August 2020, paras. 129 and 163.

116 NorthWestern Mental Health (A Division of Melbourne Health), p. 29.

117 *Witness Statement of Peter Kelly*, paras. 217–218.

118 The Australian College of Mental Health Nurses, p. 3.

119 Australian Nursing and Midwifery Federation, Victoria, *Submission to the RCVMHS: SUB.2000.0001.0002*, 2019, p. 121.

120 RCVMHS, Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings.

121 Health and Community Services Union, pp. 13–14; Australian Nursing and Midwifery Federation, Victoria, p. 121.

122 Health and Community Services Union, p. 13.

123 *Witness Statement of Peter Kelly*, para. 217.

124 Eastern Health, p. 25.

125 *Witness Statement of Dr Neil Coventry*, para. 218.

126 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 143.

127 *Witness Statement of Professor Richard Newton*, 7 May 2020, para. 75.

128 RCVMHS, Restrictive Practices Human-Centred Design Focus Group, Session 2: Record of Proceedings, 2020; Te Pou o te Whakaaro Nui, Reducing and Eliminating Seclusion in Mental Health Inpatient Services: An Evidence Review for the Health Quality and Safety Commission New Zealand, 2018, pp. 28–29.

129 *Witness Statement of Dr Neil Coventry*, 2020, paras. 219–220.

130 The Australian College of Mental Health Nurses, p. 3.

131 Australian Nursing and Midwifery Federation, Victoria, p. 120.

132 Health and Community Services Union, p. 14.

133 ORIMA Research, p. 19.

134 Australian Psychological Society, Submission to the RCVMHS: SUB.0002.0029.0349, p. 18; Australian Association of Social Workers, pp. 5–6; *Evidence of Dr Neil Coventry*, 8 July 2019, p. 455.

135 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 135 and 137.

136 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 135 and 137; *Evidence of Dr Ravi Bhat*, 15 July 2019, p. 980.

137 Australian Association of Social Workers, p. 11.

138 Occupational Therapy Australia, *Submission to the RCVMHS: SUB.3000.0001.1264*, 2019, p.12.

139 *Evidence of Dr Neil Coventry*, p. 455.

140 Refer to Chapter 4 of the Commission's Interim Report, The unrealised vision of deinstitutionalisation. Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 85–92.

141 *Evidence of Dr Ravi Bhat*, p. 980.

142 CoHealth, *Submission to the RCVMHS: SUB.0002.0029.0410*, 2019, p. 27.

143 *Evidence of Dr Ravi Bhat*, p. 980; *Witness Statement of Professor David Coghill*, 1 May 2020, paras. 53 and 97; *Evidence of Dr Paul Denborough*, 25 June 2020, pp. 36–37; *Evidence of Amelia Callaghan*, 25 June 2020, pp. 37–38.

144 RCVMHS, Psychiatrist and Psychologist Workforce Human-Centred Design Focus Group: Record of Proceedings.

145 Speech Pathology Australia, *Submission to the RCVMHS: SUB.1000.0001.3292*, 2019, p.10.

146 S Nelson and others, *Optimizing Scopes of Practice: New Models of Care for a New Health Care System Appendices*, 2014, pp. 20 and 22.

147 Victorian Psychologists Association, p. 3; Nelson and others, pp. 8 and 17.

148 Department of Health and Wellbeing, South Australia, Mental Health Services Plan 2020–2025, 2019, p. 88.

149 RCVMHS, Psychiatrist and Psychologist Workforce Human-Centred Design Focus Group: Record of Proceedings.

150 Victorian Mental Health Social Workers, *Submission to the RCVMHS: SUB.0002.0027.0084*, p.25.

151 Australian Nursing and Midwifery Federation, Victoria, p. 142.

152 RCVMHS, Psychiatrist and Psychologist Workforce Human-Centred Design Focus Group: Record of Proceedings.

153 RCVMHS, *Psychiatrist and Psychologist Workforce Human-Centred Design Focus Group: Record of Proceedings*; RCVMHS, *Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings*; Speech Pathology Australia, *Submission to the RCVMHS: SUB.1000.0001.3292*, 2019, p. 10.; The Australian College of Mental Health Nurses, *Submission to the RCVMHS: SUB.0002.0013.0020*, 2019, pp. 8-9..

