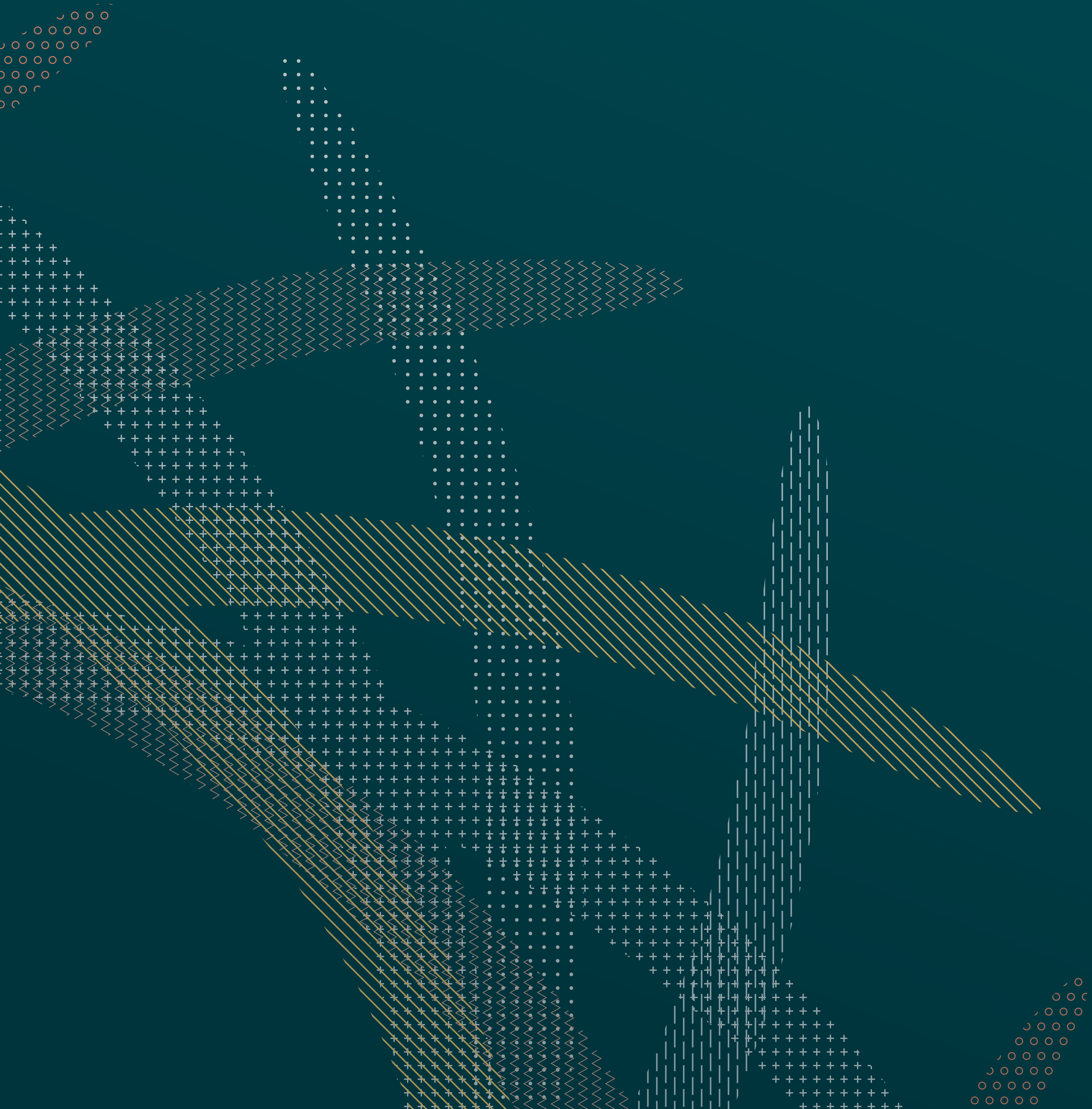
Royal Commission into
Victoria's Mental Health System

Final Report

Volume 5

Transforming the system—innovation and implementation



Royal Commission into
Victoria's Mental Health System

Volume 5
Transforming the system—innovation and implementation

Penny Armytage AM
Chair

Professor Allan Fels AO
Commissioner

Dr Alex Cockram
Commissioner

Professor Bernadette McSherry
Commissioner

ORDERED TO BE PUBLISHED

Victorian Government Printer
February 2021

PP No 202, Session 2018–2021 (document 6 of 6)

Volume 5
Transforming the system—innovation and implementation

ISBN 978-1-925789-73-7 **(Print)**

Published February 2021

Authorised and published by the Royal Commission into Victoria's Mental Health System,
Melbourne Victoria.

© State of Victoria, Royal Commission into Victoria's Mental Health System, February 2021.

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.

ISBN 978-1-925789-74-4 **(pdf/online/MS word)**

Available at the Royal Commission into Victoria's Mental Health System website <www.rcvmhs.vic.gov.au>. If you have any questions about the Commission's work please contact the Department of Health <MentalHealth@dhhs.vic.gov.au>.

ISBN

Summary and recommendations
ISBN 978-1-925789-63-8 **(Print)** 978-1-925789-64-5 **(pdf/online/MS word)**

Volume 1: A new approach to mental health and wellbeing in Victoria
ISBN 978-1-925789-65-2 **(Print)** 978-1-925789-66-9 **(pdf/online/MS word)**

Volume 2: Collaboration to support good mental health and wellbeing
ISBN 978-1-925789-67-6 **(Print)** 978-1-925789-68-3 **(pdf/online/MS word)**

Volume 3: Promoting inclusion and addressing inequities
ISBN 978-1-925789-69-0 **(Print)** 978-1-925789-70-6 **(pdf/online/MS word)**

Volume 4: The fundamentals for enduring reform
ISBN 978-1-925789-71-3 **(Print)** 978-1-925789-72-0 **(pdf/online/MS word)**

Suggested citation: State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 5: Transforming the system—innovation and implementation, Parl Paper No. 202, Session 2018–21 (document 6 of 6).

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

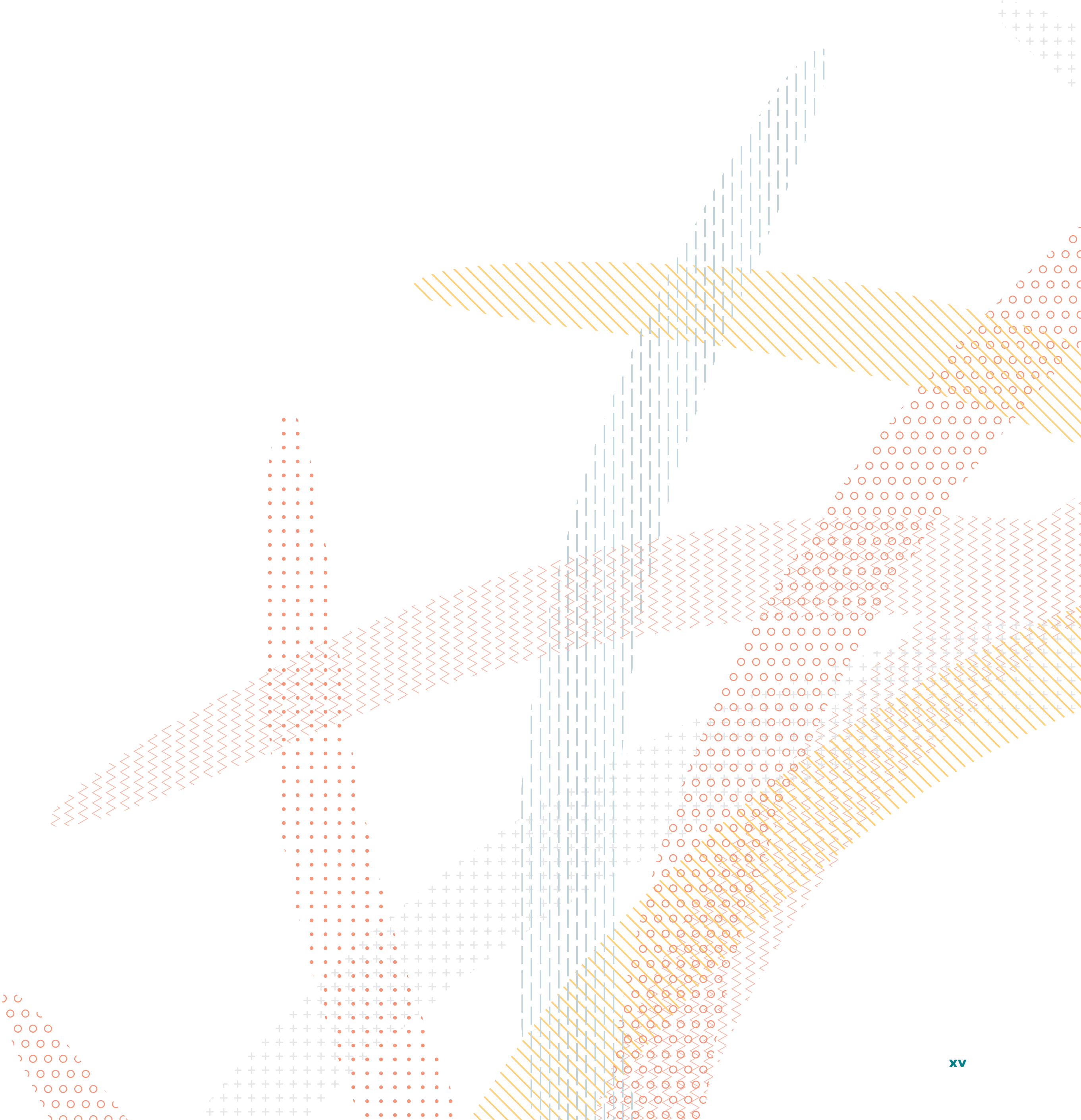
Throughout all phases of its work, the Commission has heard from people with lived experience of mental illness or psychological distress, families, carers and supporters, members of the workforce, organisations, experts and members of the broader Victorian community through consultations, submissions, 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. 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 4 explains the features that will ensure the system provides high-quality and safe services.

This volume starts by looking forward, outlining how the system will continue to be transformed. It sets out the technology, information and expertise required for a contemporary system, and how it will drive continuous improvement. It also details considerations for implementing the Commission's recommendations and proposes a 10-year implementation agenda that comprises three waves of reform. The volume concludes by looking back at the work and processes of the Commission itself.

Transformation through digital technology and new approaches to information management

The reformed mental health and wellbeing system will provide consumers with more opportunity to lead and actively participate in their own care and receive safe and effective treatment, care and support, supported by high-quality, easily accessible digital technology and information.

Harnessing the power of technology will be critical to providing a connected and accessible mental health and wellbeing system for consumers, families, carers and supporters. As outlined in Chapter 34: *Integrating digital technology*, a contemporary mental health and wellbeing system should use the latest technologies to offer people access to the full range of services and support available and help them navigate options so they receive continuity of care. It should recognise diversity and allow people to access flexible, personalised supports, regardless of where they live, the language they speak, their identity or their background.

Contemporary approaches to collecting, using and sharing information—with the needs and preferences of the consumers always in mind—will be a bedrock for an increasingly person-centred system.

State-of-the-art technology and information systems will ensure organisations and individuals have access to the information they need—and when they need it—to deliver seamless and effective treatment, care and support. New information cultures and processes will strongly protect consumers' information and privacy and promote trust in information sharing. New information systems and architecture will assist mental health professionals across the state to undertake their work, and to provide consumers with ways to view and contribute to records created about them. Data repositories and clinical registries will support research, outcome measurement and system accountability. Refer to Chapter 35: *New approaches to information management* for details.

Innovation, continuous learning and improvement

The new system must be set up to learn, develop and respond to changing needs and unexpected events—just as it has adapted in response to the COVID-19 pandemic.

The Collaborative Centre for Mental Health and Wellbeing will be the heart of this constantly learning and improving system. Drawing together expertise from across Victoria and around the world, the centre will research, develop and disseminate effective practice to effect large-scale positive changes across the system. It will translate cutting-edge research into practice through disseminating knowledge and research, and through providing treatment, care and support across the state.

Dedicated funding and support for innovation will encourage consumers, people working in the system, investors and entrepreneurs to try new approaches to providing services. The Department of Health will systematically require and support the evaluation of emerging innovations and established programs. It will use findings from research and practice to make evidence-informed approaches widely available. Refer to Chapter 36: *Research, innovation and system learning* for details.

Realising system reform

Despite the best endeavours of many, previous efforts to reform the Victorian mental health system have failed to deliver what the Victorian community deserves. This Commission carries the weight of unrealised hopes and expectations accumulated over decades. This time must be different— the results of this inquiry must lead to transformational change.

The changes described in this report are enormous and touch every part of the system. Transformation will take strong leadership, courage and collaborative effort from all partners involved in the delivery of reform over many years.

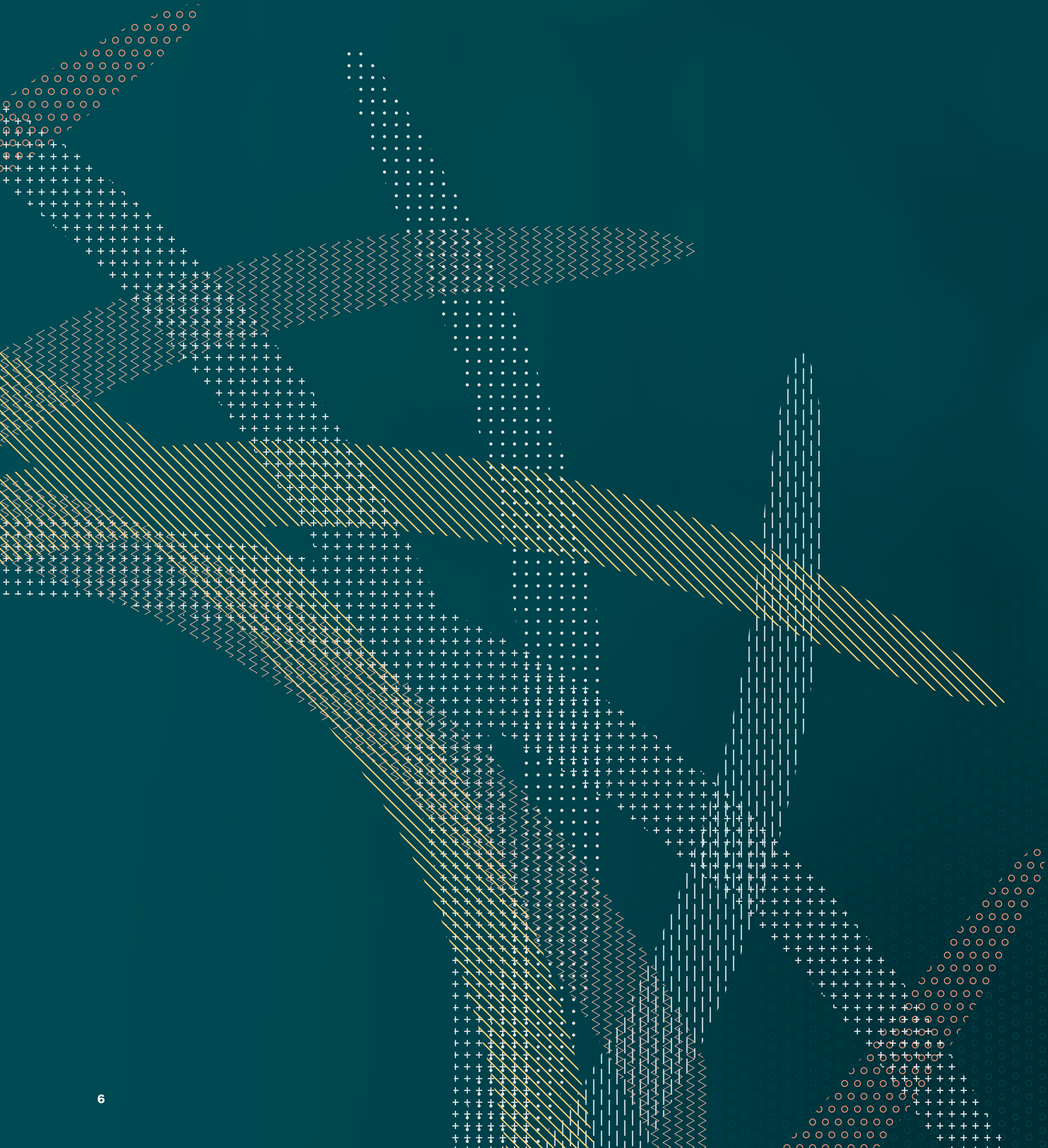
The Commission has considered the task that lies ahead for implementers and has tried to make practical recommendations, anticipate implementation challenges, and consider how to prioritise the work ahead.

Chapter 37: *Implementation* aims to help prepare the Victorian Government and all partners involved in implementation for success by exploring the requirements needed for enduring and profound change across Victoria's mental health system—as well as potential pitfalls. It also proposes a 10-year implementation agenda that comprises three waves of reform. This plan must adapt and evolve with the changing environment in which implementation will take place. Victorians need to be confident that the government will stay true to the Commission's aspirations and make the hopes of people with lived experience of mental illness or psychological distress, families, carers and supporters a reality.

Recent experiences have demonstrated the willingness and determination of people committed to the good mental health and wellbeing of the Victorian community to work together, overcome adversity and find new ways of providing treatment, care and support. This is the spirit and energy that will deliver the vision of the Commission and transform Victoria's mental health system so it is equipped to meet the needs of people both now and into the future.

The Commission's work

This volume concludes by reporting on the operations of the Commission under the *Inquiries Act 2014* (Vic) and provides details about its engagement approach, including its changed ways of working as a result of the COVID-19 pandemic.



Chapter 34

Integrating digital technology

Recommendation 60:

Building a contemporary system through digital technology

The Royal Commission recommends that the Victorian Government:

1. develop new statewide digital service requirements for all publicly funded mental health and wellbeing service providers that outline the consistent minimum digital functionality every provider should offer to consumers, families, carers and supporters.
2. support mental health and wellbeing service providers to adopt digital technologies, where safe and appropriate to do so, through:
    a. developing regulatory arrangements;
    b. providing funding; and
    c. building the ability of mental health and wellbeing service providers to integrate digital technologies.
3. enable mental health and wellbeing services to offer people living with mental illness or psychological distress access to devices, data and digital literacy support, where it is their preference to use digital services but they are otherwise unable to do so.

34.1 A digitally integrated mental health and wellbeing system

Contemporary service delivery is central to the Commission's vision for the future Victorian mental health and wellbeing system. All Victorians have the right to treatment, care and support that responds to their needs.

The Victorian mental health and wellbeing system needs to deliver services in responsive, compassionate, flexible and collaborative ways to give people the support they need, when it is needed. New service offerings where providers work collaboratively to support a consumer's needs will help to achieve this goal. New planning approaches will ensure environments, both physical and virtual, are inclusive, modern and welcoming. New skills and approaches to practice will enable services to provide people tailored treatment, care and support, regardless of their needs.

The system will also draw on, develop and test new ideas and evidence to determine what is working and what can be improved. Delivering this mental health and wellbeing system requires policy settings and service features that are designed with consumers, families, carers and supporters.

The Commission's interim report recognised that technological advancements offer the potential to reimagine service access and delivery.[1] Adopting digital technologies across the health system is recognised as an important tool to help achieve more person-centred health and wellbeing support,[2] high-quality care[3] and service delivery that focuses on early intervention and coordinated care.[4] Harnessing the power of technology will be critical to providing a connected and accessible mental health and wellbeing system that promotes continuity of treatment, care and support for consumers, families, carers and supporters.

While there has been growing support for using technology to address some of health's biggest challenges—such as increasing service demand, rising costs and shifting workforce and consumer expectations[5]—its uptake in mental health, both in Australia and internationally, has been limited.[6] The COVID-19 pandemic has sped up the adoption of some forms of technology,[7] but there are opportunities to build service delivery innovation and improve the way services are accessed and experienced by consumers.[8]

A contemporary mental health and wellbeing system should use the latest technologies to offer people access to the full range of services and support available and help them navigate options so they receive continuity of treatment, care and support. It should recognise diversity and allow people to access flexible, personalised supports, regardless of where they live, the language they speak, their identity or their background.

As described in Chapter 6: *The pillars of the new system—community-based mental health and wellbeing services*, the Commission is recommending that in order to respond to the needs of consumers across Victoria, community mental health and wellbeing services will be expected to offer treatment, care and support across the core functions through a range of delivery modes, including digital modes.

These core functions are described 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*.

People should have information at their fingertips and choice in the ways they receive treatment, care and support, whether it be face-to-face, or through telehealth, text, email or online. Automated referrals and online booking functions should simplify navigation and movement between services, and there should be greater access to blended care, which is discussed in more detail in Box 34.1. These things should be routinely available to people while maintaining the highest standards of quality, trust, safety and human rights. Of course, digital service delivery may not be the preference of every individual, nor appropriate or accessible to all consumers. A range of service options and modes should always be available, to ensure that no one is left behind.

Figure 34.1 outlines the Commission's vision for a digitally integrated mental health and wellbeing system. The Commission expects that new digital technologies will emerge, and will continue to change the services and supports on offer. Because of this, the system will need to be adaptable.

Figure 34.1: The Commission's vision for a digitally integrated mental health and wellbeing system

Stages	**Information and navigation**	**Help-seeking (initial contact)**	**Support, assessment and planning**
Settings	• at home • online • at a friend's place • at a service	• in the community • online or over the phone • at home • in an emergency department	
Consumer, family, carer and supporter experience	• online information and navigation support (mental health and other services e.g. legal aid and advocacy) • online complaints capability • over time, assisted navigation and support through chatbots	• improved choice and control through multi-channel access (phone, video, text) • ability to lodge complaints directly • ability to directly link to other mainstream service offerings	• immediate access to consultation support at preferred time and place • monitoring of complaints and real-time updates • online capacity to apply for advocacy/legal or other supports • comprehensive and person-led assessment
Provider experience	• access to up-to-date directories and information to improve referral capacity and networks	• digitally supported help seeking allowing for targeted and faster responses • more time available to support those who need extra help	• access to previous history and basic information, speeding up assessment and reducing wait times • diagnostic assessment, where needed allowing more accurate assessments • virtual assessment, reducing resource burden and freeing up time

Referral	**Service delivery**	**Transitions**	**Discharge/ end of service**
	• at home • in the community • at a hospital	• to a new service • to a new practitioner or support worker	• to home and communities
• e-referral ensuring smooth and simple access to treatment, care and support or other services • online booking systems to improve and simplify access • notifications helping to manage appointments	• blended delivery channels to reduce wait times, improve care coordination and support recovery • monitoring and tracking (with consent) to allow earlier interventions • portals and platforms to help secure contact with team • multiple channels, providing flexibility	• e-notification to tell those who need to know what's happening • e-referral to support transitions • transfer of electronic information to reduce need to repeat story and improve safety	• integrated self-help tools to support recovery maintenance and gains • monitoring to support early identification of any issues • rapid re-entry to support quick response and intervention
• e-referral enabling quick identification of available services • online booking for convenience • updated electronic records allowing forwarding of relevant information to the person's team • e-notifications letting the team know consumer has been referred	• monitoring to enable early intervention and adjustment • available information to support a swifter and more comprehensive response • secure platforms to allow quick communication with other providers	• e-notification, letting everyone know what's happening early • e-records to reduce delays in paperwork and speed up access to necessary information • monitoring to ensure no one falls through the cracks	• updated information to allow for a better response next time (if needed)

34.2 The potential of technology

Digital technologies are already having a significant impact on people's expectations of how they receive treatment, care and support, and the ways in which services are delivered, both in everyday life and in health care.[9]

One roundtable participant told the Commission that people are shifting to accessing support online, particularly where they may have previously had negative experiences of accessing face-to-face treatment, care and support:

> **I just think more people access things online, more people don't want to go into a hospital, especially if they've had negative experiences … you've got to have options available to people.[10]**

Associate Professor Simon Stafrace, Chief Adviser at Mental Health Reform Victoria, said in a personal capacity that digital technologies have the potential to markedly transform the mental health system:

> **I have little doubt that in time, digital technologies will create a new paradigm [model] for mental health services that will transform the ways in which treatment is delivered, information is shared and recorded, and the workforce is recruited, trained and developed.[11]**

There are already numerous and diverse digital tools and interventions being used within and outside of the public mental health system, and digital technologies are changing quickly.

Interventions include the use of telehealth (telephone and videoconferencing) to deliver treatment, care and support, supported online courses and therapies, self-help apps, gamification (making tasks into games) and digital assessments.[12] Tools include wearables to monitor health, track activity and support progress, websites to provide quick and easy access to information, electronic records, automated services such as e-bookings and e-referrals, and a host of other technologies.[13]

Box 34.1 summarises some of the most well-known digital interventions and tools, as well as the major terms used to describe digital technology in mental health.

Box 34.1: Key terms for digital mental health technologies

The terminology used to describe the use of technology in health and mental health care varies. The Commission considers that 'digital mental health technology' refers to the use of online and other digital technologies to improve mental health and wellbeing, including access to information, service delivery, education and wellbeing promotion.

It encompasses a vast range of technologies, including apps, portals, social media, smartphones, augmented or virtual reality, wearables and 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'.[14]

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. Some of the major technologies used in the sector are described below.

Telehealth—video teleconferencing using some form of online software or phone-conferencing to deliver services and supports directly to a consumer.[15]

Supported digital services—online courses and programs that are clinician supported.[16] They usually provide some form of low-intensity cognitive behaviour therapy.[17] For example, THIS WAY UP is a university-developed and Commonwealth-funded online program offering cognitive behaviour therapy courses for people with depression and anxiety.[18]

Self-help supports—smartphone apps and online programs that help consumers self-assess and monitor their health, and manage their symptoms and treatment, and that provide them with information.[19] Examples of self-help supports include Smiling Mind, a meditation and mindfulness app and website, and the Calm app, which helps with sleep and meditation.[20] Other examples include the IMood Journal and Recovery Record, which support a person to track their mood and any changes in their mental health, and to help identify triggers, coping strategies and when they may need to seek extra help.[21]

Text and chat-based support—the use of text (phone) and chat (web) channels to communicate with a service or support person.[22] This can be in real time, where both people communicate at the same time, or it can be asynchronous; for example, the consumer leaves a message and a support person responds later. One example is the Crisis Text Line in the United States.[23] Consumers in crisis can access free, 24/7 support. They text the supplied number and can exchange texts with a trained crisis counsellor.[24]

Blended care—providing treatment, care and support through integrating digital and face-to-face supports. In blended care, digital supports are used to complement face-to-face services and build on the gains achieved in face-to-face delivery.[25]

E-referral—automated electronic service referrals between providers.[26]

E-notification—electronic notifications to remind people they have a booking, or to let providers know a new referral has been sent.[27]

E-bookings—a technology that allows consumers or service providers to electronically select and book appointments.[28]

Websites—online mental health website pages that provide information, links and supports.

Social media—includes online peer or service-led forums and information that is delivered through a wide range of existing social media platforms (such as Facebook, Twitter, YouTube, Instagram and WeChat).

Virtual assistants (chatbots)—digital tools that assist people to navigate and find the information they need to manage their mental health.[29] Most virtual assistants are programmed to lead consumers through pre-set options based on the consumer's responses. For example, Sam the Chatbot is used on the Commonwealth Head to Health website to help people have an interactive discussion by entering information about their concerns.[30] More advanced chatbots that can have in-depth conversations with people about their mental health are being tested, but their effectiveness is still being evaluated.[31]

Artificial intelligence (AI)—the use of computer techniques in online therapy, diagnosis and monitoring to help improve outcomes and experiences.[32] AI is usually used as a tool that has the ability to quickly learn, adjust and change based on experiences, and to use that information to help people make decisions about services.[33]

Virtual or augmented reality (VR)—VR creates digitally generated worlds that the user experiences through a digital device (such as a headset). In mental health, VR is mostly being used as an aid to help clinicians to coach people through difficult scenarios (such as phobias, social anxiety or post-traumatic stress disorder), and to help them adjust their behaviour and build coping strategies that they can apply in real-world settings.[34]

Language and accessibility support—accessibility features that improve people's ability to engage with information or supports such as telehealth to support language interpretation,[35] digital translation and assistive technology to help people with disabilities access services.

Wearables—electronic devices that consumers can wear, like activity trackers and smartwatches, designed to collect data about users' personal health or social activity.[36]

Consumer records—electronic records that are used to assist the documentation of, and communication about, a consumer's treatment, care and support.[37] Some electronic records allow sharing of relevant consumer health information between a range of providers involved in a person's treatment, care and support (such as My Health Record), subject to consumer consent and privacy principles.[38]

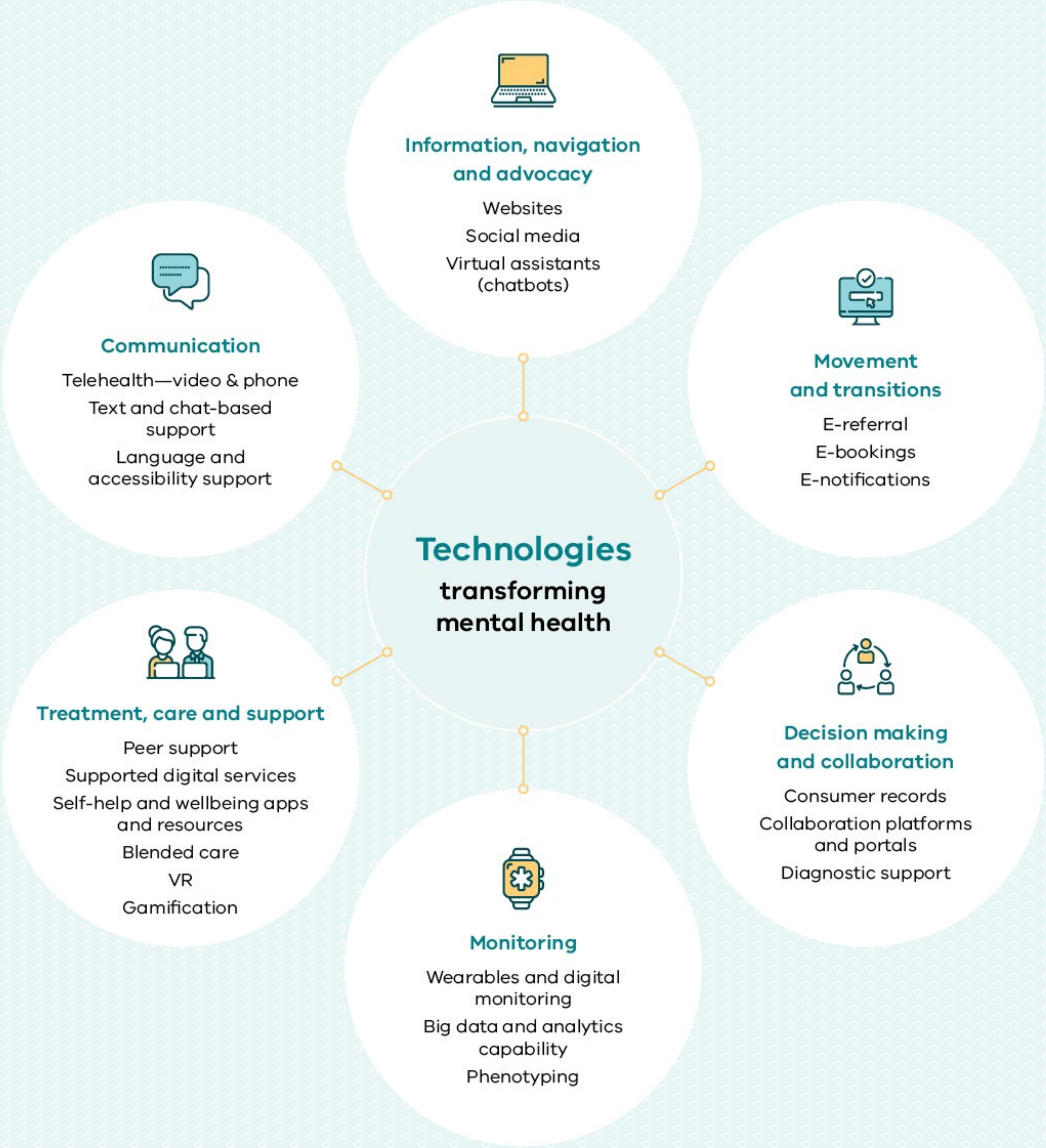
Collaboration platforms and portals—programs and digital platforms that allow people to work together virtually, or to access information and participate in their treatment, care and support. For example, the United Kingdom is trialling an electronic records and communication system called Healthlocker.[39] It allows consumers to send confidential and secure messages to their treatment, care and support teams, access their care plans, manage goals, and access and create coping strategies.[40]

As noted above, digital technologies and interventions have a range of uses. Dr Piers Gooding, Research Fellow at the Melbourne Social Equity Institute and the University of Melbourne Law School, told the Commission in a personal capacity that technologies in mental health services can be used for many purposes, including:

- to provide information and knowledge
- communication
- to deliver therapies and treatments
- to monitor consumer progress
- wellbeing and outcomes
- to support consumer movement and transitions between and within services
- to support collaboration and decision making between providers, consumers, families, carers and supporters.[41]

Figure 34.2 summarises some of the main technologies and their uses.

Figure 34.2: Major digital mental health technologies and their primary purpose



Source: *Witness Statement of Dr Piers Gooding*, 25 June 2020, paras. 18 (a–g); Piers Gooding, 'Mapping the rise of digital mental health technologies: emerging issues for law and society', *International Journal of Law and Psychiatry,* 67 (2019), 1–11.

34.2.1 Growth of digital technologies in mental health

There is a push to digitise and modernise many mental health and wellbeing services and supports in response to consumer needs and preferences.[42] However, it is not entirely clear to what extent digital technologies are currently being used in mental health.[43] This information gap makes it difficult to determine the outcomes that digital technologies are producing overall.[44] Despite this gap, there are numerous examples of how digital technologies are being applied in mental health.

Helplines such as Beyond Blue,[45] Lifeline[46] and Suicide Call Back now offer, or are moving to offer, multichannel and flexible access to support through text and web-based chat services. Ms Georgie Harman, CEO of Beyond Blue said that digital technology is shifting the way information is accessed by consumers and is enhancing choice. This has changed the way Beyond Blue responds to people.

> The digital revolution has shifted the way in which information is created, received, collected and shared. It has also enhanced the ways people can interact with each other and broader communities, with a potential 24-hour cycle of connectivity and more consumer choice than ever. These trends have changed how Beyond Blue reaches out to support people, how they reach out to us, and how they interact with each other.[47]

Beyond Blue is now implementing a new three-year strategy using technology to create an integrated online platform that offers consumers personalised experiences through a range of channels informed by consumer preference.[48]

Outside of the public mental health system, many digital mental health services have emerged in response to consumer needs and preferences, and they are gaining popularity. The Black Dog Institute, which specialises in digital mental health interventions for anxiety and depression, stated that there is growing use of and support for digital self-help tools, especially among people experiencing mild to moderate forms of depression and anxiety.[49] The uptake of these supports has increased significantly during the COVID-19 pandemic.

Dr Hila Haskelberg, Program Manager of THIS WAY UP at St Vincent's Public Hospital Sydney, told the Commission in a personal capacity that THIS WAY UP made its online courses available directly to the public in 2015 in response to consumer demand for online delivery.[50] Since the COVID-19 pandemic, THIS WAY UP has experienced a 600 per cent increase in the number of clinicians registering consumers to use their online courses and a 700 per cent increase in the number of people accessing the courses.[51] The organisation recently partnered with Bupa Australia to give more people access to the program.[52]

Dr Addie Wootten, CEO of the widely used mindfulness app Smiling Mind, told the Commission that since the COVID-19 pandemic began the app has seen a 165 per cent increase in downloads and a 367 per cent increase in monthly active users.[53] The app is especially popular with young people and is now used by one-third of Australian educators in the classroom, as well as by 50,000 participants in workplaces nationally.[54]

Large technology companies are also increasingly investing in early intervention in poor mental health.[55] During a roundtable, some companies noted that the internet is often the first place people go when seeking information on mental health or services (such as through online searches or forums). They indicated that this means online platforms provide a unique opportunity to engage with people early and to help them access the right treatment, care and support.[56]

One example is Twitter, which has partnered with Lifeline to offer the #ThereIsHelp notification service, which provides people with mental health resources, and encourages them to reach out and seek help when needed.[57] Twitter has also supported Lifeline to launch the #BeaLifeline direct message chatbot. The chatbot helps families, carers and supporters to easily discover Lifeline's resources, seek advice, or to discreetly request professional phone or text support in times of need.[58]

Recent research has shown that as many as 80 per cent of young people would like to receive support from mental health professionals via social media in the future, and others may prefer to use online forums or blogs, indicating that social media platforms could be an important avenue to support future service delivery.[59]

Advocacy organisations and groups are increasingly using digital technologies to improve people's understanding of their rights through the interactive provision of support tools and resources. For example, Independent Mental Health Advocacy has co-produced a self-help tool for people who want information and support to exercise their rights when they are receiving compulsory treatment.[60]

Digital channels are also increasing the reach of peer support networks, and offer consumers greatly expanded peer support options.[61] One example is the online peer support initiative, the Big Feels Club. The Big Feels Club offers support to people experiencing psychological distress through online forums, podcasts, articles and sometimes face-to-face meet-ups.[62]

Mr Graham Panther, a witness before the Commission and co-founder of the Big Feels Club, told the Commission that he and his co-founder, Ms Honor Eastly, established the platform to give people somewhere to go and hear from people like themselves, creating a community of people with similar experiences to support one another.[63]

The Big Feels Club's podcasts, online articles and online community are providing new forms of support that are not available anywhere else in Victoria.[64] Mr Panther noted that The Big Feels Club has amassed nearly 6,000 community members, and its articles and podcasts have been downloaded more than one million times.[65] The growing use of these types of supports indicates they are meeting a consumer need.

Within public health and mental health services, technologies such as telehealth (phone and videoconferencing) and websites are now becoming commonplace and are embedded within service delivery. These interventions have a strong evidence base and are being implemented by government-funded services.[66]

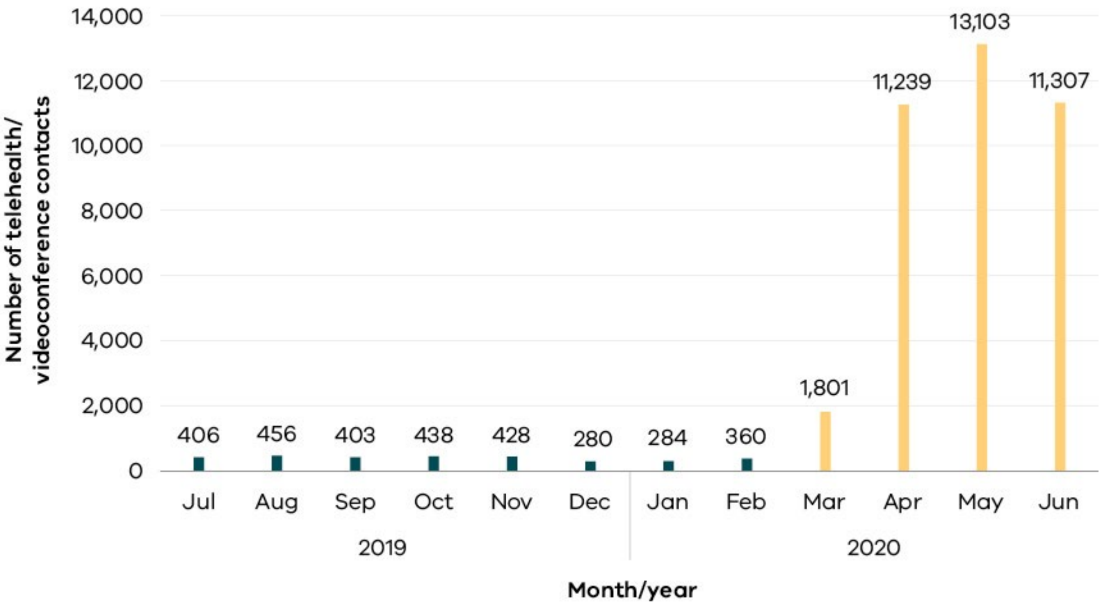
Since early 2020 the adoption of digital technologies has rapidly grown in response to the COVID-19 pandemic.[67] Associate Professor Stafrace said that in mid-2020, 40–100 per cent of private psychiatrists' work was being conducted using telehealth.[68]

Area mental health services have transitioned to using telehealth for much of their community service delivery.[69] Ms Kym Peake, then Secretary of the former Department of Health and Human Services, said that in April 2019, area mental health services had only delivered 346 consumer contacts via teleconference. In April 2020 this number increased to more than 10,000 consumer contacts.[70] Ms Peake noted that, where appropriate, telehealth is being used for triage, screening, assessment and some aspects of community-based treatment.[71]

The Commission understands that the COVID-19 pandemic has resulted in a shift in mode of contact with consumers. While face-to-face contacts reduced between March and June 2020 compared with the same time in 2019, telephone and telehealth (video) increased.[72] Figure 34.3 shows the rapid growth in telehealth use in community mental health services since the start of 2020 and compared with 2019 levels. The growth was mostly caused by the impact of the COVID-19 pandemic, but it indicates that some people were able to use telehealth to access treatment, care and support, though further work is needed to understand people's preferences.

Telehealth is also allowing for more contacts and flexibility, and improved administrative productivity. Mr Angus Clelland, CEO of Mental Health Victoria, noted that online and phone delivery has allowed services to offer consumers flexible options, such as substituting four 30-minute video sessions for a two-hour, face-to-face session.[73] This approach has allowed consumers to keep regular contact but also allowed mental health workers to provide support to more people.[74] Ms Peake noted that services are introducing innovative new ways of working, including through online clinics and the provision of virtual subacute care, as opposed to bed-based services.[75]

Figure 34.3: Number of community contacts by videoconference or teleconference, by month, Victoria, 2019–20



Source: Department of Health and Human Services, Client Management Interface/Operational Data Store, 2019–20.

Note: Includes contacts where the patient is not present. Other mode category not displayed.

Other digital interventions, such as AI-programmed chatbots, wearables and blended therapeutic care, are still emerging in Victoria but are growing in prominence. The uptake is stronger in private settings—governments are currently slower to implement these newer technologies.[76] While they hold promise, the evidence base for these digital interventions is more limited, and there are risks in investing public money in unproven interventions.[77]

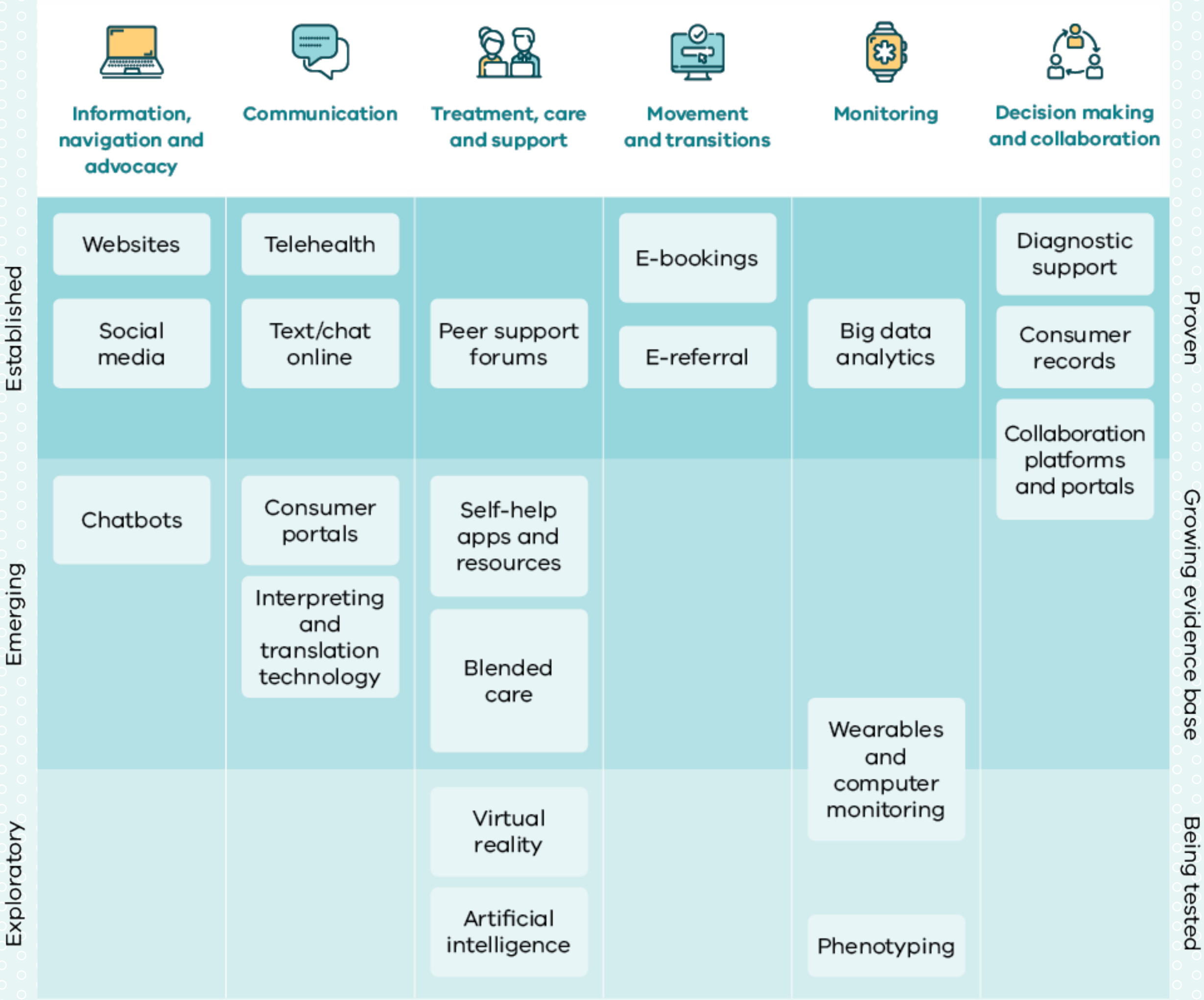
The Commission supports the statewide adoption of established and evidence-based technologies such as telehealth, evidence-based online services and multichannel access to services. However, it is mindful that other technologies and interventions are still emerging and need further evidence before they can be rolled out statewide.

The digital revolution is one of the biggest forces transforming the ways in which we as a society interact with one another and is reshaping systems globally and locally.[78] The rapid pace of change generated by the digital revolution influences how people communicate, find and receive information, and how they engage with services.[79] For example, social media platforms such as Facebook and Twitter only emerged in the early 2000s, but social media is now used by just over 70 per cent of the Australian population.[80] This pace of change continues to grow and move quickly, and so do advancements and opportunities in the digital mental health space, particularly through collaboration with industries.

Given the rapid pace of change in digital technologies, there will be a need for the Victorian Government to closely monitor new and emerging digital technologies and services and build strategies to leverage innovation to improve mental health and wellbeing outcomes. This should include testing new approaches and assessing their impact through partnerships with consumers, academics, the private sector and service providers.[81] This evidence base can then support future investment in technologies and services that will have the biggest impact on improving outcomes.[82]

Figure 34.4 outlines the Commission's assessment of the maturity of major digital technologies that may transform the mental health and wellbeing system—that is, how far progressed they are from 'being tested' to 'established' and supported by evidence. As the figure shows, some technologies require more research and evaluation to understand their potential impacts, benefits and risks for consumers and services, but given the speed at which technologies are evolving it can be difficult to predict trends.[83]

Figure 34.4: Digital mental health technologies maturity scale



	Information, navigation and advocacy	Communication	Treatment, care and support	Movement and transitions	Monitoring	Decision making and collaboration	
Established	Websites Social media	Telehealth Text/chat online	Peer support forums	E-bookings E-referral	Big data analytics	Diagnostic support Consumer records Collaboration platforms and portals	Proven
Emerging	Chatbots	Consumer portals Interpreting and translation technology	Self-help apps and resources Blended care		Wearables and computer monitoring		Growing evidence base
Exploratory			Virtual reality Artificial intelligence		Phenotyping		Being tested

Sources: RCVMHS assessment derived from a range of sources including *Witness Statement of Dr Piers Gooding*, 25 June 2020, para. 32 (d); Gerhard Andersson and others, 'Internet-delivered Psychological Treatments: From Innovation to Implementation', *World Psychiatry*, 18.1 (2019), 20–28 (p. 20); Simon Leigh and Steve Flatt, 'App-Based Psychological Interventions: Friend or Foe?', *Evidence Based Mental Health*, 18.4 (2015), 97–99 (p. 97); Mario Alvarez-Jimenez and others, 'HORYZONS Trial: Protocol for a Randomised Controlled Trial of a Moderated Online Social Therapy to Maintain Treatment Effects from First-Episode Psychosis Services', *BMJ Open*, 9.2 (2019); Ian B Hickie and others, 'Practitioner-supported Delivery of Internet-based Cognitive Behaviour Therapy: Evaluation of the Feasibility of Conducting a Cluster Randomised Trial', *Medical Journal of Australia*, 192.S11 (2010), S31–35; Laura Martinengo and others, 'Suicide Prevention and Depression Apps' Suicide Risk Assessment and Management: A Systematic Assessment of Adherence to Clinical Guidelines', *BMC Medicine*, 17:231 (2019); Michelle Burke Parish and others, 'Managing Psychiatrist-Patient Relationships in the Digital Age: A Summary Review of the Impact of Technology-Enabled Care on Clinical Processes and Rapport', *Current Psychiatry Reports*, 19.11 (2017).

34.3 Benefits and challenges of digital approaches

Consumers, families, carers and supporters have indicated that digital mental health technologies can have many benefits if they are integrated into the system effectively and in ways that enhance other service offerings.

Individual expectations will always differ, but generally speaking, the Commission has been told that consumers expect and want technology to be used in ways that improve their service experience and the quality of services, make services more accessible and personalised, and give them more choice.

Mr Dave Peters, a witness before the Commission, noted that digital technology can play a number of roles in improving consumer access to treatment, care and support, supporting consumer wellbeing, improving face-to-face service delivery and monitoring service performance:

> Digital technology can play a massive role in terms of enhancing face-to-face support. For example, it can act as a benchmarking tool to monitor progress, or as an activity diary to record exercise. I believe technology can play a huge role in supporting people to pursue their wellbeing. It is also useful for people in remote areas, where there may be a lack of face-to-face support and other options. It can also be useful for people experiencing domestic and family violence, where meeting face to face could be difficult, as well as for people who don't feel they can talk openly about these issues with or in front of their family—a text message or email can be done privately, even in the same room as other family members.[84]

While consumers can see the benefits of technology, they were clear that they want technology to improve and build on face-to-face services to make them more accessible, effective and personalised, rather than to replace the in-person human element of care.[85] As Mr Peters noted:

> These technological tools can provide amazing access to support, but I want to emphasise that technology will never be a replacement for human contact and connectedness with a real person.[86]

Mr Al Gabb, a witness before the Commission, said he still preferred one-on-one contact with a person, despite the benefits of interventions such as telehealth.

> I think it's definitely got merit. There's some people that live far more remote than I do, but I don't think it's the silver bullet. I think, you can't go past one-on-one contact as a human.[87]

Some consumers may be unable to use digital services (either completely or partially) for a range of reasons. While it can have benefits for some people, others may find the mode distressing or difficult to use.

Figure 34.5: Consumer expectations of digital technologies in mental health

Focus area	Consumer expectations	Consumer preferences
Information and navigation	**Improved knowledge and agency**	“[It] would be a lot easier to reach out, like, through the internet, rather than actually go to a place because it feels like so formal to do that, like, I feel like the digital health age is like, really helpful for the younger generation to like, talk about their mental health openly.
Access	**Increased access to the right treatment, care and support where and when needed**	“I used to struggle a lot with going to therapy once a week … it took so much energy, like it would knock me out for several days. And so since COVID … because all of my stuff is transitioned to being online, and I don’t have to leave the house. So now I can actually make all of my appointments, and like be consistent with stuff because it’s all online. So digital stuff, I think is really important.
Service delivery	**Choice, flexibility and personalisation** **Improved communication** **Build on and improve rather than replace**	“[I] was quite resistant at first with tele health, because I thought it’s just not the same … [but] having that flexibility, which is something kind of new to me … if this was six months ago, I’d be like, Oh my God, I’ve completely changed.
Transitions	**Continuity** **Reduced burden on consumers, families, carers and supporters**	“if I need to access a mental health plan, I need to sort of start from scratch every single time … it’s just a constant struggle to have to relay information over and over and over again … So it would just be a lot easier if that information was available to anyone who is treating me, and be able to just pull it up on the screen.
Safety, trust and rights	**Appropriate protections and security** **Evidence-based service offerings**	“The information would need to be protected from data mining and profiling. I would hate to think that a person’s medical information could be used for commercial purposes.

Sources: RCVMHS, *Young people Human Centred Design Focus Group, Record of Proceedings*, 2020; RCVMHS, *Information sharing Human Centred Design Focus Group, Record of Proceedings*, 2020; *Witness Statement of Dave Peters*, 22 July 2020.

The effectiveness of digital technologies in mental health services is difficult to measure, and the impact they have on the quality of services requires more research.[88] On the whole, many evidence-based digital technologies appear to perform well against the domains of high-quality care, including effectiveness, safety, appropriateness and continuity of care.[89]

People also need to know that the technology will protect their privacy, safety and rights. They want to be able to trust it.[90] The Commission has heard from several consumers of mental health services about their expectations of digital technologies. Figure 34.5 summarises some of the major features that consumers expect from these technologies, and why these features are important to them.

In general, digital technologies have the potential to improve quality and effectiveness through providing more intensive, personalised and data-informed treatment.[91] Digital technologies may be more appropriate or preferred by some consumers because they offer flexibility, choice and tailored content. They can also offer more connected treatment, care and support through providing treatment in between face-to-face sessions, helping consumers to manage their mental health and stay well.[92]

The Commission has not evaluated the effectiveness of individual digital interventions but understands that some supported online interventions have been shown to be as effective as their face-to-face counterparts.[93] Feedback on the use of telehealth indicates that some consumers are receiving the same level of service as in their face-to-face sessions.[94] However, the Commission understands that experiences are highly personalised. Dr Elizabeth Deveny, CEO of South Eastern Melbourne Primary Health Network, noted that '[s]ome consumers are enjoying the use of digital technologies to mediate clinical sessions, while others have expressed dissatisfaction with the loss of face-to-face sessions.'[95]

Overall, there is evidence indicating that digital technology can benefit consumers, families, carers and supporters, service providers and the system in many ways.

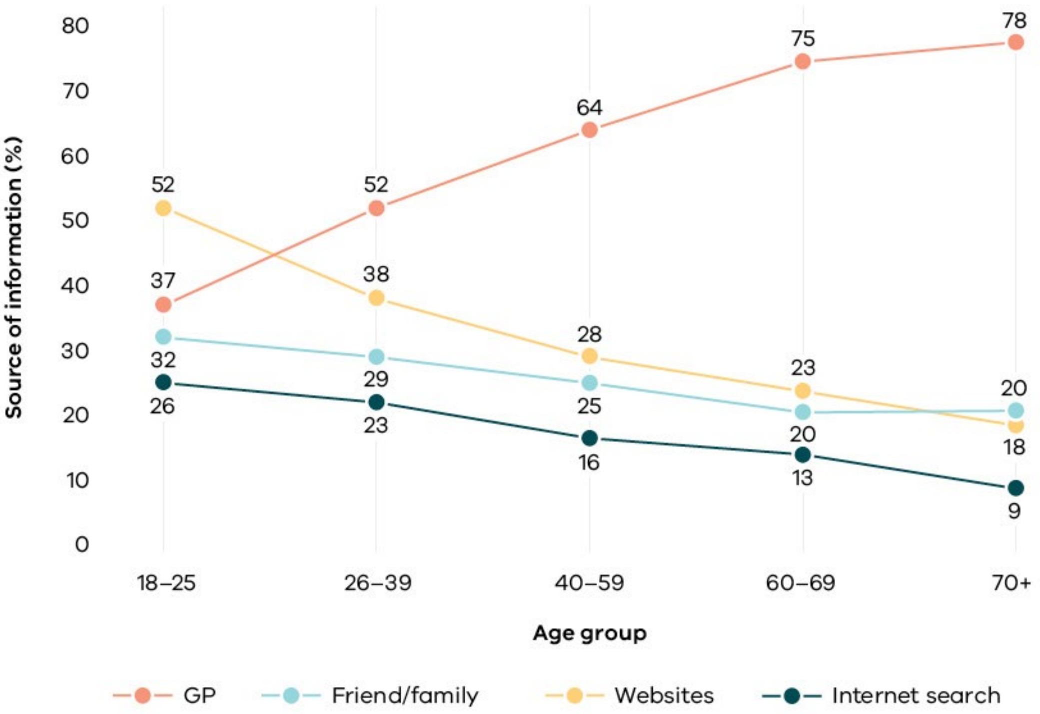
34.3.1 Improved information and service navigation

Centralised, well-maintained and user-friendly online information can improve people's access to information, increase awareness of services and give people more agency—that is, a sense of control over what happens to them.[96] As Professor Mario Alvarez-Jimenez, Director of Orygen Digital, observed, 'it is important that people are in the driver's seat [of their care] and that through technology they can … understand the pros and cons of different alternatives'.[97]

People appear to be taking advantage of online health information. Research by the Black Dog Institute indicated that people often seek help via digital and online platforms, and some people prefer to find information through these channels.[98]

The Commission's 2019 Community Sentiment Survey found that websites were a popular source of information for people facing a mental health challenge, with young people being most likely to seek information online in the first instance, as shown in Figure 34.6. ReachOut, an online mental health service provider for young people and their parents, also noted that young people are increasingly dependent on the internet for information.[99]

Figure 34.6: Where people go to seek information when facing a mental health challenge, by age group, Victoria, 2019



Source: RCVMHS, *Community Sentiment Survey-Key findings*, November 2019.

The Commission was told that access to high-quality online information and navigation tools is critical to help people manage their own mental health, understand the system and make informed choices about which services they should use.

One person told the Commission that well-designed websites can make information easily accessible to people:

> **Everybody is saying the same thing—it's hard to find services. There needs to be a website for people to just click on 'access' and all the phone numbers are there. Make it available and easily accessible.**[100]

Ms Harman also said that digital tools help people access trusted information without having to rely on service providers for advice.[101] This builds people's sense of agency and their ability to manage their own needs, where appropriate.

The Productivity Commission *Mental Health Inquiry Report* recognised the value of digital platforms to provide people with better access to information, to help them navigate between services.[102] It recommended developing a new national digital mental health platform that provides people with comprehensive information on mental health and services, online assessment and referral tools, access to supported digital interventions, and a gateway to a range of digital and face-to-face supports.[103]

Chapter 8: *Finding and accessing treatment, care and support* recommends creating a new state website for mental health and wellbeing services that will help consumers, families, carers and supporters to easily find the right services to meet their needs.

Digital technologies can also help people find their way through the system. Once people have found the information they need and sought help, online bookings, e-referrals and text notifications can provide better continuity of care and more streamlined service experiences.[104]

34.3.2 Expanded access and support

Digital mental health services can provide greater access to more personalised and flexible support for many people living with mental illness or psychological distress. There are real opportunities to use digital technologies to make a marked improvement in service access for specific cohorts and communities that are struggling to receive treatment, care and support.

Using telehealth to reach more people who struggle to access treatment, care and support

Delivering psychological or psychiatric treatments through telehealth could help ensure more people can access the services they need, when they need them. Telehealth has been shown to be just as effective as face-to-face service delivery for many consumers.[105]

One of the major benefits of telehealth is its ability to break down geographic barriers.[106] In regional Victoria, telehealth is providing access to services where they otherwise don't exist.[107] Workforce shortages in rural and regional areas significantly affect rural and regional Victorians' ability to access specialist services.[108] The use of telehealth is allowing more consumers to access specialist support, even when the service may not exist in their local area.

One person submitted to the Commission that access to telehealth services provided critical support when there was little else available in her area:

> I live in a regional area … and struggled to see any therapists, telehealth services is what saved me.[109]

Mr Trevor Thomas, a witness before the Commission, also stated that telehealth had allowed him to skip the waiting list and see a psychiatrist in another state, who now works with his local GP to provide the services he needs:

> I tried to get in to see a psychiatrist, and I was told that it was a [3] month wait. There just doesn't seem to be enough psychiatrists around. My GP said to me he would organise for me to see a psychiatrist through telehealth. So within [3] weeks I saw a psychiatrist in Sydney. My GP clinic set me up with a laptop and I spent 40 minutes talking to him. I clicked with him. He now is changing my medication. I am on a mental health plan, and currently using my sessions to see the Sydney psychiatrist via telehealth. The psychiatrist shares his notes with my local GP and so I feel like they are working together to help me.[110]

Digital technologies such as telehealth also provide more opportunities for collaboration between service providers in regional/remote areas and those in metropolitan areas.[111] This can improve access to multidisciplinary care teams and consultation liaison, which is critical for people with more complex needs.

As one example, Professor Ravi Bhat, Divisional Clinical Director of Goulburn Valley Area Mental Health Service, Goulburn Valley Health, told the Commission that Goulburn Valley Health has introduced Project Echo, a videoconferencing program that allows primary care teams and specialists to work together virtually to support a consumer, without them having to travel to a metropolitan area to see the specialist.[112] A recent systematic review of Project Echo found it to be effective at increasing provider knowledge of mental health and consumer access to services in remote locations.[113]

While telehealth has historically benefited regional areas, its value is also recognised more broadly.[114] It can provide an accessible means of service delivery for people who have other commitments, who have limited access to transport, or who may find it difficult to leave their property due to mobility issues, disability or caring duties. One person submitted that there are benefits of telehealth for people in both regional and city areas:

> Telehealth will be a great addition to mental health in both regional and city areas, giving people access to help without leaving home.[115]

Another person submitted that having the ability to access online support groups would greatly improve their ability to use these types of resources, without affecting their ability to undertake their caring role:

> I often can't attend support groups … because I'm trying to single parent and work and get better. If I could access these via audio/video conferencing I could still attend when my kids are in bed, which would really help and also limit the isolation I experience having no family around.[116]

In early 2020 in response to the COVID-19 pandemic, the Medicare Benefits Schedule was expanded to include national coverage of telehealth services for mental health services.[117] This has further demonstrated the potential of telehealth to provide greater access to services for people in metropolitan and regional areas. Since March 2020, Medicare funded telehealth consultations for mental health has continued to increase. In June 2020, national telehealth consultations for mental health services totalled 372,000, compared with only 56,000 in March 2020.[118]

Victoria has experienced similar growth in the use of telehealth for delivering mental health and allied health services. Figure 34.7 shows that between March 2020 and September 2020 the use of telehealth rose significantly for a number of services including GPs, psychologists and clinical psychologists. While use is still high, the Commission notes that telehealth use has declined slightly between September and October 2020.[119]

Figure 34.7: Number of COVID-19 Temporary Medicare Benefits Schedule telehealth items processed, by occupation, Victoria, March and September 2020

Source: Australian Government Services Australia, Medicare Statistics: Medicare Item Reports, <www.medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp>, [accessed 14 November 2020].

Note: COVID-19 – Temporary Medical Benefits Schedule telehealth items: General practitioner telehealth items—92112, 92113, 92114, 92115, 92116, 92117, 91818, 91819, 92210; Other medical practitioner items—92118, 92119, 92120, 92122, 92123, 91820, 91821; Occupational therapist items—91172, 91173; Social workers items—91175, 91176; Clinical psychologists items–91166, 91167; Psychologists items—91169, 91170.

The Productivity Commission has recognised the benefits of expanded telehealth consultations in improving consumer access to services.[120] It has recommended that the Commonwealth Government makes telehealth access to mental health services permanent.[121] The Commission considers that such a reform will help increase access to treatment, care and support for a wide range of consumers accessing primary mental health services.

Chapter 8: *Finding and accessing treatment, care and support*, Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services* and Chapter 9: *Crisis and emergency responses* recommend that digital services and modes are made available to consumers to improve accessibility and flexibility. Chapter 13: *Supporting the mental health and wellbeing of young people* also suggests that digital services be made available to young people seeking treatment, care and support.

Using digital mental health interventions to expand treatment, care and support options

There is also a growing body of evidence indicating that digital mental health services other than telehealth have the potential to increase access to mental health services and reduce demand on downstream services. Supported digital services and self-help supports have been recognised as an effective means of expanding access to quality treatment, care and support for some consumers, especially those with mild or moderate depression and anxiety.[122]

A number of organisations have called for the proper integration of digital supports into service delivery, to be offered as part of a range of treatment options.[123]

There are several evidence-based, supported digital services available that research indicates are as effective as face-to-face therapy of the same nature.[124] Some examples include THIS WAY UP and Mind Spot.[125]

The Productivity Commission conducted a detailed review of the potential for supported digital services to improve access to care.[126] It found that by improving access to these types of services, more consumers can access support that improves their wellbeing.[127] It has recommended that the Commonwealth Government funds the expansion of supported digital interventions as routine treatment, as part of its new digital platform.[128]

There is also a broad range of digital self-help supports and online peer forums that can help people manage their own mental health needs and wellbeing. Like supported digital services, self-help supports offer the potential to expand access to treatment, care and support. The Productivity Commission recognised the benefits such supports can play in improving access and choice recommending that steps be taken to improve people's ability to select and connect with relevant supports as appropriate.[129]

Mr John Brogden, Chairman of Lifeline Australia, suggested that one of the most promising opportunities for digital technology is the delivery of outbound services to keep in touch with people in between sessions.[130] He said that where the consumer consents, automatic text alerts could provide check-ins or reminders that may make a difference to someone.[131]

For example, the South East Primary Health Network has been trialling 'Nellie'—an automated text service that prompts consumers with high levels of anxiety or depression to remember to use their coping strategies, or to complete daily activities.[132] Clinicians are able to review Nellie's data to see whether people are responding, identify any red flags early, and contact the consumer if needed to offer treatment.[133] While still a trial, some consumers are responding very well to the text messages, because it feels like personal contact.[134]

Blended models of care are also being introduced. As explained in Box 34.1, blended models of care integrate online therapy and wellbeing support with face-to-face service delivery. This can provide people with immediate access to support while they wait for a face-to-face session, continuing care in between face-to-face consultations, and aftercare and recovery support to prevent relapses.[135]

Personal story:

Anh Nguyen

Anh accessed mental health support through Orygen when she was going through a 'rough time' at university. Towards the end of her treatment, her case manager suggested she try using Moderated Online Social Therapy (MOST)—an online platform that provides a safe online social network, personal therapy programs and resources to support mental health.

Anh said she found the online environment comforting and supportive, because it made her feel like she was not alone, no matter what the time of day.

> When I started going on to it, I felt more comfortable and relaxed, knowing that I've got others around to support me. If I had any problems, I could contact someone and they would be able to help make me feel a lot better and I know that I'm never alone.
>
> It's a comfortable feeling knowing someone is there. They're on there 24/7, if you need someone at a bad time, they're just there and they'll appear and start talking to you, making you feel a lot better.

Anh said she found the platform had a strong community feel, which positively contributed to her own mental health.

> You can post whatever you've got to say, for example, something encouraging, and then you can just say, 'this is what brightened up my day and I hope it brightens up your day as well'. I remember seeing people commenting on my post that it had actually brightened up their day and that made me feel a lot better as well.

Despite sometimes talking to clinicians who Anh may not have worked with before, she still felt it was easy to connect with them.

> They made themselves approachable like a friend, a very close, trusted friend so that I was able to express myself.

Anh said the accessibility of the program can fill a gap between face-to-face appointments.

> When I started having an episode, I wasn't always able to get an appointment with my case manager as soon as possible. Then when I did see my case manager, the episode was gone and I couldn't really explain how bad it was. I felt really down because I couldn't talk to anyone about it during that time phase. But MOST is carried in your pocket, you can message your case manager straight away and explain to them what's going on.

Anh said the platform helped her make social connections as well.

> One of the workers would say, ‘we’re going to have a little social gathering’, and then anyone that’s able to come can start meeting with each other and talking.

Anh spoke of a cartoon on the platform that she found supportive.

> It was a step by step cartoon that illustrated someone going through the same experiences as I was, with the help of the cartoon, it guided me through how to take control of my own wellbeing, as well as how to manage how I was feeling and that it was alright to stop and take a deep breath in and just breathe to relax and calm myself down.

Following Anh’s positive experience with the platform, she would like to see it expanded to more young people. Anh also thinks it could be a good access point to connect to Orygen, because, she says it can be difficult to take the step of going there in person and speaking to someone.

Sources: RCVMHS, *Interview with Anh Nguyen*, October 2020; Orygen, Moderated Online Social Therapy, <www.orygen.org.au/Clinical-Care/Clinical-services/Moderated-Online-Social-Therapy>, [accessed November 2020].

Orygen's Moderated Online Social Therapy (MOST) model is an example of blended care.[136] It offers flexible digital support to accompany face-to-face services, from the time a consumer enters the service, through to after they have been discharged from it.[137] Consumers can chat with clinicians in real time, 24 hours a day, seven days a week.[138] They can also use evidence-based interventions at home, a safe and supportive social network site, and talk to peer support workers.[139]

Early modelling suggests that 30 per cent of young people may not need face-to-face support once they access the digital service, which could free up waiting lists.[140] It also indicates that approximately 25 per cent of young people could require at least one fewer session of face-to-face treatment,[141] and approximately 33 per cent of young people could experience fewer relapses, or relapses of lesser intensity.[142] This could mean better health and wellbeing outcomes for young people and better allocation of resources and workforce to helping those with more complex needs.

34.3.3 Expanded and personalised service options and channels

Having access to services and information through a range of channels, including telehealth, text, email, web and phone, offers people more choice, flexibility and control in the ways they receive treatment, care and support.[143] There are significant opportunities to use this personalisation and flexibility to provide more specialised and targeted responses to some consumers and cohorts who struggle to use services.

For example, many digital options allow people to access support at a time and in a way that is convenient to them.[144] Ms Julie Anderson, Senior Consumer Advisor in the Office of the Chief Mental Health Nurse and the Office of the Chief Psychiatrist in Victoria, told the Commission in a personal capacity that digital options allowed her to receive support without compromising her work schedule and in a way that protected her privacy:

> I think digital approaches are helpful for young people and people generally who are working in this digital age. For me personally, because I work, it is easy for me to get online or to look up something up. I don't have a lot of time to attend appointments and things like that, so online is really great and allows me to easily access information on mental health and mental health services in a timely way. It is also private and people around me don't need to know what I'm doing.[145]

Dr Haskelberg told the Commission that online courses like THIS WAY UP improve convenience and allow people who wouldn't otherwise have access to treatment, care and support to access it when they want to, and faster.[146]

As suggested by headspace, some digital interventions, such as text-based support or self-help tools, can be appealing to people who may otherwise not seek mental health support.[147] One submission noted that text messaging can be much less frightening for some people, which can help them to reach out:

> The suicide hotlines work reasonably well but not for people who are too scared to pick up the phone. More app based suicide prevention services might be more useful. This way the person can text their message which is much less frightening.[148]

Dr Gooding suggested that being able to seek support anonymously may be very important to people who are concerned about sharing personal information locally.[149] This could include people in small or marginalised communities, people who may fear stigma, people who identify as LGBTIQ+, and Aboriginal people.[150]

One person at a community consultation noted that traditional phone-based supports don't always work for young people, especially boys. They suggested the system should be making far better use of online channels and forums to offer support to these groups:

> **Helplines by phone don't work for youth, boys in particular. They won't pick up the phone to ask for help. Instead, they share online. There is an opportunity to make far more use of the potential … support networks [youth are] seeking on the internet, instead of (or in addition to) phone availability.**[151]

Technology can also offer more personalised and inclusive services and support, particularly for diverse communities and groups. Alex Smith, a witness before the Commission, said that access to online social media support had helped them to connect with other gender diverse people, and the resource helped them through a challenging time:

> **A transgender and gender diverse organisation in Victoria runs a really, like, wonderful online Facebook group … which is for trans masculine people … That was an amazingly important resource for me … I really couldn't have continued with work, I think, without having that online Facebook group.**[152]

Foundation House noted that innovative responses to translation services can support culturally diverse communities to access services and supports that are tailored to their language and cultural needs.[153] They cited examples of some specialist service providers recording phone or video messages in consumers' preferred languages to organise appointments, rather than written text.[154]

Mental Health Australia, the Federation of Ethnic Communities Councils of Australia and the National Eating Disorders Association jointly told the Productivity Commission that online services have the potential to break down language barriers and deliver services that are understanding of and responsive to people's individual cultural backgrounds and beliefs:

> **For culturally diverse communities, online services could support individuals in their first language and/or understand their cultural norms and values around mental health and wellbeing. This includes established migrant and refugee communities here in Australia, international students, and second-generation Australians who may not need someone who speaks a language other than English but do need someone who understands the nuances of their cultural background.**[155]

Chapter 21: *Responding to the mental health and wellbeing needs of a diverse population* recommends developing user-centric digital technologies to support delivery of accessible, confidential, timely language service delivery for mental health and wellbeing.

34.3.4 Improved productivity and efficiency

In addition to consumer benefits, technology can have a range of service and system benefits. For example, the proper use of electronic records, e-referrals, telehealth and other technology can be a means to reduce administrative workloads and manual tasks for service providers.[156] A reduced administrative burden can leave workers more time to deliver their full scope of practice, to the benefit of consumers.[157]

In their 2019 review of digital technology and mental health, Reinhard Michael Krausz and colleagues suggested that the use of digital technology in mental health services can contribute to 'a more accessible and cost-effective system of delivery'.[158] They cited reduced travel costs, less administrative work, and wider reach and scale as the leading benefits of digital technologies.[159] In its 2018 report on the Future of Health, the Commonwealth Scientific and Industrial Research Organisation (CSIRO) also found that telehealth and digital services can drive efficiency and cost-effectiveness through a reduction in hospitalisations, reduced consumer transport costs and shorter waiting lists.[160]

Service providers and clinicians have indicated that they want technologies that reduce the amount of administrative work they have to do, that provide access to information that helps them do their jobs well and more efficiently, and that supports consumer continuity of care.[161] The Commission was told about a number of ways in which digital technology is supporting these goals.

For example, both Mr Shane Solomon, Partner at Caligo Health, providing evidence in a personal capacity, and Professor Rob Moodie, Deputy Head of School and Professor of Public Health at the University of Melbourne, individually noted that online and telehealth technologies can be more efficient for mental health workers.[162] They both suggested their use may cut workers' travel time, allowing them to have longer sessions with consumers and potentially see more consumers.[163] Dr Deveny also noted that digital technologies provide the flexibility for workers to be located anywhere when delivering services.[164]

The Commission's interim report indicated that telehealth and other technologies are being used for triaging and urgent assessment, which can reduce the need for some consumers to be transported by ambulance to larger hospitals in rural and regional areas.[165] Associate Professor Ruth Vine, Director of Forensicare, suggested the advantage of screening and triage services being provided digitally is that the services can be accessed from anywhere, and by consumers, service providers and emergency services.[166] This not only reduces the burden on consumers having to travel but also reduces the amount of resources that have to be dispatched. However, Associate Professor Vine said that mental health services depend on interpersonal relationships and does not believe it is possible to do a thorough mental state assessment of an acutely unwell person online.[167]

Further, the Commission was told that online and phone-based service delivery may reduce the number of 'no-shows'—that is, people who do not attend an appointment.[168] No-shows reduce the amount of productive time a worker has during the day, as well as the number of consumers they can see.[169]

Professor Ian Hickie AM, Co-Director of Health and Policy at the Brain and Mind Centre at the University of Sydney, confirmed in a personal capacity that the introduction of telehealth services has resulted in a reduction in non-attendance rates for people attending GP clinics.[170] He suggested that this reduction is likely due to consumers being able to attend consultations in their own home.[171] The organisation headspace produced a report about the experience of its workforces using telehealth during the COVID-19 pandemic. The report noted that the impact of the COVID-19 pandemic on consumer attendance was mixed, with 41 per cent of the workforce indicating that slightly or considerably fewer clients had cancelled or missed their appointment, but that 30 per cent had also found that more clients had not attended appointments.[172]

There are many reasons that people may be unable to attend a face-to-face appointment. As noted earlier, mobility issues, physical or mental health interruptions (including worsening of symptoms), and caring responsibilities can all be reasons that a person may struggle to make it to a face-to-face session. Telehealth can provide people with more flexibility to attend their appointments from their own home, and in hours that may suit them more.[173]

34.3.5 Feedback, accountability and performance

There is a lot of emphasis on the benefits of technology to service delivery, but digital technology can also contribute to better monitoring, data collection and feedback systems. Professor Hickie said, '[t]he role of data tracking and feedback systems in both improving service quality and system responsiveness cannot be underestimated.'[174]

Dr Gooding suggested that digital data systems can help monitor the activity and performance of services, system administrators and advocates to ensure services are being delivered effectively and safely.[175] For example, one New South Wales research team used technology to monitor medicine use in aged care facilities across Australia to identify excessive prescription of antipsychotic medication and flag areas for further checks.[176] Such an approach may be beneficial in monitoring the use of restrictive practices in inpatient units.

New tools can also empower consumers to directly provide feedback about the system or a service, and then monitor the response to that feedback.[177] Consumers should be able to electronically submit a complaint and easily see its progress through the system.

Better data collection systems and data analytics can also provide services, system administrators and researchers with a wealth of information to identify where interventions and programs are working, and where more needs to be done.[178] Chapter 35: *New approaches to information management,* discusses the need for better information systems and processes, and recommended solutions, in detail. Chapter 30: *Overseeing the safety and quality of services*, and Chapter 36: *Research, innovation and system learning* also note the importance of better using technologies to inform data collection and system improvement.

34.3.6 The challenges of digital mental health technologies

While there are many benefits to integrating digital technology in mental health and wellbeing services, there are also potential limitations and risks that the system needs to carefully consider.

Digital interventions on their own may not be appropriate for some people with high-intensity needs. Professor Alan Rosen AO, Professorial Fellow in the Illawarra Institute for Mental Health at the University of Wollongong and Clinical Associate Professor of the Brain and Mind Centre in the Sydney Medical School, University of Sydney, suggested the 'more severe' a person's mental illness is, the more likely they are to need in-person interdisciplinary services.[179] While Professor Rosen noted that digital supports can still augment care, they are unlikely to be effective on their own.[180] Dr Haskelberg holds a similar view to Professor Rosen, suggesting that digital tools should be part of a more comprehensive suite of interventions.[181]

While some people with lower intensity needs relating to their mental illness or psychological distress may respond well to online interventions, many digital mental health and wellbeing apps and online courses are general in nature, or may lack a strong evidence base.[182] The University of Melbourne told the Productivity Commission that a number of digital products appear to have been developed without consumer or clinical expertise, reducing their usability and effectiveness.[183]

A 2019 study found that most apps are sold as therapeutic tools but have not been evaluated rigorously.[184] They may be informed by evidence-based treatments, but this does not mean they actually deliver evidence-based services to consumers.[185]

While some people may stop using digital supports once it has met their needs, a lack of rigorous development can be a reason people drop out of these services. A review of clinical trials of smartphone apps to support people with depression indicated that drop-out rates were approximately 50 per cent.[186] Only 4 per cent of mental health users continue using mental health and wellbeing apps after two weeks, and even this statistic is not necessarily meaningful because people only need to open the app—not use its features—for this to be measured as 'continued use'.[187] It suggests people may not receive the results that were expected, or may have higher hopes than the app or course can deliver.

Online and mobile interventions need to provide transparency of intended benefits and limitations to help consumers manage expectations and decide if the option is truly right for them.

Dr Haskelberg noted that people may be overwhelmed by the multiple digital interventions available[188] and may find it difficult to navigate and select the digital tool that best suits their personal needs.[189] Orygen also raised concerns that some digital services may have limited quality control, safety measures and evidence to inform their development, making them unsuitable as standalone supports for people.[190]

Consumers may be concerned about the safety and privacy of their data and personal information when using such technologies. Dr Gooding and Professor Hickie both noted that there can be a lack of transparency in mental health apps and websites about privacy policies, data sharing practices and commercial interests.[191]

Victorians have a right to privacy under the *Charter of Human Rights and Responsibilities Act 2006* (Vic), and they should have reassurance that the services and supports they are using will maintain their privacy and trust.

The Productivity Commission has recommended that the Commonwealth Government improves advice and support to the public and service providers on how to select evidence-based and safe digital services that are appropriate for consumers' needs.[192] The Australian Commission on Safety and Quality in Health Care has also released the new *National Safety and Quality Digital Mental Health Standards* to improve the quality of digital mental health service provision and protect consumer safety. The standards describe the level of care and the safeguards that digital mental health services should provide consumers and providers.[193]

The Commission was also told that if not implemented correctly, new technologies could potentially increase pressure on services as they strive to input data into multiple systems, which may reduce efficiency.[194] For example, Professor Emeritus Bruce Singh AM, Clinical Director of Mental Health Services at South West Healthcare, Warrnambool told the Commission in a personal capacity that the introduction of some electronic medical records has resulted in increased administration work, rather than more time for face-to-face service delivery.[195] New technologies should create efficiencies for services and relieve administrative burden for professionals, rather than compound these issues.

34.3.7 Weighing the benefits and challenges

As noted earlier, technology use in the mental health and wellbeing system will continue to grow rapidly in response to people's preferences and needs. On balance, the Commission considers that technology's many benefits and the evidence quickly evolving from the response to the COVID-19 pandemic are promising and therefore should be built on. The Commission encourages the Victorian Government to work to integrate digital technologies into mental health and wellbeing services in a way that is safe, inclusive of diverse needs, appropriate, cost-efficient and that ultimately adds value for consumers, services and professionals.

There is a risk that if government and the mental health and wellbeing system do not move to integrate new technologies, consumers, families, carers and supporters will increasingly rely more on private or market-based digital mental health services, and the government-funded mental health services will be left behind.[196] Increasing the system's adoption of digital technologies and the ability to use them is a necessity in a contemporary system to ensure it can provide people with safe, effective and modern treatment, care and support.

34.4 The task of digital integration

While a wide range of technologies already exist that can help improve the mental health and wellbeing system, the Commission understands this is not currently being used to its full potential.[197] *The Fifth National Mental Health Plan* acknowledged that digital integration is an area where mental health systems need to improve, and has committed to developing a National Digital Mental Health Framework to guide the creation of new digital service delivery interventions in a coordinated and safe way.[198]

The COVID-19 pandemic has accelerated the integration of some forms of digital mental health technologies into the system, such as telehealth, but it has also revealed where improvement is needed. Mental health and wellbeing services need to build remote and flexible working capacity, and technology is required to achieve this.[199]

The Commission was repeatedly told that the system's biggest challenge is properly integrating digital interventions with face-to-face services.[200] Provider capacity, inequity of access, a lack of awareness and trust, and inconsistent approaches to the adoption and integration of technologies into service delivery, are all barriers to realising the potential of technology, as illustrated by Figure 34.8.

Figure 34.8: Challenges to digital integration in the mental health and wellbeing system

Limited service provider capacity

- outdated devices, internet and systems
- a lack of funding support and incentives

Workforce capability and acceptance

- the need for new skills and experiences
- the need for implementation support

Knowing and understanding what is on offer

- a lack of support to identify safe and evidence-based offerings
- unclear governance and quality standards
- varied privacy and security protections

Lack of usability

- a lack of digital literacy support
- a lack of consumer co-design

Inequity of access

- varying access to devices and internet connectivity across cohorts and regions

Inconsistent adoption and integration

- no uniform approach to test and scale what works
- traditional research models are ineffective

34.4.1 Limited service provider capacity

The capacity of service providers to deliver digital services is a major barrier to implementation. There is a lot of variation in how well developed digital technologies are across the mental health system, and this creates a situation where different service providers are offering their consumers very different experiences.

Some public mental health services do not appear to offer the range of basic technological features already demonstrated to be effective for consumers and workers, such as online bookings, e-referral, electronic access to personal health information and service delivery through multiple channels such as telehealth and text.

Under the former Department of Health and Human Services' digital health strategy, health services are building their capacity to deliver digital services.[201] However, Ms Peake suggested there is disparity between the adoption of technology in general health and mental health.[202] She said the lack of parity between the two sectors has meant that digital technologies have been integrated in a more structured way in general health than in mental health.[203]

There are no clear guidelines that tell mental health and wellbeing services what their minimum digital service offerings should look like, and no strategy to guide implementation. This has likely contributed to the varying degrees to which providers have embedded digital technologies into their service offerings.

NorthWestern Area Mental Health Service noted that this lack of strategic, service-level planning affects the system's ability to deliver modern treatment, care and support. It also pointed to a lack of technology funding as a problem:

> The lack of a dedicated funding stream and strategic planning for digitising mental health services has led to aging information technology infrastructure and inefficient systems, which does not efficiently support the contemporary approach to service delivery for instance mobile care teams. This is a significant risk in terms of transfer of information across services and service settings.[204]

A number of service providers informed the Commission that as a result of this, they have varied and often old devices and technology, which prevents them from delivering more contemporary digital treatment, care and support.[205]

It also appears that many providers have not made updates to their digital systems and IT infrastructure a priority, leading to an inability to effectively deliver digital service options for consumers. The costs of new systems can be high due to the requirements for new technology, workflow changes and workforce training.[206]

While the government has provided some funding over the past few years to introduce new electronic records systems in some hospitals, there appears to have been little funding support for devices, systems and interventions. More recently, the former Department of Health and Human Services has provided IT grants to state-funded community mental health providers to support them to offer services remotely.[207]

The Victorian Government has also recently committed $13 million to boost virtual care technology as part of its Hospital in the Home program.[208] The funding includes investment in new software to facilitate telehealth appointments, a trial of telehealth with Ambulance Victoria, and the purchase of devices to make home-based care safer for patients and clinicians.[209] These investments are good steps that can be built on.

The Commission understands that pricing and funding may not always encourage the use of digital mental health interventions in some services. Until recently, telehealth has only been funded through the Medicare Benefits Schedule for specific regional and rural areas in primary and secondary health services, and its availability in metropolitan areas has been limited.

As noted above, recent changes to the Medicare Benefits Schedule in response to the COVID-19 pandemic have expanded access to telehealth nationally. The former Department of Health and Human Services also purchased additional call volumes for area mental health services to support the switch to telehealth.[210]

34.4.2 Varied workforce capability and acceptance

Integration and uptake of new technologies in mental health depend on workers having the skills and mindset to confidently and adeptly use a range of digital technologies to benefit consumers.[211]

The Commission was told that the mental health workforce is likely to require a range of new skills to effectively use digital technologies, including communication, data security and safety, and the ability to select and recommend the right digital tools for consumers, as well as general technological competencies.[212] Professor Alvarez-Jimenez said that collaboration, education and training, implementation and funding support are all needed to help the workforce build its skills and confidence in using technology.[213]

The Commission understands that, traditionally, there has been some resistance among some of the mental health workforce to the use of new technologies in mental health services.[214] However, a lot has changed over the past decade, particularly recently as a result of the COVID-19 pandemic. The pandemic has quickly required the workforce to embrace the use of digital technology and has rapidly built the evidence base for certain modes of care, such as telehealth.[215]

There is growing recognition among mental health service providers that digital technologies can be used to complement current roles and practices by providing new ways to treat and support people, monitor their progress and receive information.

Chapter 33: *A sustainable workforce for the future*, considers how to build and support workforce capability in the future mental health system, including to support the adoption of digital technologies.

34.4.3 Inequity of access

While internet use is high among Australians and Victorians,[216] there is still a noticeable 'digital divide between richer and poorer Australians',[217] which is likely to have a stronger impact on people living with mental illness who wish to use digital options than on other people.[218]

People in rural and regional areas are less likely to have access to the internet, and the Commission has heard that people living in these areas can often struggle to access high-quality bandwidth or stable internet connections, which limits their ability to access digital mental health services.[219] Aboriginal Australians, people who are unemployed, people with low incomes and people with a disability are also less likely to have access to the internet, and may be disadvantaged as a result.[220]

Even when people do have access to data or devices, these may be shared among one household, or may be old and ineffective. The cost of mobile data or devices has been a barrier for some people wanting to access digital support, and unreliable internet access in some regional areas limits the effectiveness of this support.[221]

Ms Peake shared these concerns:

> **Funded mental health services are reporting that some consumers are not able to access telehealth because cost barriers prevent them from purchasing a smart device, while for some consumers and service providers, poor connectivity can be a barrier.**[222]

Mr Solomon told the Commission that some investment is needed to improve consumer access to digital resources.[223] Both the Victorian Government and the Commonwealth Government have recently invested in digital upgrades to better support rural and regional communities to access fast internet. The Victorian Government has committed $626 million to deliver its Digital Future Now package, which will vastly improve mobile coverage and broadband access in regional areas.[224] The Commonwealth Government has also committed more than $4.5 billion to extend the National Broadband Network and accelerate the 5G network.[225] These investments will help rural and regional consumers to access digital mental health services.