154 Royal Australian College of General Practitioners, *Submission to the RCVMHS: SUB.1000.0001.1063, 2019*, p. 8.

155 Fiona Kumar, *Submission to the RCVMHS: SUB.0002.0019.0033*, 2019, p. 2.

156 Australian Psychological Society, Submission to the RCVMHS: SUB.0002.0029.0349, p. 32.

157 Australian Psychological Society, p. 32.

158 RCVMHS, Psychiatrist and Psychologist Workforce Human-Centred Design Focus Group: Record of Proceedings.

159 *Witness Statement of Dr Tricia Szirom*, para. 82; RCVMHS, Lived Experience Workforce Roundtable: Record of Proceedings; RCVMHS, Workforce Needs of the Future and Enabling Transformation Roundtable: Record of Proceedings.

160 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 139.

161 Centre for Mental Health Learning Victoria, Submission to the RCVMHS: SUB.0002.0029.0292, 2019, p. 11.

162 RCVMHS, Future Mental Health Workforce Capabilities Roundtable: Record of Proceedings, 2020.

163 Mindful, Centre for Training and Research Developmental Health, The University of Melbourne, *Correspondence to the RCVMHS: CSP.0001.0001.0219*, Response to Questions on Workforce Development, 2020, p. 4.

164 Centre for Mental Health Learning Victoria, pp. 9–10.

165 RCVMHS, Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings.

166 Australian Psychological Society, Submission to the RCVMHS: SUB.0002.0029.0349, p. 32.

167 Australian Nursing and Midwifery Federation, Victoria, p. 120.

168 headspace, Submission to the RCVMHS: SUB.0002.0030.0100, 2019, p. 7.

169 ORIMA Research, p. 38.

170 RCVMHS, Nurses Workforce Human-Centred Design Focus Group: Record of Proceedings.

171 RCVMHS, Psychiatrist and Psychologist Workforce Human-Centred Design Focus Group: Record of Proceedings.

172 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 130.

173 'Multidisciplinary care' denotes the capacity of a service or team to deliver holistic and person-centred treatment, care and support. It occurs when professionals from a range of disciplines work together to deliver comprehensive care that addresses consumers' strengths and needs. Importantly, care that is truly multidisciplinary involves 'non-clinical' services such as wellbeing supports that support a person holistically, within their social, cultural and economic context. Multidisciplinary collaboration should happen within teams, within services and across services to ensure continuity of care between services and settings.

174 Commission Analysis of ORIMA Research, Mental Health Workforce Survey, 2020.

175 RCVMHS, Australian Health Practitioner Regulation Agency (Ahpra) Roundtable: Record of Proceedings, 2020.

176 Department of Health and Wellbeing, South Australia, p. 88.

177 *Witness Statement of Dr Ravi Bhat*, 4 July 2019, para. 142.

178 Victorian Mental Illness Awareness Council, *Submission to the RCVMHS Terms of Reference: SUB.0002.0011.0020,* 2019, p. 14..

179 *Witness Statement of Nicole Bartholomeusz*, paras. 35–36; Centre for Multicultural Youth, *Submission to the RCVMHS: SUB.0002.0032.0067*, 2019, p. 35.

180 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 508–509.

181 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 507.

182 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 132.

183 It is important to note that the projection targets are derived from the National Mental Health Service Planning Framework assumptions regarding the 'ideal' allocation, composition and mix of disciplines across different specialist mental health settings. The future service design may be based on different 'ideals' yet to be determined. As per the planning framework, current fulltime-equivalent and forecasted need are less meaningful in terms of actual fulltime-equivalent numbers and more meaningful in terms of whether supply in the public system is adequate or inadequate.

184 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; Australian Institute of Health and Welfare, Mental Health Services in Australia: Specialised Mental Health Care Facilities 2018–19. Table FAC.34.

185 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; Australian Institute of Health and Welfare, Mental Health Services in Australia: Specialised Mental Health Care Facilities 2018–19. Table FAC.34.

186 The National Health Workforce Dataset has been used to derive a current state analysis of the numbers, distribution and work activities of different mental health professionals in Victoria. The dataset uses information generated by the National Registration and Accreditation Scheme, a single national registration scheme for health professionals established under the Health Practitioner Regulation National Law Act.

187 Commission Analysis of Commonwealth Department of Health, National Health Workforce Dataset.

188 Commission Analysis of Commonwealth Department of Health, National Health Workforce Dataset.

189 Commission Analysis of Commonwealth Department of Health, National Health Workforce Dataset.

190 Australian Psychological Society, *Submission to the RCVMHS: SUB.0002.0029.0349*, p. 79; Victorian Psychologists Association Inc, p. 40.