34.4.4 A lack of usability

Digital literacy and usability are critically important to ensure consumers, families, carers and supporters can find, engage with and use digital technologies that could help improve their mental health. Not all supports are user friendly, and some people may struggle to use them successfully.[226]

De Beurs and others indicate in their research that it is important to take users' needs and preferences into account when designing and delivering mental health interventions using technology.[227] Mr Bruce Bonyhady AM, Executive Chair of the Melbourne Disability Institute at the University of Melbourne, noted in a personal capacity that all people should be able to enjoy the benefits of new technological advancements, but that this may be compromised where the design of new technology discriminates against certain groups.[228]

A number of organisations, including the Australian Human Rights Commission, have promoted the need for a 'human rights by design' approach to developing and delivering government services that use digital technologies, to ensure they are accessible and usable by people living with mental illness, people living with disability and other diverse groups.[229]

However, because people with lived experience are often not part of the process to develop digital mental health interventions, many barriers are overlooked.[230] As a result, people with mental illness can have difficulty using the tools that are being developed for their benefit.[231]

The Commission considers that digital mental health technologies and interventions should always be inclusive and accessible and, wherever possible and appropriate, should be designed in partnership with consumers, families, carers and supporters.

Digital mental health services may also be difficult to access for people who do not have the technical skills to participate fully in the digital world. People need support to learn and build the skills and confidence required to use technology.[232] In saying this, services should try, wherever possible, to use digital platforms that people are familiar with and prefer, rather than assuming people have low digital literacy.

The Commission was told that many newly arrived migrants already engage with digital technology but use different platforms from those typically offered in Australia.[233] Adapting services to meet the preferences and needs of consumers can be beneficial in expanding access and usability.

A service provider at a roundtable discussing digital mental health opportunities told the Commission that many of its consumers are already able to use technology, so it has adapted its offerings to provide services on platforms that consumers are familiar with:

> **people are already digitally engaging. You know, when they come from different countries, they're already talking to their friends. They're in refugee camps in different countries, they're already doing it. But their platforms were very different. And we have discovered there [are] you know, 20 different platforms people are using. So the simple thing we did was [ask] what do you use WhatsApp, FaceTime, zoom, WeChat? What are you using currently, and tapping into those systems because they're already familiar and they are using it.**[234]

34.4.5 A lack of visibility and trust for consumers and workers

The uptake of digital mental health services by consumers, families, carers, supporters and service providers depends on their awareness of the service offerings available to them. As previously noted, people often struggle to determine what supports are right for them and to navigate through the range of options available. The e-Mental Health Alliance suggested that increasing consumer, family, carer and supporter awareness of digital mental health services would likely result in a significant rise in their use.[235] However, many consumers and service providers are not aware of what is available or how it might be used to augment existing treatment, care and support options.[236]

Some platforms already exist to help people find supports. The Commonwealth Government's Head to Health website, which was co-designed with consumers, carers, service providers, health professionals and other interested parties, provides free access to evidence-based information and advice on digital mental health supports.[237] There are also some supports provided to sections of the workforce to support the uptake of digital technologies. Since 2013, E-Mental Health in Practice (eMHPrac) has been funded by the Commonwealth Department of Health to 'promote the use of digital mental health services and resources by primary healthcare providers across Australia'.[238]

While these resources are beneficial, those involved have suggested they can be improved. The Productivity Commission was told that the Commonwealth's Head to Health platform is too generalist to provide support to some cohorts and that it has become a static website, rather than a proper navigation tool.[239]

GPs and other professionals need to be better educated about available digital mental health services and encouraged to inform and refer people to these services.[240] The Productivity Commission has recommended that Head to Health be expanded to include a broader range of services and improved to better direct people to the right service for them.[241] The Productivity Commission has also recommended that, over time, the site be amalgamated with the new national digital mental health platform and its gateway service offerings.[242] The Commission supports this approach.

People also need to trust digital service offerings. This requires assurance that digital offerings will suit their needs, be effective, and that they will work well with any other services they are using.[243] It also means that people need to know the offerings are safe, evidence-based and meet the same quality standards as any other service offering. This includes approval from government and services, but also from other consumers.[244]

Dr Deveny noted that some clinicians may choose not to refer their consumer to a digital resource because they are unsure if it is safe:

> **I also am aware that some clinicians are not comfortable referring people to certain digital health solutions because they do not know if the content of the app is evidence based and there is concern about any potential adverse health outcome from its use.**[245]

There is no single organisation responsible for the oversight and regulation of digital mental health services. Oversight occurs through 'a mix of government regulation, industry self-regulation, and direct education of consumers and practitioners'.[246] Experts have noted that current legal and regulatory structures for digital mental health services may not be adequate, but there is debate about the extent to which these services should be governed.[247]

As a first step, the new *National Safety and Quality Digital Mental Health Standards* will help to provide transparency about what good practice looks like, and ensure that digital interventions are designed safely and effectively. While this is a good start, Dr Gooding informed the Commission that further work will be needed to ensure these standards are met, and consumer trust is maintained and respected.[248]

Ms Peake also said the standards need to be 'complemented by local mechanisms to ensure appropriate quality assurance frameworks are in place to facilitate the shift towards digital health solutions'.[249]

Protecting privacy and data is another challenge in the digital age. Consumers need to have assurance that their data is being collected and used in a responsible, secure way, and only for the purpose for which they supplied it.[250] However, personal data gathered by digital mental health technologies may have insufficient protections.[251] There are digital supports that present risks to consumer safety and privacy due to inappropriate data security standards or on-selling of data to third parties.[252]

The University of Melbourne noted that without good protections for data and information, there is a risk that consumers' low levels of trust will have negative flow-on effects for mental health service use.[253] In turn, this may be a barrier to people accessing support through these channels.[254] According to the Consumer Policy Resource Centre, 'consumers may well start to avoid accessing important healthcare services and support, if they feel companies or governments cannot be trusted with that information or that they may be disadvantaged by that information in future'.[255]

34.4.6 Inconsistent adoption and integration

There is currently no overall approach to support the adoption and integration of digital services across the system so they become routine practice. There are also limited strategies to test promising approaches and see whether they can be scaled—that is, whether they are effective for a range of groups or only in limited circumstances. Traditional 'develop, build and release' approaches to implementing new service designs are not effective because they cannot keep up with the continuous and rapid improvement of digital mental health technologies.[256] One mental health technology entrepreneur at an innovation roundtable noted that the mental health system needs to take a more iterative approach to adopting new technology:

> the current system is built for products that release once and in a similar way that you might have a drug and don't change for the next three years. That's not how you build a technical product. And that won't be how you build the best technical products for years to come. In terms of both usability from a patient's perspective, usability from a healthcare perspective, effectiveness on outcomes, everything is tied against continuous improvement. And that's how good products are made … It's all built around this one soft build and release model, which won't survive long term. [We should be] focused around how we can create more of an iterative process to policymaking that adapts to changing products and changing environments in the product developer process.[257]

Another entrepreneur noted that current research and implementation approaches are too slow and are hampering progress:

> I think fundamentally, the challenges for health services, that we have an accepted gold standard of evidence that's required before something is taken up and integrated into clinical practice. And until we're willing to flip that, and actually experiment with and adopt these new technologies, we're going to keep getting the same solutions … Research is done in a university context, it may or may not get adopted, if it does, it probably takes 10 to 15 years, by which point, the technology is well and truly out of date. And so, I think as a system, we need to be creating an environment where it is accepted that we can take these new technologies, use them in our practice, and then grow from there.[258]

Professor Alvarez-Jimenez told the Commission that the integration of digital supports requires new approaches to the development, research and funding of digital technologies in mental health to accelerate their adoption into routine practice over time.[259]

34.4.7 Carving a way forward

In light of the evidence before it, the Commission is confident that digital technologies should be integrated into the mental health and wellbeing system to provide better access, choice and flexibility for consumers, families, carers and supporters. However, structural change and new arrangements will be necessary to ensure they can be effectively, safely and efficiently integrated with service delivery.

The Commission sees a need for:

- clear guidance and pathways to support the integration of digital mental health technologies into routine service delivery and to create greater service consistency and equity across Victoria
- greater support for services to build their digital offerings
- better support for disadvantaged groups and consumers to access technologically enabled mental health services to the same level as others, if that is their preference.

Regardless of what technologies are used across the system, consumers, families, carers and supporters must have reassurance that they can trust the technology and service offerings available.

While the Commission understands there is support for the greater adoption of digital technologies into mental health services, most consumers, experts and service providers have emphasised that people should still have a choice about how they wish to receive services, including face-to-face services, wherever possible. The Commission agrees that this choice should lie with the consumer, and they should receive appropriate information, advice and support to help them decide which services best meet their needs.

Considering this, the Commission recommends that the Victorian Government ensures that public mental health and wellbeing services have the ability to offer consumers, families, carers and supporters a consistent suite of digital services. These offerings should meet people's individual needs and provide them with an improved experience across their entire recovery journey. To achieve this, the Commission recommends that the Victorian Government implements several initiatives.

34.5 A statewide approach to building service provider capacity

The Commission considers that there should be a much stronger focus on building service provider capacity to deliver digitally integrated mental health and wellbeing service offerings.

In other jurisdictions and sectors, policymakers and funders have implemented clear and concise digital service requirements and guidance to help service providers deliver contemporary digital service offerings.

Victoria's *Digitising Health* strategy guides overall digital health policy and investment in Victoria's general health system.[260] It reflects a general health system that is well on its way to improving digital service delivery and technology capacity. However, mental health remains behind general health in integrating digital channels into service delivery, and requires a strategy that is tailored to support the adoption of forthcoming reforms and accelerate uptake of technology. Such an approach will also ensure accountability for implementation and provide clear timelines and milestones.

In the province of Ontario, Canada in the Ministry of Health has developed new minimum recommended requirements to ensure the basic digital tools and functionalities are in place across health teams.[261] These requirements are underpinned by digital health policy guidelines to ensure a consistent approach to setting up digital supports across the province.[262] The guidelines give service providers directions on selecting, procuring and implementing digital technologies. They include four general digital health policy directions and three system-specific policy directions.[263]

The four general digital health policy directions support the implementation and use of all digital health systems. [264] They focus on:

- information exchange expectations—for example, minimum interoperability standards to promote efficient and seamless access to electronic patient information across services
- digital health investment and value for money expectations—for example, guidance to ensure service providers achieve value for money, invest in innovations and utilise their collective purchasing power
- digital health access and privacy and security—for example, policies to implement good practice information collection, use and disclosure, in compliance with relevant legislation
- digital health reporting and performance—that is, indicators that ensure investments in IT are transparent and accountable.

The three system-specific policy directions guide providers' digital service delivery and require them to offer consumers virtual consultations, and digital self-management tools including access to digital information, online booking functions and e-referral.[265]

The Commission supports this approach. It offers consistency and transparency, and provides a clear framework for integrating, investing in and making digital supports a priority, without stifling innovation or flexibility.

To this end, the Commission recommends that the Department of Health develops and implements new statewide minimum digital service requirements for all publicly funded mental health and wellbeing service providers. The requirements should align with the Commission's recommended service standards and further define the general digital capacity expected of all service providers. They should be broad enough to allow for technological advancements that are not yet anticipated.

As a minimum, the requirements should include the statewide uptake of telehealth (video preferred and phone if video is not possible), access to services through multiple channels, e-referrals and online booking capability. They should also support and inform the necessary investment in interoperability functionality—that is, the ability for IT systems to connect to one another, and support electronic information exchange for service delivery and service accountability, with relevant parameters.

The requirements should be supported by a new statewide digital mental health and wellbeing strategy and framework that articulates the Victorian Government's approach to improving service providers' capacity to use digital technologies across the mental health and wellbeing system over time, the desired outcomes to be achieved, and the statewide roadmap to support integration. It should clearly set out the IT infrastructure needed to ensure digital mental health technologies are adopted.[266]

At the service-provider level, organisations should be supported to assess how advanced their digital offerings are (that is, carry out a digital maturity assessment), using a consistent and agreed framework, so they can develop their own local digital transformation road maps.

One model that could be explored is the National Health Service in the United Kingdom, which has introduced digital maturity assessments as part of a comprehensive digital health transformation plan.[267] These have led to the development of 73 local digital road maps, which are championed by chief information officers across service areas.[268]

At the local level, the maturity assessments and road maps are used to promote local service investment and transformation, in a uniform and staged way.[269] System-wide, the information has allowed the United Kingdom to create its first digital maturity index for health, to monitor progress and determine investment priorities for the future.[270]

Requirements should be designed in consultation with consumers, families, carers and supporters and service providers to ensure they meet the needs of people using and delivering the services.

The Commission suggests following these principles when developing requirements:

- High-quality and safe services are delivered in alignment with established standards of treatment, care and support, new digital mental health standards and the pending national digital mental health framework.[271]
- Requirements are informed by the experiences and preferences of consumers, families, carers and supporters.[272]
- Digital services promote and support diversity and cultural inclusiveness, including through accessibility and language options.
- Alternative approaches are available, wherever possible, recognising that it is the consumers' choice whether they wish to use digital services.

34.5.1 Funding support to build service capacity

Digital expectations and requirements will provide greater clarity, but service providers will also require appropriate funding and support to meet them. For example, Associate Professor Stafrace said that consumers and service providers will need access to devices, data plans and high-speed internet to take full advantage of technologies.[273]

It is highly unlikely that all mental health service providers will have the digital capacity or maturity to meet the requirements quickly. At the state level, some community mental health services and hospitals lack the devices and high-speed internet to support a major shift in service delivery.[274] As the provider landscape adapts to deliver the new system, new providers will be expected to demonstrate or build their digital capacity, in order to deliver on digital requirements.

The Commission recommends that the Department of Health provides some form of dedicated capability funding to help organisations build their digital maturity over time, linked to the statewide framework and service-level maturity assessments. In the United Kingdom, the National Health Service introduced the Integrated Digital Care Fund to support providers to develop their maturity over time.[275]

Investment in regional areas should be given priority in the first instance to support Local Mental Health and Wellbeing Services, Area Mental Health and Wellbeing Services and statewide services to procure new technologies, introduce innovation and build their capability to deliver digitally integrated service offerings. Chapter 24: *Supporting the mental health and wellbeing of people in rural and regional Victoria*, discusses this approach in more detail.

To improve cost-efficiency—that is, to get value for money—the government could also consider purchasing some technology where it would make sense to have consistency across the state. For example, the government could purchase licences for a preferred telehealth system, for rollout across community and inpatient mental health services. The Commonwealth Government has already provided free access to a preferred and secure telehealth platform for all GPs.[276]

The Victorian Government should also identify digital interventions that have shown positive outcomes for consumers, and invest in rolling them out across the state. For example, in April 2020, the Victorian Government provided funding to Orygen to implement its Moderated Online Social Therapy (MOST) program across all state-funded child and adolescent youth mental health services and all Victorian headspace centres by mid-2021.[277] The significant research and evaluation effort put into Moderated Online Social Therapy (MOST) over the last decade has resulted in the government choosing to fund, expand and roll out the model statewide.

This expansion will allow all young people in headspace or child and youth mental health services to receive digital services that are fully integrated with their face-to-face therapy, if they wish to. A new partnership between Orygen and other state youth services will deliver the service. While careful evaluation of the rollout is needed, it could be a model for future projects.[278]

34.5.2 Ensuring safety while sparking innovation

The Commission understands that digital mental health technologies must be effective, based on strong evidence, and protect the rights and safety of those using them.

Existing legislation and policy set out privacy standards and protections for many digital mental health interventions, but as technologies change, so too will the governance and regulation needed.[279]

As its first step towards ensuring consumer safety, the Victorian Government should promote all relevant standards and policies for digital mental health, including the new *National Safety and Quality Digital Mental Health Standards*. As the evidence grows, the government should ensure that governance, funding and regulatory arrangements continue to account for any impacts of digital technologies on service delivery and consumer wellbeing.

A roundtable participant told the Commission that the government should consider which tools it makes available, and how closely it oversees them, based on the level of risk and benefit to consumers:

> there is a need to have a wide variety of tools available [but] we actually want to make sure that for those that are being used for the most serious of conditions, we … require a level of evidence and rigor and quality assurance … There may however, be other tools that we think are useful, but don't require that level of evidence … And we don't think they need such a strong and rigorous evidence base. But we do want to make sure … they're reasonable, they don't make outlandish claims for people. And then there may be a whole lot of other tools that we make freely available with very little controls.[280]

Supported digital services or interventions that deliver mental health services should be subject to appropriate tests and safeguards to ensure consumer safety is upheld. The new Collaborative Centre for Mental Health and Wellbeing should play an active role in publicly endorsing evidence-based and quality mental health technologies.[281] This will help to build consumer, carer and service provider trust in good-practice technologies.

34.6 Better supports that improve equity of access

All Victorians are entitled to access and use digital mental health services and channels, if they prefer to do so. Increasing disadvantaged consumers' access to digital equipment and the internet will help them to use digital mental health technology as part of their treatment, care and support. Improving strategies to support consumers' digital literacy will also help them to better engage with digital mental health technology and gain the most benefits from it.

In April 2020, the former Department of Health and Human Services announced it would supply phones and extra data to eligible clients of public mental health services to help them stay engaged with treatment and services during the COVID-19 pandemic.[282] Associate Professor Stafrace said the impact of such a program is difficult to measure.[283] He did note, however, that the pandemic and the resulting reduction in face-to-face content has not slowed the provision of community services, indicating that the program may be having some effect.[284]

The Victorian Government has also recently committed funding to deliver more Hospital in the Home health care.[285] Investment includes software to facilitate telehealth appointments and purchasing of devices to make home-based care safer for consumers and clinicians.[286]

The Commission recommends that the Department of Health uses these programs as a model, and allows Local Mental Health and Wellbeing Services, Area Mental Health and Wellbeing Services and statewide services to offer digital support packages to eligible consumers. These packages will provide access to devices, data and digital literacy support.

The digital support packages should be offered to eligible consumers who have demonstrated disadvantage and cannot access data or devices of their own. The package should be directly connected to the supports a consumer is receiving, and should be open to all eligible consumers receiving mental health and wellbeing services through the state government, including adults, young people and children. The package would be strictly opt in, and based on a consumer's preference to use digital tools to access mental health and wellbeing services.

The support packages should be funded through the Victorian Government, but the government could also work with technology companies that are willing to provide in-kind contributions to the program, such as devices and data. The government could also consider setting up a donation program that allows members of the public to provide their second-hand devices (in good working condition) to mental health and wellbeing services for use by consumers.

The Department of Health should also support mental health and wellbeing services to offer digital literacy support to any registered consumer who wishes to use digitally integrated services, potentially through the future system's new recovery colleges (or discovery colleges), as outlined in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults* and Chapter 13: *Supporting the mental health and wellbeing of young people*.

This support should include teaching consumers about:

- the basics of using the chosen technology and intervention—for example, how to work a smartphone, and how to connect to telehealth services or a chosen mobile app
- safe and effective use of their chosen technology and intervention
- risks and benefits of digital intervention
- how to use the technology safely—for example, having telehealth consultations in a space where their conversation cannot be overheard
- data and privacy protections.

1 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 527.

2 Department of Health and Human Services, *Digitising Health: How Information and Communications Technology Will Enable Person-Centred Health and Wellbeing Within Victoria*, 2016, p. iv.

3 Australian Digital Health Agency, *Safe, Seamless and Secure: Evolving Health and Care to Meet the Needs of Modern Australia: Australia's National Digital Health Strategy*, 2017, p. 3.

4 Piers Gooding, Mapping the Rise of Digital Mental Health Technologies: Emerging Issues for Law and Society, *International Journal of Law and Psychiatry*, 67 (2019), 1–11 (pp. 1–2).

5 Department of Health and Human Services, p. 2; CSIRO, *Future of Health: Shifting Australia's Focus from Illness Treatment to Health and Wellbeing Management*, 2018, p. vii.

6 Jennifer Nicholas and others, Issues for EHealth in Psychiatry: Results of an Expert Survey, *Journal of Medical Internet Research*, 19.2 (2017), 1–11 (p. 2).

7 John Torous, Keris Jän Myrick and others, Digital Mental Health and COVID-19: Using Technology Today to Accelerate the Curve on Access and Quality Tomorrow, *JMIR Mental Health*, 7.3 (2020), 1–6 (p. 1).

8 *Witness Statement of Kym Peake*, 4 October 2020, para. 284.

9 *Witness Statement of Dr Hila Haskelberg*, 13 July 2020, para. 38.

10 RCVMHS, *Consumer Human-Centred Design Focus Group—Crisis Response: Record of Proceedings*, 2020.

11 *Witness Statement of Associate Professor Simon Stafrace*, 14 August 2020, para. 184.

12 Shalini Lal, E-Mental Health: Promising Advancements in Policy, Research, and Practice, *Healthcare Management Forum*, 32.2 (2019), 56–62 (p. 57); Mental Health Commission of Canada, *E-Mental Health in Canada: Transforming the Mental Health System Using Technology*, 2014, p. 7.

13 Lal, p. 57; Mental Health Commission of Canada, *E-Mental Health in Canada: Transforming the Mental Health System Using Technology*, p. 7.

14 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), 171–177 (p. 171).

15 Mental Health Commission of Canada, *Toolkit for E-Mental Health Implementation*, 2018, p. 12.

16 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, 2020, pp. 491–492.

17 Productivity Commission, *Draft Report on Mental Health, Volume 1*, 2019, p. 208.

18 *Witness Statement of Dr Hila Haskelberg*, para. 8.

19 Beyond Blue, *Submission to the RCVMHS: SUB.0002.0029.0099*, 2019, p. 18; Gooding, p. 4; Commonwealth Department of Health, Head to Health, <www.headtohealth.gov.au/>, [accessed 9 November 2020].

20 Smiling Mind, *Briefing Note to the RCVMHS: CSP.0001.0118.0001*, 2020, p. 1; Calm Blog, About, <www.calm.com/blog/about>, [accessed 14 December 2020].

21 iMoodJournal, About, <www.imoodjournal.com/>, [accessed 14 December 2020].

22 Simon Hoermann and others, Application of Synchronous Text-Based Dialogue Systems in Mental Health Interventions: Systematic Review, *Journal of Medical Internet Research*, 19.8 (2017), 1-10 (p. 1).

23 World Economic Forum, *Empowering 8 Billion Minds Enabling Better Mental Health for All via the Ethical Adoption of Technologies: White Paper*, 2019, p. 14.

24 Crisis Text Line, Text HOME To 741741 to Connect with a Crisis Counselor, <www.crisistextline.org/>, [accessed 17 November 2020].

25 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).

26 Clare Liddy and others, The Current State of Electronic Consultation and Electronic Referral Systems in Canada: An Environmental Scan, *Studies in Health Technology and Informatics*, 209 (2015), 75–83 (p. 76).

27 Ministry of Health, Ontario, *Ontario Health Teams: Digital Health Playbook*, 2019, p. 31; Katie O'Leary and others, 'Collaborative Health Reminders and Notifications: Insights from Prototypes', *AMIA Annual Symposium Proceedings Archive*, 2018, 837–846 (p. 837).

28 Peng Zhao and others, Web-Based Medical Appointment Systems: A Systematic Review, *Journal of Medical Internet Research*, 19.4 (2017), 1–17 (p. 3).

29 Kobi Leins and others, *Correspondence to the RCVMHS: CSP.0001.0111.0001, To Chat, or Bot to Chat, Just the First Question: Potential Legal and Ethical Issues Arising from a Chatbot Case Study*, 2020, pp. 2–3; Aditya Nrusimha Vaidyam and others, Chatbots and Conversational Agents in Mental Health: A Review of the Psychiatric Landscape, *The Canadian Journal of Psychiatry*, 64.7 (2019), 456–464 (p. 457).

30 Commonwealth Department of Health, Head to Health, <headtohealth.gov.au/>, [accessed 9 November 2020].

31 Leins and others, pp. 3–4.

32 Grant Blashki and Simon Lock, Artificial Intelligence and Mental Health, *Artificial Intelligence for Better or Worse, Future Leaders*, 2019, 73–85 (pp. 75–84).

33 Blashki and Lock, pp. 75–84.

34 Błażej Cieślik and others, Virtual Reality in Psychiatric Disorders: A Systematic Review of Reviews, *Complementary Therapies in Medicine*, 52 (2020), 1–15 (p. 2); D. Freeman and others, Virtual Reality in the Assessment, Understanding, and Treatment of Mental Health Disorders, *Psychological Medicine*, 47.14 (2017), 2393–2400 (pp. 2394–2395).

35 Mary C. Masland, Christine Lou and Lonnie Snowden, Use of Communication Technologies to Cost-Effectively Increase the Availability of Interpretation Services in Healthcare Settings, *Telemedicine and E-Health*, 16.6 (2010), 739–745 (pp. 740–741).

36 Mental Health Commission of Canada, *Toolkit for E-Mental Health Implementation*, p. 12.

37 Australian Digital Health Agency, Types of Digital Health Records, <www.digitalhealth.gov.au/get-started-with-digital-health/digital-health-evidence-review/types-of-digital-health-records>, [accessed 10 November 2020].

38 Australian Digital Health Agency, My Health Record, <www.myhealthrecord.gov.au/>, [accessed 13 August 2020].

39 *Witness Statement of Dr Piers Gooding*, 25 June 2020, para. 18(g).

40 *Witness Statement of Dr Piers Gooding*, para. 18(g).

41 *Witness Statement of Dr Piers Gooding*, para. 18(a)–18(g).

42 *Witness Statement of Professor Mario Alvarez-Jimenez*, 10 June 2020, para. 31; Commonwealth Department of Health and Ageing, *E-Mental Health Strategy for Australia*, 2012, p. 5; Dr Tom Foley and Dr Woollard, *The Digital Future of Mental Healthcare and Its Workforce: A Report on a Mental Health Stakeholder Engagement to Inform the Topol Review*, 2019, p. 11; Sandra Bucci, Matthias Schwannauer and Natalie Berry, The Digital Revolution and Its Impact on Mental Health Care, *Psychology and Psychotherapy: Theory, Research and Practice*, 92.2 (2019), 277–297 (p. 279).

43 *Witness Statement of Dr Piers Gooding*, para. 25.

44 *Witness Statement of Dr Piers Gooding*, para. 25.

45 *Witness Statement of Georgie Harman*, 2 July 2020, para. 16.

46 *Witness Statement of John Brogden AM*, 7 July 2020, para. 26.

47 *Witness Statement of Georgie Harman*, 2020, para. 21.

48 *Witness Statement of Georgie Harman*, 2020, paras. 25–26.

49 Black Dog Institute, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, 2020, p. 2.

50 *Witness Statement of Dr Hila Haskelberg*, paras. 12 and 39.

51 *Witness Statement of Dr Hila Haskelberg*, para. 101.

52 *Witness Statement of Dr Hila Haskelberg*, para. 34.

53 Smiling Mind, p. 5.

54 Smiling Mind, p. 2.

55 RCVMHS, *BCA Digital Fireside Chat Roundtable: Record of Proceedings*, 2020; CSIRO.

56 RCVMHS, *BCA Digital Fireside Chat Roundtable: Record of Proceedings*.

57 Kara Hinesley, Working Together to Prevent Suicide, <blog.twitter.com/en_au/topics/company/2018/working-together-to-prevent-suicide.html>, [accessed 10 November 2020].

58 Kara Hinesley, Lifeline's New Twitter DM Chatbot Helps Friends and Family #BeALifeline, 17 October 2018, <blog.twitter.com/en_au/topics/company/2018/Lifeline-launches-Twitter-DM-chatbot-to-help-BeALifeline.html>, [accessed 10 November 2020].

59 *Witness Statement of Professor Mario Alvarez-Jimenez*, para. 13. Citing Michael L Birnbaum and others, 'Role of social media and the Internet in pathways to care for adolescents and young adults with psychotic disorders and non-psychotic mood disorders', *Early Intervention Psychiatry*, 11.4 (2017) 290–295 (pp. 290-295); Bucci, Schwannauer, and Berry, p. 277.

60 Independent Mental Health Advocacy, Self-Help Tool, <www.imha.vic.gov.au/self-help-tool>, [accessed 11 November 2020].

61 Gooding, p. 4.

62 *Witness Statement of Graham Panther*, 6 July 2020, para. 9.

63 *Witness Statement of Graham Panther*, paras. 1 and 13.

64 *Witness Statement of Graham Panther*, para. 32.

65 *Witness Statement of Graham Panther*, para. 9.

66 *Witness Statement of Kym Peake*, 2020, para. 273.

67 *Witness Statement of Kym Peake*, 2020, para. 279.

68 *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 181.

69 *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 181.

70 *Witness Statement of Kym Peake*, 2020, para. 282.

71 *Witness Statement of Kym Peake*, 2020, paras. 280–281.

72 Department of Health and Human Services, Client Management Interface/Operational Data Store, 2019–20. Note: Includes contacts where the consumer was not present.

73 *Witness Statement of Angus Clelland*, 2020, para. 15.

74 *Witness Statement of Angus Clelland*, para. 15.

75 *Witness Statement of Kym Peake*, 2020, para. 283.

76 *Witness Statement of Kym Peake*, 2020, para. 274.

77 *Witness Statement of Kym Peake*, 2020, para. 274.

78 Commonwealth Department of Industry, Science, Energy and Resources, *Australia's Tech Future: Delivering a Strong, Safe and Inclusive Digital Economy*, 2018, pp. 6–9.

79 Commonwealth Department of Industry, Science, Energy and Resources, pp. 6–9.

80 Statista, Active Social Media Users as Percentage of the Total Population in Australia from 2015 to 2020, <www.statista.com/statistics/680201/australia-social-media-penetration/>, [accessed 14 December 2020].

81 *Witness Statement of Kym Peake*, 2020, para. 285.

82 *Witness Statement of Kym Peake*, 2020, para. 285.

83 *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 184.

84 *Witness Statement of Dave Peters*, 22 July 2020, para. 64.

85 *Witness Statement of Professor Mario Alvarez-Jimenez*, para. 51; *Witness Statement of Dr Piers Gooding*, para. 32(a).

86 *Witness Statement of Dave Peters*, para. 67.

87 *Evidence of Al Gabb*, 15 July 2019, p. 952.

88 *Witness Statement of Dr Piers Gooding*, para. 25.

89 *Witness Statement of Professor Mario Alvarez-Jimenez*, para. 34; G. Andrews and others, Computer Therapy for the Anxiety and Depression Disorders Is Effective, Acceptable and Practical Health Care: An Updated Meta-Analysis, *Journal of Anxiety Disorders*, 55 (2018), 70–78 (p. 76); Rebecca E. Reay, Jeffrey C.L. Looi and Philip Keightley, Telehealth Mental Health Services during COVID-19: Summary of Evidence and Clinical Practice, *Australasian Psychiatry*, 28.5 (2020), 514–516 (pp. 515–516).

90 Australian Digital Health Agency, *Safe, Seamless and Secure: Evolving Health and Care to Meet the Needs of Modern Australia: Australia's National Digital Health Strategy*, p. 17.

91 *Witness Statement of Georgie Harman*, 2020, para. 40.

92 *Witness Statement of Professor Mario Alvarez-Jimenez*, para. 56.

93 Black Dog Institute, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, p. 2.

94 The Royal Australian and New Zealand College of Psychiatrists, *Telehealth Survey Results*, 2013, p. 13; Reay, Looi and Keightley, p. 514.

95 *Witness Statement of Dr Elizabeth Deveny*, 8 June 2020, para. 111.

96 *Witness Statement of Dr Piers Gooding*, para. 30(d); *Witness Statement of Georgie Harman*, 2020, para. 24(a).

97 *Witness Statement of Professor Mario Alvarez-Jimenez*, para. 87.

98 Black Dog Institute, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, p. 2.

99 ReachOut Australia, *Submission to the Productivity Commission Inquiry into Mental Health: The Social and Economic Benefits of Improving Mental Health*, 2019, p. 17.

100 RCVMHS, *Bendigo Community Consultation—May 2019*.

101 *Witness Statement of Georgie Harman*, 2020, para. 22.

102 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 476.

103 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 476.

104 *Witness Statement of Amelia Callaghan*, 5 May 2020, para. 116.

105 The Royal Australian and New Zealand College of Psychiatrists, Telehealth in Psychiatry, 6 May 2020, <www.ranzcp.org/practice-education/telehealth-in-psychiatry>, [accessed 4 November 2020].

106 Call to Mind, *Submission to the Productivity Commission Inquiry into Mental Health*, 2019, pp. 1–2.

107 Natalie Bradford, Liam Caffery and Anthony C. Smith, 'Telehealth Services in Rural and Remote Australia: A Systematic Review of Models of Care and Factors Influencing Success and Sustainability', *Rural and Remote Health*, 2016, 1–24 (p. 3).

108 Bradford, Caffery and Smith, pp. 2–3; CSIRO, p. 26.

109 Danni Mills, *Submission to the RCVMHS: SUB.0002.0025.0001*, 2019, p. 2.

110 *Witness Statement of Trevor Thomas*, 2 July 2019, paras. 24–25.

111 Bradford, Caffery, and Smith, p. 1.

112 Goulburn Valley Health, *Submission to the RCVMHS: SUB.0002.0029.0213*, 2019, p. 9; *Witness Statement of Dr Ravi Bhat*, 4 July 2019, para. 128.

113 Carrol Zhou and others, 'The Impact of Project ECHO on Participant and Patient Outcomes: A Systematic Review', *Academic Medicine*, 91.10 (2016), 1439–1461 (p. 1439).

114 CSIRO, p. 26.

115 Clive Kempson, *Submission to the RCVMHS: SUB.0002.0001.0066*, 2019, p. 5.

116 Natasza Purser, *Submission to the RCVMHS: SUB.0002.0001.0265*, 2019, p. 7.

117 MBS Online, Commonwealth Department of Health, COVID-19 Temporary MBS Telehealth Services, <www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-TempBB>, [accessed 14 December 2020].

118 C.L Snoswell and others, Telehealth and Coronavirus: Medicare Benefits Schedule (MBS) Activity in Australia, 19 May 2020, <coh.centre.uq.edu.au/telehealth-and-coronavirus-medicare-benefits-schedule-mbs-activity-australia>, [accessed 4 November 2020].

119 C.L Snoswell and others.

120 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 551.

121 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 551.

122 ReachOut Australia, pp. 17–19.

123 Black Dog Institute, *Submission to the Productivity Commission Inquiry into Mental Health*, 2019, pp. 23–25; ReachOut Australia, p. 18; MindSpot, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, 2020, p. 3; *Witness Statement of Georgie Harman*, 2020, para. 66; Orygen, The National Centre of Excellence in Youth Mental Health, *Submission to the Productivity Commission Inquiry into Mental Health*, 2019, p. 34.

124 Andrews and others, p. 70.

125 Jill M Newby, 'The Effectiveness of Internet-Delivered Cognitive Behavioural Therapy for Health Anxiety in Routine Care', *Journal of Affective Disorders*, 264 (2020), 535–542 (p. 541); Nickolai Titov and others, 'MindSpot Clinic: An Accessible, Efficient, and Effective Online Treatment Service for Anxiety and Depression', *Psychiatric Services*, 66.10 (2015), 1043–1050 (p. 1043).

126 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, pp. 491–507.

127 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, pp. 491–500.

128 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, pp. 495–503.

129 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 541.

130 *Witness Statement of John Brogden AM*, para. 79.

131 *Witness Statement of John Brogden AM*, para. 79.

132 *Witness Statement of Dr Elizabeth Deveny*, para. 107.

133 *Witness Statement of Dr Elizabeth Deveny*, para. 108.

134 *Witness Statement of Dr Elizabeth Deveny*, para. 108.

135 Erbe and others, p. 9.

136 *Witness Statement of Professor Mario Alvarez-Jimenez*, para. 68.

137 Orygen, Moderated Online Social Therapy (MOST) Flyer, 2020, pp. 1–3.

138 Orygen, Moderated Online Social Therapy (MOST) Flyer, pp. 1–3.

139 *Witness Statement of Professor Mario Alvarez-Jimenez*, paras. 69–70.

140 *Witness Statement of Professor Mario Alvarez-Jimenez*, para. 130.

141 *Witness Statement of Professor Mario Alvarez-Jimenez*, para. 131.

142 *Witness Statement of Professor Mario Alvarez-Jimenez*, para. 132.

143 ReachOut Australia, p. 17.

144 Jan Orman and others, 'E-Mental Health for Mood and Anxiety Disorders in General Practice', *Australian Family Physician*, 43.12 (2014), 832–837 (p. 836).

145 *Witness Statement of Julie Anderson*, 28 May 2020, para. 95.

146 *Witness Statement of Dr Hila Haskelberg*, para. 47(a).

147 headspace, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, 2020, p. 46.

148 Talia Dow, *Submission to the RCVMHS: SUB.0002.0010.0038*, 2019, p. 1.

149 *Witness Statement of Dr Piers Gooding*, para. 30(b).

150 *Witness Statement of Dr Piers Gooding*, para. 30(b).

151 RCVMHS, *Seymour Community Consultation—May 2019*.

152 *Evidence of 'Alex Smith' (pseudonym)*, 17 July 2019, p. 1218.

153 Foundation House, *Submission to the RCVMHS: SUB.1000.0001.0868*, 2019, p. 27.

154 Foundation House, p. 27.

155 Mental Health Australia, Federation of Ethnic Communities' Council of Australia and National Ethnic Disability Alliance, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, 2020, p. 12.

156 *Witness Statement of Shane Solomon*, 22 May 2020, paras. 54 and 79(a).

157 Australian Digital Health Agency, *Safe, Seamless and Secure: Evolving Health and Care to Meet the Needs of Modern Australia: Australia's National Digital Health Strategy*, p. 3; *Witness Statement of Shane Solomon*, para. 79(a).

158 R.M. Krausz and others, Chapter 8: Accessible and Cost-Effective Mental Health Care Using E-Mental Health, in *Advances in Psychiatry* (Cham: Springer International Publishing, 2019), pp. 129–141 (p. 129).

159 Krausz and others, pp. 132–135.

160 CSIRO, p. 26.

161 Australian Digital Health Agency, *Safe, Seamless and Secure: Evolving Health and Care to Meet the Needs of Modern Australia: Australia's National Digital Health Strategy*, p. 3.

162 *Witness Statement of Shane Solomon*, para. 79(b); *Witness Statement of Professor Rob Moodie*, 9 June 2020, para. 28.

163 *Witness Statement of Shane Solomon*, para. 79(b); *Witness Statement of Professor Rob Moodie*, para. 28.

164 *Witness Statement of Dr Elizabeth Deveny*, para. 103.

165 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 308.

166 *Witness Statement of Associate Professor Ruth Vine*, 29 April 2020, para. 103.

167 *Witness Statement of Associate Professor Ruth Vine*, 2020, para. 157.

168 *Witness Statement of Shane Solomon*, para. 79(b).

169 Parviz Kheirkhah and others, 'Prevalence, Predictors and Economic Consequences of No-Shows', *BMC Health Services Research*, 16:13 (2015), 1–6 (pp. 1 and 5)

170 *Witness Statement of Professor Ian Hickie AM*, 11 August 2020, para. 120.

171 *Witness Statement of Professor Ian Hickie AM*, para. 120.

172 headspace, *Staff Experience of Telehealth During COVID-19*, 2020, p. 15.

173 CSIRO, p. 26.

174 *Witness Statement of Professor Ian Hickie AM*, para. 122.

175 *Witness Statement of Dr Piers Gooding*, para. 30(f).

176 Lisa G Pont and others, 'Leveraging New Information Technology to Monitor Medicine Use in 71 Residential Aged Care Facilities: Variation in Polypharmacy and Antipsychotic Use', *International Journal for Quality in Health Care*, 30.10 (2018), 810–816 (p. 810).

177 *Witness Statement of Professor Ian Hickie AM*, para. 122.

178 *Witness Statement of Professor Ian Hickie AM*, para. 123.

179 *Witness Statement of Professor Alan Rosen AO*, 23 July 2020, para. 90.

180 *Witness Statement of Professor Alan Rosen AO*, para. 90.

181 *Witness Statement of Dr Hila Haskelberg*, para. 32(b).

182 Simon Leigh and Steve Flatt, 'App-Based Psychological Interventions: Friend or Foe?', *Evidence Based Mental Health*, 18.4 (2015), 97–99 (p. 97).

183 The University of Melbourne, *Submission to the Productivity Commission Inquiry into Mental Health: The Social and Economic Benefits of Improving Mental Health*, 2019, p. 3.

184 John Torous, Gerhard Andersson and others, 'Towards a Consensus around Standards for Smartphone Apps and Digital Mental Health', *World Psychiatry*, 18.1 (2019), 97–98 (p. 97).

185 Torous, Andersson and others, p. 97.

186 John Torous, Jessica Lipschitz and others, 'Dropout Rates in Clinical Trials of Smartphone Apps for Depressive Symptoms: A Systematic Review and Meta-Analysis', *Journal of Affective Disorders*, 263 (2020), 413–419 (p. 417).

187 Dr Piers Gooding and Dr Yvette Maker, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, 2020, pp. 3–4.

188 *Witness Statement of Dr Hila Haskelberg*, para. 32(c).

189 H. Wisniewski and J. Torous, 'Digital Navigators to Implement Smartphone and Digital Tools in Care', *Acta Psychiatrica Scandinavica*, 141.4 (2020), 350–355 (p. 352).

190 Orygen, The National Centre of Excellence in Youth Mental Health, p. 34.

191 Gooding, p. 4; *Witness Statement of Professor Ian Hickie AM*, para. 126.

192 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, pp. 483–484.

193 Australian Commission on Safety and Quality in Health Care, National Safety and Quality Digital Mental Health Standards, <www.safetyandquality.gov.au/standards/national-safety-and-quality-digital-mental-health-standards>, [accessed 3 December 2020].

194 *Witness Statement of Dr Piers Gooding*, para. 32(c).

195 *Witness Statement of Professor Emeritus Bruce Singh AM*, 23 July 2020, para. 36.

196 Black Dog Institute, *Submission to the Productivity Commission Inquiry into Mental Health*, p. 23.

197 *Witness Statement of Terry Welch*, 11 July 2019, para. 71.

198 Commonwealth Department of Health, *The Fifth National Mental Health and Suicide Prevention Plan*, 2017, pp. 46–47.

199 Australian Government Services Australia, Medicare Statistics: Medicare Item Reports, <www.medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp>, [accessed 14 November 2020].

200 *Witness Statement of Georgie Harman*, 2020, para. 66; *Witness Statement of Professor Mario Alvarez-Jimenez*, para. 102.

201 Department of Health and Human Services, pp. v–vii.

202 *Witness Statement of Kym Peake*, 2020, paras. 275–276.

203 *Witness Statement of Kym Peake*, 2020, paras. 275–276.

204 NorthWestern Mental Health (A Division of Melbourne Health), *Submission to the RCVMHS: SUB.0002.0030.0061*, 2019, p. 29.

205 RCVMHS, *Regional AMHS Provider Information Sharing Roundtable: Record of Proceedings*, 2020.

206 RCVMHS, *Regional AMHS Provider Information Sharing Roundtable: Record of Proceedings*.

207 *Witness Statement of Kym Peake*, 2020, para. 291.

208 Victorian Government, *Victorian Budget 2020–21: Overview*, 2020, p. 23.

209 Victorian Government, *Victorian Budget 2020–21: Overview*, p. 23.

210 *Witness Statement of Kym Peake*, 2020, para. 291.

211 Health Education England NHS, *The Topol Review. Preparing the Healthcare Workforce to Deliver the Digital Future*, 2019, p. 10.

212 *Witness Statement of Dr Hila Haskelberg*, para. 65.

213 *Witness Statement of Professor Mario Alvarez-Jimenez*, paras 185–186.

214 Wisniewski and Torous, p. 10.

215 McKinsey and Company, Returning to Resilience: The Impact of COVID-19 on Mental Health and Substance Use, <www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/returning-to-resilience-the-impact-of-covid-19-on-behavioral-health>, [accessed 23 April 2020].

216 Australian Bureau of Statistics, Household Use of Information Technology, 2016–17, <www.abs.gov.au/statistics/industry/technology-and-innovation/household-use-information-technology/latest-release>, [accessed 4 November 2020].

217 Julian Thomas and others, *Measuring Australia's Digital Divide: The Australian Digital Inclusion Index 2019*, 2019, pp. 5–6.

218 *Witness Statement of Shane Solomon*, para. 50.

219 Royal Flying Doctor Service Victoria, *Submission to the RCVMHS: SUB.0002.0029.0072*, 2019, p. 5.

220 *Witness Statement of Professor Rob Moodie*, p. 32.

221 Grow Australia, *Submission to the RCVMHS: SUB.0002.0029.0325*, 2019, p. 7.

222 *Witness Statement of Kym Peake*, 2020, para. 289.

223 *Witness Statement of Shane Solomon*, para. 50.

224 Victorian Government, *Victorian Budget 2020–21: Rural and Regional Budget Information Paper*, 2020, p. 11.

225 Commonwealth Government, *Budget 2020–21: Economic Recovery Plan for Australia Overview*, 2020, p. 20.

226 CSIRO, p. 10.

227 Derek de Beurs and others, 'Active Involvement of End Users When Developing Web-Based Mental Health Interventions', *Frontiers in Psychiatry*, 8:72 (2017), 1–5 (p. 4).

228 *Witness Statement of Professor Bruce Bonyhady AM*, 16 June 2020, p. 51.

229 Sophie Farthing and others, *Human Rights and Technology Discussion Paper*, 2019, pp. 170–171; *Witness Statement of Professor Bruce Bonyhady AM*, p. 56.

230 Lisa Hoffman, Social Services Innovations—Equity and Inclusion in Digital Mental Health Literacy, *Social Work Today Magazine,* <www.socialworktoday.com/archive/SO19p10.shtml>, [accessed 4 November 2020].

231 Hoffman, Social Services Innovations—Equity and Inclusion in Digital Mental Health Literacy, Social Work Today Magazine, <www.socialworktoday.com/archive/SO19p10.shtml>, [accessed 4 November 2020].

232 CSIRO, pp. 28–29.

233 RCVMHS, *Virtual Help—The Future of Digital Services Roundtable: Record of Proceedings*, 2020.

234 RCVMHS, *Virtual Help—The Future of Digital Services Roundtable: Record of Proceedings.*

235 Helen Christensen and others, *E-Mental Health Services in Australia 2014: Current and Future*, 2014, p. 10.

236 Christensen and others, pp. 3–4 and 10–11.

237 Commonwealth Department of Health, *Initial Submission to the Productivity Commission Inquiry into Mental Health*, 2019, pp. 22–23.

238 E-Mental Health in Practice, *Submission in Response to the Draft Report, Chapter 6: Supported Online Treatment from the Productivity Commission Inquiry into Mental Health*, 2020, p. 2.

239 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, pp. 666–667.

240 EY, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, 2020, p. 4.

241 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 667.

242 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 667.

243 Gooding and Maker, p. 4.

244 Michael Bauer and others, 'Ethical Perspectives on Recommending Digital Technology for Patients with Mental Illness', *International Journal of Bipolar Disorders*, 5.6 (2017), 1–14, (pp. 6 and 8).

245 *Witness Statement of Dr Elizabeth Deveny*, para. 106.

246 Quinn Grundy and others, *Finding Peace of Mind: Navigating the Marketplace of Mental Health Apps*, 2017, p. 12.

247 Gooding, p. 4.

248 *Witness Statement of Dr Piers Gooding*, para. 27.

249 *Witness Statement of Kym Peake*, 2020, para. 295.

250 CSIRO, p. 10.

251 Gooding and Maker, p. 4.

252 Grundy and others, pp. 7–10.

253 Gooding and Maker, p. 4.

254 Gooding and Maker, p. 4.

255 Brigid Richmond, *A Day in the Life of Data: Removing the Opacity Surrounding the Data Collection, Sharing and Use Environment in Australia*, 2019, p. 37.

256 Bucci, Schwannauer and Berry, pp. 289–290.

257 RCVMHS, *Innovation Roundtable—Hosted by LaunchVic: Record of Proceedings*, 2020.

258 RCVMHS, *Innovation Roundtable—Hosted by LaunchVic: Record of Proceeding*s.

259 *Witness Statement of Professor Mario Alvarez-Jimenez*, para. 38.

260 Department of Health and Human Services, pp. v–vii.

261 Ministry of Health, Ontario, p. 12.

262 Ministry of Health, Ontario, p. 64.

263 Ministry of Health, Ontario, p. 64.

264 Ministry of Health, Ontario, p. 64.

265 Ministry of Health, Ontario, p. 64..

266 *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 192.

267 Daniel S. Johnston, 'Digital Maturity: Are We Ready to Use Technology in the NHS?', *Future Hospital Journal*, 4.3 (2017), 189–192 (p. 191).

268 Johnston, p. 191.

269 Johnston, pp. 190–191.

270 Johnston, p. 191.

271 *Witness Statement of Terry Symonds*, 2 November 2020, para. 302(a).

272 *Witness Statement of Terry Symonds*, para. 302(b).

273 *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 189.

274 *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 181.

275 Johnston, p. 191.

276 *Witness Statement of Shane Solomon*, para. 57.

277 Orygen, Online Innovation Supports the Mental Health of Young Victorians, <www.orygen.org.au/About/News-And-Events/2020/Online-innovation-supports-the-mental-health-of-yo>, [accessed 8 October 2020].

278 *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 190.

279 *Witness Statement of Dr Piers Gooding*, paras. 27–28.

280 RCVMHS, *Virtual Help—The Future of Digital Services Roundtable: Record of Proceedings*.

281 *Witness Statement of Dr Piers Gooding*, para. 29.

282 *Witness Statement of Kym Peake*, 2020, para. 290.

283 *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 189.

284 *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 189.

285 Victorian Government, *Victorian Budget 2020–21: Service Delivery: Budget Paper No. 3*, 2020, p. 65.

286 Victorian Government, *Victorian Budget 2020–21: Service Delivery: Budget Paper No. 3*, p. 65.

Chapter 35

New approaches to information management

Recommendation 61:

Sharing mental health and wellbeing information

The Royal Commission recommends that the Victorian Government:

1. develop policies, standards and protocols to enable the effective, safe and efficient collection and sharing of mental health and wellbeing information.
2. set expectations that mental health and wellbeing services will provide opportunities for consumers to contribute to the information held about them and gain easy access to it.
3. collaborate with consumers to introduce a consent-driven approach to information sharing with mental health and wellbeing services and individuals outside of the mental health and wellbeing system.

Recommendation 62:

Contemporary information architecture

The Royal Commission recommends that the Victorian Government:

1. develop, fund and implement modern infrastructure for Information and Communications Technology (ICT) systems, including:
    - **a.** a new statewide Electronic Mental Health and Wellbeing Record for mental health and wellbeing services to replace the current Client Management Interface/ Operational Data Store (CMI/ODS) system;
    - **b.** a review of data items currently required for service delivery and system administration, the removal of unused items and the addition of new items that accurately reflect mental health service activity and consumer outcomes;
    - **c.** a new Mental Health Information and Data Exchange that allows interoperability between the proposed Mental Health and Wellbeing Record and other services' major ICT systems to support information sharing in real time within and across services and sectors;
    - **d.** a new user-friendly online consumer portal (web and mobile) connected to the Mental Health Information and Data Exchange that allows consumers to view key information about themselves and authorise sharing of information with members of their care team, including families, carers and supporters; and
    - **e.** a comprehensive data repository and associated clinical registries for mental health (within the recommended Mental Health Information and Data Exchange) that will support outcome measurement, future service planning, continuous improvement and mental health research.

35.1 A contemporary approach to information management

As the mental health and wellbeing system becomes increasingly person-centred, consumers will have more opportunity to lead and actively participate in their own care, and to receive high-quality, safe and effective treatment, care and support. Contemporary approaches to the collection, use and sharing of information—with the needs and preferences of the consumer always in mind—will be one of the bedrocks that will allow this to happen.

In the digital age, a person's mental health and wellbeing information should be easily accessible to them—they should be able to get it quickly and efficiently.[1] Consumers having access to their own information helps to build their trust and supports them to participate in discussions and decisions about their treatment, care and support.[2]

Organisations and service providers involved in a person's treatment, care and support need to have access to appropriate, timely and accurate information to provide services that are compassionate, safe, effective and coordinated. The flow of this information helps consumers move seamlessly and safely within and between services.[3] Families, carers and supporters also need access to appropriate information to support people living with mental illness or psychological distress.

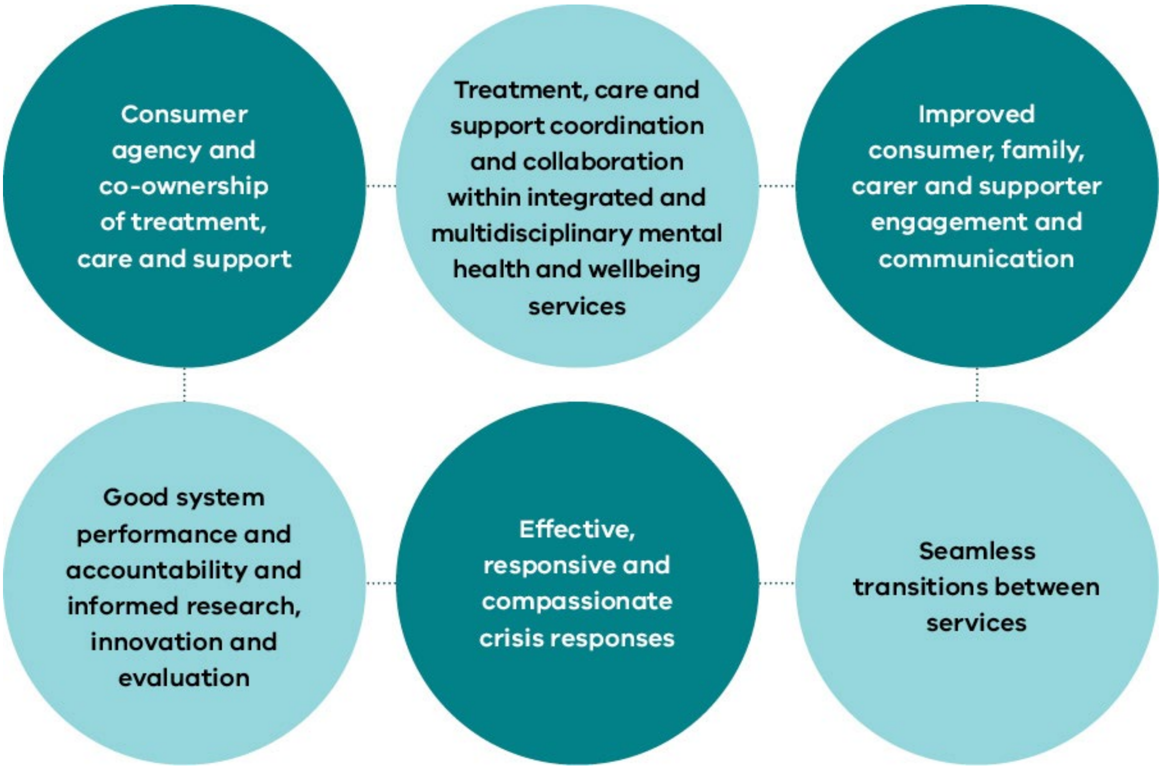
A wide range of information is collected and used across the mental health system. This information is often sensitive and personal to the consumer. It needs to be collected and used to help service providers and mental health workers understand a consumer's experiences, needs and preferences, and to work closely with them to identify and deliver appropriate treatment, care and support. Information and data are also needed to help services and the system to remain accountable for their performance, to forecast and respond to future service demand, and to continually improve the quality of service delivery.[4]

The National Mental Health Commission and the Productivity Commission recently highlighted the need for future mental health services and systems to be underpinned by high-quality information and data to support better consumer outcomes and good system administration.[5]

In the new mental health and wellbeing system, many people will receive treatment, care and support that requires some form of collaboration across multiple services and individuals. This might include health services, emergency departments, acute inpatient services, community-based services and GPs, as well as families, carers and supporters and other services.[6] The effective, safe and efficient collection, use and sharing of information is essential for this to occur.

Figure 35.1 outlines some of the Commission's major reform objectives that will need to be supported by contemporary approaches to information collection, use and sharing.

Figure 35.1: Reform objectives requiring contemporary information management

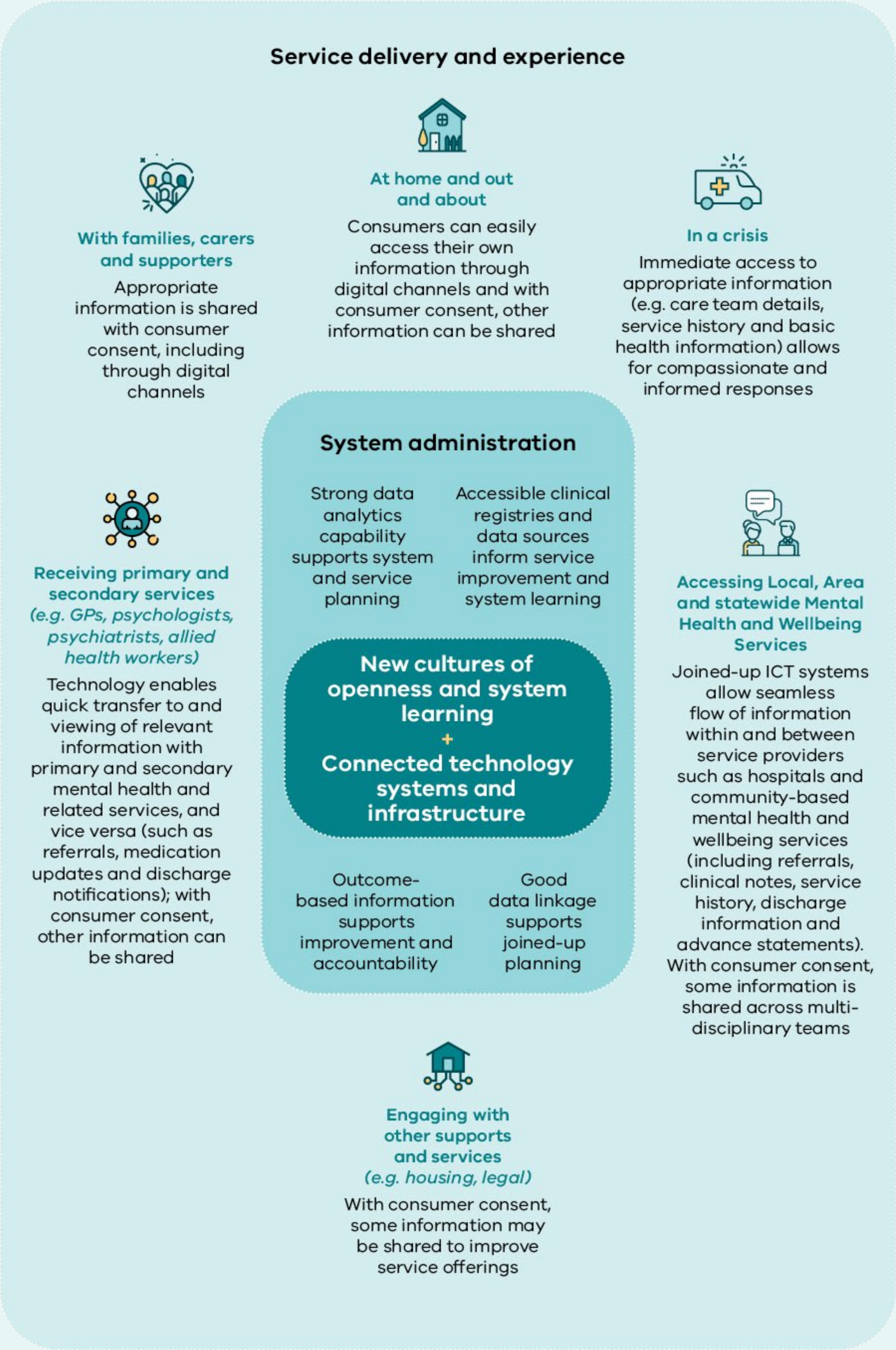


These approaches must be supported and enabled through state-of-the-art technology, systems and structures. Systems and structures should ensure organisations and individuals have access to the information they need, when they need it.

They should help people move within and between services seamlessly and should provide for consumers to actively participate in and collaboratively manage their own mental health and wellbeing. They should also enable families, carers and supporters to undertake their caring roles effectively.

Figure 35.2 describes the Commission's vision for a connected and high-performing mental health and wellbeing system across all age cohorts that uses contemporary approaches to information collection, use and sharing to improve consumer experiences, outcomes and service and system performance. These arrangements will improve communication and collaboration between service providers, improve service efficiency through reduced administrative burden and duplication of effort, and improve decision making. Most importantly, they will improve the consumer experience.

Figure 35.2: A reformed system requiring contemporary information management



Service delivery and experience

With families, carers and supporters
Appropriate information is shared with consumer consent, including through digital channels

At home and out and about
Consumers can easily access their own information through digital channels and with consumer consent, other information can be shared

In a crisis
Immediate access to appropriate information (e.g. care team details, service history and basic health information) allows for compassionate and informed responses

System administration

Strong data analytics capability supports system and service planning

Accessible clinical registries and data sources inform service improvement and system learning

New cultures of openness and system learning
+
Connected technology systems and infrastructure

Outcome-based information supports improvement and accountability

Good data linkage supports joined-up planning

Receiving primary and secondary services ***(e.g. GPs, psychologists, psychiatrists, allied health workers)***
Technology enables quick transfer to and viewing of relevant information with primary and secondary mental health and related services, and vice versa (such as referrals, medication updates and discharge notifications); with consumer consent, other information can be shared

Accessing Local, Area and statewide Mental Health and Wellbeing Services
Joined-up ICT systems allow seamless flow of information within and between service providers such as hospitals and community-based mental health and wellbeing services (including referrals, clinical notes, service history, discharge information and advance statements). With consumer consent, some information is shared across multi-disciplinary teams

Engaging with other supports and services ***(e.g. housing, legal)***
With consumer consent, some information may be shared to improve service offerings

35.1.1 Upholding privacy, safety and trust

Mental health information[7] generally refers to 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.[8] Information from others—including families, carers and supporters—may also be included in mental health information, where appropriate.

Mental health information can take a number of forms but includes items such as assessment results, clinical notes, medication information, admission and discharge summary information, prior service delivery history and interventions received, consumer advance statements—which are formal documents that set out consumer preferences for treatment, care and support—and consumer outcomes.

There is widespread support for better information sharing across the system from consumers, families, carers and supporters and service providers, but they have emphasised that ensuring people's privacy and safety must remain a major feature of the future system.[9] Mr Dave Peters, a witness before the Commission, said that while information sharing is beneficial, unfortunately the stigma of mental illness means that too much sharing may have a negative impact on consumers:

> **there's a real opportunity to use the available information to benefit both the patient and the clinician by preventing repeated tests and helping prevent a need for the patient to tell their history again. Unfortunately there is a risk that too much shared information could impair the diagnostic process due to the stigma related to mental illness.**[10]

The Commission understands that some mental health information is very sensitive. While increased information sharing will most likely improve the continuity of treatment, care and support and consumer experiences, when implementing the recommended reforms, the Victorian Government will need to carefully consider the extent to which different types of information are collected, stored and shared, to uphold consumer privacy and safety.[11]

New information cultures and systems will need to strongly protect consumers' information and privacy, and promote trust in information sharing. Some information may continue to be shared as it currently is. Examples include existing permissions that allow for workers on the same team to communicate about a consumer in their treatment, care and support or existing obligations to provide information to relevant authorities when legally required. However, to allow services to deliver integrated and seamless treatment, care and support, the movement of information around the mental health and wellbeing system must change.

Supported by appropriate permissions and protections, new approaches to the collection, use and sharing of information can enable:

- consumer access to their own information to help them to manage their own treatment, care and support and increase their agency—that is, their sense of control over their own lives
- sharing information within a mental health and wellbeing service to deliver treatment, care and support

- sharing information between different mental health and other health services (such as physical health, general practice or allied health) to enable effective consumer transitions
- where appropriate and necessary, sharing basic information with broader service systems such as community providers and other services including alcohol and other drug, housing, employment and other support services
- improved system administration and accountability
- more effective continuous improvement of services, interventions and the system as a whole.

Box 35.1 discusses these purposes in more detail.

Box 35.1: Definitions, purposes and types of information collection, use and sharing in mental health

Information collection, use and sharing

For the purpose of this report, '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, care and support or accountability.[12]

Purpose and types of information collection, use and sharing in mental health

For service delivery
Information is used in the delivery and use of services, both by consumers and by service providers.

Consumers access and use their own health information so they can make decisions about their treatment, care and support. Having timely access to complete information helps them to manage their own recovery.

Mental health and wellbeing workers and services also use consumer mental health records to document a consumer's health history, medications, diagnoses, treatment plans and clinical notes and outcomes.

Different information can be shared across services for several purposes:

- Information sharing within mental health and wellbeing services—this involves sharing of information between practitioners and workers within the same service for the purpose of service delivery. This generally includes clinical notes, consumer outcomes and consumer preferences and service history.
- Information sharing between mental health services and general health services—this includes the sharing of information between different mental health and wellbeing services and general health services for the purpose of service delivery and consumer transitions. For example, as a consumer moves through the system, some information may need to pass from the emergency department to an inpatient unit, and then to a community-based mental health and wellbeing service when the consumer is discharged. Information may also need to be shared with general health services at various points.
- Information sharing with services outside the state mental health and wellbeing system—this includes sharing of some basic information (such as discharge information or medications) with a range of other providers that may be involved in a person's care. For example, primary and secondary services such as GPs, allied health workers and private psychologists or psychiatrists. In certain circumstances, or with consent, some information might also be relevant to providing wellbeing supports and other services, such as housing, justice, legal aid and family violence.
- Information sharing with individuals—this includes sharing of information with families, carers and supporters involved in a person's care.

For service and system administration and continuous improvement
At the state and national levels, comprehensive and high-quality data helps to determine areas of need, service and program effectiveness and efficiency, and areas for policy improvement and funding reform. It also informs strong compliance and accountability regimes.[13]

At the service level, access to data and information, coupled with data analytics capability, helps with performance monitoring and supports clinical practice and the management, delivery and evaluation of health services.[14] Comprehensive outcomes-based data also helps inform research into the effectiveness of interventions, both for specific groups of people and at the system level.[15]

This type of information use includes:

- clinical registries and data repositories to monitor and inform service intervention improvements
- data collections and datasets to inform administrative responsibilities (state and national).

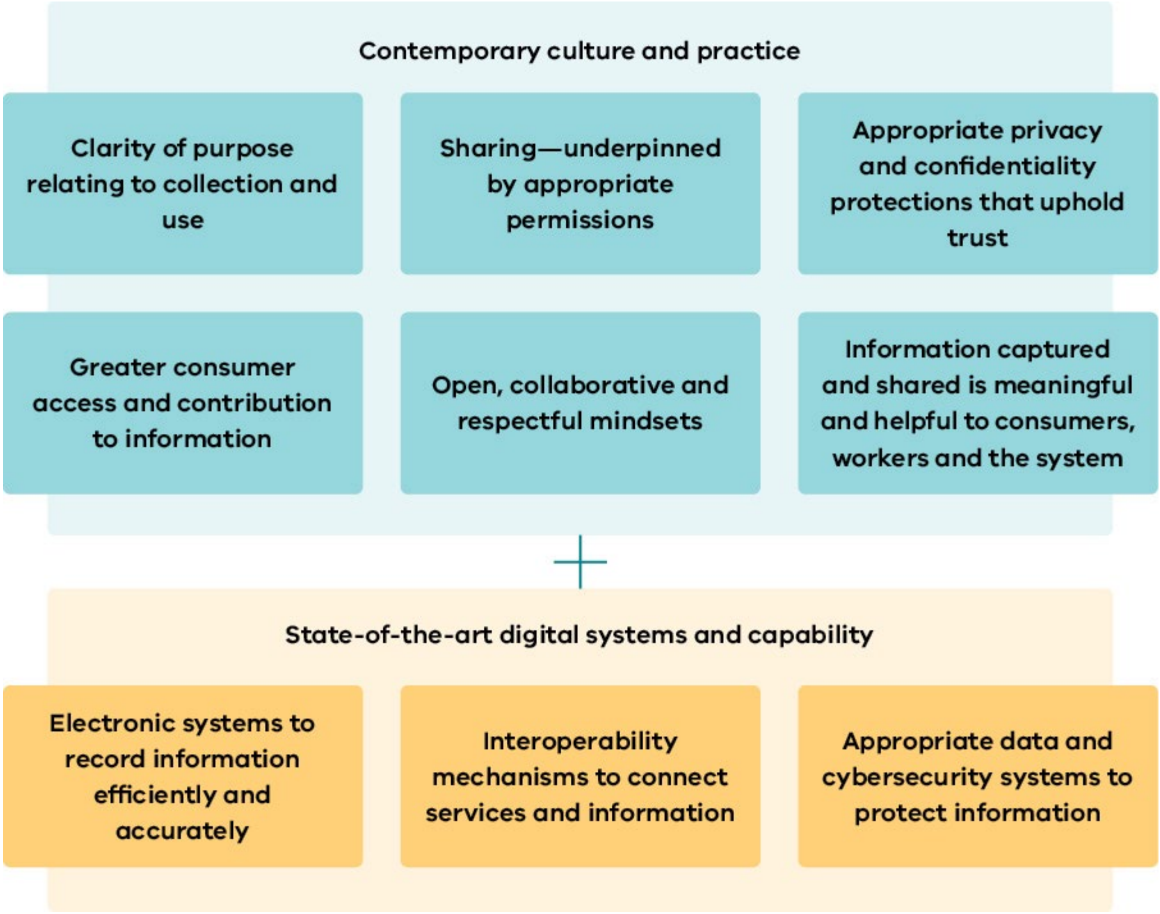
35.2 Features of contemporary information collection, use and sharing

A range of features are essential to contemporary information collection, use and sharing in the mental health and wellbeing system. These features support honest and open communication, collaboration, consumer agency and effective, efficient and safe information sharing. The Commission considers that the following features should be central to information management in the mental health and wellbeing system:

- clarity about the purpose of information collection, use and sharing—to ensure everyone understands how, when and why information should be captured or shared, and to recognise that each person involved in someone's treatment, care and support has information that others may need to know
- open sharing of information between workers, services and organisations, governed by clear and transparent permissions that describe what information should be shared and in which circumstances—noting that not all information needs to be shared with everyone
- increased consumer access to their own mental health and wellbeing information, and the ability for consumers to contribute to their own records, where appropriate—noting that there are circumstances when this cannot occur due to risk to the person or others
- an open and respectful mindset when recording information about consumers
- privacy and credentialling arrangements to ensure mental health and wellbeing information is only shared with those who need to see it—with clear and simple consent policies and mechanisms that give as much control as possible to consumers in terms of who sees what information, and in which circumstances
- information is recorded securely in electronic form in interoperable systems, and there are mechanisms in place to enable efficient and appropriate flow of information within and between services
- progressive improvement based on experience of what works and what does not.

Figure 35.3 summarises these features.

Figure 35.3: Features of contemporary information management in mental health and wellbeing



35.3 The challenges of information collection, use and sharing

Over recent years, Victoria has attempted to improve information sharing between service providers to support services to connect with each other, deliver high-quality treatment, care and support for consumers, and to reduce safety risks.[16]

However, the Commission found there are limitations in the sharing of information within mental health services, between mental health services and with other organisations involved in a person's treatment, care and support.[17] These limitations have a negative impact on consumer experiences and outcomes. There are also challenges associated with consumers accessing their own mental health information, and families, carers and supporters often struggle to access appropriate information when needed.

The Commission's interim report emphasised that, at the service and system levels, 'inadequacies in information gathering and data collection across all levels of the mental health system also constrain system accountability and monitoring'.[18] It observed that 'information and data are incomplete, inconsistent and often inaccessible, lacking a nationally consistent approach to outcomes measurement, collection and use'.[19]

The Commission is concerned about the negative impacts these challenges are having on consumers, families, carers, supporters, service providers and mental health workers, and the system.

35.3.1 The harmful impacts of limited information sharing

Many people told the Commission that the lack of information sharing between individuals and services in the mental health system places the burden of communication, information collection and follow-up largely onto consumers, families, carers and supporters. This results in people having to explain their circumstances over and over, which can be traumatic.

In their witness statement, Mary and Jacob Corbett described how the lack of information sharing between services, and even within services, forces people to explain their circumstances time and again, negatively affecting the experience of receiving treatment, care and support:

> In our experience, there is not very good communication and sharing of information between services, or even within the same service. For example, if a person goes to hospital in an ambulance, the paramedics ask questions, which the patient answers. Then the receptionist asks the same questions, then the doctor on the ward asks the same questions, and so on and so on. Even before a patient is settled in their room, they may have been asked the same questions by five or six different people. It is obviously counterproductive to have to relive the traumatic experiences over and over, especially when you are just freshly sick and disoriented.[20]

Similar challenges occur as consumers move between public mental health services and primary and secondary mental health and related services, sometimes negatively affecting their wellbeing. For example, one person shared the damaging impact poor information sharing between her hospital team and private psychiatrist had on her physical health:

> And well, for me, a really big thing happened earlier this year. It was between the hospital service and my private psychiatrist. Because I had a really rare reaction to medication. And the hospital didn't communicate what actually happened to my psychiatrist, even though they said they did. And he put me on another medication, which caused the same thing. And I've now been in a wheelchair since February, because they didn't communicate …[21]

The experience of limited information sharing was echoed by a number of consumers, who cited examples of poor information sharing between their GP and public area mental health services, between community-based services and inpatient services, and between public mental health and private services.[22]

Area mental health services noted that a reliance on paper-based files and the lack of sufficiently accessible and joined-up clinical information sharing systems often meant lengthy delays in receiving information from other services. As a result, consumers may be discharged without a comprehensive assessment, forced to wait for lengthy periods in the emergency department, or given inadequate responses.[23]

Mental health services also currently have no way of identifying how many times a person may have attended an emergency department or called for help.[24] This means that someone's deterioration may go unnoticed for long periods of time.[25] Limited information sharing between different services means that services are often unaware of a person's history. One carer informed the Commission about the terrible result the lack of access to prior information had on her daughter's life. Unfortunately, her experience reflected others across the system:

> There needs to be access to a patient's file across all mental health institutions. My daughter was taken to [hospital] … in a heightened state claiming she wanted to die, she was assessed, and released. She was found dead in the city at 7am. My first question to the Detective who told me this was 'Why was she released when she had a long history of [mental health] treatment and had only been in Psych Ward 4 days earlier?' You can only imagine my disbelief when informed that they had no way of knowing unless told by the patient or someone with them.[26]

Outdated systems and processes also affect people's privacy and safety. The Commission heard from a consumer who had suffered a severe breach of privacy due to a lack of secure and efficient digital sharing capability:

> My private doctor doesn't have a fax. They wouldn't take an email, they wouldn't take a phone call. And so I ended up getting my parents to print a copy so that I could physically hand it to the treating team so that they would have the relevant information. However, what happened in that exchange was that my parents, particularly my mother read it, which is a huge violation of privacy, but also there's a history of family violence there. And so it really wasn't an appropriate mechanism at all for that information sharing to occur between my private doctor and the public hospital treating team. And it was incredibly disempowering that there was no efficient, streamlined way for that information sharing to occur, it was detrimental to my treatment, it was detrimental for them not to have that contextual information.[27]

While the lack of information sharing within and between services is a considerable challenge, the Commission was equally concerned with the apparent lack of consumer access to their own mental health information. Consumers indicated that they want to access their own information for a number of reasons, including as closure for past circumstances, as a means of understanding their experiences, to assist their recovery and to challenge the record.[28] However, they often struggle to access their mental health information when they need it.

One person told Victoria Legal Aid that the lack of access to their clinical notes made it challenging to exercise their rights:

> It's not easy to exercise your rights when you don't have any of the information you need. In there I tried to access my own clinical notes, to understand what they were saying about me. Instead they said that I would have to go through this rigorous freedom of information process, to access the notes that they were writing about me! I just gave up. For someone doing worse than me, this would be impossible.[29]

Access to appropriate levels of information was also a big challenge for families, carers and supporters. The Victorian Government's submission to the Productivity Commission recognised that families, carers and supporters are often not provided with relevant information or excluded from the treatment of their loved ones.[30] Chapter 19: *Valuing and supporting families, carers and supporters* discusses these information challenges in detail and highlights that the lack of information sharing with families, carers and supporters makes it incredibly challenging for them to undertake their caring role successfully, and can make them feel alienated.[31] One carer at a roundtable told the Commission that they felt excluded from the person's care team:

> they weren't sharing [information] and they weren't treating me as an important part of the team.[32]

Another carer noted that the role carers play is not acknowledged, and the information that they hold is not always valued:

> the communication just isn't there, that acknowledgement that we have, I suppose wisdom and resilience as a consequence of the role that we play is overlooked and I think there's the potential for allyship and collaboration, [but] the lack of communication just means that that's always missed.[33]

The Commission understands there are many reasons for the current challenges with the collection, use and sharing of information outlined above, including:

- the system being under pressure, which compromises the creation of information-oriented cultures and relationships, where curiosity and collaboration are supported and rewarded
- complex legislation and policy environments that limit, or are perceived to limit, sharing and collaboration
- outdated ICT systems that hinder effective information collection, use and sharing.[34]

The Productivity Commission's *Mental Health Inquiry Report* also found culture, legislation and ICT systems to be the major barriers preventing routine sharing of information in mental health to enable continuity of care.[35] The Royal Commission into Family Violence found similar barriers to information collection, use and sharing, indicating that these types of issues are common in large and complex systems.[36]

35.3.2 A lack of an information sharing culture

The current service system cultures do not promote collaboration, information sharing or openness. Siloed approaches to working, in which services do not communicate with each other, appear to have contributed to this situation, as have the stigma around mental illness and confusion about what information can be shared. These circumstances have existed for a long time, and the result is a culture in which information is tightly held.

The Commission was told that there is a lack of engagement with information and a general lack of collaboration and process. A consumer at a roundtable said that there needs to be a culture that promotes reading and engaging with information:

> we can develop the best and incredibly well designed information sharing system with state of the art technology, that will only be as good as the way that it's implemented … any system that we design in terms of information sharing is only as good as people actually having time to read it, having a culture around the importance of reading it, and engaging with it.[37]

However, some consumers told the Commission that there appears to be a lack of willingness or time on the part of mental health workers to read consumer information, resulting in consumers continually being asked the same questions, or receiving ineffective responses:

> My experience is that staff often don't have time to read information, even when it's there. So even when I've had an advance directive on file … my experience is that even though they're legally required to the overwhelming majority of staff don't read it.[38]

The Commission also understands that practitioners may refuse to share information either within or between services. Sometimes this is due to a lack of trust, or different attitudes and beliefs between different workforces; or a fear of causing further stigma for a consumer.[39] The stigma surrounding mental illness means that clinicians, often with the best of intentions, may be unwilling to share sensitive information with other members of the team, or with other services.[40]

Dr Stuart Lewena, Director of Emergency Medicine at The Royal Children's Hospital, cited the lack of willingness of some service providers to collaborate as a central cause of poor information sharing. He also noted that a reluctance to collaborate can be caused by practitioners disagreeing about diagnosis or approaches to treatment, care and support:

> The predominant barrier that needs to be overcome … is the apparent lack of willingness of some stakeholders to engage and collaborate with one another. My observations of this as a stakeholder who interacts with the mental health system and its practitioners are that this manifests in … some mental health care providers refusing to share patient information [and] clinical disagreements between mental health care providers on diagnosis and treatment methodology for particular shared patients.[41]

One consumer at a roundtable told the Commission that staff appeared to disregard important information about her health from another clinical expert:

> I'm actually trying to share clinical information and they don't even care about clinical information from another … experienced doctor who's known me for five years.[42]

Consumers also felt that the mental health system in general was unwilling to share notes with them, and that the systems and processes in place to access their own information are cumbersome and ineffective.[43]

Placing a freedom of information request with services to receive information, and associated lengthy delays, can be a cause of strain for consumers. One consumer was sent only screenshots from clinical systems that were impossible to decipher:

> I asked for all my medical records from the [hospital] … all they did was give me screenshots of my admissions, there were no notes, there was no nothing. Like, you know, no one wants to share your information, like I can't even get my own information.[44]

Another consumer described receiving heavily redacted copies of their own records, which caused great anxiety and fear that there was something terrible in the record that they should not see.[45] Under the *Freedom of Information Act 1982* (Vic), service providers can be legally obliged to redact information for many reasons, including when the provider believes (on reasonable grounds) that providing the information to the person would pose a serious threat to the life or health of the person or another person.[46] However, some consumers find this practice to be inconsistent across and within services, and that it is overused and excludes them from understanding their service history.[47]

While consumers recognised that there may be some circumstances where information sharing may need to be delayed, or where information may not be shared, they argued that in most cases people should be able to know and see what is written about them.

One roundtable participant said:

> I think, there needs to be a culture shift in the mental health system, to see that in the majority of situations, consumers should know what is written about them, and have the opportunity to disagree or to clarify information.[48]

When consumers did receive their records, they stated that the information was often written in clinical language that was not accessible to them, or felt disrespectful, judgemental and hurtful.[49] One roundtable participant said that the notes they received were unprofessional:

> the notes that were written about me some of them were bordering on insulting, some of them are bordering on incredibly disrespectful. Very judgmental language, language that was very much not recovery-oriented … it was like reading a playbook of insults. And I was like, this is supposed to be my medical record. This is absurd … how can this mental health service legitimately claim that this is a medical record when parts of it read like a schoolyard series of insults.[50]

Consumers were adamant that there needs to be a cultural shift in the recording of information that places the person at the centre, is therapeutic and captures the consumer's own voice. Another person noted the need for more accessible language in records:

> An issue with the clinical notes at the moment, is that they're so clinical and written in a language that individuals don't use those words to describe themselves … And I think there's sometimes potentially a case for writing two notes, one in a clinical language and another one, that it's an accessible language for consumers to process themselves, or just ditch the clinical language in the first place and have all of it written in accessible language. So I think it's a change in the way things are written rather than a not sharing at all.[51]

The Commission expects that in the future mental health and wellbeing system, information recorded about, and provided to, consumers will be accessible and understandable. The Commission also understands the critical importance of accurate, clear and clinically relevant notes to support practitioners to appropriately assess people experiencing mental illness or psychological distress, diagnose their conditions and provide them with treatment, care and support. In many cases, this requires the creation of notes that contain technical language and apply commonly used terms or phrases. As these notes are used across periods of time and sometimes shared between practitioners, there needs to be a level of consistency and clinical rigour to ensure they can be used to deliver high-quality treatment, care and support.

Providers are required to capture relevant and sufficient content to safely perform their roles, and regulated practitioners and clinicians are required to take appropriate, relevant and accurate notes as part of their professional registration.[52] Consumers should be supported to understand any technical references in their notes and, where feasible, safe and appropriate, information should be recorded in an accessible format. Information should always be communicated in a respectful way.

The Commission was also told that it is rare for consumers to be able to contribute to their own mental health records, which reduces their sense of agency and their control over their own treatment, care and support.[53] Consumers were clear that, wherever possible, they would like the opportunity to contribute to their own records.[54] A person told Victoria Legal Aid that their inability to contribute risked organisations forming a negative perception of them:

> I have no meaningful way to be involved in how these are written, to see them or to correct them when they are wrong. This then goes to places like the [Mental Health Tribunal] where it defames me.[55]

Families, carers and supporters said that some service providers may use privacy and confidentiality obligations as a way to exclude them from accessing relevant information,[56] stating that there is an overall culture of not including consumers' support networks in consultations.[57] The Commission understands that there are a number of potential factors leading to such practices. For example:

- Many professionals are trained to work with consumers in a one-on-one context, which means they might not have the information needs of families, carers and supporters front of mind.
- Professional codes of ethics generally impose confidentiality as a fundamental principle.
- The management of legal or other risks within services may require them to routinely reinforce the importance of privacy and confidentiality.
- Time and capacity to think and work with an individual and their families, carers and supporters is limited in the current system.
- Sometimes families, carers and supporters can be perceived as 'difficult' because they have had to advocate strongly for the person they care for in a broken system. As a result, some practitioners are reluctant to engage with them or do not feel confident doing so.

35.3.3 Complex and confusing legislative, regulatory and policy frameworks

The current legislative, regulatory and policy frameworks that guide the collection, use and sharing of mental health information are extremely complex, and are challenging to navigate and understand. The Commission's assessment of the frameworks and legislation that deal with information sharing indicates a number of challenges including:

- the complexity and number of legislative, regulatory and policy frameworks, which creates uncertainty about which regimes or rules apply, to whom and in what circumstances
- uncertainty creating a default position of privacy and confidentiality, even when information may be able to be shared
- a focus on the obligations of individual service providers, rather than consumer needs, which means that information sharing across multiple providers is difficult, despite information being essential for consumers accessing mental health services and consumers often requesting it.

While intended to protect consumers' privacy and safety, the current frameworks have been established with a focus on what information individual service providers can collect, use and share. These rules are important but do not always support an integrated and responsive approach that focuses on individual consumers and their preferences or needs. Consumers, families, carers, supporters and service providers are sometimes restricted from accessing or receiving information that may improve treatment, care and support.

Information collection, use and sharing is already taking place under current arrangements. However, given the scale of change needed to establish the new mental health and wellbeing system, changes to legislation, protocols, processes and practices will be required to ensure information can flow safely and effectively. The Commission has identified several areas where change will likely be needed.

Consumers' access to their own information

Under the *Health Records Act 2001* (Vic), consumers have a right of access to their own information,[58] subject to requirements in the Freedom of Information Act. A consumer's request to access their information is often initiated through a freedom of information request to their relevant mental health service provider. Consumers are required to submit a separate freedom of information request for each health service provider they require information from and may also need to pay a fee for the administrative cost of gathering or preparing the information.[59]

Under current laws, service providers must not give a person access to their mental health information if the organisation believes on reasonable grounds that providing the information would pose a serious threat to the life or health of the individual or any other person,[60] or where the information has been handed over to the organisation in confidence.[61] This may result in the redaction of certain information provided to a consumer.

When consumers try to access their own information as allowed by legislation, this process can take a very long time. It is not an efficient way for consumers to check that the health information about them is accurate, up to date and fairly records their position and views. There are also inconsistent approaches in the redaction of information.

So, while current legislation does not in itself appear to be a barrier to consumers accessing their own records, it is clear that the means of gaining this access are cumbersome and require reform. New practices and processes are needed to improve consumers' ability to easily gain access to their mental health information, supported by technology.

Progress towards this objective is already underway in parts of the mental health system. For example, a number of services are trialling new consumer portals that improve consumer and practitioner access to information.[62] Epic at Melbourne Health is introducing a portal called the Health Hub. Professor George Braitberg AM, Executive Director of Strategy, Quality and Improvement at The Royal Melbourne Hospital, said that the hub will:

> allow medical practitioners and patients to access their records securely and document any changes to their treatment plan, review their admissions to hospital, pathology results and upcoming appointments, and facilitate correspondence between medical practitioners.[63]

Family, carer and supporter access to information

As discussed in Chapter 19: *Valuing and supporting families, carers and supporters*, current legislative and policy arrangements set out several provisions that allow families, carers and supporters to access some consumer mental health information that will allow them to carry out their caring role.[64] A range of different provisions exist for different circumstances, but Chapter 19 acknowledges that these provisions are complex, not always well understood by service providers, families, carers and supporters, and so are not always effective. The Commission has suggested that these provisions be simplified as part of legislative change recommended in Chapter 26: *Rebalancing mental health laws—a new Mental Health and Wellbeing Act*, and has recommended new standards to help guide information sharing in the mental health and wellbeing system.

Highly complex and constrained collection, use and sharing of information for service delivery

Under current arrangements in Victoria, designated mental health services[65] can collect and use consumer mental health information and share it between one another for the purpose of service delivery.[66]

However, for other types of health service providers, such as primary and secondary providers, emergency services and non-government organisations, information collection, use and sharing is more complex. Different frameworks govern their ability to collect, receive, use and share information in different circumstances.

This complexity can make it difficult for workers and services to understand which regime applies to which organisation, and in what circumstances. Even when legislation does not formally restrict the collection or disclosure of information, its complexity can mean that services avoid collecting and sharing information out of an abundance of caution.[67]

35.3.4 Implications arising from future reforms

Victoria's reformed mental health and wellbeing system will be large and adaptive due to its size and the number of service offerings. There will continue to be diverse service types and providers, and over time this mix may evolve further. This will mean that much work will need to be done, potentially on an ongoing basis, to ensure information is managed and shared in a way that supports system objectives and individual consumers' needs.

In this section, the Commission outlines its reforms and an assessment of the limitations of current information arrangements. This analysis is indicative rather than comprehensive because the operational requirements of the recommended reforms will need to be further considered before they are implemented.

New approaches to assessment and referral

As part of its broader reforms, the Commission has recommended—in Chapter 8: *Finding and accessing treatment, care and support*—that any service provider can refer people to Local Mental Health and Wellbeing Services and that medical practitioners can refer people to Area Mental Health and Wellbeing Services.

Electronic referrals will be the preferred form of non-crisis referrals to Local Mental Health and Wellbeing Services, Area Mental Health and Wellbeing Services and statewide services, allowing information about the consumer to be received by the services, with the consumer's consent, in a standard form. Medical practitioners will collect basic referral information on the consumer's health and mental health, as well as other information about their needs and preferences to facilitate effective transitions.