191 Mind Australia, Submission to the RCVMHS: SUB.0010.0029.0372, 2019, p. 28.

192 Neami National, *Submission to the RCVMHS: SUB.0002.0029.0069*, 2019, p. 8; Health and Community Services Union, pp. 40–41 and 77; Australian Services Union, Victorian and Tasmanian Authorities and Services Branch, *Submission to the Productivity Commission Inquiry into Mental Health*, 2019, pp. 3 and 32; Mind Australia, Neami National, Wellways and SANE Australia, *Joint Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, 2020, p. 21.

193 Victorian Mental Illness Awareness Council, *Submission to the RCVMHS Terms of Reference: SUB.0002.0011.0020*, 2019, p. 15.

194 Mind Australia, Neami National, Wellways and SANE Australia, p. 21.

195 Department of Health and Human Services, *Occupational Therapy Workforce Report*, 2018, p. 69; Australian Services Union, Victorian and Tasmanian Authorities and Services Branch, pp. 4–5; Mind Australia, Neami National, Wellways and SANE Australia, p. 21.

196 These descriptors have been adapted from the Family Violence Reform Implementation Monitor's description of the purpose and composite elements of an effective implementation plan. Refer to: Family Violence Reform Implementation Monitor, Report of the Family Violence Reform Implementation Monitor as at 1 November 2017, 2017, p. 30.

197 Australian Psychological Society, Submission to the RCVMHS: SUB.0002.0029.0349, p. 32.

198 Australian Medical Association, Victoria, *Submission to the RCVMHS: SUB.4000.0001.0008*, 2019, p. 89.

199 Australian Psychological Society, *Submission to the RCVMHS: SUB.0002.0029.0349*, p. 32.

200 Australian Medical Association, Victoria, *Submission to the RCVMHS: SUB.4000.0001.0008*, 2019, pp. 83–84; Australian Psychological Society, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, 2020, pp. 15–16; Occupational Therapy Australia, *Submission to the Productivity Commission Inquiry into Mental Health*, 2019, p. 6.

201 Australian Psychological Society, Submission to the RCVMHS: SUB.0002.0029.0349, p. 32.

202 Australian Psychological Society, *Submission to the RCVMHS: SUB.0002.0029.0349*, p. 32; RCVMHS, *Australian Health Practitioner Regulation Agency (AHPRA) Roundtable: Record of Proceedings.*

203 RCVMHS, Australian Health Practitioner Regulation Agency (AHPRA) Roundtable: Record of Proceedings.

204 Occupational Therapy Australia, *Submission to the RCVMHS: SUB.3000.0001.1264*, 2019, p.13.

205 RCVMHS, Workforce Needs of the Future and Enabling Transformation Roundtable: Record of Proceedings.

206 RCVMHS, Workforce Needs of the Future and Enabling Transformation Roundtable: Record of Proceedings.

207 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 537–538.

208 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 132; Victorian Government, Submission to the RCVMHS: SUB.5000.0001.0001, p. 28.

209 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 132.

210 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, 2020, p. 1184.

211 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 737.

212 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 737.

213 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1204.

214 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1204.

215 Jobs Victoria, Working for Victoria, <jobs.vic.gov.au/about-jobs-victoria/our-programs/working-for-victoria>, [accessed 7 December 2020].

216 Jobs Victoria, Working for Victoria, <jobs.vic.gov.au/about-jobs-victoria/our-programs/working-for-victoria>, [accessed 7 December 2020].

217 Victorian Government, *Victorian Budget 2020–21: Service Delivery: Jobs Plan*, 2020, p. 24.

218 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 707.

219 Commonwealth Department of Health, *Correspondence to the RCVMHS: CSP.0001.0001.0093*, p. 25.

220 Victorian Department of Health, <www1.health.gov.au/internet/main/publishing.nsf/Content/national-mental-health-workforce-strategy>, [accessed 5 January 2020].

221 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 708.

222 Commonwealth Department of Health, National Mental Health Workforce Strategy, <www1.health.gov.au/internet/main/publishing.nsf/Content/national-mental-health-workforce-strategy>, [accessed 7 December 2020].

223 Specialist registration and area of practice endorsement are both mechanisms under the National Health Practitioner Law that identify practitioners who have undertaken additional qualifications. The Ministerial Council is responsible for approving specialties and protected specialist titles and for approving areas of practice for endorsement and their relevant protected titles for each health profession. The difference between area of practice endorsement and specialist registration as regulatory tools is about the level of risk to the public. While specialisation poses a higher level of risk to the public than endorsement and requires a separate register and a higher level of regulatory oversight, only three health professions have specialist registration in Australia—medicine (for example, anaesthesia, surgery); dentistry (for example, orthodontics, oral surgery); and podiatry (for example, podiatric surgery). Area of practice endorsement is a regulatory mechanism under the National Law that enables a notation to be included on the public register to identify practitioners who have an approved qualification and supervised experience in an approved area of practice. An endorsement is a notation on general registration and published on the National Register, while specialist registration is a separate register and requires a higher level of regulatory oversight. Psychology Board, Australian Health Practitioner Regulation Agency, Endorsement and Specialist Registration, <www.psychologyboard.gov.au/About/Education/Endorsement-and-specialist-registration.aspx>, [accessed 8 December 2020].

224 Commonwealth Department of Health, Specialist Training Program, <www1.health.gov.au/internet/main/publishing.nsf/Content/work-spec>, [accessed 7 December 2020].

225 Commonwealth Department of Health, Specialist Training Program.

226 Australian Medical Association, Victoria, *Submission to the RCVMHS: SUB.4000.0001.0008*, 2019, p. 82.

227 Australian Medical Association, Victoria, p. 89.

228 Medical Student Council of Victoria, Submission to the RCVMHS: SUB.0002.0028.0163, 2019, p.3.

229 ORIMA Research, p. 11.

230 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 708.

231 Royal Commission into Victoria's Mental Health System, *Interim Report*, p.391.

232 RCVMHS, Future Mental Health Workforce Capabilities Roundtable: Record of Proceedings.

233 Pharmaceutical Society of Australia, *Submission to the RCVMHS: SUB.0002.0030.0097*, 2019, p.12.

234 *Witness Statement of Gail Bradley*, 26 June 2019, pp. 73–74; RCVMHS, Future Mental Health Workforce Capabilities Roundtable: Record of Proceedings.

235 RCVMHS, Future Mental Health Workforce Capabilities Roundtable: Record of Proceedings.

236 RCVMHS, Future Mental Health Workforce Capabilities Roundtable: Record of Proceedings.

237 Mental Health Victoria and Victorian Healthcare Association, Submission to the RCVMHS: SUB.0002.0029.0005, 2019, p. 28.

238 *Witness Statement of Dr John Reilly*, 29 May 2020, para. 63; Australian Psychological Society, Submission to the RCVMHS: SUB.0002.0029.0349, pp. 12–13; *Witness Statement of Sue Williams*, para. 15.

239 RCVMHS, Future Mental Health Workforce Capabilities Roundtable: Record of Proceedings; Substance Abuse and Mental Health Services Administration, About the Evidence-Based Practices Resource Center, <www.samhsa.gov/ebp-resource-center/about>, [accessed 7 December 2020].

240 For details of the current structure and functioning of the Centre for Mental Health Learning, refer to: Centre for Mental Health Learning Victoria, Submission to the RCVMHS: SUB.0002.0029.0292, 2019, p. 4; Victorian Auditor-General's Office, Access to Mental Health Services, 2019, p. 36.

241 In its Interim Report, the Commission suggested establishing an Aboriginal Social and Emotional Wellbeing Centre and tasked the centre with a number of workforce responsibilities including developing: workforce capability and clinical effectiveness; professional supervision, secondary consultation, counselling, debriefing and cultural support to improve cultural and clinical skills and reduce the risks of burnout and vicarious trauma for workers; training and other forms of professional development; support for recipients of the proposed scholarships; dissemination of existing tools (for example, validated questionnaires); and developing and validating new tools to support culturally appropriate clinical assessment, diagnosis and treatment and the identification of attractive clinical and non-clinical career pathways for the social and emotional wellbeing workforce. Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 484.

242 ORIMA Research, p. 10.

243 ORIMA Research, p. 10.

244 Mercy Mental Health, Submission to the RCVMHS: SUB.0002.0029.0267, 2019, p. 16; Bendigo Health, Submission to the RCVMHS: SUB.0002.0030.0051, 2019, p. 6; Centre for Mental Health Learning Victoria, p. 10.

245 Skills for Health, Health Education England and Skill for Care, Mental Health Core Skills Education and Training Framework, 2016.