While legislation already allows medical practitioners to make referrals into public mental health services, new referral processes, guidelines and policies will need to be established to ensure consistent referral approaches across the state. However, legislative change may be required to support circumstances where other service providers may be making a referral into Local Mental Health and Wellbeing Services. As described in Chapter 8: *Finding and accessing treatment, care and support,* the Department of Health should develop and promote an access policy for mental health and wellbeing services. This will promote a clear and consistent approach to managing referrals and people's initial contact with mental health and wellbeing services.

The legislation will also likely need to be amended to allow for electronic collection of information and referral into mental health and wellbeing services, as the current scope of electronic information collection and sharing appears limited.

Delivery of connected treatment, care and support with seamless transitions

In the future mental health and wellbeing system, services and practitioners will be expected to work in a much more multidisciplinary and integrated way, both within and between services. The Commission intends that alcohol and other drug services, physical health services, allied health services, wellbeing services, primary and secondary services and a range of other services will work much more closely together to provide people with effective treatment, care and support. Functions that have predominantly been the responsibility of area mental health services may also be undertaken by a broader range of practitioners and service providers including non-government organisations. Chapter 5: *A responsive and integrated system*, and Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services* describe these arrangements in detail.

Current arrangements already support the legal sharing of information between primary and secondary service providers and new mental health and wellbeing services, but there does not appear to be a uniform process or approach to information sharing with these organisations, or at least there is little evidence of this. New information sharing protocols and practices will be needed between mental health and wellbeing services and primary or secondary providers to allow for Area Mental Health and Wellbeing Services to provide secondary consultation, and for shared treatment, care and support arrangements, where relevant.

As part of its recommended multidisciplinary and integrated service arrangements, the Commission is also proposing that Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services work much more closely with alcohol and other drug services and broader social supports including housing, family violence prevention, employment services and others. Current legislation is unlikely to allow for the collection, use and sharing of information between mental health and wellbeing services and these other services where these practices are not captured under either the Health Records Act or the *Mental Health Act 2014* (Vic). Without legislative change, the new system will struggle to offer consumers the joined-up and integrated treatment, care and support the Commission envisages. Revised approaches and clear permissions will likely be necessary to ensure relevant information flows between these organisations, without affecting consumer privacy and safety.

Provision of effective crisis services and responses

The Commission's proposed crisis reforms mean that Ambulance Victoria will take a lead role in responding to consumers experiencing a mental health crisis, as outlined in Chapter 9: *Crisis and emergency responses*. Police will be involved only where necessary to protect people's safety.

The Commission understands that under current arrangements, Ambulance Victoria and emergency departments not operated by a designated mental health service are unable to access any consumer mental health information directly.[68] Mr Simon Thomson, Regional Director of Ambulance Victoria, told the Commission that ambulance workers are unable to access even basic consumer data, such as whether they have a mental health care plan or an existing provider, to determine the best approach to respond to a person in crisis.[69]

He indicated that to effectively respond to consumers, Ambulance Victoria requires direct access to basic consumer mental health information.[70] Similarly, area mental health services have indicated that all emergency departments would benefit from being able to access basic consumer information to help form an appropriate response for them.[71]

While these organisations can receive consumer health information from a designated mental health service under certain circumstances prescribed by the Mental Health Act, the database that holds this information must be accessed by someone from a designated mental health service.[72]

The Commission is supportive of emergency responders having access to the information they need to deliver an effective response, but understands the importance of skilled people receiving and interpreting information. Without this skill, there is a risk that judgements may be made about a person's behaviour or circumstances based on their history of mental illness or psychological distress.[73] Legislative change is likely needed to allow Ambulance Victoria to access the information it needs to undertake its lead role effectively, and appropriate mental health clinical supports, as recommended in Chapter 9: *Crisis and emergency responses*, should be in place to help first responders to interpret the information sensitively and appropriately.

Better coordination and collaboration for people needing ongoing intensive treatment, care and support

The Commission recognises that some people who seek treatment, care and support from multiple service providers find it very challenging to access responsive and coordinated service responses. Chapter 5: *A responsive and integrated system* recommends establishing new Regional Multiagency Panels to support collaboration and accountability of service provision to some adults, older adults and children and young people who need ongoing intensive treatment, care and support. Regional Multiagency Panels will support people and the services that provide treatment, care and support to this cohort to ensure they are held accountable and collaborate in their work. Participants in Regional Multiagency Panels will be diverse and will vary, but may include clinical, housing and wellbeing support services.

Health, mental health and other information about people's needs and preferences will need to be shared between representatives of participating providers to support good outcomes. Some information will also need to be shared between Regional Multiagency Panels, the Multiple and Complex Needs Initiative (MACNI) and the Victorian Fixed Threat Assessment Centre, especially when community safety is a concern.

In relation to MACNI, there is already some legislative provision to allow for the collection and sharing of health and personal information between service providers involved in an approved care plan for eligible people with multiple or complex needs.[74] However, this legislation is not broad enough to allow information to be collected and shared for all consumers receiving support under the panels, and was crafted specifically for the MACNI program.

The Regional Multiagency Panel regime will accordingly require its own legislated information sharing regime. This regime can be modelled on the MACNI information sharing regime but will need to be crafted to allow sharing of information between those people and organisations involved in providing treatment, care and support to these cohorts. Ensuring appropriate delegations and protocols are in place to protect privacy and sensitive information will also be important.

Better support for people in or leaving prison who are living with mental illness or psychological distress

The Commission understands that much stronger collaboration and coordination needs to occur between services and organisations detaining (due to their actual or alleged offending) people living with mental illness or psychological distress in the criminal and youth justice systems, particularly people who require ongoing intensive treatment, care and support.

Currently, there is a failure to share critically important mental health and health information across relevant settings and providers, and this greatly impedes the capacity to deliver effective mental health services in custodial settings, including prisons and police cells. The Coroners Court of Victoria has previously recommended that better information sharing occurs between institutional parties involved in a prisoner's treatment, care and support and transitions, including Victoria Police, corrections (in both custodial and community settings) and mental health services.[75]

While it is not appropriate for officers or general staff to have access to a person's clinical information, good communication between these agencies in certain circumstances is paramount—such as when a person is at high risk of self-harm or suicide or when they have a need for intensive treatment, care and support.[76] Better coordination of referrals at key transition points is important, including when someone is transferred from police custody to a correctional facility, and when they are released from a custodial setting and require treatment, care and support from an area mental health service.[77] Some level of electronic access to mental health and other information will be necessary to achieve this.

This sharing of limited information will likely require legislative changes and very clear protocols and delegations to ensure access to any sensitive information is tightly held. There are already examples in other sectors, including the family violence information sharing reforms and the Criminal Justice Enhancement Program, which have implemented comprehensive access rules and oversight arrangements to ensure only authorised people can view sensitive information.[78]

The Commission is also recommending the creation of a program to help transition people in prison living with mental illness or psychological distress who require ongoing intensive treatment, care and support to Area Mental Health and Wellbeing Services, as outlined in Chapter 23: *Improving mental health outcomes across the criminal justice, forensic mental health and youth justice systems*. The Commission was told of a need to improve information sharing between health services in prisons and community and mental health and wellbeing services when someone is released from prison. For example, limited information may be shared about a person's medical treatment in prison, and discharge summaries can be lost.[79] Privacy and confidentiality concerns may also limit shared information between agencies.[80]

Improvements in protocols, practice and enabling technology will be needed to support better and more effective transitions for all consumers transferring from prison to an Area Mental Health and Wellbeing Service.

Chapter 30: *Overseeing the safety and quality of services,* suggests that the new mental health quality and safety functions include oversight of the mental health of prisoners to ensure they receive high-quality mental health treatment, care and support. This will require prisoner mental health information to be shared as part of custodial mental health oversight arrangements. New legislation will be necessary to allow this to occur.

Service and system administration

As noted earlier, information and data are also routinely collected and shared for service and system administration purposes. Current legislation allows de-identified information—that is, information that does not identify an individual—to be used for research in the public interest. It can also be used for service planning, funding, management, monitoring and improvement. Thoroughly assessing and revising, if necessary, existing policy and legislative provisions will be critical to ensure they enable the generation of more advanced information, including better datasets and new clinical registries to inform research, evaluation, continuous improvement and system accountability.

Further, the Commission is concerned that the current definition of electronic collection and use of health information in the Mental Health Act[81] appears to be outdated and no longer fit for purpose. Future electronic information management and sharing arrangements will require amendments to this section of the legislation so it enables the information sharing arrangements and associated ICT solutions proposed by the Commission to fulfil their intended purposes.

35.3.5 A lack of effective ICT systems

Digital technology allows information and data to be effectively captured and transferred, thus supporting good practice and service delivery and allowing performance and outcomes to be monitored, analysed and improved.[82]

Multiple service providers have told the Commission that antiquated ICT systems and inefficient information collection and sharing arrangements limit their capacity to provide good-quality treatment, care and support and to work within and across services in an integrated and collaborative way.[83] Mr Terry Symonds, then Deputy Secretary of Health and Wellbeing at the former Department of Health and Human Services, also noted that '[c]urrent IT infrastructure and data capabilities for mental health are unable to support contemporary best practice approaches to service delivery in Victoria.'[84]

While digital records and electronic sharing of information can raise privacy concerns for some people, consumers at a roundtable indicated that they would ultimately prefer some form of efficient electronic system:

> I think we have the technology to abate any concern about [privacy]. And I think the other mechanisms that we have, like printing out paper, like faxing, like phone calls, all of that is very non-ideal and an electronic system that is secure is much preferable to that.[85]

Both nationally and internationally, there is a push to digitise information and records to improve information sharing through connected systems. The main drivers of this change have been:

- greater efficiency through automating previously manual processes
- ease of access to people's clinical information among multiple people involved in their treatment, care and support
- improved safety and quality by reducing human error
- consumer empowerment by increasing access to their own information
- improved data for management, funding and accountability.

Box 35.2 outlines some of the major trends.

Box 35.2: Major trends in the use of technology to improve information collection, use and sharing

Electronic medical records systems are now commonplace in health care globally and nationally. For example, New South Wales, Queensland and South Australia are progressively implementing electronic medical records systems across all their major hospitals.[86] More than 60 per cent of Victoria's public hospital beds have electronic medical record systems, and this is being extended.[87]

Nationally, the Commonwealth Government has introduced the My Health Record system, which covers 90 per cent of Australians.[88] It contains important basic health information about consumers, such as their medications, a list of Medicare-billing practitioners, immunisations they have had, some of their hospital discharge summaries and, increasingly, their pathology results.[89]

Recognising that a person's health information is kept in multiple places, governments are increasingly moving to connect systems.[90] There is a global trend towards 'interoperability', which accepts that there will never be one, all-encompassing electronic medical record system, and that information needs to be shared between the different electronic health record systems and providers to improve consumer treatment, care and support.[91]

In 2019, the Australian Health Ministers Advisory Council endorsed the *National Health Interoperability Roadmap*, which sets out a framework for sharing of health information between all parts of health care—primary, specialist and inpatient, whether public or private.[92] All states and territories are moving to support this framework.[93]

Internationally, electronic medical records are increasingly shared among interoperable systems. For example, Ontario Health teams in Canada have implemented the award-winning Health Report Manager system, which integrates health team records with primary care electronic records.[94] It is designed to improve communication among healthcare providers by enabling services to receive patient reports, such as discharge summaries, from hospitals and other healthcare facilities directly into their own electronic medical records systems.[95]

Private sector organisations are also starting to share records or communication platforms.[96]

The health ICT landscape

In Victoria, most public mental health service delivery occurs within the broader health service system. The state's hospital and community health ICT systems are advanced. The Victorian Government's investment through the 2016 *Digitising Health* strategy has focused on implementing new clinical systems and electronic medical records within hospitals; sector-wide shared clinical information, integration and interoperability in line with state and national standards; and international good practice.[97]

As a result of this and health service investment, more than 60 per cent of acute hospitals have advanced digital health records and information management systems and most others are upgrading their systems.[98] Victoria allows health services to choose their own electronic medical record systems in line with a set of standards, leading to implementation of different systems in different hospitals.[99]

Despite the ICT advancements in general health, the Commission was told that investments have not always incorporated mental health service needs.[100] As a result, the use and type of electronic health records for acute and community-based mental health services are mixed.[101] The major hospital records include records for acute inpatient mental health wards.[102] In a limited number of cases, these electronic records have been configured to include mental health services in community-based settings.[103] For example, one metropolitan hospital has adapted its system to operate in the adult community mental health service, informing both inpatient and community mental health staff about what is happening with consumers.[104]

However, most community-based mental health services do not have an electronic health record system, instead recording information on paper and transferring it by fax.[105] The Commission is aware that some of these services are moving to adopt electronic records, but on the whole there are very limited digital records in community-based mental health services.

There are also multiple patient management systems in primary and secondary health services. For example, there is widespread adoption of clinical information systems in general practice.[106] Private specialists are increasingly using patient management systems as the market responds to differing needs in this sector.[107]

While the switch to digital records is a positive step, hospital electronic medical records only enable intrahospital information capture and sharing.[108] They do not allow for sharing with other services and sectors.[109]

A tailored but outdated approach in mental health

Existing area mental health services use a longstanding statewide data system called the Clinical Management Interface/Operational Data Store (CMI/ODS) to record and share basic information about registered consumers.[110] CMI/ODS records a range of mental health–related data including details of consumer admissions to bed-based services, clinical contacts in the community, consumer outcome measures (consumer and clinician completed) and details of consumers receiving compulsory treatment under the Mental Health Act.[111] The Department of Health manages the system, and area mental health services input their data into the server to report to the department.[112]

The advantages of CMI/ODS are that it generates a unique statewide identifier for registered consumers, which lets any area mental health service access information, in real time, recorded about that person, regardless of which service they use.[113] It ensures the legal basis for providing treatment on a compulsory basis is evident to all services and provides the mechanism for the services to meet their departmental data reporting obligations, as well as reporting obligations to the Chief Psychiatrist and Mental Health Tribunal.[114] Registered consumers are those who have been admitted into a public mental health service for treatment, care and support.

CMI/ODS does not at this time capture information on non-registered consumers.[115] Non-registered consumers include people who have made contact with a service (either through the emergency department or triage), but who have not been assessed as needing or able to be treated by that service.[116] This means that it is currently not possible for services to see any information or prior history for a person who has sought help previously but not received public services.[117] General emergency department workers and non-designated health service providers are not able to access CMI/ODS information.[118]

While the statewide view of mental health consumers available in CMI/ODS is useful, several area mental health services and others told the Commission that the information in the system is largely administrative and is not used for day-to-day service delivery.[119] They also noted that it has very limited capacity to record or share clinical notes.[120] Its clinical use is limited to the initial assessment of a person, for discovering whether the person is already registered in the mental health system, and for reporting to the department.[121]

Other aspects of CMI/ODS are also less than ideal. The data for CMI/ODS is collected manually by the mental health worker and entered into the system by administrative staff.[122] This is inefficient, and not consistent with how modern health record systems work, such as those used in hospitals and by GPs, where a person's data is entered directly into the system and replaces paper records.

Further, CMI/ODS also does not allow for any sharing of information with other health systems, including hospital electronic records or primary care systems.[123] This means that electronic information sharing within and between mental health providers is very limited, and that CMI/ODS is not useful as a tool to support integration of physical and mental health treatment, care and support across sectors. There is currently no other statewide information sharing system that enables quick and secure sharing of records.[124]

NorthWestern Mental Health described the challenges of current ICT arrangements, which limit both information capture and information sharing:

> **Whilst the [department's] statewide mental health information system, Client Management Interface/Operational Data Store (CMI/ODS) is a valuable asset, it has significant limitations and does not appear to have a system development life cycle aligned to the service delivery changes. There is functionality that is either not used or no longer meets the services' needs. This issue along with the lack of interoperability with other health service systems creates inefficiencies resulting in local bespoke systems being developed.[125]**

Monash Health also stated that data system management needs to be refocused towards clinical care, and that better use must be made of available technology and digital health solutions to improve information collection and sharing:

> The current data system for Victoria, CMI, fundamentally restricts clinical care. It is a legacy system and should be retired so that best practice clinical care is facilitated by, not dictated by, the data system. Technology needs to assist the clinical process and allow flexibility in the clinical work as well as in the design of services. We need to move on from CMI to something much simpler and flexible. Currently, CMI is highly prescriptive, encourages silos in the way it opens and closes cases, and increases likelihood of people falling through the cracks rather than decreasing the likelihood which was intended. It should be designed from the bottom up to assist clinicians.[126]

Area mental health services advised the Commission that due to the lack of shared electronic records, they mostly use phone, fax or hard copy to share clinical records during transitions and care coordination.[127] In regional settings, a courier is sometimes needed to transport paper information.[128]

This reliance on fax and phone-based communication is inefficient and ineffective. Consumers must merely hope that service providers have contacted their next service and passed on relevant information, and that this information has been received and accepted.[129]

Moreover, because CMI/ODS and service provider electronic records do not currently connect to one another, this leads to duplication of data entry, inefficiency and increased chance of data entry error.[130] Duplication of entry can also result in human error inputs, which may put consumers at physical or non-physical risk.[131]

Bendigo Health recognised that services have had to implement bespoke systems to capture data but that this duplicates data entry and requires extra resources:

> While use of the system [CMI/ODS] is mandated, the system lacks functionality and usability is poor. In addition, ability to access live data from the system at a service level is limited. As a result, [designated mental health services] are utilising bespoke systems in addition to CMI/ODS to allow for local analysis and interrogation of data to both monitor performance and inform service provision, duplicating both data collection and resource effort as system integration with CMI/ODS is not supported.[132]

Outside of state mental health services, there is virtually no electronic connectivity between primary and secondary care and the state system, which solely relies on fax, phone and paper-based sharing of clinical information.[133] This lack of even the most basic secure electronic messaging is a major barrier to sharing information and limits providers' ability to seek important information about a consumer.

Primary Health Networks described how challenging this lack of integrated systems is when trying to help consumers move between service sectors. Primary Health Network representatives suggested that Victoria is difficult because it does not have statewide data infrastructure to manage patient flow.[134] They argued that Victoria needs a statewide architecture to maximise data and improve how patient information is shared so consumers do not need to tell their story over and over again.[135]

Dr Elizabeth Deveny, CEO of South Eastern Melbourne Primary Health Network, also said that electronic information sharing is important for ensuring smooth transitions between public mental health services and GPs:

> In my view, digital technologies and e-records in relation to a person's care are necessary when a consumer of mental health services may move from an inpatient stay in hospital to a GP and to other community service providers. Having one source of readily accessible information about a consumer is very important particularly in relation to stepped models of care and the main game, which is keeping people well and out of hospital.[136]

The Commission is concerned that the current disconnect, variability and inefficiency of ICT systems and processes hampers the ability of service providers to capture, use and share consumer information effectively. At the core of the issue, the Commission was told that services needed to 'demolish the fax machine' and implement more contemporary systems that support better consumer experiences and safety.[137]

35.3.6 A lack of data to drive service and system improvements

Better collection and dissemination of mental health data is also critical for improving the performance of mental health and wellbeing services and the system, and can help translate research into practice.[138] However, current mental health data collection arrangements and systems are not fit for purpose.

As noted above, CMI/ODS is the primary source of data for Victorian mental health services. It does have some advantages: it enables longitudinal studies—that is, studies over a period of time—of consumer outcomes and it contains some rich data.[139] However, Mr Symonds noted that mental health data collection, analysis, synthesis and dissemination are all hampered by the CMI/ODS system, which has limited use in informing performance monitoring and improvement.[140] Mr Symonds, Mr Shane Solomon (Partner of Caligo Health and giving evidence in a personal capacity), and others have noted major issues with current data collection including:

- a lack of data about effective interventions[141]
- a focus on collecting data for compliance purposes rather than to inform future planning and monitor service quality and efficacy (including treatment and intervention data)[142]
- a lack of information on all people who access public specialist mental health services (rather than just registered clients, who are only recorded in the system after they are deemed eligible for mental health services)[143]
- poor or inconsistent data collection on specific consumer cohorts and their outcomes[144]
- poor and inconsistent triage data that limits understanding of who is or is not able to access public specialist mental health services[145]
- the way in which contacts are recorded, which may underreport true hours of contact[146]
- limited capacity to share information for quality and safety purposes[147]
- inconsistent collection of data on diverse communities, reducing transparency regarding the use of mental health services and associated outcomes in diverse communities, and the capacity to plan for and respond to their needs.[148]

At the service level, the Commission was told that CMI/ODS does not allow service providers to easily see their own data that they have inputted into the system, nor produce live reports and graphs to track their performance and outcomes.[149] Ms Karyn Cook, Executive Director of Mental Health Services at Warrnambool Community Health's South West Healthcare, said that improving digital infrastructure and capability could improve data analytics, research and innovation, including by enabling 'services to access their own data, monitor performance easily, and slice it to suit their own strategic planning'.[150]

At the system level, Mr Solomon noted that there is scant evidence to indicate what type of service model and level of intervention works best.[151] He indicated there is little focus on recording and describing the types of services consumers receive and linking that to outcomes, which is important for evaluating the effectiveness of different models of treatment, care and support.[152] Instead, mental health services tend to record only basic output data such as number of bed days or number of phone calls made.[153] Mr Symonds also said that the Victorian Government holds multiple valuable datasets that could be better linked to improve evidence-based policy, planning and service delivery.[154]

The Victorian Government noted that a 'redesign of the client management system would facilitate the delivery of high-quality services',[155] and that new data standards and mechanisms would be beneficial to improve system administration and accountability:

> In particular, development of a centralised live information system would support more active statewide monitoring, stronger forecasting and more timely quality improvement. Further, a redeveloped system would reduce clinician documentation burden which currently requires data entry across multiple systems. In addition, centralised triage data capture at the gateway to the specialist service system would support stronger oversight of specialist mental health service access. This would make it possible to determine whether people are being appropriately triaged, or whether they are not being admitted to services because of pressures on the available resources. The Royal Commission also has an opportunity to recommend that the Victorian Government refine data collection definitions, methodologies and mechanisms to collect standardized and comparable data on outcomes.[156]

Mr Solomon suggested that such changes to the type of data that is collected, and how, are necessary for researchers to undertake more effective studies. He also stated that the impact of existing institutes and new ones like the Collaborative Centre for Mental Health and Wellbeing will depend on getting access to this type of data.[157]

Professor Suresh Sundram, Head of the Department of Psychiatry at the School of Clinical Sciences at Monash University and Director of Research at Monash Health Mental Health Program, told the Commission in a personal capacity that '[a] clinical registry concept similar to that successfully established in oncology is required in the public mental health system.'[158] Clinical registries collect health-related information to monitor outcomes from various interventions and guide service and system improvements.[159] He noted that this would allow 'the collection of high-quality clinical data for every individual who engages with the public mental health system, and long-term data associated with that individual'.[160] This data could be linked with demographic data, creating a record of outcomes associated with interventions and socioeconomic variables.[161] Professor Sundram suggested that a mental health registry would be invaluable for research into effective interventions, and could reduce ineffective practices.[162]

Many other services and universities also suggested to the Commission that access to better data is essential to create a learning culture. For instance, in its submission, the Adult Psychiatric Imperative noted that linking health datasets with other national and state datasets is critical to help determine factors that contribute to and precipitate mental illness, as well as to determine outcomes from interventions.[163] However, there is currently limited ability to link data and information across different sectors and with primary mental health services.[164]

The Commission considers that a new approach to information collection, use and sharing is needed to support measuring outcomes, system accountability, research, innovation and evaluation.

35.4 A pathway forward for information management

Victoria's mental health and wellbeing system must be supported by more efficient and innovative use of information and data to improve service delivery, the consumer experience and system administration.

The Commission believes that the Victorian Government needs to shift the culture of information collection and sharing in mental health from one of risk avoidance and silos, to one of collaboration, openness and presumed but protected access.

To achieve this, there need to be major reforms that give priority to:

- new mechanisms that will contribute to an appropriate culture of openness based on informed consent, protections, and clear policies, standards, protocols and delegations
- enhancing technology and information architecture to improve information collection, use and sharing
- refocusing information and data on people, and on consumer outcomes and experiences in particular.

35.5 Creating a culture of openness and co-ownership

Consumers, service providers and families, carers and supporters have expressed the desire for a much more open, collaborative and seamless culture of information collection, use and sharing. This will lead to better service delivery and improved consumer outcomes and experiences.

To achieve this, the Commission recommends that the Victorian Government establishes the following approaches to promote a more open culture of recording and sharing information between mental health and wellbeing service providers and with consumers, families, carers and supporters.

35.5.1 New policies, standards and protocols for information collection, use and sharing

Relevant policy documents, strategies and performance and accountability frameworks should clearly communicate the need for new approaches to information collection, use and sharing. They should enable the effective, safe and efficient collection and sharing of mental health and wellbeing information between individuals and service providers who have a genuine need to know such information for the purpose of service delivery, safety or good system administration.

These documents should not be prescriptive in nature but should clearly emphasise the expectation that new ways of collecting, using and sharing information are required to ensure:

- they reflect the principle of 'open and presumed but protected access', including transparency about how information is being collected, used and shared
- they reflect existing and emerging information security standards and arrangements that ensure data and information is secure and only accessed by those who need to see it
- integrated and joined-up care between workers, within and between services and for continuity of care
- seamless consumer transitions that reduce the burden on consumers, families, carers and supporters to have to tell their story multiple times or to bear the responsibility of maintaining and transferring their health information
- improved service monitoring, performance and accountability
- enhanced outcome measurement, research and innovation to deliver better interventions and outcomes over time.

The complexity of the mental health and wellbeing system also means that clear guidance about information management is needed for service providers, consumers, families, carers and supporters. The Victorian Government should develop and release standards developed in consultation with consumers, families, carers and supporters to ensure they effectively respond to the priority needs of each.

Wherever appropriate, specific protocols should also be implemented to guide the delivery of information-related reforms, including for referral approaches into Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services, and transitions and shared care arrangements between primary and secondary care providers and mental health and wellbeing services.

Alongside the protocols and standards, the government should also ensure information security arrangements are in place to inform the proper access, use and protection of consumer mental health information. Mr Symonds noted that 'records must be kept, stored and used in ways that protect and preserve the safety of clients'.[165] This should include that the system and services have appropriate delegations, permissions and operational policies to make sure only those who need to view information can access it and are responsible for safe and proper management of the information. Oversight of information sharing will also be critical. The Victorian Information Commissioner has combined oversight of information access, information privacy and data protection.[166] The Information Commissioner has the power to undertake inquiries and audits into organisations' compliance with relevant privacy regulation and legislation—for example, its 2017 Review of Information Governance in the then Department of Health and Human Services.[167] Together, strong information security arrangements and oversight functions should provide openness of information sharing, clarity of roles and responsibilities, and consequences for breaches.

The Commission recognises that in some instances legislative change will be necessary to modernise information sharing arrangements and to ensure the future system delivers contemporary services. Removing legislative and regulatory barriers that prevent open sharing of information between service providers, while retaining appropriate consumer and worker rights and protections, is critical.

The new Mental Health and Wellbeing Act recommended in Chapter 26: *Rebalancing mental health laws—a new Mental Health and Wellbeing Act* will specify the ways in which information should be collected and used for the purpose of: electronic collection, use and sharing; service provision; system administration; accountability; measuring outcomes; and conducting research and evaluation.

Outside of this Act, the Victorian Government will need to ensure it regularly reviews and revises other legislative frameworks that may affect the ability to use or share information in line with the new reforms.

35.5.2 Consumer contributions and access to information

At the service level, leaders should also promote a more open culture of information collection and sharing with consumers. The Victorian Government should set clear expectations of mental health and wellbeing services that includes:

- recording information that is sensitive, factual and assumes from the beginning that consumers will be able to access it
- providing consumers with opportunities to contribute to the information held about them, where appropriate
- supporting consumers to easily access their own information.

35.5.3 A consent-driven approach

Informed consumer consent is essential to a culture of open information collection and sharing. During consultations, consumers were clear that consent is important to them, but that it should not get in the way of sharing limited basic information that improves their outcomes and experiences.[168]

Comprehensive consent arrangements will help ensure consumer privacy and increase their agency, and such arrangements will help service providers understand when information should and should not be shared. Consent is important to ensure a consumer-centric system of service delivery.

The Victorian Government should, without removing existing permissions, co-design and implement a consumer consent approach with consumers. This system will inform service providers, families, carers and supporters involved in a person's treatment, care and support about how consumer information can be collected, used and shared. Importantly, the consent approach needs to adequately consider and capture the information needs of parents and guardians of children and young people, as well as legal guardians responsible for the wellbeing of some adult consumers. Parents of children need access to their child's mental health and wellbeing information, and many parents and guardians of young people play an active role in that person's treatment, care and support. Consent arrangements should consider these needs and transition arrangements while protecting the privacy and safety of individuals.

The consent system should also build on information currently available in CMI/ODS (it would not scale back existing access permissions) and should inform the implementation and accessibility of information in the Mental Health Information and Data Exchange proposed in section 35.6.3. The consent system would be aligned to and work within the parameters of future legislation.

This consent system will give consumers more power over their information and will support them in working closely with their treatment, care and support team in the way that best suits them. This will also mean families, carers and supporters can get more detailed information where a consumer requests it, more easily.

35.5.4 Implementation and phasing considerations

The Victorian Government should establish the policy directions and protocols that will guide information collection, use and sharing across all mental health and wellbeing reforms. This should include the development and release of the new standards for information sharing to help guide service providers, consumers, families, carers and supporters. These policies, protocols and standards should be regularly reviewed and updated. The consumer consent approach and associated permissions should be co-designed and established as part of this work.

At the same time, legislative change will occur through establishing a new Act to enable effective and efficient information sharing aligned with the new reforms. Over time, legislation, including the new Act and other relevant legislation, should be routinely reviewed to ensure it enables effective and safe information collection, use and sharing.

35.6 New ICT systems and infrastructure

While legislative and policy changes are necessary to establish a new information culture, modern ICT systems will be critical to implementing the efficient collection, use and flow of information in line with the protections and permissions discussed previously.

A number of service providers and experts have suggested that new information systems are needed to allow for better service delivery to consumers, and better performance monitoring. Sharing of records has been raised as a major enabler of increased safety and improved service delivery.[169] St Vincent's Hospital Melbourne suggested that connected ICT systems will help to improve service delivery:

> **Ensuring integrated ICT systems where information is readily accessible across [area mental health services] is important. Solutions that clinicians can readily access, wherever they see the consumer, as well as technology that allows people to connect, would improve service delivery and efficiency.**[170]

The Commonwealth Scientific and Industrial Research Organisation (CSIRO) noted that electronic information sharing systems are critical to providing more holistic, precise and preventative health responses in future health systems.[171] They indicated that these systems can improve consumer outcomes by 'enabling safer medicines management, improving care coordination, and helping inform treatment decisions'.[172] The Productivity Commission found that expanding the use of digital records in mental health services would facilitate a much better consumer experience and improve information sharing.[173] The Productivity Commission recommended that My Health Record, the national shared health record, provides a good platform for this information sharing to occur.[174]

The Commission is broadly supportive of this approach, and concurs that digital records and systems need to be better used to allow for contemporary service delivery. The Commission also notes that My Health Record is one valuable tool for sharing some mental health information, and that its utility in the sector will improve as more services adopt it.

However, the Commission notes that many of Victoria's mental health services do not even have the basic electronic records systems nor functionality to connect to My Health Record, which itself does not have the full functionality needed to effectively and appropriately collect and share the full range of information needed to deliver comprehensive mental health services. As Peninsula Health stated, 'My Health Record does not appear to have materially assisted with information sharing in the mental health sector.'[175]

Mr Symonds noted that significant investment is needed in Victoria to redesign how the system manages case information and service delivery, as well as collection of data for administrative purposes.[176] Without this investment, the mental health and wellbeing system will continue to fall further behind general health and will not deliver on its reform objectives.

As previously described, Victoria has the existing CMI/ODS system that allows public mental health services to share some information on common registered consumers, and also includes a central statewide data store of information. However, the system is outdated and does not have many of the features needed for contemporary information collection, use and sharing, including:

- the ability to record clinical notes and access clinical information between mental health services
- the ability to see prior service delivery information on non-registered people—that is, those people who have sought treatment, care and support from a mental health provider but have not been accepted
- the ability to easily and efficiently generate performance and service reports to improve service responses.

There is also limited ICT capacity to allow connectivity or sharing of information between public mental health and wellbeing services and other health services involved in a person's day-to-day treatment, care and support, including GPs, private psychologists and psychiatrists and allied health workers.

To this end, the Victorian Government should fund and establish new state-of-the-art technology infrastructure and systems for mental health and wellbeing that at a minimum will ensure:

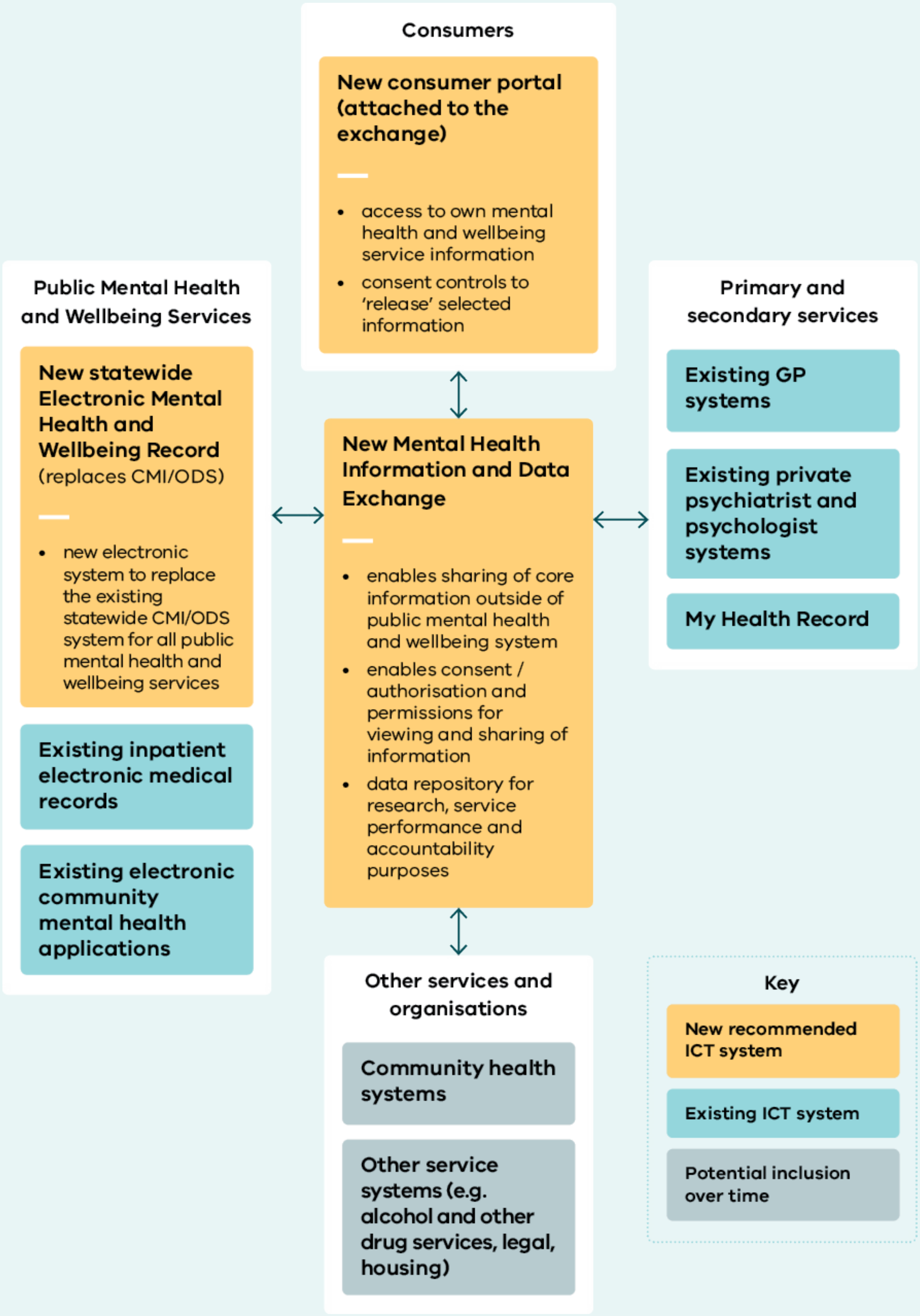
- information is recorded efficiently and safely in electronic form, removing the reliance on paper records, reducing double entry of information, and creating easily retrievable information for providers
- it is easy to access and share information—providers should not have to search through multiple applications to find essential information
- the technology solution draws on digital information already available in other systems, with a focus on what information is to be shared with other permitted parties
- recording and visibility of consistent information across all mental health and wellbeing systems and service streams, with appropriate parameters and protections in place
- systems are designed to progressively improve over time, based on experience of what works and what does not and on evolving needs
- the design and oversight of the projects and ICT systems are controlled by those people with most to gain from their success, including frontline mental health and wellbeing workers, consumers and families, carers and supporters.

The Commission recommends introducing three new major ICT components to achieve this:

- A new statewide Electronic Mental Health and Wellbeing Record—this would be for all public mental health and wellbeing services (including services within the infant, child and youth mental health and wellbeing system, and those within the adult and older adult mental health and wellbeing system), which will replace the current CMI/ODS system. For community mental health and wellbeing services, which are almost all still paper-and fax-based, using the record will bring their mental health service digitisation to a level comparable to that in hospitals and primary health care. The new record will interoperate with hospitals that have electronic medical records, and so avoid duplication of data entry and resources.
- A new Mental Health Information and Data Exchange—this would allow for sharing of information outside of public mental health and wellbeing services, such as GPs and community mental health and wellbeing services, where appropriate. This could happen for one of two purposes: to facilitate service delivery or to enable access to deidentified data for research and administrative purposes.
- A new consumer portal to allow consumers to easily access their own information.

Figure 35.4 summarises the Commission's intent for the new ICT arrangements, noting that the Victorian Government should partner with consumers, families, carers, supporters, service providers and frontline workers to design and implement all of the priority initiatives listed.

Figure 35.4: Conceptual map—ICT arrangements for information collection, use and sharing in the mental health and wellbeing system



Consumers

New consumer portal (attached to the exchange)

- access to own mental health and wellbeing service information
- consent controls to 'release' selected information

Public Mental Health and Wellbeing Services

New statewide Electronic Mental Health and Wellbeing Record (replaces CMI/ODS)

- new electronic system to replace the existing statewide CMI/ODS system for all public mental health and wellbeing services

Existing inpatient electronic medical records

Existing electronic community mental health applications

New Mental Health Information and Data Exchange

- enables sharing of core information outside of public mental health and wellbeing system
- enables consent / authorisation and permissions for viewing and sharing of information
- data repository for research, service performance and accountability purposes

Primary and secondary services

Existing GP systems

Existing private psychiatrist and psychologist systems

My Health Record

Other services and organisations

Community health systems

Other service systems (e.g. alcohol and other drug services, legal, housing)

Key

New recommended ICT system

Existing ICT system

Potential inclusion over time

35.6.1 A new statewide Electronic Mental Health and Wellbeing Record

Digital records are essential to support good consumer treatment, care and support, choice and easy transitions. As a core component of the new system, community-based mental health and wellbeing service providers need access to digital records to deliver on their core functions. However, community-based mental health settings are where digital mental health records are currently missing. The Department of Health should rectify this situation so these services can provide more seamless transitions, joined-up care and efficient practice. It will also reduce the need for consumers to tell multiple providers their story and will help mitigate risks of harm.

The department should develop and implement a contemporary Electronic Mental Health and Wellbeing Record using new governance arrangements outlined later in this chapter. This will replace the current CMI/ODS system for all public mental health and wellbeing service providers that do not currently have an electronic medical record with a mental health module. Mental health and wellbeing services that do have a mental health module as part of their electronic medical record should have the opportunity (and be encouraged) to opt in if they wish.

This record should be a single system created and maintained for the whole state and across age cohorts to ensure sustainability and consistency across the sector. Functionality should be progressively developed in line with consumer and service provider needs, but initially this record should hold the basic information that mental health and wellbeing workers need to provide treatment, care and support. This functionality would include:

- demographic information
- contacts
- intervention codes and services delivered
- outcomes and experience measurements
- bookings
- full clinical notes recording capacity
- visible access to consumer advance statements and preferences
- ability to generate performance reports.

The record should retain the strengths of CMI/ODS, including statewide look-up capacity, a single consumer record number, initial assessment functionality and data definitions (where appropriate).[177]

Over time, further functionality could be added to support activity such as prescribing and ordering tests or medications. The design of the record should allow for easy updating and for new modules and functions to be progressively added as new needs arise over time.

While the record should support service delivery to consumers of all ages, the Victorian Government should ensure appropriate parameters are in place that control viewing of specific information based, for example, on age at the time of treatment or other factors that may affect consumer privacy. These issues should be the focus of the co-design process outlined in section 35.6.7 involving consumers, families, carers, supporters and service providers.

The new Electronic Mental Health and Wellbeing Record should be cloud-based to support a mobile workforce and interoperable with existing and emerging hospital electronic medical records and other patient management systems. It should build on existing state platforms wherever possible.

35.6.2 A review and update of currently recorded data items

Improved service delivery and better system administration, research, innovation and evaluation require improved data and better analytical capability.

The Victorian Government should undertake a comprehensive review of the current data being captured by public mental health services. It should reduce those items that are not routinely used and add items that better reflect mental health activity and consumer mental health and wellbeing outcomes.

This review should be led in consultation with service providers and other experts to identify unnecessary measures and to determine the most appropriate new items for inclusion.

At a minimum, new items should:

- capture accurate counting of hours of client-related work
- record contacts for ‘unregistered’ clients, aligned with the new statewide triage data collection approach recommended in Chapter 8: *Finding and accessing treatment, care and support*
- include ‘intervention codes’ to classify what services are offered to clients across different types of treatment, care and support (this is important for future research into which interventions are most effective)
- capture consumer and clinician completed outcome and experiences measures, and any family, carer and supporter measures developed
- include fully integrated and improved assessment and referral data to better understand who is trying to access the system and who is not receiving support, including a range of demographic data such as (but not limited to) diversity and socioeconomic status
- capture consumer needs that would lead to better experience and outcomes (such as accessibility requirements and language support needs)
- capture accurate clinical costings data to price mental health and wellbeing services effectively.

The new data items will give service providers more comprehensive information about the types of services their consumers are receiving and their effectiveness. This information will support optimum service model design in the future.

New data items and standards will also improve system capability to undertake service planning, commissioning and performance monitoring. A better understanding of which interventions work will guide more targeted research and investment, leading to improved treatment and intervention models for mental health and wellbeing.

The Victorian Government should consider the way the system operates in the context of broader data management approaches for health and also community services.

35.6.3 A new Mental Health Information and Data Exchange

A new Mental Health Information and Data Exchange is needed to allow sharing of core information beyond the public community and inpatient mental health service system with the broader range of those services involved in a person's recovery, including private psychiatrists and psychologists, GPs, and non-government organisations.

The Victorian Government should, through the governance model outlined below, fund and implement development of the new Mental Health Information and Data Exchange.

The Mental Health Information and Data Exchange should allow interoperability between the recommended Electronic Mental Health and Wellbeing Record and other major systems such as (but not limited to) hospital electronic medical records, GP practice management systems, specialist psychiatric and psychologist systems and My Health Record.

The Mental Health Information and Data Exchange would not share every piece of information about a consumer with everyone who has access to it. It should have a 'clinical viewer' function that allows each relevant service or worker to view relevant information easily. It should provide basic information needed for other entities to provide treatment, care and support effectively and in line with consumer preferences.

In the beginning, the Mental Health Information and Data Exchange should allow for seamless viewing and sharing of information between Victorian funded mental health and wellbeing services and health entities directly involved in responding to mental health and wellbeing needs, including emergency departments and emergency responders. This does not mean that every party should have access to every part of a consumer's record, but they should be able to view the fundamental information they need to deliver their services effectively.

Once established, the Mental Health Information and Data Exchange should allow for sharing of some relevant information between funded mental health and wellbeing services and primary and secondary service providers (for example, GPs, allied health workers and private psychiatrists and psychologists). This access should be informed by the consumer consent approach previously proposed, and should be controlled by the consumer.

Over time, the Mental Health Information and Data Exchange could be expanded to include a more diverse range of services involved in a person's treatment, care and support, such as alcohol and other drug services and housing. Sharing of information with these entities should be limited to only the information that they need to know to deliver services effectively, informed by strict information privacy and security protocols and protections, and strictly informed by consumer consent.