246 For example: Department of Health and Human Services, Capability Frameworks for Victorian Maternity and Newborn Services, 2019; Queensland Health, Clinical Services Capability Framework Frequently Asked Questions, 2016; Family Safety Victoria, Preventing Family Violence and Violence Against Women Capability Framework, 2017; Victorian Government, Keeping Our Sector Strong: Victoria's Workforce Plan for the NDIS, 2019.

247 RCVMHS, Future Mental Health Workforce Capabilities Roundtable: Record of Proceedings.

248 RCVMHS, Future Mental Health Workforce Capabilities Roundtable: Record of Proceedings.

249 RCVMHS, Future Mental Health Workforce Capabilities Roundtable: Record of Proceedings.

250 RCVMHS, Future Mental Health Workforce Capabilities Roundtable: Record of Proceedings.

251 RCVMHS, Future Mental Health Workforce Capabilities Roundtable: Record of Proceedings.

252 RCVMHS, Future Mental Health Workforce Capabilities Roundtable: Record of Proceedings.

253 Thomas Bodenheimer and Christine Sinsky, 'From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider', The Annals of Family Medicine, 12.6 (2014), 573–576 (pp. 573–576).

254 RCVMHS, Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings.

255 RCVMHS, Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings.

256 RCVMHS, Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings.

257 RCVMHS, Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings.

258 RCVMHS, Nurses Workforce Human-Centred Design Focus Group: Record of Proceedings.

259 RCVMHS, Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings; Glassburn, McGuire, and Lay, pp. 692–695; Fiona L Calvert, Trevor P Crowe and Brin FS Grenyer, 'An Investigation of Supervisory Practices to Develop Relational and Reflective Competence in Psychologists: Relational and Reflective Competence', *Australian Psychologist*, 52.6 (2017), 467–479 (p. 476); Nicole L Robinson, Robert D Schweitzer and Erin L O'Connor, 'Early Reflections on Becoming a Therapist: Development of Reflective Practice in Clinical Training Programmes in an Australian Context', *Counselling and Psychotherapy Research*, 19.4 (2019), 388–398 (pp. 388–389); Jack Nathan, Chapter 1: The Making of the Advanced Practitioner in Social Work, in Reflective Practice in Mental Health. Advanced Psychosocial Practice with Children, Adolescents and Adults (Jessica Kingsley Publishers, 2010), pp. 29–45 (p. 36).

260 *Witness Statement of Lucinda Brogden AM*, 11 May 2020, para. 54; *Witness Statement of 'Rachel Bateman' (pseudonym)*, 16 June 2020, paras. 87 and 92–93; *Witness Statement of Sam Biondo*, 7 July 2020, para. 60(b); *Witness Statement of Dr Nick Kowalenko*, 9 September 2020, paras. 91–92; *Witness Statement of Dr Robyn Miller*, 7 August 2020, paras. 114 and 122–123; Robinson, Schweitzer and O'Connor, p. 392; Glassburn, McGuire and Lay, pp. 692–693 and 695–696; Calvert, Crowe and Grenyer, p. 2.

261 Cobaw Community Health, p. 5.

262 RCVMHS, Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings; RCVMHS, Lived Experience Workforce Roundtable: Record of Proceedings; RCVMHS, Workforce Needs of the Future and Enabling Transformation Roundtable: Record of Proceedings; RCVMHS, Nurses Workforce Human-Centred Design Focus Group: Record of Proceedings.

263 ORIMA Research, p. 24.

264 RCVMHS, Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings.

265 Australian Services Union, p. 26.

266 *Witness Statement of Amelia Callaghan*, 5 May 2020, para. 84.

267 Health and Community Services Union; Mental Health Victoria and Victorian Healthcare Association; RCVMHS, Bendigo Community Consultation—May 2019; RCVMHS, Australian Health Practitioner Regulation Agency (AHPRA) Roundtable: Record of Proceedings.

268 *Joint Witness Statement of Lisa Annese and David Morrison AO*, 14 July 2020, para. 66.

269 Australian Psychological Society, Submission to the RCVMHS: SUB.0002.0029.0349, p. 32; RCVMHS, Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings.

270 It should be noted that clinical and professional practice supervision provisions are embedded into some current industrial instruments. For example, the Victorian Public Health Sector (Medical Scientists, Pharmacists and Psychologists) Single Interest Enterprise Agreement 2017–2021 mandates that psychologists are provided with clinical (professional) supervision by a more senior psychologist of at least 10 hours per annum, with Grade 2 psychologists receiving fortnightly clinical supervision and Grade 1 interns and Grade 2 registrars receiving additional supervision in order to comply with the requirements of the enterprise agreement. Clinical supervision is not operational supervision. The Public Sector Agreement states that the clinical supervisor should not be the psychologist's line manager. Victorian Psychologists Association, p. 20.

271 Lynette Cataldo, Submission to the RCVMHS: SUB.0002.0006.0079, 2019, p. 6.

272 Victorian Psychologists Association Inc, p. 41; Australian Services Union, p. 25.

273 Victorian Psychologists Association Inc, p. 44.

274 NorthWestern Mental Health (A Division of Melbourne Health), p. 29.

275 *Witness Statement of Associate Professor Simon Stafrace*, 7 July 2019, para. 96(c).

276 *Witness Statement of Lynne Allison*, paras. 159–160.

277 *Witness Statement of Professor David Castle*, para. 47.

278 ORIMA Research, p. 8.

279 RCVMHS qualitative thematic analysis of RCVMHS, Psychiatrist and Psychologist Workforce Human-Centred Design Focus Group: Record of Proceedings; RCVMHS, Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings; RCVMHS, Lived Experience Workforce Roundtable: Record of Proceedings; RCVMHS, Nurses Workforce Human-Centred Design Focus Group: Record of Proceedings.

280 RCVMHS, Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings; RCVMHS, Psychiatrist and Psychologist Workforce Human-Centred Design Focus Group: Record of Proceedings.

281 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 526.

282 RCVMHS, Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings, 2020.

283 RCVMHS, Nurses Workforce Human-Centred Design Focus Group: Record of Proceedings.

284 RCVMHS, Psychiatrist and Psychologist Workforce Human-Centred Design Focus Group: Record of Proceedings.

285 Australian Nursing and Midwifery Federation, Victoria, p. 127.

286 RCVMHS, Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings.

287 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, 2020, p. 745; The Police Association Victoria, *Submission to the RCVMHS: SUB.0002.0028.0659*, 2019, p. 7.

288 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 745; Jacqueline V. Pich, Ashley Kable and Mike Hazelton, 'Antecedents and Precipitants of Patient-Related Violence in the Emergency Department: Results from the Australian VENT Study (Violence in Emergency Nursing and Triage)', *Australasian Emergency Nursing Journal*, 20.3 (2017), 107–113 (p. 107).

289 Productivity Commission, Mental Health Inquiry Report, Volume 2, p. 314.

290 Productivity Commission, Mental Health Inquiry Report, Volume 2, p. 744.

291 The Royal Australian and New Zealand College of Psychiatrists, Submission to the Productivity Commission Inquiry into Mental Health: The Role of Mental Health in Supporting Economic Participations, Enhancing Productivity and Economic Growth, 2019, p. 30.

292 Productivity Commission, Mental Health Inquiry Report, Volume 2, p. 745.

293 The Royal Australian and New Zealand College of Psychiatrists, Submission to the RCVMHS: SUB.0002.0029.0228 (Appendix 1), 2019, p. 18.

294 *Occupational Health and Safety Act 2004* (Vic).

295 Productivity Commission, Mental Health Inquiry Report, Volume 2, p. 745.

296 The Police Association Victoria, *Submission to the RCVMHS: SUB.0002.0028.0659*, 2019, pp. 7–8; Victorian Ambulance Union, *Submission to the RCVMHS: SUB.0002.0028.0277*, 2019, p. 17.

297 Productivity Commission, Mental Health Inquiry Report, Volume 2, pp. 304 and 306–307.

298 Productivity Commission, Mental Health Inquiry Report, Volume 2, pp. 304 and 306–307.

299 Productivity Commission, Mental Health Inquiry Report, Volume 2, p. 305.

300 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 131, 501 and 507.

301 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 510.

302 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 507.

303 Centre for Mental Health Learning Victoria, *Submission to the RCVMHS: SUB.0002.0029.0292*, 2019, p. 18.

304 Victorian Mental Illness Awareness Council, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, 2020, p. 4.

305 Australian Association of Social Workers, p. 12.

306 RCVMHS, *Lived Experience Workforce Human-Centred Design Focus Group: Record of Proceedings*; ORIMA Research.

307 *Witness Statement of Dr Tricia Szirom*, para. 82; RCVMHS, *Lived Experience Workforce Roundtable: Record of Proceedings*; RCVMHS, *Workforce Needs of the Future and Enabling Transformation Roundtable: Record of Proceedings*; Susan Ainsworth and others, *Leading the Change: Co-Producing Safe, Inclusive Workplaces for Consumer Mental Health Workers*, 2020, p. 2.