Appropriate privacy and security protections should be applied to the Mental Health Information and Data Exchange to ensure consumer privacy, safety and trust, and strict delegations should ensure that only authorised personnel can view relevant information about the consumer. Transparent communication about how and when information is used and shared should also be available to consumers and service providers. Mr Peters told the Commission that people's lack of confidence in being able to control digital information sharing can be a hindrance to adopting digital records.[178] Mr Peters noted that the system needs 'strict controls around information sharing', and in addition, that information should wherever possible, be shared with consent, and should be opt in.[179]

Ms Kym Peake, then Secretary of the former Department of Health and Human Services, also said that electronic records should have strong safeguards, and that it is important to cultivate trust in consumers that their privacy will be maintained.[180] Ms Peake noted that actively engaging with the public about how their information will be used, communicating the benefits of information sharing, and listening and responding to concerns will help to build support and trust for electronic systems and processes.[181]

The Victorian Government should ensure the Mental Health Information and Data Exchange is designed in partnership with service users and service providers to help build usability and trust as recommended in the implementation approach below. The Department of Health should also consider establishing a clear communication plan to promote the features of the new system to consumers and service providers that explains the benefits of the new system and implementation timelines. Communication materials should also be transparent about how information will be collected, shared and protected across all parts of the system.

While the Mental Health Information and Data Exchange is being developed, secure messaging capability should be implemented to allow basic information such as discharge summaries and medication lists to be sent to a consumer's primary and secondary care team, including GPs and private providers. This will allow basic information to be shared quickly and securely while the larger systems are being developed. This approach should also be used to support electronic referrals between medical practitioners and Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services in the interim.

In the immediate term, while the Mental Health Information and Data Exchange is being established, the Victorian Government should also provide Ambulance Victoria with access to the basic information they need from CMI/ODS so they can effectively respond to mental health crises in the community. As described in Chapter 9: *Crisis and emergency responses*, while Ambulance Victoria should have access to this information, mental health expertise should also be offered to the attending responders to help them understand the context and implications of this information for the consumer, and therefore the most appropriate response. Chapter 9 outlines the current trial of such an approach that Ambulance Victoria is undertaking in partnership with Eastern Health.[182]

35.6.4 A new data repository, clinical registries and accessible information

The aggregate data collected under the new Mental Health Information and Data Exchange should be used to create a central data repository of all mental health and wellbeing information. There are a number of purposes for this data repository.

The information in the data repository should inform the suite of mental health and wellbeing data collections the Department of Health collects to advise on policy and service design, and performance monitoring and accountability.

Information in the data repository should also be made available to services to help them benchmark and improve their own performance.

The Mental Health Information and Data Exchange and data repository should also be used to house and inform new clinical registries for mental health and wellbeing that will support future research and practice translation. These registries should be available to authorised researchers, advocates, innovators, service providers, practitioners, consumers, families, carers and supporters, as well as some government organisations, to inform service and system improvements. Strict permissions should apply to the registries to ensure information is only accessible to those who need to see it.

De-identified information from the Mental Health Information and Data Exchange—that is, information that is aggregated to a level that ensures that an individual cannot be identified—should also be used to create new public dashboards that provide the general community with access to regularly updated data on a range of mental health and wellbeing system performance and outcome measures. This will help to improve transparency about system performance. Figure 35.5 outlines the major features a new data repository should have.

Figure 35.5: Features of the mental health and wellbeing data repository

Mental Health Information and Data Exchange

Mental health and wellbeing data repository

Captures information and data from a range of sources including Commonwealth service provision and state service provision

	Data collections	Clinical registries	Data dashboards
Description	• specific data collections such as triage data and emergency data	• databases that collect consumer intervention and outcome data for common cohorts or service interventions	• public-facing online resources that provide de-identified data and information on mental health and wellbeing system performance and outcomes
Purpose	• to inform system administration, quality and safety and performance monitoring and reporting	• to inform research and continuous improvement by identifying what interventions work best and for whom	• to provide members of the community with accessible and transparent system performance and outcomes data
Accessibility	• the Department of Health and the Victorian Agency for Health Information would have primary access to this information • some data would be reported to the Commonwealth Government	• de-identified data and information would be available to approved researchers, service providers and experts only • in limited circumstances, identified data may be available to researchers with consumer consent	• the general public

35.6.5 A new, user-friendly consumer digital portal

The Victorian Government should establish a new user-friendly online consumer portal linked to the Mental Health Information and Data Exchange. This portal will be web and mobile friendly and will allow consumers to quickly and easily view crucial information about themselves and to authorise sharing of that information with members of their treatment, care and support team, including families, carers and supporters.

The online portal should give consumers access to their mental health information (including medications, discharge information, contacts and clinical notes, where appropriate). The portal should draw information from the Mental Health Information and Data Exchange and the Electronic Mental Health and Wellbeing Record, and put it into a user-friendly format that consumers can easily engage with. It should provide a consumer-friendly viewing window that makes it easy for consumers to find relevant information about their mental health and wellbeing.

The Victorian Government should ensure the portal is accessible, inclusive and supports multiple languages. It should be co-designed with consumers to ensure it meets their needs and preferences.

A number of health services are already moving to introduce consumer portals, and their design could help inform the new approach. The portal should be available to both current consumers and consumers who have been discharged from mental health and wellbeing services, ensuring they can easily access their history and information as required.

For children, parents and guardians should have access to the portal in line with relevant best practice, legislation and the consent approach. Consumers should also be able to authorise sharing their portal access with families, carers and supporters if they wish.

The Commission notes that, in limited circumstances, it may not be safe or appropriate for service providers to automatically provide consumers with access to their information (for example, in times of severe distress).[183] In such circumstances, the release of this information could be delayed until the consumer is ready to receive this information, and the service provider should ensure they discuss the information with the consumer before releasing it.[184]

The portal should not be used to communicate information to a consumer that they are not already aware of through discussions with their service provider, such as a medication change.

Mental health and wellbeing service providers should also continue to ensure they can offer user-friendly non-digital versions of records if requested, noting that some consumers may choose not to receive their information in a digital format. Use of the portal should be optional.

35.6.6 An inclusive implementation approach with strong oversight

Strong oversight of the new ICT projects will be required to ensure effective development and implementation, and to ensure continuing maintenance and upgrades. The following principles should guide the management approach:

- The roles and authorities should be clearly defined, including decisions about system design, responsibility for commissioning/contracting and implementation of the system.
- The authority on specifications, selection and configuration should lie with those who will benefit most from the system—those with lived experience and mental health professionals ('the users').
- Entities should consult with people with expertise and knowledge, and not rely only on staff tasked with implementing the system.
- ICT experts will need to advise on what is technically possible and implement the decisions made by users.
- Leadership of the program should be embedded in the mental health and wellbeing service delivery system, in collaboration with ICT experts.

The Commission advises the Victorian Government to establish a Mental Health Information Sharing Program Board (within the Department of Health) with overall responsibility for the program, including specifying the system requirements and setting priorities for investment.

The board would comprise those with lived experience of mental illness or psychological distress, frontline mental health professionals who will use the system, families, carers and supporters, experts who have successfully implemented health ICT systems, and the department. For accountability purposes, the board should be chaired by an independent person outside the public service.

A small commissioning, configuration and contract management unit—a program office—should also be established within the department. The program office would ensure the specifications and configuration of the new ICT systems are consistent with user needs and reflected in the board's decisions. It would create processes for consulting and engaging frontline staff and those with lived experience. It would also support the work of the board. The program office would be responsible for day-to-day management of the program budget, based on the board's investment priority decisions. The program office should comprise people with frontline mental health experience and health informatics expertise.

Implementation of the proposed systems could be contracted out or delivered in house by the department, depending on capability and cost. The board should decide who is to implement the system based on advice from the program office.

35.6.7 Implementation considerations for new technology systems

The Department of Health should establish the proposed Mental Health Information Sharing Program Board and program office to undertake a detailed upfront exploration of service provider and consumer needs. This will inform the design of the new ICT systems, including information to be collected, the new data items needed, and the systems' functions and operations.

The project should be guided by mental health and wellbeing workers and consumers, and approached from a content and user perspective. It should not be led primarily from an ICT point of view. This will ensure it is built to benefit those who will use it the most, and that the systems are fit for purpose and sustainable.

As noted above, secure messaging should be quickly introduced to allow for appropriate referrals to be electronically sent to Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services, and for sharing of information between these services and primary and secondary services. Ambulance Victoria should also be given access to relevant information.

A minimum viable version of the new Electronic Mental Health and Wellbeing Record should be established and rolled out in a staged way across Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services and statewide services. This will allow for iterative change and improvement in response to early testing and implementation.

The new Mental Health Information and Data Exchange should be established and trialled with primary and secondary providers, emergency responders and Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services, and with a selected Regional Mental Health and Wellbeing Board. Findings from the trial should be used to refine the arrangements and functions of the Mental Health Data and Information Exchange and support its statewide rollout. The consumer portal should be trialled at the same time.

The ICT systems need to be developed in conjunction with the rollout of the broader reforms recommended by the Commission. Careful initial planning and implementation will be critical to ensure cost-effectiveness and good outcomes. This will also ensure the systems are designed appropriately for the new provider landscape in a responsive and integrated mental health and wellbeing system.

1 *Witness Statement of Professor Ian Hickie AM*, 11 August 2020, para. 118.

2 Sarah Kipping and others, 'A Web-Based Patient Portal for Mental Health Care: Benefits Evaluation', *Journal of Medical Internet Research*, 18.11 (2016), 1–9 (p. 2); Deede Gammon and others, 'Shifting Practices Toward Recovery-Oriented Care Through an E-Recovery Portal in Community Mental Health Care: A Mixed-Methods Exploratory Study', *Journal of Medical Internet Research*, 19.5 (2017), 1–15 (p. 2).

3 *Witness Statement of Kym Peake*, 4 October 2020, para. 313; *Witness Statement of Terry Symonds*, 2 November 2020, paras. 313–314; Queensland Health, Information Sharing Between Mental Health Staff, Consumers, Family, Carers, Nominated Support Persons and Others, 2018, p. 1.

4 Victorian Government, *Submission to the RCVMHS: SUB.5000.0001.0001*, 2019, p. 34.

5 National Mental Health Commissioner, *Vision 2030: Blueprint for Mental Health and Suicide Prevention*, 2020, p. 21; Productivity Commission, *Draft Report on Mental Health: Overview and Recommendations*, 2019, p. 47.

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

7 Under the *Health Records Act 2001* (Vic), section 3, a person's identity must be apparent or be reasonably able to be ascertained from the information to be health information.

8 *Health Records Act 2001* (Vic), sec. 3.

9 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*, 2020; Australian Medical Association, Victoria, *Submission to the RCVMHS: SUB.4000.0001.0008*, 2019, pp. 103–104; Lifeline Australia, *Submission to the RCVMHS: SUB.0002.0029.0151*, 2019, p. 32; Queensland Health, Information Sharing Between Mental Health Staff, Consumers, Family, Carers, Nominated Support Persons and Others, p. 1.

10 *Witness Statement of Dave Peters*, 22 July 2020, paras. 41–42.

11 *Witness Statement of Kym Peake*, 2020, para. 315.

12 Health.vic, Disclosure of Health Information, <www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook/oversight-and-service-improvement/disclosure-of-health-information>, [accessed 5 November 2020].

13 *Witness Statement of Terry Symonds*, paras. 303–309; *Witness Statement of Shane Solomon*, paras. 72–78.

14 *Witness Statement of Karyn Cook*, 21 May 2020, para. 202.

15 *Witness Statement of Shane Solomon*, paras. 19–21.

16 *Witness Statement of Terry Symonds*, para. 313.

17 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 171.

18 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 115.

19 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 115.

20 *Joint Witness Statement of 'Mary Corbett' and 'Jacob Corbett' (pseudonyms)*, 25 June 2020, para. 105.

21 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*.

22 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*.

23 RCVMHS, *Metro AMHS Provider Information Sharing Roundtable: Record of Proceedings*, 2020.

24 *Witness Statement of Shane Solomon*, paras. 23 and 39.

25 *Witness Statement of Shane Solomon*, paras. 22–23.

26 Anonymous 49, *Submission to the RCVMHS: SUB.0002.0028.0627*, 2019, p. 2.

27 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*.

28 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*; *Witness Statement of 'Rachel Bateman' (pseudonym)*, 16 June 2020, paras. 149–150.

29 Victoria Legal Aid, *Your Story, Your Say*, 2020, p. 8.

30 Victorian Government, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, 2020, p. 6.

31 RCVMHS, *Carer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*, 2020.

32 RCVMHS, *Carer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*.

33 RCVMHS, *Carer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*.

34 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 262.

35 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, 2020, p. 675.

36 Royal Commission into Family Violence, *Report and Recommendations, Volume VI*, 2016, p. 142.

37 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*.

38 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*.

39 Wei Wen Chong, Parisa Aslani and Timothy F. Chen, 'Shared Decision-Making and Interprofessional Collaboration in Mental Healthcare: A Qualitative Study Exploring Perceptions of Barriers and Facilitators', *Journal of Interprofessional Care*, 27.5 (2013), 373–379 (p. 376); Timothy C. Kariotis and Keith M. Harris, 'Clinician Perceptions

of My Health Record in Mental Health Care: Medication Management and Sharing Mental Health Information', *Australian Journal of Primary Health*, 25.1 (2019), 66–71 (pp. 68–69).

40 Gillian Strudwick, Anthony Yeung and David Gratzer, 'Easy Access, Difficult Consequences? Providing Psychiatric Patients With Access to Their Health Records Electronically', *Frontiers in Psychiatry*, 10:917 (2019), 1–2 (p. 1).

41 *Witness Statement of Dr Stuart Lewena*, 11 May 2020, para. 69.

42 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*.

43 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*.

44 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*.

45 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*.

46 *Freedom of Information Act 1982* (Vic), sec. 33(4).

47 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*.

48 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*.

49 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*.

50 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*.

51 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*.

52 Australian Psychological Society, *APS Code of Ethics*, 2007, pp. 14 and 19; Medical Board, Australian Health Practitioner Regulation Agency, *Good Medical Practice: A Code of Conduct for Doctors in Australia*, 2020, pp. 6 and 21.

53 *Witness Statement of 'Rachel Bateman' (pseudonym)*, paras. 150–151.

54 *Witness Statement of 'Rachel Bateman' (pseudonym)*, paras. 150–151.

55 Victoria Legal Aid, p. 8.

56 National Mental Health Consumer and Carer Forum, *Privacy, Confidentiality and Information Sharing—Consumers, Carers and Clinicians: A Position Statement and Issues Paper by the National Mental Health Consumer and Carer Forum (NMHCCF)*, 2011, p. 7; L. S. Wilson and others, 'Mental Health Professionals and Information Sharing: Carer Perspectives', *Irish Journal of Medical Science*, 184.4 (2015), 781–790 (p. 782).

57 RCVMHS, *Carer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*; Wilson and others, pp. 781–782.

58 *Health Records Act 2001* (Vic), sec. 25.

59 Department of Health and Human Services, Making a Freedom of Information Request, <www.dhhs.vic.gov.au/making-freedom-information-request>, [accessed 12 November 2020]; RCVMHS, Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings; Office of the Victorian Information Commissioner, Make a Freedom of Information Request, <ovic.vic.gov.au/freedom-of-information/for-the-public/make-a-freedom-of-information-request/>, [accessed 22 December 2020].

60 *Health Records Act 2001* (Vic), sec. 26.

61 *Health Records Act 2001* (Vic), sec. 27.

62 Kipping and others, p. 2; Gammon and others, p. 2.

63 *Witness Statement of Professor George Braitberg AM*, 19 May 2020, para. 23.

64 *Health Records Act 2001* (Vic), sec. 2.4; *Mental Health Act 2014* (Vic), sec. 346(2)(h); *Mental Health Act 2014* (Vic), sec. 346(2)(g).

65 A designated mental health service is a service defined as being able to deliver mental health services under the Mental Health Act 2014 (Vic). There are a limited number of designated mental health services in Victoria.

66 *Mental Health Act 2014* (Vic), sec. 346(2).

67 Department of Health and Human Services, New Laws to Improve Quality and Safety in the Health System: Frequently Asked Questions—For Patients, 2020, p. 2.

68 *Witness Statement of Simon Thomson*, 24 June 2019, para. 51.4.

69 *Witness Statement of Simon Thomson*, paras. 51.4 and 88.1.

70 *Witness Statement of Simon Thomson*, para. 59.1.

71 RCVMHS, *Metro AMHS Provider Information Sharing Roundtable: Record of Proceedings*.

72 RCVMHS, *Metro AMHS Provider Information Sharing Roundtable: Record of Proceedings*.

73 *Witness Statement of Dave Peters*, paras. 47 and 48.

74 *Human Services (Complex Needs) Act 2009* (Vic), secs. 1, 14 and 17.

75 Coroner Simon McGregor, *Coronial Inquest into the Death of Darren Brandon* (Melbourne, 2020), pp. 56–57.

76 *Witness Statement of Associate Professor Ruth Vine*, 29 April 2020, para. 151.

77 *Witness Statement of Dr Shaymaa Elkadi*, 25 May 2020, para. 128.

78 *Family Violence Protection Amendment (Information Sharing) Act 2017* (Vic), sec. 7; Victorian Auditor-General's Office, *Implementation of the Criminal Justice Enhancement Program (CJEP)*, 2008, pp. 11–14 and 65–69; Family Safety Victoria, *Family Violence Information Sharing Guidelines*, 2018, pp. 18–34.

79 *Witness Statement of Julie Edwards*, 21 May 2020, para. 12.

80 *Witness Statement of Julie Edwards*, para. 66.

81 *Mental Health Act 2014* (Vic), sec. 347.

82 *Witness Statement of Terry Symonds*, para. 298.

83 Monash Health, *Submission to the RCVMHS: SUB.7000.0003.0001*, 2019, p. 78; *Witness Statement of Dr Elizabeth Deveny*, 8 June 2020, paras. 98–100; *Witness Statement of Dr Stuart Lewena*, para. 68; *Witness Statement of Dr Shaymaa Elkadi*, para. 128.

84 *Witness Statement of Terry Symonds*, para. 304.

85 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*.

86 Queensland Health, Integrated Electronic Medical Record (IeMR), <www.health.qld.gov.au/clinical-practice/innovation/digital-health-initiatives/queensland/integrated-electronic-medical-record-iemr>, [accessed 10 December 2020]; eHealth New South Wales, EMR Connect, <www.ehealth.nsw.gov.au/programs/clinical/emr-connect>, [accessed 10 December 2020]; South Australia Health, Sunrise EMR and PAS, SA Health's Electronic Medical Record, <www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+information+systems/sunrise+emr+pas/sunrise+emr+pas+sa+healths+electronic+medical+record>, [accessed 10 December 2020].

87 RCVMHS, *Meeting with Department of Health and Human Services Meeting Notes*, 22 June 2020, p. 3.

88 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 676.

89 Australian Digital Health Agency, My Health Record, <www.myhealthrecord.gov.au/>, [accessed 13 August 2020].

90 Australian Digital Health Agency, *National Health Interoperability Principles*, 2020, pp. 6 and 15–16.

91 CSIRO, *Future of Health: Shifting Australia's Focus from Illness Treatment to Health and Wellbeing Management*, 2018, p. 34; Australian Digital Health Agency, *National Health Interoperability Principles*, p. 34.

92 Australian Digital Health Agency, *National Health Interoperability Principles*, p. 8.

93 Australian Digital Health Agency, *National Health Interoperability Principles*, p. 6.

94 Ontario Health ICT System, Health Report Manager Supports Virtual Care and the Integration of Patient Information in Ontario Health Teams, 5 February 2020, <www.globenewswire.com/news-release/2020/02/05/1980410/0/en/Health-Report-Manager-supports-virtual-care-and-the-integration-of-patient-information-in-Ontario-Health-Teams.html>, [accessed 5 November 2020].

95 Ontario Health ICT System, Health Report Manager Supports Virtual Care and the Integration of Patient Information in Ontario Health Teams, 5 February 2020, <www.globenewswire.com/news-release/2020/02/05/1980410/0/en/Health-Report-Manager-supports-virtual-care-and-the-integration-of-patient-information-in-Ontario-Health-Teams.html>, [accessed 5 November 2020].

96 Precedence Health Care, How Inca Works, <precedencehealthcare.com/inca/>, [accessed 17 December 2020].

97 Department of Health and Human Services, *Digitising Health: How Information and Communications Technology Will Enable Person-Centred Health and Wellbeing Within Victoria*, 2016, pp. v and 4.

98 RCVMHS, *Meeting with Department of Health and Human Services Meeting Notes*, p. 2.

99 RCVMHS, *Metro AMHS Provider Information Sharing Roundtable: Record of Proceedings*; RCVMHS, *Regional AMHS Provider Information Sharing Roundtable: Record of Proceedings*, 2020; *Witness Statement of Shane Solomon*, para. 33.

100 *Witness Statement of Terry Symonds*, para. 307.

101 RCVMHS, *Meeting with Department of Health and Human Services Meeting Notes*, p. 2.

102 *Witness Statement of Shane Solomon*, paras. 33–34.

103 RCVMHS, *Regional AMHS Provider Information Sharing Roundtable: Record of Proceedings*; *Witness Statement of Shane Solomon*, para. 35.

104 RCVMHS, *Metro AMHS Provider Information Sharing Roundtable: Record of Proceedings*.

105 RCVMHS, *Metro AMHS Provider Information Sharing Roundtable: Record of Proceedings*; RCVMHS, *Regional AMHS Provider Information Sharing Roundtable: Record of Proceedings*.

106 Royal Australian College of General Practitioners, RACGP Practice Technology and Management: Minimum Requirements for General Practice Clinical Information Systems to Improve Usability, 2019, p. 1.

107 *Witness Statement of Shane Solomon*, para. 47.

108 *Witness Statement of Professor George Braitberg AM*, para. 22.

109 *Witness Statement of Professor George Braitberg AM*, para. 22.

110 *Witness Statement of Terry Symonds*, para. 305.

111 *RCVMHS Meeting with DHHS and VAHI Meeting Notes*, 6 July 2020, p. 3.

112 health.vic, Client Management Interface/Operational Data Store Service Contacts, <www2.health.vic.gov.au/mental-health/research-and-reporting/reporting-requirements-for-clinical-mental-health-services/service-contacts>, [accessed 15 May 2020]; Witness Statement of Shane Solomon, para. 36; Witness Statement of Terry Symonds, paras. 303–311.

113 *RCVMHS Meeting with DHHS and VAHI Meeting Notes*, p. 8.

114 *RCVMHS Meeting with DHHS and VAHI Meeting Notes*, p. 8.

115 *RCVMHS Meeting with DHHS and VAHI Meeting Notes*, p. 3.

116 *RCVMHS Meeting with DHHS and VAHI Meeting Notes*, p. 3.

117 *RCVMHS Meeting with DHHS and VAHI Meeting Notes*, p. 6; *Witness Statement of Dr Neil Coventry*, 29 July 2020, para. 92.

118 RCVMHS, *Metro AMHS Provider Information Sharing Roundtable: Record of Proceedings*; *RCVMHS Meeting with DHHS and VAHI Meeting Notes*, p. 5.

119 Bendigo Health, *Submission to the RCVMHS: SUB.0002.0030.0051*, 2019, pp. 21–22; RCVMHS, *Regional AMHS Provider Information Sharing Roundtable: Record of Proceedings*; *Witness Statement of Shane Solomon*, para. 36.

120 Victorian Auditor-General's Office, *Access to Mental Health Services*, 2019, p. 46; RCVMHS, *Metro AMHS Provider Information Sharing Roundtable: Record of Proceedings*.

121 Victorian Auditor-General's Office, *Access to Mental Health Services*, p. 46; RCVMHS, *Metro AMHS Provider Information Sharing Roundtable: Record of Proceedings*.

122 RCVMHS, *Metro AMHS Provider Information Sharing Roundtable: Record of Proceedings*; RCVMHS, *Regional AMHS Provider Information Sharing Roundtable: Record of Proceedings*.

123 *Witness Statement of Professor Robert Thomas OAM*, 12 May 2020, para. 75.

124 *Witness Statement of Dr Stuart Lewena*, paras. 67–68.

125 NorthWestern Mental Health (A Division of Melbourne Health), *Submission to the RCVMHS: SUB.0002.0030.0061*, 2019, p. 29.

126 Monash Health, p. 78.

127 RCVMHS, *Metro AMHS Provider Information Sharing Roundtable: Record of Proceedings*; RCVMHS, *Regional AMHS Provider Information Sharing Roundtable: Record of Proceedings*.

128 RCVMHS, *Regional AMHS Provider Information Sharing Roundtable: Record of Proceedings*.

129 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*.

130 RCVMHS, *Metro AMHS Provider Information Sharing Roundtable: Record of Proceedings*; *RCVMHS Meeting with DHHS and VAHI Meeting Notes*, p. 4.

131 Mental Health Australia, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, 2020, p. 32; Productivity Commission, *Draft Report on Mental Health, Volume 1*, 2019, p. 66; *Witness Statement of Scientia Professor Helen Christensen AO*, 18 July 2019, para. 52; Mental Health Legal Centre, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, 2020, p. 5; Allied Health Professions Australia, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, 2020, p. 3.

132 Bendigo Health, p. 21.

133 RCVMHS, *Metro AMHS Provider Information Sharing Roundtable: Record of Proceedings*; RCVMHS, *Regional AMHS Provider Information Sharing Roundtable: Record of Proceedings*.

134 RCVMHS, *Primary Health Networks Roundtable: Record of Proceedings*, 2020.

135 RCVMHS, *Primary Health Networks Roundtable: Record of Proceedings*.

136 *Witness Statement of Dr Elizabeth Deveny*, para. 100.

137 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*.

138 The Adult Psychiatry Imperative, *Submission to the RCVMHS: SUB.3000.0001.0070*, 2019, p. 68.

139 *Witness Statement of Terry Symonds*, para. 182.

140 *Witness Statement of Terry Symonds*, para. 183.

141 *Witness Statement of Shane Solomon*, para. 19.

142 *Witness Statement of Shane Solomon*, paras. 76–78.

143 RCVMHS, *Metro AMHS Provider Information Sharing Roundtable: Record of Proceedings*.

144 *Witness Statement of Terry Symonds*, para. 185.

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

146 *Witness Statement of Shane Solomon*, para. 73.

147 *Witness Statement of Dr Lynne Coulson Barr OAM*, 4 June 2020, para. 89; *Witness Statement of Louise Glanville*, 8 July 2019, paras. 68–73.

148 RCVMHS, *Culturally and Linguistically Diverse People Roundtable: Record of Proceedings*, 2019.

149 *Witness Statement of Terry Symonds*, para. 185.

150 *Witness Statement of Karyn Cook*, para. 202(a).

151 *Witness Statement of Shane Solomon*, para. 19.

152 *Witness Statement of Shane Solomon*, para. 20.

153 *Witness Statement of Shane Solomon*, para. 20.

154 *Witness Statement of Terry Symonds*, para. 187.

155 Victorian Government, *Submission to the RCVMHS: SUB.5000.0001.0001*, p. 34.

156 Victorian Government, *Submission to the RCVMHS: SUB.5000.0001.0001*, p. 34.

157 *Witness Statement of Shane Solomon*, para. 21.

158 *Witness Statement of Professor Suresh Sundram*, 19 May 2020, para. 115.

159 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].

160 *Witness Statement of Professor Suresh Sundram*, para. 116.

161 *Witness Statement of Professor Suresh Sundram*, paras. 115–116.

162 *Witness Statement of Professor Suresh Sundram*, paras. 115–116.

163 The Adult Psychiatry Imperative, p. 68.

164 Latrobe Regional Hospital, *Submission to the RCVMHS: SUB.0002.0028.0034*, 2019, pp. 5–6.

165 *Witness Statement of Terry Symonds*, para. 317(a).

166 Office of the Victorian Information Commissioner, What We Do, <ovic.vic.gov.au/about-us/what-we-do/>, [accessed 18 December 2020].

167 Office of the Victorian Information Commissioner, What We Do; PricewaterhouseCoopers, *Review of Information Governance in the Department of Health and Human Services (DHHS)*, 2017.

168 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*.

169 *Witness Statement of Terry Symonds*, para. 314; The Adult Psychiatry Imperative, pp. 70–71.

170 St Vincent's Hospital Melbourne, *Submission to the RCVMHS: SUB.0002.0030.0106*, 2019, p. 28.

171 CSIRO, p. 32.

172 CSIRO, p. 32.

173 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 678.

174 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 678.

175 Peninsula Health, *Submission to the RCVMHS: SUB.0002.0028.0109*, 2019, p. 7.

176 *Witness Statement of Terry Symonds*, para. 303.

177 *Witness Statement of Terry Symonds*, para. 308.

178 *Witness Statement of Dave Peters*, para. 44.

179 *Witness Statement of Dave Peters*, para. 44.

180 *Witness Statement of Kym Peake*, 2020, para. 315.

181 *Witness Statement of Kym Peake*, 2020, para. 317.

182 Ambulance Victoria, COVID 19 Enhanced Mental Health Triage Response Pilot Proposal, 2020.

183 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*; *Witness Statement of Emeritus Professor Terry Carney AO*, 17 July 2020, para. 73.

184 RCVMHS, *Consumer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*.

Chapter 36

Research, innovation and system learning

Recommendation 63:

Facilitating translational research and its dissemination

The Royal Commission recommends that the Victorian Government:

1. building on the interim report's recommendation 1, by the end of 2023, enable the Collaborative Centre for Mental Health and Wellbeing, to:
    - **a.** facilitate translational research throughout the mental health and wellbeing system, including in collaboration with other research centres and institutes;
    - **b.** ensure new research aligns with initial reform priorities identified by the Royal Commission;
    - **c.** strengthen and support a formal network of academic service leaders responsible for sharing and applying research in service settings;
    - **d.** ensure that evidence informs workforce education and training, and promotes cultures of inquiry, innovation and learning;
    - **e.** provide a 'clearing house' to collect, combine and share information from research, innovation projects and evaluations; and
    - **f.** provide authoritative advice on evidence-informed approaches to treatment, care and support to inform policy development, planning and investment.
2. identify and promote opportunities to increase collaboration in translational research on the mental health and wellbeing of infants, children and young people.

Recommendation 64:

Driving innovation in mental health treatment, care and support

The Royal Commission recommends that the Victorian Government:

1. commission an existing entity to provide dedicated support and resources for innovation in mental health treatment, care and support.
2. fund this entity to:
    - **a.** administer a dedicated mental health innovation fund for projects selected by an expert panel;
    - **b.** establish and promote collaborative networks to drive and facilitate innovation in mental health treatment, care and support; and
    - **c.** provide practical support to services to implement and test new approaches to mental health treatment, care and support.

Recommendation 65:

Evaluating mental health and wellbeing programs, initiatives and innovations

The Royal Commission recommends that the Victorian Government:

1. set an expectation that adequate evaluation is a condition of funding for all new mental health and wellbeing programs, initiatives and innovations.
2. develop and fund a strategy to ensure evaluation routinely informs the implementation of reforms and ongoing decision making about policies and investment.
3. promote and improve evaluation practices throughout the mental health and wellbeing system by issuing guidance and facilitating access to evaluation expertise.

36.1 Why an adaptive system is needed

The Commission's recommendations call for considerable changes to all aspects of Victoria's mental health system. The Commission stated in its interim report that the new reforms must represent the beginning of a contemporary system that adapts and responds to the needs of Victorians.[1]

As Dr Ravi Bhat, Divisional Clinical Director at Goulburn Valley Area Mental Health Service, Goulburn Valley Health, explained, the system needs to be flexible enough to respond to new developments:

> we can easily fall into the trap of thinking that we have all the answers. I think we should not. I think that the future is inherently uncertain. It's not like a roulette machine where the odds are known and we can predict what's going to happen, it's inherently uncertain. So, I think that we should be careful about saying things like lasting changes and so on. I think that we should design a system for the realities that we know today, but I think that we should develop a system that is reflective, that is adaptive, that is responsive, that is data-informed.[2]

A system must adapt in a changing context. An adaptive system is one that can identify and test new ideas, gather evidence about what works, and translate this into effective treatment, care and support. In an adaptive system, evidence about what works is used to continually improve professional practice, service design and system policy. The knowledge, expertise and experience of consumers, carers and people who work in the system are integral to effective change and improvement.

To meet a gap in translational research into treatment, care and support for adults, the Commission boosted the foundations for an adaptive mental health and wellbeing system, by recommending the establishment of the Victorian Collaborative Centre for Mental Health and Wellbeing in its interim report (refer to Box 36.1). The collaborative centre will bring together clinical, academic and peer researchers with a range of disciplinary expertise, and will be pivotal in growing the research base and supporting the translation of research evidence into practice.

The Commission's vision is for a modern and sustainable system that responds to Victorians' needs into the future. It must be designed with components that allow the system to be reflective and evolving. It must also create conditions where improvement and innovation can flourish.

Box 36.1: The Victorian Collaborative Centre for Mental Health and Wellbeing

The Commission's interim report recommended that the Victorian Government establish a new entity, the Victorian Collaborative Centre for Mental Health and Wellbeing.[3] The Commission's vision is that the collaborative centre will deliver a long-identified need for the Victorian mental health system.

The interim report envisaged that the collaborative centre will:

- lead exemplary practice for the full and effective participation and inclusion of people with lived experience across the mental health system
- lead interdisciplinary, translational research into new treatments and models of care and support, to inform service delivery, policy and law making
- educate the mental health workforce through practice improvement, training and professional development programs.

The collaborative centre will conduct interdisciplinary research alongside service delivery for adults, reinforcing the translation of research and evidence into high-quality care through Regional Mental Health and Wellbeing Boards, including in rural and regional areas. It will also run a Statewide Trauma Service providing direct service delivery to adults, and working in partnership with services for infants, children and young people.

The purpose-built collaborative centre will provide comprehensive services to adults in its local community, including community-based and home-based treatment, services provided in outpatient clinics and other non-hospital settings, crisis responses and inpatient care (subacute and acute). Non-clinical services will include programs that involve: a consumer's network and their choice of friends and family; wellbeing supports; and creative and supportive group therapy. In line with the recommendations made in Chapter 5: *A responsive and integrated system*, services will also integrate physical health care and support for substance use or addiction, to meet the holistic needs of people living with mental illness.

These local services will be complemented by specialist (including statewide) services that focus on treatment, care and support for people living with mental illness needing ongoing intensive treatment, care and support.

The interim report stated that the collaborative centre will embody the characteristics of responsiveness, collaboration and continuous improvement that exemplify the future system. Critically, it will emphasise the participation of people with lived experience in the design, development and production of research programs.

The Productivity Commission highlighted the collaborative centre as an example of an innovative and networked approach to enable research translation and knowledge dissemination.[4] It called for 'national research infrastructure and networks that enable coordinated and collaborative research to … help achieve translation and dissemination of research evidence', to enable stronger alignment of research to national priorities.[5] It reported that the National Health and Medical Research Council has announced funding to establish a national centre in mental healthcare that will support a collaborative network.[6] As a forerunner, the collaborative centre and its future partners will be able to provide leadership and offer a strong contribution to national research efforts.

36.1.1 Forces shaping the mental health and wellbeing system

The social, cultural, economic and physical environments in which we live influence our mental health and wellbeing. As a society, we are facing major trends and challenges from declining social connection and support;[7] population changes that are increasing disparities in people's quality of life;[8] and growing economic inequalities, particularly for people living in rural and regional locations.[9] As disadvantage and inequity grow, disparities in access to healthcare and health outcomes also grow.

Despite past reforms, however, the mental health system has failed to keep up with the changing needs and expectations of the people for whom it exists.[10] It is the Commission's view that the system must be designed to tackle inequity head on, and it must be able to respond and adapt as the issues driving inequity evolve. This means ensuring that the best aspects of the system are widely accessible across the state, by speeding up the diffusion of leading practices and approaches.

Victoria also needs a system that is resilient and adaptable in the face of unpredictability. Unexpected events, such as the 2019–20 summer bushfires and the COVID-19 pandemic, have had considerable effects on the health and wellbeing of Victoria's population, and on the ways that treatment, care and support are provided.

The Commission has heard many accounts of rapid innovation in response to these events. These include the use of telehealth, digital improvements to youth mental health services, and collaborative governance arrangements.[11] Solutions have drawn on expertise that is not traditionally used in public system problem solving.[12] Barriers that would usually take years to remove have been swept aside, allowing solutions to be implemented quickly.[13] Mr Angus Clelland, CEO of Mental Health Victoria, noted that 'even with tight resources, we are seeing changes occur rapidly in response to COVID-19'.[14]

While tragic, the effects of COVID-19 have created a new spirit of cooperation. Continuing this collaborative approach beyond the pandemic will be important to the mental health and wellbeing system's future success.[15]

36.1.2 Continued capacity to respond, learn and improve

The ability to continually respond and improve is vital to the success of the future mental health and wellbeing system. Unexpected challenges and events will continue to arise.

The Commission believes that the system will be better equipped if it can use the momentum generated by the challenges faced in 2020 to solve collective problems in the future. It has considered how governments and systems around the world are finding better ways to solve problems, respond to challenges and develop sustainable systems that continually improve. In response to these considerations, the Commission has adopted a systems-change mindset to the mental health system. This approach, explained in more detail in Chapter 2: *The Commission's approach to reform*, is suited to dealing with complex and shared problems. It brings together a wide range of interested parties with diverse skills and expertise, who work to fully understand a problem, identify innovative solutions and speed up the change needed to achieve them.[16]

Governments, locally and globally, are actively engaging innovation and entrepreneurship in public service priorities. Examples within Victoria include:

- LaunchVic, a government agency established to develop Victoria's start-up environment, to grow and deliver economic and cultural benefits for the state[17]
- the Better Care Victoria Innovation Fund, which supports sector-led innovation and improvement projects in the Victorian health sector[18]
- social impact bonds[19] and Partnerships Addressing Disadvantage, which encourage innovative collaboration and investment strategies between public, private and not-for-profit sectors, to reduce social disadvantage [20]
- the Victorian Government's 2020–21 budget provision for a $2 billion Breakthrough Victoria Fund to drive investment in translational research and innovation in industries including health and life sciences, and digital technologies.[21]

As described in the Commission's interim report, decades of past reforms have failed to deliver a mental health system that can meet consumer needs, keep up with demand, or deliver contemporary approaches to treatment, care and support. There is the potential now to make 'exponential progress' supported by technology and innovation, but this requires a change in culture to adopt new approaches and innovation.[22]

Research, practice development, innovation and evaluation are critical parts of an adaptive system. To ensure continuous improvement, mechanisms must be put in place to ensure evidence reaches the people who design and deliver services, and new ideas and innovative approaches must be rapidly and consistently applied to policy and practice.

36.2 Building an adaptive mental health and wellbeing system for Victoria

Transforming Victoria's mental health system is an inherently complex process. The sheer scale and diversity of the system's components are considerable. However, complex systems can be transformed. The adaptive and dynamic nature of systems means that transformation is not achieved by directing or controlling the system. Instead, it is achieved through changing, influencing or encouraging the system to produce better outcomes.[23] This requires:

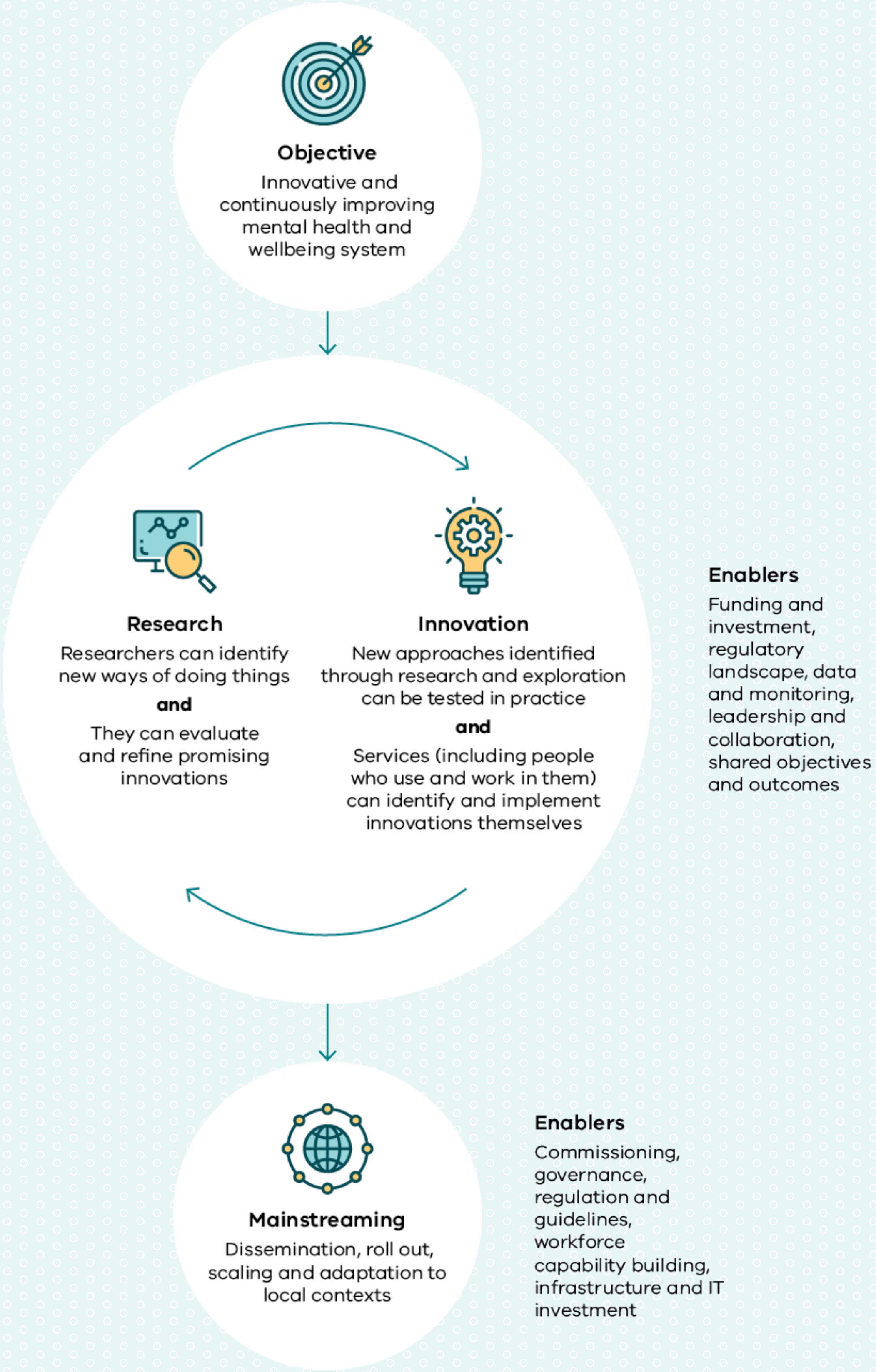
- a willingness to deal with ambiguity, complexity and uncertainty, and to focus on identifying ways to effect change
- creating intentional platforms for continuing dialogue between people with diverse perspectives, expertise and experiences, to encourage new ways of thinking
- continued reflection to identify what works and promote a flexible and responsive approach to uncertainty and complexity.

The new system design must include and connect core improvement activities through cycles of learning as depicted in Figure 36.1. These include:

- **research** to establish a strong evidence base about effective models of care
- capacity for **innovation** to test and grow the evidence base with new ideas
- processes to capture new knowledge and ideas and **translate them into practice**
- capabilities to monitor and **evaluate** the effects of new and established approaches
- mechanisms to synthesise and share the **information** from all these sources, and use it to make decisions and improvements across the system.

The Commission's recommended approach (outlined in section 36.6) will support the necessary activities and relationships to connect innovation and improvement activities in cycles of learning. The Commission envisages that the Victorian mental health and wellbeing system will have a range of leading centres contributing to this effort.

Figure 36.1: Cycles of learning incorporating research, innovation, practice translation and sharing knowledge



Objective

Innovative and continuously improving mental health and wellbeing system

Research

Researchers can identify new ways of doing things

and

They can evaluate and refine promising innovations

Innovation

New approaches identified through research and exploration can be tested in practice

and

Services (including people who use and work in them) can identify and implement innovations themselves

Enablers

Funding and investment, regulatory landscape, data and monitoring, leadership and collaboration, shared objectives and outcomes

Mainstreaming

Dissemination, roll out, scaling and adaptation to local contexts

Enablers

Commissioning, governance, regulation and guidelines, workforce capability building, infrastructure and IT investment

Box 36.2: Key concepts

Research and knowledge translation

Mental health research refers to a wide spectrum of activities that include investigating: causes of mental illness and psychological distress and how to respond to these; potential treatments for mental illness; models of system design and service delivery; and social science–based approaches to interventions and services.

Translational research involves testing and applying new treatments and models of care in service delivery environments. *Knowledge translation* refers to the process of disseminating translational research or other new knowledge though the system.

Innovation

- The term *innovation* is often loosely defined. In this chapter, it is used broadly to mean experimentation and entrepreneurial activity that creates value-adding change by developing and testing new solutions.
- Innovation can be thought of as: a *disruptive force* that interrupts old approaches or creates new value for consumers; or a *sustaining activity* that improves and builds on what already exists, but maintains continuity.[24]
- Innovation can take place at the system, service or community level, and can emerge from individuals or small groups within the system finding better ways to undertake their day-to-day activities (*grassroots innovation*).
- *Collective impact* is where different people work together to tackle complex social issues in local communities. A collective impact framework consists of five supporting conditions: a common agenda, continuous communications, a shared measurement system, mutually reinforcing activities, and a coordination function.[25]
- *Start-ups* are companies or projects initiated by an entrepreneur to seek, develop, test and validate a scalable business model and bring it to market.[26] Start-up *accelerators* provide initial investment and intensive, time-limited business or partnership support to help get new ideas ready for investment as rapidly as possible.

Practice translation

- *Practice translation* is the process of using knowledge about what works—from research, innovation and locally developed approaches—to embed new approaches into the routine activities of people working in the system.

Evaluation

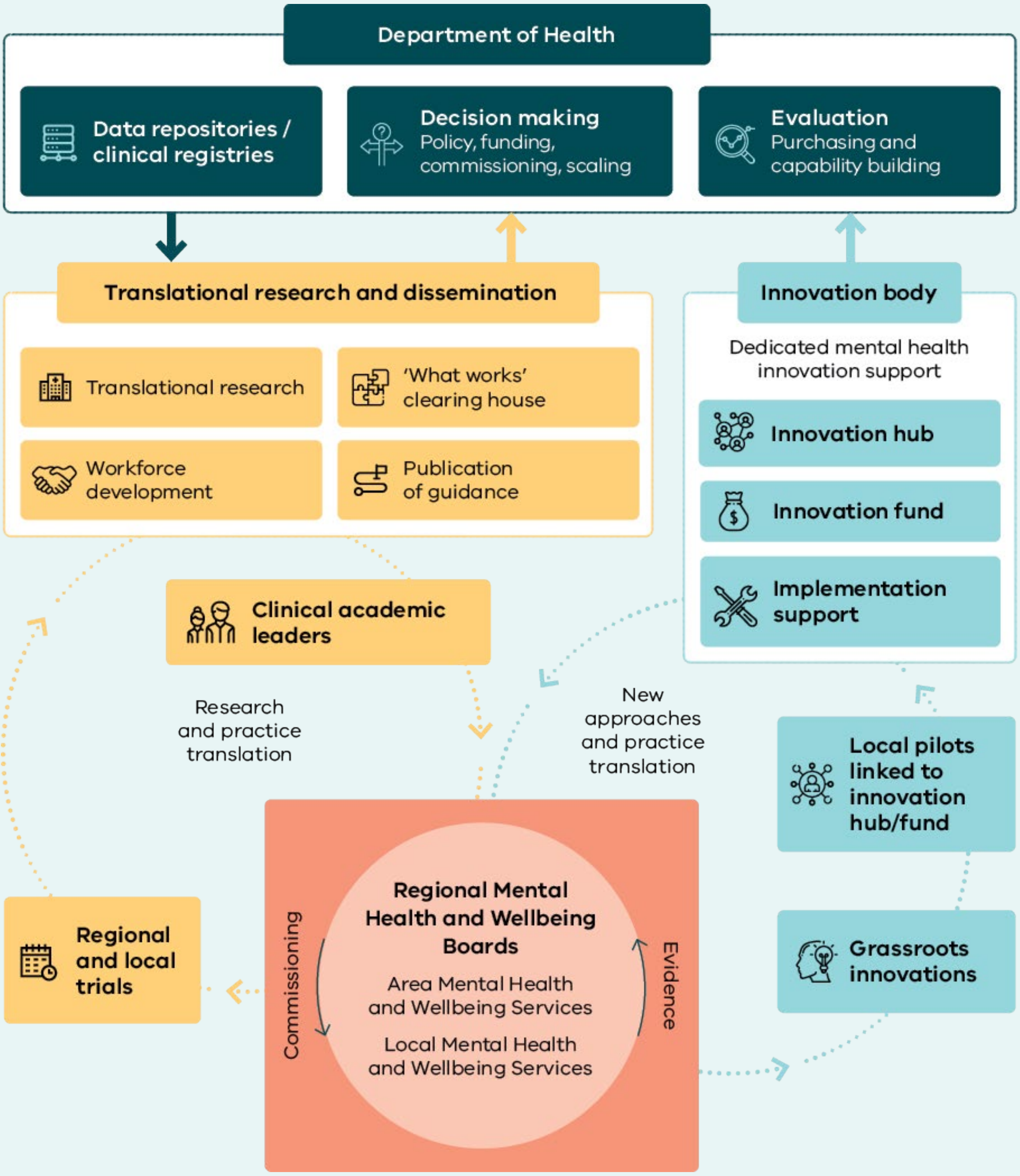
- *Evaluation* is the systematic process of collecting and analysing information to enable assessment of an activity, project, policy or program.[27] The purpose is often to support knowledge translation, to grow and expand effective approaches, or to inform future policy or investment decisions.
- *Formative* or *developmental evaluations* determine whether a new initiative is on track to achieve desired outcomes, and are used to make adaptations during the implementation process. *Summative or impact evaluations* assess what has been achieved, once implementation is complete.

Figure 36.2 outlines the Commission's recommended functions and activities for a mental health and wellbeing system that innovates, learns and adapts. It shows the activities that will be performed by the collaborative centre and a range of potential partners. It also depicts the relationships between those functions, mental health and wellbeing services, and the Department of Health. The goal of the new arrangements is to use knowledge and expertise in the most widespread and coordinated way possible, and allow promising and proven ideas to flourish.[28]

These arrangements provide for:

- translational research to be undertaken by the collaborative centre and other partner organisations working in a learning 'network', in which many parties contribute to, and benefit from, improved data and knowledge sharing about what works
- Regional Mental Health and Wellbeing Boards, Area Mental Health and Wellbeing Services, and Local Mental Health and Wellbeing Services to be formally connected to translational research activities and receive support to enable local innovation and put research into practice
- innovation capability that, across the entire mental health and wellbeing system:
    - develops networks to bring together innovators and partners
    - administers a fund to support innovation activity
    - assists testing, monitoring and refinement of new approaches and innovations
    - creates feedback loops from service-level activities to share learning from implementation experiences, and promote promising innovations for evaluation and potential scaling
- the Department of Health to receive information from research, innovation and practice on the ground, to evaluate what works and inform decisions about policy design, commissioning and investment.

Figure 36.2: An adaptive mental health and wellbeing system in Victoria



36.3 An example of innovation and system learning in action

The Commission looked globally and found many examples of innovation and system learning in practice. Ontario Health Teams, created by the Government of Ontario in Canada, were a major reform to make Ontario's health system more responsive to local needs.[29]

The Ontario Health Teams model builds on local innovation to 'transform the way health care is provided and funded'. The model enables 'patients, families, communities, providers, and system leaders to better work together, innovate and build on what is best in Ontario's healthcare system. The goal is to provide better, more connected care across the province'.[30] This partnership approach is also discussed in Chapter 29: *Encouraging partnerships*.

These self-organising, locality-based teams are supported by a government-funded Rapid Improvement Support and Exchange (RISE) function to enable learning and improvement (refer to case study).

RISE aims to create a rapidly learning health system that achieves 'the quadruple aims of improving care experiences and health outcomes at manageable per capita costs and with positive provider experiences'.[31] Through RISE, Ontario Health Teams receive consistent and equitable access to help and guidance when implementing new approaches. This allows questions, suggestions and improvements to be discussed and implemented quickly and effectively, helping Ontario Health Teams to generate improvement at the point of care for their local populations. Evidence of the successes and failures of local initiatives is collected and shared with the RISE and Ontario Health Team communities of practice. Over time, this will generate a self-improving system that is able to adapt and respond to issues identified, and create sustainable improvements.

The strength of this model is its focus on continuous improvement and knowledge exchange, which grows consistency and resilience in the system.

Case study:

Rapid Improvement Support and Exchange

Ontario Health Teams are designed to make Ontario's health system more responsive to local needs. They are groups of health providers who partner to deliver integrated healthcare services. The first teams were announced in December 2019. Once fully operational, they will be jointly accountable for the cost and provision of services. They will also share accountability for health outcomes and care experiences of their local population, including for mental health and addiction.

Rapid Improvement Support and Exchange (RISE) is a collaborative platform supported by a grant from the Ontario Ministry of Health, and is designed to help Ontario Health Teams achieve their goals. As health teams develop, they need to learn and improve quickly. RISE helps them do this by providing access to 'rapid learning and improvement assets'.

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

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

RISE provides teams with three types of support: coaching, collaboratives and communities of practice.

The more active forms of support—coaching and collaboratives—are targeted at the most difficult part of the health system transformation, namely the shift from a traditional, reactive model of care to a more practice-based and coordinated 'population-health management' approach to care.

Online communities of practice, which are less intensive, member-driven supports, focus on the other critical building blocks of the transformation (for example, patient partnership and digital health). They provide an opportunity for teams to identify their own learning needs, to share experiences of success and failure, and to build their ability to become a sustainable, self-improving system.

RISE also delivers an 'on demand' suite of activities (for example, convening 'jamborees' to work through important challenges like how best to engage clinicians in teams) and products (for example, briefs and analyses of evidence on priority topics like collaborative governance).

RISE uses a number of approaches to share tools and resources with teams, including a website, monthly newsletter, webinars and Twitter. It puts a lot of effort into ensuring that all products use frameworks and language specific to and consistent with the transformation project.

Professor Rob Reid, Chief Scientist of Trillium Health Partners and co-lead of RISE, said researchers are the backbone of RISE.

> Researchers help teams to push through the stages of the learning cycle. This starts with developing a deep understanding of the problem they are trying to solve, and how it has been tackled elsewhere. Then we bring science into the design of better models of care, making consumer experiences the focus, and building in the new skills, resources and ways of working that will be needed to implement them. Then we help them use the Ontario Health Teams evaluation framework to assess what's happening when they implement new models in the field, and feed information back to them in a continuous loop so they can adjust their approach.

RISE also partners with many health system partners to support research translation, capability development and evidence building. These partners include the new Ontario Centre of Excellence for Mental Health and Addictions as well as the Centre for Effective Practice, an independent research and knowledge translation organisation focusing on primary care.

Professor John Lavis, Director of the McMaster Health Forum and co-lead of RISE, said that government, health system partners, research partners and RISE staff are all motivated to collaborate in improving mental health services for people in Ontario.

> The outcomes that matter are mental health and care experiences—and you must be able to measure and improve both. Mental health touches everyone. And we can and must do better for people.

Sources: McMaster University, Rapid-Improvement Support and Exchange, <mcmasterforum.org/rise/learn-about-rise/overview>, [accessed 6 October 2020]; RISE, *RISE brief 12: Rapid learning and improvement,* <mcmasterforum.org/docs/default-source/rise-docs/rise-briefs/rb12_rapid-learning-improvement.pdf?sfvrsn=a1bf54d5_14>, [accessed 15 December 2020]; RCVMHS, *Interview with Professor John Lavis*, 17 August 2020; RCVMHS, *Interview with Professor John Lavis*, 19 November 2020.; RCVMHS, *Interview with Professor Rob Reid*, 10 December 2020.

36.4 The features of an adaptive mental health and wellbeing system

In exploring how different systems are set up for continual learning and improvement, the Commission has observed commonly identified components and features of adaptive systems.

36.4.1 Cultures of inquiry, reflection and courage

Transformational leadership is needed to allow innovation to flourish. Organisations and leaders need to create supportive environments for people to collaborate, develop new ideas, take risks, work closely with consumers and test new models that inspire change.[32]

Associate Professor Simon Stafrace, Chief Adviser, Mental Health Reform Victoria, told the Commission in his personal capacity that enabling systems and organisations to adapt and innovate involves allowing for 'multiple mindsets to operate in a complex environment'.[33] Dr Hila Haskelberg, Program Manager of THIS WAY UP at St Vincent's Public Hospital Sydney, providing evidence in her personal capacity, suggested that this requires relationships built on trust, supported by technology and promoted by committed leaders.[34]

Getting the most out of collaborative innovation requires a cultural shift to support the inclusion of multiple voices, flexibility in problem solving, and spaces and time for invention and reflection. The National Health Service Institute for Innovation and Improvement in the United Kingdom identifies cultural features that need to be encouraged for innovation (refer to Figure 36.3).[35]

Associate Professor Jo-An Atkinson, Managing Director, Computer Simulation and Advanced Research Technologies; Head of Systems Modelling and Simulation with the Brain and Mind Centre, University of Sydney, also advocated in a personal capacity for more innovation in mental health. She suggests that structures and mechanisms governing mental health research influence the extent to which research partnerships are created and sustained, and innovation is supported. She also advised that a conservative culture in mental health research persists 'such that forays into alternative methods … are perceived as high risk and exploratory'.[36]

Associate Professor Stafrace argues that the following conditions must be actively encouraged to challenge the dominant culture within Victoria's mental health system:

> **There must be investment in individual and organisational development … An element of this process should embrace adaptive and transformational work that challenges established assumptions about power, safety and change.[37]**

The Commission's view is that a more open and collaborative culture of reflection and innovation in mental health is important to ensure Victorians will benefit from new ideas and ways of working.

Figure 36.3: Cultural framework for innovation

Risk-taking: establishing a climate that is open to testing new ideas while predicting and lessening the effects of risks.

Resources: including funding, autonomy and authority to act on innovation.

Knowledge: information is widely gathered, easily accessible, rapidly transmitted and honestly communicated

Goals: objectives and policy environments that strive to solve complex problems.

Rewards: recognition of innovative behaviour and success, and encouraging more people to participate.

Tools: building capability and capacity through flexibility, training and leadership.

Relationships: collaboration, building trust and creating an open environment.

Source: Adapted from NHS Institute for Innovation and Improvement, *Creating the culture for innovation: A practical guide for leaders*, 2010.

36.4.2 Place people with lived experience at the centre

Consumer-led research and evaluation is fundamental to an adaptive system. Consumers are needed to set new research agendas and help develop new theories and ways of knowing.[38] The collaborative centre presents a unique opportunity to place people with lived experience at the centre of service design, delivery, research and evaluation.[39]

Lived experience experts advised the Commission that consumers need to lead research and innovation. Ms Cath Roper, Consumer Academic at the Centre for Psychiatric Nursing, University of Melbourne, said:

> There are two things we can do to champion the co-production of research and innovation in mental health. First, we can open up leadership roles for consumers which means … others will need to step back into support roles; and secondly, we can start elevating consumer leaders as thinkers and innovators.[40]

Consumer academics Dr Louise Byrne and Professor Dame Til Wykes describe the value of consumer-led research:

> commonly researchers from traditional backgrounds don't understand the mental health experience well enough to know how to approach participants or design questions that are relevant and likely to receive meaningful responses. This is the crux of the issue, why meaningful co-production and lived experience leadership are essential in any research. Lived experience provides a bridge, a means of translation between mainstream research and service users.[41]

Australian National University academic, Dr Michelle Banfield, says that lived experience researchers can break down the barriers between consumers and researchers, and in the process, change perceptions about the importance of consumers in research.[42]

Principles of co-design and co-production are critical. These ensure that consumers are involved from the outset; that power imbalances between participants are acknowledged and addressed; and that developing the knowledge and capability of all involved is an integral part of the process.[43] Ms Georgie Harman, CEO of Beyond Blue, told the Commission that such co-design principles are integral to all stages of innovation if they are to respond to the greatest needs:

> Co-design principles should be in place from the beginning to ensure that innovative models meet genuine gaps and use approaches that are attractive to people that need them. Involvement of people with lived experience must continue through the life of the project, including in governance, implementing improvements and evaluation.[44]

It is the Commission's strong view, shared by the Productivity Commission in its *Mental Health Inquiry Report*, that people with lived experience should be involved in all stages of development, trialling, monitoring and evaluation,[45] to support the production of more valuable services, programs and policies. This includes initial thinking and priority setting through to co-planning, co-design, co-delivery and co-evaluation stages.[46]

36.4.3 Diverse collaboration, partnerships and relationships

Adaptive systems create ways to bring people, ideas, information and expertise together to learn, translate and scale what works. As Associate Professor Stafrace notes, an adaptive system requires collaboration with a shared sense of purpose and challenge:

> **Delivering mental health services successfully is above all an adaptive challenge … An adaptive response to the changing needs of the client requires interventions that take into consideration the priorities of different stakeholders and lead to a common understanding of what thriving entails in the setting of a new environment. It builds on the past, changes through experimentation, draws in diverse perspectives, and ultimately discards tightly held beliefs …**[47]

The Commission's interim report recognised that private sector competition and partnerships can lead to improvements in service quality, innovative new service models and better outcomes for consumers.[48] Global analysis demonstrates that non-traditional players are disrupting traditional service delivery across industries. They are building new capabilities to empower consumers and creating smoother service experiences.[49]

Analysts suggest that people outside of the healthcare system could soon be reshaping models of business and care:

> **In a data- and technology-enabled world, it is not a stretch to imagine that whole new business models could be created by nonhealthcare players to deliver superior health outcomes.**[50]

Melbourne Connect, a purpose-built innovation precinct led by The University of Melbourne (refer to Box 36.3), observes that '[m]odern innovation flourishes when there is a convergence of disciplines, skills and ideas.'[51] Leading innovators from the Victorian start-up community echoed this view, advising the Commission that parties within and outside the mental health system need to come together to generate and test new ideas.[52]

Where different people are coming together to solve problems, common goals and values are essential.[53] A review of successful research centres indicates that common goals and values help develop a clear mission and rationale for building partnerships that motivate innovation and ensure it can be applied in the real world.[54] This includes partnerships with other national and international academic organisations, entrepreneurs, businesses and local services.[55] Including consumers and focusing on their needs also creates a unifying purpose.[56]

The What Works Centre for Wellbeing in the United Kingdom is an example of a growing clearing house that functions by attracting a network of collaborators and innovators (refer to Box 36.4).

Box 36.3: Melbourne Connect

Melbourne Connect is a purpose-built innovation precinct led by The University of Melbourne.[57] Melbourne Connect aims to bring together the digital expertise of leading industry and University of Melbourne researchers to 'create a culture of excellence in ideation, knowledge sharing and sustainable innovation' to find 'solutions to our most pressing future challenges'.

Melbourne Connect will house the Melbourne Entrepreneurial Centre, including:

- the *Melbourne Accelerator Program*, which provides start-ups with $20,000 equity-free funding, office space and access to business programs and supports to help accelerate their growth
- *Translating Research at Melbourne* (TRAM), a training function that uses networks of entrepreneurs to provide professional development, mentoring and ongoing support for researchers.

Another partner is the Melbourne Centre for Data Science, which aims to collaborate across academia, the private and public sectors, research centres, centres of excellence and research groups to lead innovation; and assemble interdisciplinary teams to tackle long-term or large-scale projects.

The Melbourne Connect building is designed to attract tenant partners from industry, government, research, talent and entrepreneurs as 'true peers, equated by a shared commitment to innovation, world-class expertise and an appetite for collaboration that will speed the process of bringing new thinking to life'. The building design includes dedicated collaboration space, and The Telstra Creator Space to develop prototypes and test early concepts 'to drive ground-breaking innovation'.

Source: Melbourne Connect, <www.melbconnect.com.au>, [accessed 2 November 2020].

Box 36.4: What Works Centre for Wellbeing (United Kingdom)

The mission of the What Works Centre for Wellbeing, an independent organisation, is to develop and share strong, accessible and useful evidence that governments, businesses, communities and people can use to improve wellbeing. Its team works closely with partners to answer important questions on what works to improve wellbeing and to identify gaps in the research.

The centre is part of a broader 'What Works Network' and the Evidence Quarter. These networks improve the way government and other organisations create, share and use high-quality evidence for decision making. Other members represent a broad range of social policy areas, including health and social care, education, justice, early intervention, economic growth and homelessness.

The Evidence Quarter aims to bring together centres to increase collaboration and tackle joint challenges. Each evidence organisation has its own purpose, but they share overlapping goals and face common challenges to do with methodology, building movements and achieving change with their research. The Evidence Quarter provides physical and virtual spaces to bring organisations together to share resources and ideas, so that they more strongly influence change.

Partners included in the Evidence Quarter are:

- national and local governments
- individual government departments and agencies
- universities
- economic and research bodies
- national and international commercial and not-for-profit entities
- investors
- health agencies, including the National Institute for Health and Care Excellence.

Another partner is the Education Endowment Foundation, which helped establish Evidence for Learning—a clearing house for global evidence on educational practice—in Australia.

Sources: What Works Centre for Wellbeing, About Us, , <www.whatworkswellbeing.org/about-us/>, [accessed 16 October 2020]; Evidence for Learning, Who we are and what we do, <www.evidenceforlearning.org.au/about/who-we-are/>, [accessed 16 October 2020].

36.4.4 Innovation that is enabled and supported

Innovation is required in Victoria's mental health and wellbeing system to push the boundaries of knowledge, as well as to explore new products and services that will lead to better service quality, outcomes and economic value.[58]

International consulting firms recognise that the world is entering an era of exponential, disruptive improvement in how consumers access health care, how providers deliver it, and what outcomes it achieves.[59] Much of this value will be created by innovation that enables more community-based delivery, more effective care delivery and improved clinical productivity.[60]

The Commission identified the conditions, structures and relationships (what it calls 'enablers') that are required to support innovation in a future, adaptive mental health and wellbeing system. These are outlined in Figure 36.4.

Bring players together

Governments and the private sector are moving to support more rapid innovation that will enable improvement in public and social services.[61] Efforts are being made to create broader networks, which are needed for public and social services innovation.

Governments have created departments and agencies to support innovation across a range of service sectors, including transport, power, environment, health and education.[62]

In many instances, larger companies are partnering with non-government organisations or private mental health providers to offer new types of service models and pathways for consumers. The Commission heard that companies such as Microsoft, Google and Twitter are increasingly partnering with organisations such as Beyond Blue and Lifeline to provide new services to consumers.[63]

There is a window of opportunity for Australia, as an early developer of e-health self-care tools, to show leadership in this area. The Black Dog Institute told the Productivity Commission:

> There is a timely opportunity for public sector-led initiatives that can address questions concerning trust and safety, equality of access, integration of data and ensuring data is accessible rather than within the control of tech giants.[64]

A major trend in both general health care and mental health care is innovation-led entrepreneurship in the form of start-up companies. The Commission heard from a number of mental health entrepreneurs who were motivated to help build a more equitable service system and have a positive effect on people's lives.[65]

Figure 36.4: Major enablers of innovation

Dr Haskelberg observed that people who engage with and work in the system are also motivated to see it improve, so it is critical to involve them in innovation:

> I believe real innovation comes from people who are part of the system and/or using the services, and who have the drive and passion to make things better. It needs to be built from the ground up ...[66]

The Commission understands that people often discover new and better ways of doing things while working in their day-to-day roles. The system must capture promising new approaches that are developed on the ground, so that more people can benefit from these grassroots innovations.

As Mr Edmund Phelps, winner of the 2006 Nobel Prize in Economics, said:

> It's very important to emphasise that most innovation comes from ordinary people, not extraordinary. Some extraordinary people get lucky enough to produce some innovation. But a lot of extraordinary innovations are the concepts of ordinary people.[67]

Create conditions to support innovation

Innovation requires flexible funding. Development and testing can be resource intensive, so innovators need access to funding that accepts an element of risk in trialling, and properly testing and assessing unproven approaches.[68] A review of 60 successful healthcare reforms across the world found that funding to test and scale innovation initiatives is a factor behind longer-term system improvement:

> By funding projects that are initially modest in scale, and piloting or testing the improvement initiatives, reformers can help shape the environment, preparing the ground for later implementation of measures that can lead to systems-wide enhancements.[69]

Innovation also requires regulatory environments that welcome new activity and are responsive to change.[70] More flexible regulatory approaches can provide greater opportunities to design and test new ideas rapidly, and determine the right safeguards to use.[71]

Innovators told the Commission that health systems in the United Kingdom and Germany provide a clear basis for reimbursing development expenses, empowering start-ups to create new tools for consumers. They still apply rigorous quality and safety standards. Innovators also indicated that governments could learn from the way the private and start-up sectors safely manage concurrent implementation and testing of new interventions.[72]

Recognising and rewarding innovative practice can encourage people to participate in innovation. Mr Frank Quinlan, former CEO of Mental Health Australia, giving evidence in a personal capacity, said people need to know they are both encouraged and supported to be innovative:

> Innovation often happens on the fringes of the system which is absolutely welcome—funding should be set aside to seed new ideas and spark experiments. However, we must also provide people working within the system with enough certainty and stability to learn from their mistakes.[73]

Dr Haskelberg advised that clinicians should be provided with time and incentives for research and development.[74] Mr Clelland proposed the use of initiatives such as service awards to recognise innovative practice. He said, '[y]ou cannot force people to innovate: it is better to bring them along by recognising good practice and modelling it.'[75]

36.4.5 Research, knowledge and practice translation

The Commission's interim report acknowledged the importance of 'research that bridges the gap between 'discovery and practice' [to] drive high-quality care'.[76] This involves three distinct activities: translational research; knowledge translation; and practice translation. The Cancer Institute NSW characterises these three stages as:

7. developing treatments and interventions
8. testing the efficacy and effectiveness of these treatments and interventions
9. dissemination and implementation for systemwide change.[77]

Together, these processes support cycles of learning that translate new knowledge into practice, to improve consumer experiences and outcomes.[78]

A system that successfully translates evidence into practice requires feedback loops between different types of research, services, government and consumers. This loop (refer to Figure 36.5) is what transforms knowledge into action and action back into knowledge, through new or improved interventions and innovations in the system.[79]

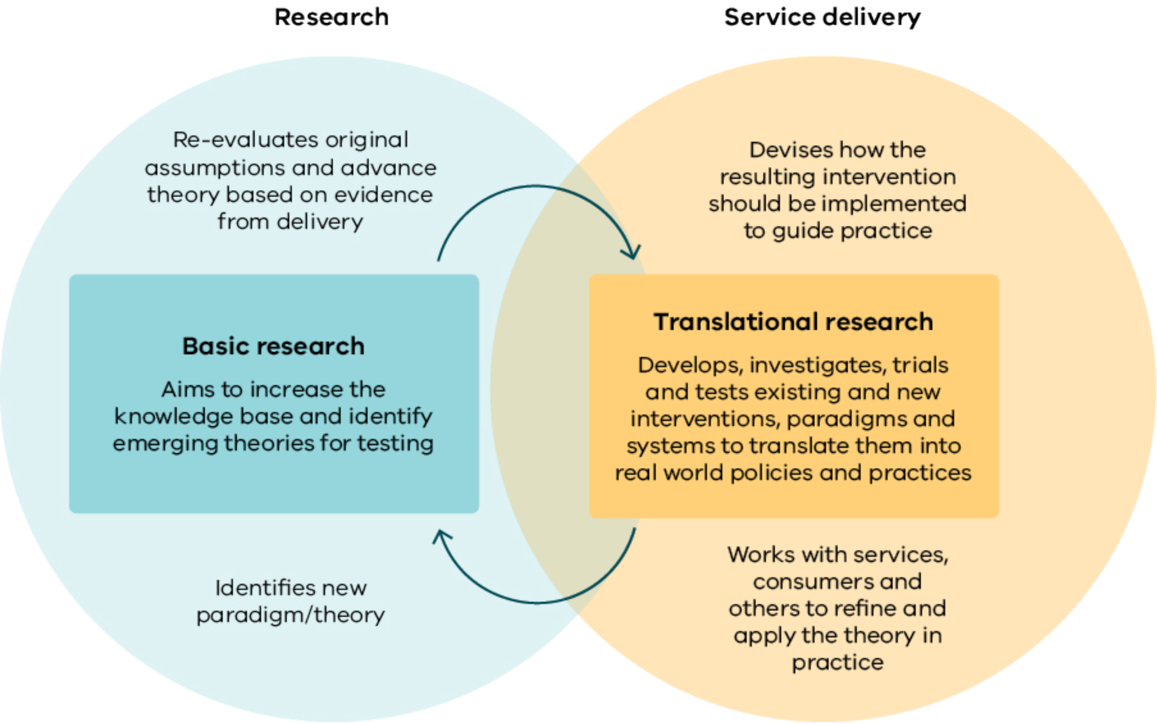
In some cases, leading practice within the system may be more advanced than the established research base. Therefore, feedback loops also need to capture, test and expand learning and innovation that is taking place in different settings and services. Innovators who met with the Commission said that effective loops also allow for rapid testing and adaptation during the development of new solutions:

> I think government[s] need to look to the start-up community [for how to] concurrently gather evidence and data so quickly … that you can actually make smart decisions and pivots around the product as you go in a really safe, clever manner. [Technology increases] the data feedback loop that's so important to measure effectiveness … that's the kind of stuff that you can do … on the run.[80]

Ms Mary-Ann O'Loughlin AM, Deputy Secretary, Skills and Higher Education in the New South Wales Department of Education, speaking in her personal capacity, supports this approach:

> Adaptive responses are also experimental: 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.[81]

Figure 36.5: Basic and translational research relationship



Innovators also advised that continuous feedback loops are essential to ensure that promising and proven initiatives can be rapidly scaled, and that investment and commissioning processes need to keep pace:

> the current system is built for products that release once [and] don't change … In terms of both usability from a patient's perspective, usability from a healthcare perspective, effectiveness on outcomes, everything is tied against continuous improvement. And that's how good products are made … how we can create more of an iterative process to policymaking that adapts to changing products and changing environments.[82]

36.4.6 A strong foundation of evaluation capability and activity

Evaluation involves collecting, analysing and using information from a range of sources to improve learning and decision making. When done well, it demonstrates what works and what does not work, and for whom, in what context and why. When it is part of a continuous improvement approach, evaluation supports good practice and policy. Evaluation can also empower people whose voice might otherwise not be heard, by giving them a say about decisions and services that affect their lives.[83]

In general, evaluations tend to be carried out for three reasons:

1. to inform investment decisions[84]
2. to maintain accountability obligations for funding or other resources received[85]
3. to inform continuous improvement processes.[86]

Evaluation is a critical part of ensuring that a 'learning system' can respond to changing needs, and of keeping policy and programs adaptive and responsive. As *The Australian Policy Handbook* states:

> A commitment to evaluation … emphasises that policy is iterative—an endless chain of experiments and rethinking, as policies adjust to their changing circumstances.[87]

Professor David Castle a consultant psychiatrist at St Vincent's Hospital and Professor of Psychiatry at The University of Melbourne, advocates in a personal capacity for a continual cycle of evaluation in relation to digital health care, which is increasingly important to a contemporary system:

> In respect of digital health care generally, we need to have a continual cycle of assessment including reviewing uptake, acceptability and efficacy. This assessment is apt for researchers and will help in developing, testing and validating the efficacy of digital technology in mental health care. Research findings can then be disseminated to provide guidance to consumers and providers, [and] users and potential users …[88]

In an adaptive system, evaluation should be included as a regular part of program or service design, as well as implementation from the beginning.[89] It should also use success measures that are established during the planning stage.[90] This allows for an iterative development process where evaluation findings inform ongoing adjustments. These can extend beyond the implementation phase of a new program or service to support a deliberate approach to continuing improvement.

In addition to co-design and co-production of new approaches, assessment of how well the system is currently working and how it could be improved should include the views of those it is designed for.[91] Therefore, people who use services should lead and collaborate in their evaluation.[92]

Ms Robyn Kruk AO, Interim Chair of Mental Health Australia, said in her personal capacity that lived experience is one of the best sources of advice about flaws in the system:

> Lived experience voices can provide insight on where the gaps and opportunities are in delivery of the mental health system. From this perspective alone, having the voice of lived experience built into decision-making is logical from a first principles basis.[93]

The Australian Policy Handbook further emphasises that evaluation should be viewed as a collaborative learning opportunity:

> Evaluation teams should see their work as collaborative exercises, a learning opportunity for all involved. The lessons generated will change the program before the evaluation is complete.[94]

The Commission shares the view of the Productivity Commission in its *Mental Health Inquiry Report* that, to achieve continuing improvement, evaluation should be included in program design implementation and delivery. This will ensure that programs make the best possible contributions to mental health and wellbeing, and use public funds efficiently.[95]

The Productivity Commission notes that '[w]here evaluations of mental health programs have been undertaken, they have tended to be 'monitoring evaluations' … [whereas] evaluations … are most useful when they reveal the effectiveness or the 'impact' of a program.'[96] It says this is best achieved through randomised control trials that allow comparison between the group of individuals who receive an intervention and a control group that does not.

This may not always be feasible or ethical, in which case alternative approaches should involve 'careful measurement of changes in mental health over time, controlling for any other factors that change during the evaluation period'.[97] The Productivity Commission argues that state governments should undertake more impact evaluations, particularly based on trials, ahead of broader rollout of programs.[98]

The Productivity Commission also recommends extending the functions of the National Mental Health Commission to lead evaluations nationally in relation to 'aspects of the system that are of national significance or that relate to multiple jurisdictions'. The Productivity Commission says that this does not rule out evaluating individual state or territory programs, but 'would involve close consultation with jurisdictions to discern where and when the [National Mental Health Commission] could best add value'.[99] It also stated that a national evaluation function does not take away the primary responsibility of all governments to monitor and evaluate programs.[100]

It is this Commission's firm view that reflective and evaluative professional practice within the workplace is also important. It is highly valued by people working in the system, and needs to be enabled and supported across the workforce.[101]

To empower consumers and professionals as researchers and evaluators of their own practice, they need the permission, knowledge and skills to measure and assess the effects of new approaches on consumer experiences and outcomes. They also need support to apply that learning in a process of continued practice improvement. This involves collecting data and evidence, analysing the impact and adapting approaches based on the findings, and reflecting on what has been learned about through undertaking the process—cycles of learning that lead to growth in professional attitudes and practices.[102]

36.4.7 Sharing and promoting what works

Using and sharing knowledge about what works effectively—from research, innovation and evaluation—allows for better visibility of the suitability, efficiency and effectiveness of programs and policies. This can inform decisions at system and service levels about investing in and scaling proven approaches.

To ensure knowledge about what works is translated into equitable access to best practice across the system, it is important that there is a definitive source of guidance and advice, where a clear evidence base has been established. As Professor Alexander McFarlane AO, Professor of Psychiatry in the School of Medicine at the University of Adelaide told the Commission in his personal capacity, 'there needs to be a system that actually treats people in a coordinated way guided from the top by excellent co-ordination of knowledge and research'.[103]

The National Institute for Health and Care Excellence in the United Kingdom (refer to Box 36.5) runs a longstanding and successful model of this kind.

Box 36.5: National Institute for Health and Care Excellence, United Kingdom

The National Institute for Health and Care Excellence (NICE) produces evidence-based recommendations by committees of experts, professionals and members of the public across health and social care topics.

NICE publishes:

- clinical and practice guidelines
- quality standards that define clinical best practice
- advice and evidence about the latest medical and therapeutic innovations.

Topics for guidance are agreed with NHS England or the Department of Health and Social Care, and then formally referred to NICE.

NICE coordinates an inclusive and consultative process that includes:

- developing and testing a draft scope
- collecting and reviewing literature and evidence
- preparing draft guidance and getting feedback from interested parties for revisions
- formal sign off for publication by its Guidance Executive team
- carrying out regular reviews and updates of published guidance.

These guidelines are developed for a range of interested parties, including practitioners, local authorities and service commissioners. Although practitioners are expected to take NICE guidelines fully into account, they are not mandatory.

The development process is overseen by a committee of practitioners, professionals, care providers, commissioners, consumers, and family members or carers. The committee considers the cost-effectiveness of programs and interventions when developing NICE guidelines.

NICE has developed several guidelines for mental health and related conditions, including depression in children and young people, generalised anxiety disorder and panic disorder in adults, common mental health problems, and preventing suicide in community and custodial settings.

Sources: National Institute for Health and Care Excellence , <www.nice.org.uk/>, [accessed 8 October 2020]; National Institute for Health and Care Excellence, Developing NICE guidelines: the manual, <www.nice.org.uk/process/pmg20/chapter/introduction>, [accessed 12 October 2020]; Productivity Commission, *Mental Health Inquiry Report*, Volume 3, pp. 1239–1240.

36.5 Strong potential but some missing features

The Commission acknowledges that Victoria has resources and expertise to support the system to evolve and reform. However, they are not currently working together to achieve their collective potential.

The state has a diverse range of independent bodies and experts engaged in mental health research, and is well recognised in a number of mental health research fields.[104] In its interim report, the Commission recognised the valuable contributions of many bodies—including Orygen, the Victorian Institute of Forensic Medicine, and headspace's Discovery College—and Victorian health services, universities and foundations who are collaborating with them to research and improve mental health treatment, care and support.[105] Many others are highlighted throughout this report.

Further, Victorian legislation, health service performance frameworks, and departmental guidance and resources acknowledge evaluation and evidence-based program and policy development.[106] Healthcare innovation is gaining momentum, representing the largest start-up environment in the state.[107]

Based on evidence received and consultations conducted, the Commission is convinced that the knowledge and expertise required to strengthen Victoria's mental health system already exist or are emerging. As stated in the Commission's interim report, there is a need to bring these together, and 'develop a culture of improvement and research … which combines clinical, academic and peer leadership and seeks interdisciplinary collaboration'.[108]

Unifying this expertise and experience will reposition Victoria as a leader in mental health and wellbeing research and innovation, able to attract further eminent expertise, and secure available funding and resources to undertake pioneering work.

However, the current system struggles to support widespread innovation and continuous improvement. In particular, the Commission considers that the system lacks the structures and processes needed to bring together and use the available intelligence and expertise to the greatest possible effect. As a result, the mental health system is not adapting quickly to evidence about what works in practice, and Victorians are not benefitting from this evidence in the services they receive.

This was summed up in a submission from Alfred Health:

> the current system is not geared for constant learning, improvement and change so that it can meet the needs of service users and communities. The system finds difficulty in drawing on publicly funded researchers, quality improvement specialists, clinicians and people with lived experience to be part of the research process … there is limited public investment in research and training and there is no coordination of outputs, priorities and desired research.[109]

The collaborative centre will be a pivotal addition to Victoria's ability to grow the research base and support the translation of research evidence into practice through collaborative methods.[110] This new landscape reflects many of the functions required in an adaptive system. However, other capabilities will need to be established to fully develop and use new knowledge and evidence.

The following section outlines the aspects of the current system that need strengthening, in order to become truly adaptive.

36.5.1 Diverse contributions

The Commission heard that the current mental health system is failing to use diverse sources of expertise—including people who interact with and work in the system—to progress system and service improvement.

While there is a strong basis for consumer research capability in Victoria, the voices of experts and people with lived experience are not given enough power within the current mental health system. Consumer-led research is often not given priority, or enough funding or commitment, and it has 'no real power to set agendas, influence decision-making, or bring about structural change'.[111]

The Commission was told of consumer researchers being required to align with unrelated disciplines, such as nursing or social work, in order to find support to develop research or projects that are fully grounded in what matters to consumers.[112]

Ms Roper advocates for more consumer academics, because '[t]hese roles are key influencers of mental health workforce practices and policies and can achieve so much more if further embedded in other academic settings.'[113] She argues that a lack of influence means research agendas can overlook issues that are most important to consumers:

> consumer perspective in policy and research are not well developed areas in Victoria and need investment. There is also a need for consumer led research ... which prioritises the research areas of interest to consumers ... [A]dopting human rights perspectives in mental health research ... tends to matter most to consumers who have the least control over research agendas. This needs to change ...[114]

As a result, consumers say that research can fail to use their strengths or to respond to their needs:

> Currently, consumers are often excluded from innovation. Innovations often meet clinical and carer, but not consumer needs. The process for developing these innovations often occurs without our involvement, let alone co-design or co-production. And there seems little space for us to set the agenda, by developing our own innovations to meet our strengths and needs.[115]

Ms Indigo Daya, Consumer Academic, Centre for Psychiatric Nursing at the University of Melbourne, says in her personal capacity that one cause of this is that consumers are not invited to participate early enough in the process:

> Most commonly … we're invited to join a research project, after the funding and ethics (and therefore major decisions) have all been made.[116]

The underrepresentation of consumers in research is compounded by the fact that traditional forms of testing and evaluation by large organisations are more likely to gain funding, exposure and validation than non-traditional researchers.[117] Associate Professor Atkinson observes that locally generated and non-traditional research still struggles to secure resources.[118]

Victorian innovators warned that funding was not reaching the most likely sources of innovation, with one saying:

> There's clear funding out there, it's just not directed into the right areas. And we think about the [Medical Research Future Fund which] has significant capital. But of course, it's still directed towards universities.[119]

In a meeting with the Commission, LaunchVic innovators stated that they saw the current hierarchical biomedical model as unwelcoming to new voices, ideas or technology. This stifles opportunities for new contributions and solutions:

> I think one of the biggest barriers is the outdated and very hierarchical medical model … so how are we actually going to shake out that model and bring in new thinking? I think the biggest missing link is … that there is no connector … so how do we actually get these ideas heard and accepted … how do we make it part of the system rather than just a nice to have?[120]

The Commission also heard that the mental health workforce is not supported to develop and improve models of care. Professor Ian Hickie AM, Co-Director, Health and Policy at the Brain and Mind Centre at the University of Sydney, reported in his personal capacity that reflective practice is often not prioritised within services, and that the 'system has somewhat stultified the personal drive in individuals to engage in innovation and development'.[121]

As discussed in section 36.6.1, joint clinical academic leaders—clinically active health researchers funded by the Victorian government—have researched and developed new ways of delivering better outcomes for the people they treat and care for over several decades.[122] However, Orygen argues that the joint clinical academic leadership model, which was designed to support workforce development projects and expand the crossover between research and practice, has 'fallen into disrepair'. It argues that professional isolation and a lack of support has made it 'unproductive academically and translationally'.[123]

Professor Suresh Sundram, Head of Department of Psychiatry in the School of Clinical Sciences at Monash University and Director of Research of the Monash Health Mental Health Program, calls in his personal capacity for more multidisciplinary clinical academic leadership roles (most are currently held by psychiatrists), and for these leaders to be given more prominence.[124]

In the Commission's view, this could include currently underrepresented research groups, including clinical psychology, specialist mental health nursing, occupational therapy, social work, and consumer academic leaders.[125]

36.5.2 Funding and investment to generate improvement

A lack of funding, resources and promotion of innovation within the Victorian mental health care system is stifling a culture of exploration and creativity.[126]

Australian mental health research has demonstrated a strong economic return from investment. One study of Australian and international research investments found that the returns were two to three times higher than for cardiovascular disease and cancer.[127] However, funding allocated to mental health research is out of step with the prevalence and impact of mental health conditions in our community.[128]

The Commission heard about the de-prioritisation of mental health investment, planning and improvement, compared to other forms of health.[129] In its interim report, the Commission noted that mental health receives less funding and attracts less investment in research than physical health problems, such as cancer, diabetes and cardiovascular disease.[130]

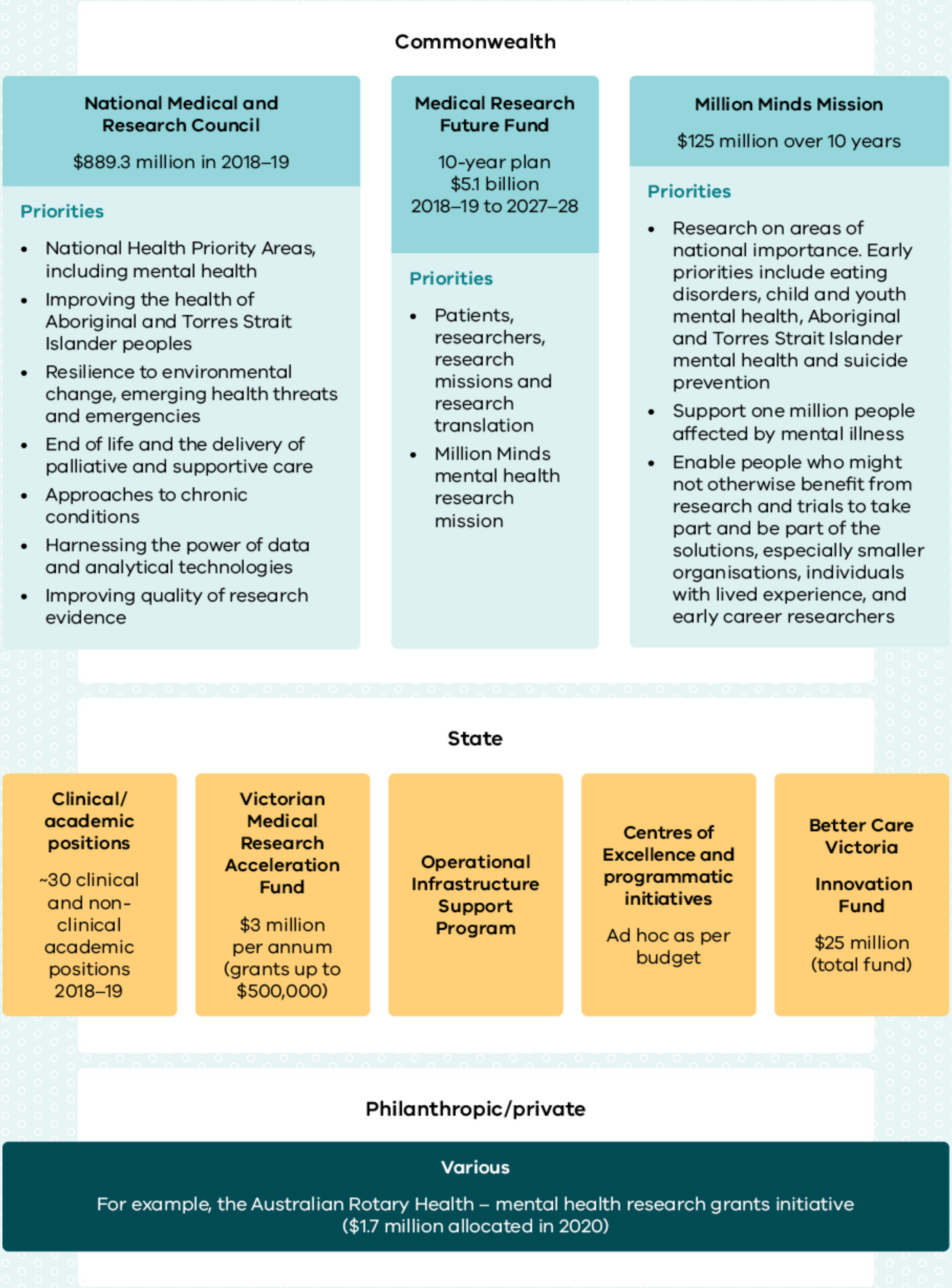
Cancer attracts around twice the amount of research funding from the Commonwealth Government,[131] and up to 2.5 times more from the National Health and Medical Research Council.[132] Since 2016–17, just 1.1 per cent of the Medical Research Future Fund grants have been committed to mental health.[133] Mental health research also receives comparatively low support from corporate, community, family foundations and private charitable trusts.[134]

In its submission, Orygen noted that the recent introduction of the Commonwealth's Million Minds Mental Health Research Mission fund has boosted investment, but mental health continues to be underfunded compared to other health areas, both nationally and globally.[135] Other submissions contend there is relatively little funding for mental health research.[136]

The Productivity Commission states that '[r]eliable estimates of the total amount of research funding in mental health are unavailable due to the variety of funding sources and differences in reporting', but that Commonwealth Government funding for mental health research has increased in recent years. This includes $15 million to support mental health research in the 2017–18 budget, and $12 million to establish a National Suicide Prevention Research Fund. National Health and Medical Research Council funding has grown around fivefold from 2000 to 2019, when mental health and addiction expenditure of $110.2 million comprised 16 per cent of the Council's expenditure on the Australian Government's National Health Priority Areas.[137]

Mental health research funding is summarised in Figure 36.6.