308 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 510.

309 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 700.

310 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 700.

311 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 507.

312 *Witness Statement of Erandathie Jayakody*, 4 June 2020, paras. 55 and 59; Consumer Foundations Working Group, Correspondence to the RCVMHS: Consumer Leadership and Mobilisation, 2020, p. 14.

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

1 National Aboriginal Community Controlled Health Organisation, *Submission to the Productivity Commission Inquiry into Human Services: Identifying Sectors for Reform*, 2016, p. 4.

2 Victorian Government, *Victorian Aboriginal Affairs Framework: 2018–2023*, 2018, p. 1.

3 Department of Health and Human Services, *Clinical Mental Health Funding Reform: Building a Stronger Foundation for Funding Adequacy, Growth and Fairness*, 2020, p. 3.

4 Australian Institute of Health and Welfare, *Mental Health Services in Australia 2004–05*, 2007.

5 *Mental Health Act 2014* (Vic), sec. 28.

6 *Mental Health Act 2014* (Vic), sec. 150.

7 Doris Erbe and others, 'Blending Face-to-Face and Internet-Based Interventions for the Treatment of Mental Disorders in Adults: Systematic Review', *Journal of Medical Internet Research*, 19.9 (2017), 1–15 (p. 2).

8 Michael E Porter and Robert S Kaplan, *How Should We Pay for Health Care? Working Paper 15-041*, 2015, p. 3.

9 *Carers Recognition Act 2012* (Vic), sec. 3.

10 *Carers Recognition Act 2012* (Vic), sec. 3.

11 Department of Health and Human Services, *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality of Care. Report of the Review of Hospital Safety and Quality Assurance in Victoria*, 2016, p. 3.

12 Karen Gardner and others, 'A Rapid Review of the Impact of Commissioning on Service Use, Quality, Outcomes and Value for Money: Implications for Australian Policy', *Australian Journal of Primary Health*, 22.1 (2016), 40–49 (p. 40); Productivity Commission, *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services, Inquiry Report*, 2017, p. 21.

13 Helen Dickinson and others, 'Making Sense of Joint Commissioning: Three Discourses of Prevention, Empowerment and Efficiency', *BMC Health Services Research*, 13.S6 (2013), p. 1.

14 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 615.

15 Australian Institute of Health and Welfare, *State and Territory Community Mental Health Care Services*, 2019, p. 15; Productivity Commission, *Mental Health Inquiry Report, Volume 2*, 2020, p. 570.

16 Note: Where there is a gap of no more than five minutes between the orders.

17 Kathryn Williams and others, *Patient-Reported Outcome Measures: Literature Review* (Australian Commission on Safety and Quality in Health Care, 2016), pp. 1 and 18.

18 Cath Roper, Flick Grey and Emma Cadogan, *Co-Production: Putting Principles into Practice in Mental Health Contexts*, 2018, p. 2.

19 Pet Dudgeon, Helen Milroy and Roz Walker (eds.), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing*, Second Edition (Canberra: Commonwealth of Australia, 2014), p. 544.

20 *Health Services Act 1988* (Vic), sec. 3. Note: the reference to a health service includes a public hospital, public health service, denomination hospital, privately-operated hospital or private hospital within the meaning of the *Health Services Act 1988* (Vic).

21 *Mental Health Act 2014* (Vic), sec. 3.

22 Ana Hategan, Caroline Giroux and James A. Bourgeois, 'Digital Technology Adoption in Psychiatric Care: An Overview of the Contemporary Shift from Technology to Opportunity', *Journal of Technology in Behavioral Science*, 4 (2019), 171–77 (p. 171).

23 *Equal Opportunity Act 2010* (Vic) secs. 4 and 6. The Commission recognises that terms such as 'psychological disease or disorder' can be pathologising and stigmatising.

24 *Equal Opportunity Act 2010* (Vic), sec. 9.

25 *Equal Opportunity Act 2010* (Vic), sec. 10.

26 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 35.

27 *Mental Health Act 2014* (Vic), sec. 3.

28 Porter and Kaplan, p. 2.

29 *Mental Health Act 2014* (Vic), sec. 305.

30 Centers for Disease Control and Prevention, United States, Indicators: CDC Approach to Evaluation, <www.cdc.gov/eval/indicators/index.htm>, [accessed 3 December 2020].

31 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 50; Family Safety Victoria, *Everybody Matters: Inclusion and Equity Statement*, 2018.

32 *Mental Health Act 2014* (Vic), sec. 153.

33 *Mental Health Act 2014* (Vic), sec. 4.

34 *Mental Health Act 2014* (Vic), sec. 3.

35 *Mental Health Act 2014* (Vic), sec. 24.

36 Peter C Smith, Elias Mossialos and Irene Papanicolas, *Performance Measurement for Health System Improvement: Experiences, Challenges and Prospects* (World Health Organization, 2008), p. 4.

37 Smith, Mossialos and Papanicolas, p. 4.

38 Department of Treasury and Finance, *Performance Management Framework: For Victorian Government Departments March 2016*, 2017, p. 18.

39 *Witness Statement of David Martine PSM*, 28 June 2019, para. 17.

40 Department of Treasury and Finance, p. 12.

41 *Witness Statement of David Martine PSM*, para. 17.

42 PHN Eastern Melbourne, Mental Health, AOD and Suicide Prevention, <www.emphn.org.au/what-we-do/mental-health>, [accessed 24 October 2019].

43 National Mental Health Commission, *Monitoring Mental Health and Suicide Prevention Reform: National Report 2019*, 2019, p. 87.

44 Department of Health, Victoria, *Framework for Recovery-Oriented Practice*, 2011, p. 2; Geoff Shepherd, Jed Boardman and Mike Slade, *Making Recovery a Reality Policy Paper*, 2008, p. 2.

45 *Mental Health Act 2014* (Vic), sec. 3.

46 *Mental Health Act 2014* (Vic), sec. 3.

47 *Mental Health Act 2014* (Vic), sec. 3.

48 *Mental Health Act 2014* (Vic), secs. 105, 110 and 113.

49 *Mental Health Act 2014* (Vic), sec. 105.

50 *Mental Health Act 2014* (Vic), sec. 3.

51 Dudgeon, Milroy and Walker, p. 548.

52 Douglas G Travis, *Travis Review: Increasing the Capacity of the Victorian Public Hospital System for Better Patient Outcomes*, 2015, pp. 1 and 39.

53 World Health Organization and the Calouste Gulbenkian Foundation, Social Determinants of Mental Health, p. 43, <www.who.int/mental_health/publications/gulbenkian_paper_social_determinants_of_mental_health/en/>, [accessed 4 December 2020].

54 Victorian Auditor-General's Office, *Managing Victoria's Public Housing*, 2017, p. vii.

55 *Witness Statement of Associate Professor Nicola Reavley*, 3 July 2019, para. 8; World Health Organization, *The World Health Report 2001. Mental Health: New Understanding, New Hope*, 2001, p. 16.

56 James D Livingston, *Mental Illness-Related Structural Stigma: The Downward Spiral of Systemic Exclusion Final Report*, 2013, p. 6.

57 Mark L. Hatzenbuehler, Jo C. Phelan and Bruce G. Link, 'Stigma as a Fundamental Cause of Population Health Inequalities', *American Journal of Public Health*, 103.5 (2013), 813–821 (p. 817).

58 Mark L. Hatzenbuehler and Bruce G. Link, 'Introduction to the Special Issue on Structural Stigma and Health', *Social Science and Medicine*, 103 (2014), 1–6.

59 M. B. Simmons and P. M. Gooding, 'Spot the Difference: Shared Decision-Making and Supported Decision-Making in Mental Health', *Irish Journal of Psychological Medicine*, 34.4 (2017), 1–12 (p. 5); General Assembly, United Nations, *Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary-General, Human Rights Council, Tenth Session, Agenda Item 2*, 26 January 2009, p. 15.

60 Department of Justice, *An Equality Act for a Fairer Victoria: Equal Opportunity Review Final Report*, 2008, p. 7.

61 Mental Health Commission of Canada, *Toolkit for E-Mental Health Implementation*, 2018, p. 12.

62 *Mental Health Act 2014* (Vic), sec. 45.

63 *Mental Health Act 2014* (Vic), sec. 6.

64 *Mental Health Act 2014* (Vic), sec. 52.

65 Dr Shalika Hegde and Dr Rebecca Haddock, *Re-Orienting Funding from Volume to Value in Public Dental Health Services, Issues Brief No. 32*, 2019, p. 44.

66 State Services Authority Victoria, *Joined up Government: A Review of National and International Experiences Working Paper No. 1*, 2007, p. 2.