Figure 36.6: Mental health research funding summary



Commonwealth

National Medical and Research Council

$889.3 million in 2018–19

Priorities

- National Health Priority Areas, including mental health
- Improving the health of Aboriginal and Torres Strait Islander peoples
- Resilience to environmental change, emerging health threats and emergencies
- End of life and the delivery of palliative and supportive care
- Approaches to chronic conditions
- Harnessing the power of data and analytical technologies
- Improving quality of research evidence

Medical Research Future Fund

10-year plan
$5.1 billion
2018–19 to 2027–28

Priorities

- Patients, researchers, research missions and research translation
- Million Minds mental health research mission

Million Minds Mission

$125 million over 10 years

Priorities

- Research on areas of national importance. Early priorities include eating disorders, child and youth mental health, Aboriginal and Torres Strait Islander mental health and suicide prevention
- Support one million people affected by mental illness
- Enable people who might not otherwise benefit from research and trials to take part and be part of the solutions, especially smaller organisations, individuals with lived experience, and early career researchers

State

Clinical/academic positions

~30 clinical and non-clinical academic positions 2018–19

Victorian Medical Research Acceleration Fund

$3 million per annum (grants up to $500,000)

Operational Infrastructure Support Program

Centres of Excellence and programmatic initiatives

Ad hoc as per budget

Better Care Victoria

Innovation Fund

$25 million (total fund)

Philanthropic/private

Various

For example, the Australian Rotary Health – mental health research grants initiative ($1.7 million allocated in 2020)

Source: National Mental Health Research Council Corporate Plan 2019–20; Medical Research Future Fund 10-year plan; Million Minds Research Mission (Department of Health); Victorian Medical Research Acceleration Fund (Health Vic); Victorian Government 2018–19 budget papers; Australian Rotary, Funding Breakdown, <www.australianrotaryhealth.org.au/home/funding-breakdown>, [accessed 20 November 2020].

Underinvestment in mental health research at state, national and global levels has meant that advances in understanding about the causes of mental illness, and better ways to manage and treat mental illness, have been described as 'negligible'.[138] In particular, new treatments and drug therapies fall far behind other areas of medicine, such as cancer and cardiovascular disease treatment (refer to Box 36.6).[139]

Box 36.6: The importance of research and innovation in pharmacology

The development and widespread use of medications to treat mental illness or psychological distress began in the 1950s. New drug therapies made independent living and community-based care a viable option, and became an important factor in the deinstitutionalisation of people living with mental illness in Australia.[140]

However, Professor Arthur Christopoulos, Professor of Analytical Pharmacology at Monash University, advised the Commission in his personal capacity that there have been no truly novel medicinal breakthroughs in treatments for mental illness or psychological distress over the past 50 years.[141] Further, Professor Patrick McGorry AO, Professor of Youth Mental Health at the University of Melbourne and Executive Director of Orygen, told the Commission that improvements in new treatments and drug therapies for mental illness have not been made available.[142] One consequence is that side effects of mental health drugs continue to have a significant impact on the physical health and social wellbeing of consumers.[143] Further, research into modern medications may benefit workforce retention, as morale of staff is impacted when they perceive that available treatments do not help the consumer.[144]

In 2017–18, complaints about medication constituted 19 per cent of new submissions to the Mental Health Complaints Commission.[145] A common concern was that medication side-effects were not being adequately considered or responded to.[146] For example, many psychotropic medications are known to dramatically increase appetite, resulting in physical health challenges including weight gain.[147] Other side effects include insomnia, drowsiness, excessive thirst, swallowing difficulties, social withdrawal, muscle spasms and lack of coordination.[148] Other pharmacology issues raised included interactions between pain medication and psychiatric medications and the effects of psychiatric medication on potential pregnancies.[149]

The Association of Counselling Psychologists raised concerns to the Productivity Commission about 'diagnostic inflation', whereby a large percentage of people presenting to GPs with mental health concerns receive prescriptions for psychiatric medication despite limited assessment and little or no impact on symptoms.[150] Antidepressants are widely used treatments for major depressive disorder, despite long-lasting debate and concern about their efficacy.[151] Back in 2008, a meta-analysis found that the 'epidemic' use of antidepressants was supported by 'a seemingly evidence-based myth' generated by inadequate research:

> the use of many small randomized trials with clinically non-relevant outcomes, improper interpretation of statistical significance, manipulated study design, biased selection of study populations, short follow-up, and selective and distorted reporting of results has built and nourished a seemingly evidence-based myth on antidepressant effectiveness.[152]

Other researchers have claimed that over-reliance on psychopharmacology 'created the conditions for a blindness towards the serious adverse effects of some psychiatric drugs [and allowed] the illusion of major innovations in antipsychotic drugs'.[153]

Meanwhile, advances in other areas of medicine have created opportunities for mental health research that are going unrealised. For example, genetics research has provided fundamental insights into schizophrenia. However, further research and investment in pharmaceuticals using these developments is needed to make meaningful progress on new treatments.[154]

The Productivity Commission found that more research into the clinical benefits and long-term health implications of mental health medications 'could generate significant improvements in mental healthcare treatment outcomes'.[155]

Therefore, the Royal Commission considers that research and innovation in psychopharmacology is of crucial importance to ensure that consumers receive appropriate, evidence-based treatment without harmful side-effects. Other priorities for research and innovation are discussed in section 36.6.5.

Submissions from research bodies confirmed that a lack of funding and the low assignment of priority for mental health research has contributed to slow translation of evidence-based models of care into practice.[156] The Florey Institute of Neuroscience and Mental Health said that more support is needed for translational or participatory research:

> At a fundamental level, the quality of treatments for mental disorders hinges on the successful translation of basic science research to clinical interventions. Yet the translational gap … to implementation at the bedside remains a significant issue … A major impediment between the bench and bedside is the cultural and academic divide between basic and clinical research, and the resultant difficulty in successfully translating research through to the point where it is available for use by the public.[157]

Professor Shitij Kapur, Dean of the Faculty of Medicine Dentistry and Health Sciences, and the Assistant Vice Chancellor for Health at the University of Melbourne, argued in his personal capacity that this support must come from within Victoria:

> We are not really leveraging funding for [translational research]. The reason for this is that there are currently not many national or international agencies that will fund that research. Therefore, if Victoria wants translational and implementation science research, if it is a priority, Victoria will need to pay for it.[158]

The need for more research into mental health and wellbeing is increasingly understood, and levels of research funding in Australia for mental health are higher than ever and growing.[159] Establishing the collaborative centre, and building strong and diverse networks of research expertise, will put Victoria in a strong position to attract and secure research funding, and grow its reputation as a research leader.

There also appears to be a lack of funding and impetus for evaluation, particularly at the community level.[160] The Productivity Commission observed in its *Mental Health Inquiry Report* that 'Australia generally has a lack of routine program evaluation and evidence gathering to inform funding allocations and program improvements in mental health ... [a]nd where evaluations are undertaken, it is not clear if they are used to improve programs.'[161]

The Australian Psychological Society contends that 'lack of investment in quality outcome evaluations means the effectiveness of much of the expenditure on mental health remains unclear', and calls for outcome evaluation of programs and services provided by the public mental health sector to be mandated and routinely undertaken.[162]

Foundation House said more support is needed for evaluation of community-based programs and initiatives in Victoria:

> Evaluation and research must be resourced if they are to be undertaken at all or effectively. The Victorian Government provides in-kind support for some research partnerships but ... [f]urther investment is required. Among other areas, community based agencies undertaking mental health projects commonly require external assistance to design and implement evaluations of their work.[163]

Expert evidence also suggests that a lack of funding and resources, and low assignment of priority for innovation within the system, is stifling a culture of exploration and creativity.[164]

Victorian innovators have said it is hard to find opportunities, resources and support for innovation, and ways to translate it into practice:

> Often peer alternatives are trapped in a Catch-22 where the argument against commissioning alternative models of care is based on them having a less established evidence-base compared to other models, and yet it is often difficult to get substantial funding to research consumer-led alternatives to build that evidence base.[165]

> I think the big challenge is, so many organisations, I think, fall through the cracks of being able to access the support and funding … how can we provide quick, agile paths to funding for organisations that are probably a bit smaller? And on the coalface? And how can we equip them with the skills and the know-how to be able to put their hat in the ring to even access these sorts of opportunities?[166]

Mr Graham Panther, witness and co-founder of the Big Feels Club, told the Commission that government funding often comes with excessively restrictive requirements that force innovators to find financial support from outside the system:

> to truly build your offering with your users, you have to go into it not knowing what your solution will be … The money we've accepted has been money that came with few strings attached … This has allowed us to experiment in a way that we could not have if we were funded via health funding.[167]

36.5.3 Culture and conditions that support innovation

Dr Haskelberg warns that the public system is seen as very risk-averse.[168] Ms Harman also observes a culture that does not trust the 'new', or reward risk-taking, which limits the scale and uptake of innovation:

> [There is] enormous pressure on innovative enterprises to demonstrate success. Yet, a major influence on innovation is being allowed to try new things and fail … This doesn't mean that we shouldn't do such things, but … may mean we need to consider learnings, failures and partial successes, rather than only looking at outcomes.[169]

Innovators who met with the Commission also perceive low levels of government trust and confidence in small and non-traditional enterprises:

> [Government needs to recognise] that there's significant technologies and start-ups out there with solutions that can save lives and help people feel much better. But we just fear it, unless it comes from a large branded organisation we're not going to buy it. And this is a problem.[170]

Innovation is often hampered by a lack of evidence and outcomes in the early days of development, which is required to secure resources for further development. Professor Lisa Brophy, Discipline Lead in Social Work and Social Policy, Department of Occupational Therapy, Social Work and Social Policy at La Trobe University, observed in a personal capacity that this can undermine innovative approaches before they are able to demonstrate value:

> Often when implementing new models of care, the model is corrupted by the impact of having insufficient resources to properly analyse its impacts and see it flourish. New innovations must be supported on a continued basis, so they can be given the opportunity to operate as intended.[171]

As a result, consumers and carers, or smaller innovation organisations, are often not eligible or able to scale up their ideas and evaluate them:[172]

> There's all of these announcements about … new funds to support innovation and support collaboration. But very few start-ups or NGOs [non-government organisations] are eligible … it means that we end up with the same old solutions all the time. So it has to … come completely out of those systems, and into a completely new environment.[173]

The Black Dog Institute identified other barriers to innovative and digital solutions that exist. These include:

- a lack of encouragement for industry involvement
- failure to work with clinicians on expectations and benefits
- a lack of confidence in quality, safety and evidence
- concerns about potential legal liabilities
- governments and users being unwilling to pay.[174]

Even where an innovation is developed and receives a positive evaluation, it often lacks the investment and support required to make it widely available.[175] This can discourage further innovation. Ms Harman explained:

> Successful projects need to be scaled up and integrated within wider service systems. Running short term, small scale pilots that never reach scale despite positive evaluations becomes a significant disincentive to further innovation.[176]

The Florey Institute of Neuroscience and Mental Health, and Professor Mario Alvarez-Jimenez, Director at Orygen Digital, cite research indicating that it takes 17 years to move research innovation into clinical practice.[177] Even then, 85 per cent of innovations never reach those who need them.[178] A major cause of this delay is the cultural divide between clinical research and basic research (which includes local innovation).[179]

Innovators told the Commission that the failure to sustain and grow proven innovations creates inefficiencies, because effort and resources are wasted on reinventing approaches:

> [Start-ups have] got technologies with solutions out there already. And they fall over after a couple of years, because we just don't have the ability to get adopted into the system … And so, then we invent the wheel, and we do another one … we're just going to see this constant circulation of failure happening.[180]

The Black Dog Institute pinpointed self-help technologies as one area where successful ideas are not being picked up and invested in:

> e-health programs and apps are … effective, cost-effective and can be scaled up cheaply … Although these products are effective, they are underused even when the need is high … There are many more specialised digital services that have been created but do not receive Government funding for scale up or roll out.[181]

However, while the system has been slow to encourage and adopt innovations, many people have chosen to access information and support through digital, multichannel and flexible sources. This has been accelerated during the COVID-19 pandemic.[182] Beyond Blue,[183] the Black Dog Institute,[184] and the Clinical Research Unit for Anxiety and Depression at the University of Sydney[185] all report increased demand for digital mental health tools and resources. For example, the online cognitive behavioural therapy program, THIS WAY UP, has experienced a 700 per cent increase in the number of individuals accessing the courses.[186]

In Victoria, area mental health services delivered 346 consumer contacts via teleconference in April 2019. A year later, this number increased to over 10,000 consumer contacts.[187] The growing use of online communities such as The Big Feels Club clearly indicates these alternative supports are meeting a consumer need for other options to clinical care.[188]

Professor Kapur stated that the integration of lived experience, and digital and technological leadership could place Victoria 'at the cutting edge':[189]

> I think it is feasible for us to be at the cutting edge of digital mental health here in Victoria. It is not just about medicine, it is about getting a lot of input from our sociologists, our historians, our ethicists, our lawyers, and of course our mental health professionals, along with the community of people with lived experience. We have a strong tradition of it in Australia and I think Victoria could amplify it.[190]

While some innovation will happen organically through investment in research and the translation of new knowledge into practice, the Commission believes there needs to be more disruptive innovation that reflects the views and preferences of consumers. The mental health and wellbeing system needs to create flexible funding and regulatory environments that encourage invention, risk-taking and controlled trial and error, in order to find new and effective approaches to mental health treatment, care and support.

36.5.4 Dedicated innovation support

Innovation is carried out within the system (by academics and services) or outside of the system (between private organisations, non-government organisations and individual entrepreneurs). There is no space or platform in Victoria to bring together consumers, innovators, mental health services, accelerators and investors dedicated to mental health innovation.
The Victorian Government accepts that these parties are not being formally supported to promote continuous development and improvement of mental health services together.[191]

The Commission believes that spaces and funding opportunities must be created to encourage collaborative experimentation, learning and solution design. LaunchVic has observed that parties want to come together with the system to contribute, but they do not know how to do this. They are also often overwhelmed by the complexity of the environment.[192] Innovators told the Commission that these supports will need to be carefully chosen and organised, and have the flexibility and openness to enable consumers, smaller innovators and non-traditional researchers to participate with other experts:

> If there was a facilitator of passionate and talented and capable innovators to have a safe place to play, it kind of opens up the other side of the funnel … I think it's a huge catalyst to unlocking a whole amount of, like really passionate, really smart, really capable people not being scared away …[193]

36.5.5 Knowledge and practice translation support

The Commission heard that a lack of coordination and collaboration between different research institutions and levels of government prevents research and evidence being translated into policies, programs and on-the-ground practices.[194] Ms Kym Peake, then Secretary of the Department of Health and Human Services, observed that evidence-based approaches are not being systematically translated into practice across the system:

> There is also strong and consistent evidence supporting specific therapies and … specialist therapeutic interventions … These interventions are not systematically embedded in … models of care …[195]

Professor McGorry emphasised that the failure to translate evidence into practice means consumers miss out on the most effective treatments, and may be exposed to unproven alternatives.

> The evidence-base for mental health care has improved a lot in recent years, however fewer and fewer patients get exposed to this. Examples include clozapine, cognitive behavioural therapy (CBT), individual placement and support (IPS), assertive community treatment (ACT), family interventions and home-based treatment. Non-evidence based models have emerged, such as [emergency department] based admission beds, to replace models that were evidence-based, such as home based treatment of acute episodes.[196]

The Commission is concerned that, as a result, services may continue using outdated treatment and delivery models that do not meet the needs of consumers, families, carers and supporters.

The collaborative centre will need strong connections with service delivery organisations across the state to translate research into practice. Currently, limited academic and clinical connections exist at a service level to build these networks.[197] Without translation at the service level, the benefits of research, innovation and evaluation will not be realised.

The Commission recognises the need for dedicated resources to support, capture and scale innovation that is happening on the ground, so that practitioners and small organisations are able to contribute to the evidence base.[198] Feedback loops and connections to decision making are also needed to ensure the system is equipped to use local innovation to develop and test policies. To effectively trial and test new approaches, and then validate and scale proven innovation, it is important to develop inquiry and assessment skills throughout the system to support learning and evaluation activities, along with leadership capability to enable high-quality reflective practice.[199]

36.5.6 Sources of evidence and information

In 2017, the former Department of Health and Human Services identified that no organisation had direct authority to practically support the translation of mental health research and other knowledge into better ways to deliver treatments, supports and best practice.[200]

The Commission considers that the system still lacks a function that brings a diversity of knowledge and evidence together. This includes knowledge and evidence from the research community, and system data and evaluation, as well as from the expertise and experiences of consumers, carers and staff.

Dr Shaymaa Elkadi, Executive Director of Strategy, Planning and Performance at Forensicare, noted that the lack of a knowledge system is a problem for consumers, researchers and innovators:

> **There are currently very archaic data and knowledge systems in place in the mental health system. These systems are not integrated and prevent the sharing of information across services in the clients' best interests as well as effective research and innovation.**[201]

In its interim report, the Commission stated that this knowledge-translation gap is 'a deficiency that must be redressed'.[202] This will require the creation, synthesis and sharing of data, evaluation findings and evidence-based guidance, as well as support and resources to implement it in practice.

The Productivity Commission in its *Mental Health Inquiry Report* similarly noted that the collection and use of outcomes data is crucial to making improvements. It observed the mental health system has been criticised for being 'data rich but information-poor', and said '[m]uch more can be done to improve the collection and use of mental health data to inform decision making and improve outcomes for consumers and carers.'[203] It noted that 'program evaluations in mental health across Australia are, for the most part, ad hoc, uncoordinated and lacking in objective evidence'.[204]

The Commission agrees, and considers that evaluation is not being systematically used as a tool for continuous improvement.

The former Department of Health and Human Services released an evaluation guide that promotes the use of evaluation before, during and after the implementation of programs.[205] The Commission has seen evidence of many impact and outcome evaluations carried out for specific programs and local service innovations within Victoria's mental health system. However, it is not clear whether this information is used to invest in and expand effective initiatives. This requires: evaluation that incorporates collecting feedback from consumers and practitioners; and the system using evaluation findings to adapt new initiatives and maximise their potential benefit.

In fact, there appears to be little system-level evaluation to determine the collective and independent effects of mental health services on consumer and carer outcomes, or on system sustainability. The Victorian Auditor-General's Office noted in 2019 that a formal evaluation framework for the government's 10-year mental health plan (launched in 2015) was yet to be completed.[206]

There is also no function to formalise 'definitive' evidence on behalf of the system to guide the translation of research into practice. There are many examples of practice guidance and standards that relate to particular professions, service settings or diagnoses.[207] However, to ensure all consumers can choose or experience a consistent, high standard of care, the mental health and wellbeing system needs a function to publish authoritative, evidence-based practice guidance that can be applied more universally.

Innovators said that without this, there is uncertainty about what is effective and supported:

> **it's really hard to get information on what's evidence-based, what's supported by the government, what has evidence behind it, what doesn't, and that leads to … big uncertainty … for self-management tools … what patients should look for themselves, and leaves a lot of inability to find the correct things.[208]**

As detailed in Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect*, there is a broader need for authoritative advice to help other community sectors and organisations better support people's mental health and wellbeing. For example, the Commission was advised that frameworks and programs which support mental health and wellbeing are inconsistently applied across early childhood and school settings,[209] and that 'accreditation' of evidence-informed initiatives would greatly assist schools.[210]

Similarly, participants in the Commission's Mentally Healthy Workplaces Roundtable said that businesses need guidance and clarity about how to support the mental health and wellbeing of their workers, and that it is unclear which workplace interventions are effective.[211]

The lack of authoritative evidence also makes it harder for objective, consistent and evidence-based policy design and investment decisions to be made at system, regional and service levels.

36.6 Supporting research, innovation and system learning

The Commission believes that continual development, innovation and adaptation will be central to the effectiveness of Victoria's mental health and wellbeing system.

As Alfred Health argues, '[m]uch is still unknown about the causes and treatments of mental illness'.[212] Therefore, Victoria's mental health and wellbeing system must be set up to continue learning:

> **[Victoria's mental health system] must be explicitly designed for learning and improvement, with the capacity to monitor performance, evaluate services and innovation and undertake research into new knowledge through engagement with academics, patients and clinicians.**[213]

Figure 36.2 presents the recommended functions and relationships for a mental health and wellbeing system that innovates, learns and adapts. It outlines arrangements that are designed to:

- build the culture and capabilities needed to encourage collaboration, courage and reflection
- bring together interdisciplinary experts, researchers, service leaders and people with lived experience to carry out research, translate it through service delivery, and share knowledge to improve treatment, care and support across the system
- support collaborative innovation, and assist with the application of new and proven approaches to treatment, care and support
- collect, combine and share evidence and lessons learned about effective practice to continually develop service design, policymaking and investment, to improve experiences and outcomes.

Collectively, these functions will enable an adaptive, responsive system that is designed for current realities, but has an inbuilt capacity for self-review and adjustment if it is not meeting future needs or achieving expected outcomes.[214]

36.6.1 Translational research and dissemination

The Commission views the establishment of the collaborative centre as an opportunity to create a networked approach to research and knowledge translation within the future system. As a new entity, the collaborative centre will model an open and inclusive culture of research that gives primacy to the needs, interests and expertise of the people that the system is designed to support.

Working with established research organisations, including those featured in this and other chapters, the collaborative centre will bring together people with lived experience, and a broad range of multidisciplinary experts and researchers to develop, translate and share best practice across the system.[215] Working closely together, this network of research organisations will collaborate on further research into priority needs in the system, and bridge gaps between research and practice. They will share the objective of making world-class treatment, care and support widely available to Victorians in the future system.

A promising example of a networked approach that brings together research, clinical and lived experience expertise to improve services and outcomes for Victorians is the Change to Improve Mental Health Centre of Excellence (CHIME) partnership between Barwon Health and Deakin University (refer to Box 36.7).

During its early deliberations, the Commission recognised established research expertise and activity in Victoria, relating to mental illness in children and young people (refer to Box 36.8). It identified a clear gap in current translational research focused on adults and older Victorians.

The collaborative centre is designed to fill this gap. It will lead translational research, and provide mental health and wellbeing services to adults (from 26 years) and older adults. This remit, including people aged 65 years and older, will align with the adult and older adult mental health and wellbeing system recommended in Chapter 5: *A responsive and integrated system* and Chapter 14: *Supporting the mental health and wellbeing of older people*. The collaborative centre will work closely with existing research bodies—such as the National Ageing Research Institute—to ensure that available expertise is used to develop the evidence base.

It has been suggested to the Commission that there is less translational research for infants and children (aged 0–11) and there would be benefit in creating the system-wide capability equivalent to the collaborative centre for children and younger people aged 0–25.

The Victorian Government should identify and promote opportunities to increase collaborative translational research between multiple organisations and multidisciplinary experts, and people with lived experience, to improve the mental health and wellbeing of infants, children and young people across Victoria.

Box 36.7: Change to Improve Mental Health Centre of Excellence

Barwon Health has established a new type of translational research partnership with Deakin University called CHIME (Change to Improve Mental Health Centre of Excellence), that places people with lived experience at the forefront. CHIME aims to leverage the deep community connections of both organisations to drive innovation and collaboration in mental health care and to improve access, services and outcomes for rural and regional communities in the Barwon area.

Associate Professor Steve Moylan explained the purpose of this networked research approach:

> CHIME aims to engage people with lived experience of mental illness, clinicians and academics in co-design and co-production of models of care, and to build capacity for evidence-based continuous improvement of mental health services within the region … The partnership will create a regional 'Learning Healthcare System for Mental Health'. Underpinned by systems thinking … It will drive transformation in mental health services in regional Victoria.

Research projects engage clinical staff from Barwon Health into Deakin's research team, enhancing knowledge exchange across both organisations and diversifying the skills, experiences and perspectives of all involved.

Initial research collaborations through CHIME include:

- using data to understand risk factors for poor mental health for youth in the region to inform early intervention measures
- clinical research into the efficacy of particular interventions (such as diet and exercise) as part of mental health treatments and models of care. The aim is to both improve mental health outcomes for rural and regional consumers and at the same time address common co-morbidities associated with mental illness such as cardiovascular disease
- evaluation of the rollout of mental health telehealth services in the region in response to the COVID-19 pandemic.

Future research priorities for CHIME include integrating digital capabilities such as artificial intelligence in the development of new therapies and technologies; and working with IMPACT (Deakin's Institute for Mental and Physical Health and Clinical Translation), to expand opportunities for consumers, families, carers and supporters across the region to participate in mental health clinical trials, and enhance the Barwon community's access to world-leading treatment, care and support.

Sources: Interview with Associate Professor Steven Moylan, Barwon Health and Renae Carolin, Interim Director – CHIME, 14 December 2020; Barwon Health, CHIME (Change to Improve Mental Health Centre of Excellence), <www.barwonhealth.org.au/research/our-research/item/chime-change-to-improve-mental-health-centre-of-excellence>, [accessed 15 December 2020].

Box 36.8: Collaborative research—children and young people

The Commission, in its interim report, identified a particular need for research focused on treatment, care and support for adults and older Victorians. It recommended that this be the focus of translational research led by the collaborative centre. In doing so, the Commission recognised that within Victoria, there are already bodies with established reputations and expertise in the fields of infant, child and adolescent mental health that could partner with the collaborative centre and other bodies in networks and communities of practice.

The Murdoch Children's Research Institute is Australia's leading child health research organisation that translates knowledge into effective prevention and treatment strategies across a range of disorders.

The Institute is also the custodian of research within the Melbourne Children's Campus—a strategic and physical alignment including the Institute, the Royal Children's Hospital, and the University of Melbourne's Department of Paediatrics co-located with the Royal Children's Hospital Foundation. The Foundation supports clinical trials and research with the aim of improving mental health provision on the campus.[216]

The Institute helped establish the Centre for Research Excellence in Childhood Adversity and Mental Health, a five-year research program co-funded by the National Health and Medical Research Council and Beyond Blue, to support multidisciplinary and community-based approaches to child mental health.[217] During 2020, the Victorian Department of Education and Training partnered with the Institute and the Ian Potter Foundation to develop and pilot evidence-based training and resources to help staff better identify and respond to mental health issues affecting primary school students (refer to Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect*).[218]

Orygen is Australia's largest mental health research entity. It focuses on early intervention and treatment for mental illness in young people.[219] Orygen's translational research capability spans discovery, novel treatment, clinical trials, service delivery, health economics and practice improvement research.[220]

Orygen has established a reputation as 'one of the world's leading research and knowledge translation organisations focused on mental ill-health in young people',[221] and is involved in a range of international research partnerships and activities.

During 2018–19, Orygen delivered clinical and non-clinical services training and consultations to workforces in Ireland, Hong Kong, New Zealand and the United States.[222] In 2019, it also co-hosted the International Association of Youth Mental Health's fifth International Conference.[223]

Orygen also partnered with the World Economic Forum as part of the Forum's initiative to develop a global youth mental health model, and to 'put youth mental health on the global agenda for the World Economic Forum Annual Meeting in Davos 2020'.[224]

In 2018–19, Orygen delivered clinical services for more than 3,500 young people (aged 12–25) at four headspace centres in the north and north-west of Melbourne. It was involved in 36 research projects, published more than 200 articles, led 17 clinical trials, delivered 15 training programs and events, and supported 250 young people in its youth participation programs.[225]

In April 2020, the Victorian Government announced funding for Orygen to implement its Moderated Online Social Therapy (MOST) program across all state-funded child and adolescent youth mental health services, and all Victorian headspace centres (refer to Chapter 34: *Integrating digital technology*).[226] In the same year, Orygen secured a $33 million grant from the United States' National Institutes of Health to develop models for predicting outcomes for young people who are at imminent and high risk of psychotic illness.[227]

Research translation

The collaborative centre and other research partners will carry out applied research through their respective service delivery arms, including testing it in different contexts and settings.

To support knowledge dissemination and implementation of research findings, the Commission recommends that the Victorian Government strengthen the joint clinical academic model by expanding and diversifying the cohort of clinical academic leaders, and strengthening the supports provided to them (refer to Box 36.9). The collaborative centre will build a network of academic leaders to translate, test and apply research in the areas of greatest need, through a regional hub-and-spoke model.

Professor Sundram and Professor Emeritus Bruce Singh AM, Clinical Director, Mental Health Services at South West Healthcare Warrnambool, advised in their personal capacities that embedding clinical advocates of research and translation within the service system is essential to create a strong translational research culture.[228] Professor Sundram also observed that it is important to build a research culture in the workforce, so that clinicians 'will become alive as to how research will improve practice'.[229] He noted that this is a challenge in the current system:

> At present, the difficulty is that research is hitting a cold workforce, one that has no experience with research. There is antagonism towards research, with many clinicians seeing it as a burden on their day to day work. The only way to overcome this is to embed research into mainstream practice.[230]

Orygen suggested that restructuring and better investing in leadership academic posts would greatly improve research translation on the ground. It would also build the critical mass needed to generate change.[231]

The Commission believes these clinical leadership positions need greater respect, support and assignment of priority by universities, service providers and government to be effective.

Box 36.9: Joint clinical academic positions

Clinical academics have been described as:

> clinically active health researchers. They work in health and social care as clinicians to improve, maintain or recover health while in parallel researching new ways of delivering better outcomes for the patients they treat and care for.
>
> Clinical academics also work in higher education institutions, while providing clinical expertise to health and social care. Because they remain clinically active, their research is grounded in the day-to-day issues of their patients and service. This dual role also allows the clinical academic to combine their clinical and research careers rather than having to choose between the two.[232]

Clinical academic positions are designed to fulfil a number of leadership, clinical activity, training and research functions, including:

- raising the profile and prestige of mental health services
- improving the quality of services
- undertaking high-quality research and disseminating research findings
- seeking to effectively translate research, knowledge and outcomes into practice
- contributing to the recruitment and retention of quality staff
- providing clinical leadership to the Victorian mental health workforce.[233]

The introduction of the first clinical academic positions fostered some of Victoria's most influential mental health leaders and voices in the system.[234] Advancements under their leadership (such as Orygen's considerable improvements in the youth space) can be partially attributed to these positions and the opportunities they afforded.

In 2018–19, the former Department of Health and Human Services invested over $4.7 million in clinical and non-clinical academic positions, with funding allocated to a range of service agencies. This clinical academic program funded around 30 mental health clinical and non-clinical academic positions (suitably qualified clinicians who have both an academic role within a university and a senior clinical role within specialist mental health services) to provide clinical leadership in mental health, and promote innovation through a range of workforce development and knowledge translation projects.[235]

Authoritative evidence, guidance and advice

The Commission recommends that the Victorian Government gives the collaborative centre responsibility for creating a 'clearing house' to bring together high-quality data and learning from research, evaluations and innovation relating to mental illness in adults and older people.

The purpose is to combine and promote evidence about proven and effective treatment, care and support. This will inform policy development and investment at the system level, and service design and commissioning by Regional Mental Health and Wellbeing Boards. It will also provide a source of reliable and contemporary evidence and information to local, area and statewide services, innovators and the general public.

These evidence synthesis and publication activities could be modelled on the National Institute for Health and Care Excellence (described in Box 36.5) and the What Works Centre for Wellbeing in the United Kingdom (described in Box 36.4).

Topics for guidance will be self-determined or referred to the collaborative centre by the Department of Health or the Mental Health and Wellbeing Commission, and informed by phases of reform and research priorities.

Other research bodies may also be mandated to perform similar activities relating to evidence about mental illness in infants, children and young people in the future. The networked model within which organisations will work can ensure that promising innovations and validated approaches across the lifespan will be identified, captured and integrated where appropriate into authoritative evidence and guidance.

The guidance and advice that is developed could include systematic reviews and other synthesised research evidence of the effectiveness of clinical and non-clinical approaches to mental health treatment, care and support; guidance on adopting new, evidence-based therapeutic innovations; tools and resources to support evidence-based professional practice; and operationalising and implementing culturally responsive and recovery-oriented care in partnership with consumers, families, carers and supporters, as modelled by the Yale Program for Recovery and Community Health (refer to Box 36.10).

The Department of Health should establish processes to ensure the guidance from the collaborative centre and any other mandated research partners is used to inform the assignment of priorities for policy development; integrated in commissioning and planning cycles; and made available to service and system oversight functions.

In undertaking these roles, the collaborative centre and other research centres will be well placed to contribute to, and benefit from, interjurisdictional work led by the National Mental Health Commission to build the evidence base in mental health—part of the Productivity Commission's recommendations for a significantly strengthened national evaluation environment.[236]

Box 36.10: Yale Program for Recovery and Community Health

The Yale Program for Recovery and Community Health—part of the Connecticut Mental Health Center of the Department of Psychiatry at Yale School of Medicine—conducts research and evaluation in the areas of recovery from serious mental illness, substance use, citizenship, social inclusion, and health disparities and equity.

The Program for Recovery and Community Health research and evaluation is rooted in community work and connections. It is developed as a learning activity in partnership with people, families and organisations across the boundaries that academic disciplines and diagnostic labels can at times create.

The program 'has developed a national and international reputation as a leader in articulating, operationalising and implementing culturally responsive and recovery-oriented care … by:

- researching innovative and effective community and peer-based services and supports
- assisting systems of care in becoming more culturally responsive and recovery oriented
- reducing health care disparities
- improving individual, agency and system-level outcomes'.

Source: Yale School of Medicine, Yale Program for Recovery and Community Health, <www.medicine.yale.edu/psychiatry/prch/about>, [accessed 26 August 2020].

36.6.2 Dedicated support and resources for innovation and practice translation

For the future mental health and wellbeing system to continuously evolve, it needs more collaborative innovation. New, promising and proven approaches need to be applied more readily to treatment, care and support across all service settings and age ranges. This will require creating collaborative innovation networks supported by flexible funding, to expand and diversify networks between mental health consumers and services, innovators and investors.

Collaborative networks should:

- be made up of a flexible and evolving group of partners from different fields of national and international expertise (including lived experience, technology, private investors and organisations, mental health services and government)
- use a 'collective impact' framework to bring people and organisations together to solve problems
- focus on supporting co-design and co-production with consumers and carers
- allow for rapid design and testing of new ideas that demonstrate strong alignment with consumer, carer and system needs
- offer resourcing and support to people or small organisations with inventive ideas.

A new mental health and wellbeing innovation fund should reflect the model and principles of the Better Care Victoria Innovation Fund, which supports sector-led innovation and improvement projects in the Victorian health sector.[237]

The mental health and wellbeing innovation fund will:

- be flexible, providing the initial funding to test new ideas, and encourage creative exploration and testing, without needing a fully established theory or guaranteed outcome
- require alignment to principles of co-design and co-production, and fund consumer-led initiatives[238]
- respond to clearly defined system problems and support innovators to raise and tackle new challenges
- establish a funding stream for 'spreading and growing' good ideas that demonstrate effectiveness, and provide financial and technical support to scale them.[239]

The innovation fund and networks should be coordinated through an existing entity that has the culture and conditions to foster new ideas and approaches. It should be arm's length from government, and visibly and culturally separate from formal research and system entities, including the collaborative centre. This is so that innovation initiatives can attract a diverse range of partners, allow flexible ways of working, and promote non-traditional inquiry to help build the evidence base.

The coordinating body will ensure the funding and activities for mental health and wellbeing innovation are aligned with system needs and expectations, including a commitment to consumer leadership, and provide meaningful support to a variety of service providers and service systems to implement, test and evaluate new approaches in various settings.

CivVic Labs is a local example of collaborative innovation. It provides a space for entrepreneurs and government to come together to tackle identified problems (refer to Box 36.11).

Box 36.11: CivVic Labs (a LaunchVic and public sector collaboration)

LaunchVic is Victoria's state start-up agency. It was established by the Victorian Government in March 2016 as an independent agency responsible for developing a globally connected start-up ecosystem for Victoria.[240] To date, the agency has committed $45.6 million in Project Activities funds through grant rounds, sponsorship and other commissioned activities.[241]

LaunchVic partnered with the Victorian Government and its Public Sector Innovation Fund to create the CivVic Labs accelerator. CivVic Labs provides a space for government and start-ups to come together to solve identified public sector challenges.

A government department or agency submits a challenge to the start-up ecosystem through the lab and invites suggested solutions from Victorian start-ups. The best ideas are chosen by the government department for refinement, and the best approach is then selected for acceleration.

Start-ups work within the accelerator to build a version of a product with just enough features to attract investment and provide feedback for future development. The accelerator provides funding, mentors and resources. Start-ups can secure up to $30,000 to develop their idea, and $150,000 to scale and implement the solution on the ground.

While government sets the 'challenges' to be solved, the solutions are brought in from outside thinking, and are not prescriptive.

Source: <www.civvic.launchvic.org/the-program> [accessed 13 November 2020].

The innovation body must have the expertise to identify leading practice wherever it emerges, and to test and develop promising innovation. It should also partner with the Department of Health and relevant regulators to ensure the right conditions for safe yet flexible testing. This will allow new ideas to be designed and tested quickly, and for appropriate safeguards to be progressively determined.[242] Such an approach also allows regulators and innovators to determine what regulatory changes may be required to ensure they deliver projects safely.[243]

The innovation body will support developmental testing and assessment of promising initiatives. It will also identify to the Department of Health, innovations that have the potential to be shared more widely for greater benefit. The department will be responsible for ensuring independent evaluation of innovative approaches, as part of a defined process of decision-making and investment, to scale proven approaches and provide equitable access across the system. This will include translation and innovation efforts by area partnerships and local services that are funded by Regional Mental Health and Wellbeing Boards.

The innovation body will also be responsible for supporting practice translation—applying knowledge and guidance on the ground, and embedding effective innovation in routine practice. Alfred Health says that services need to have the capacity to develop and test new ideas:

> **we also believe that every Area Mental Health Service (AHMS) must have capacity to use data, patient, family and clinician feedback to develop ideas for improvement, rapidly test and evaluate them in practice and then spread those ideas in order to generate learning about what changes, in which contexts actually work.**[244]

Drawing on the example of Ontario's Rapid Improvement Support and Exchange model, the innovation body will provide practical tools and support to translate new innovations, and both promising and evidence-based models and guidance, into service delivery at area and local levels.

It will support organisations and service providers through coaching and step-by-step capability building in assessment and testing, and empower workforces and professionals, including lived experience experts, as researchers of their own practice.

These supports will be informed by established approaches and methodologies to implement improvement processes, such as the Institute for Healthcare Improvement's Model for Improvement promoted by Safer Care Victoria.[245] The methodologies draw on a body of 'implementation science' literature, which recognises that improvement efforts are more successful when structured processes are used. These processes are most effective where they have the commitment of senior leadership, and are implemented by frontline staff, based on local data and co-designed with consumers.[246]

Other system supports for implementing quality improvement are discussed in more detail in Chapter 30: *Overseeing the safety and quality of services.*

If successful, this practical support model could be extended to local and regional implementation of the Commission's recommendations more broadly, and where needed.

The Victorian Government should design processes to support regional commissioning that encourages innovation in areas of need by area partnerships and local services, and also to collect information from Regional Mental Health and Wellbeing Boards about local service needs, activity or improvement.

36.6.3 Build evaluation activity and capability across the system

Evidence-based decision making is a key principle of the *Public Health and Wellbeing Act 2008* (Vic).[247] In Victoria, the consistent use of evaluation to determine the effectiveness and cost effectiveness of interventions, policies and programs is one of the primary tools to ensure the health system, including mental health, delivers on this obligation.[248]

The Commission considers that including evaluation mechanisms to continually measure and improve service responsiveness and effectiveness is critical to the success of the future system.[249] This reflects the Commission's seventh guiding principle for Victoria's mental health and wellbeing system:

> Mental health services use continuing research, evaluation and innovation to respond to community needs now and into the future.

As previously stated, it is the Commission's view that the system must respond and adapt to inequity within it. This includes making leading practices and approaches available across the system, in line with the Commission's third guiding principle:

> Comprehensive mental health treatment, care and support services are provided on an equitable basis to those who need them and as close as possible to people's own communities—including in rural areas.

The Commission is concerned that the failure to validate, sustain and grow proven approaches is denying Victorians the best possible treatment, care and support. Mr Alan Woodward, witness, believed that this failure also worsens inequity when best practice interventions are available to some consumers, but are not made widely available:

> My concern is that while some regions in Victoria have benefited from trials, there needs to be more consistency across the State. As the trials move into the delivery of services phase, there needs to be an application of what is being learnt from them and translation into more consistently improved services for all Victorians, regardless of where they live.[250]

Austin Health said that the system needs services to evaluate local improvements, and that expectations about evaluating and sharing learnings should be made clear as part of funding arrangements:

> Good governance calls for robust evaluation of all activities and trials undertaken within the mental health system, with a particular focus on identifying and sharing learnings from those events. Where a health service has made an attempt to improve services, or a discovery of a new way of overcoming an issue, there should be mechanisms in place for sharing or collaborating these breakthroughs and innovations ... [for funded programs] reporting against expectations should be required ... following completion with results and learnings promulgated appropriately.[251]

Therefore, the Commission places great value on effective evaluation at all levels of the system, and capturing new ideas and approaches from research and innovation, wherever they may occur.

Under the *Mental Health Act 2014* (Vic), the Secretary of the Department of Health has responsibility to 'monitor and evaluate the performance, standards and outcomes of mental health service providers and the quality and safety of the mental health services they provide'.[252]

The Mental Health and Wellbeing Commission recommended in Chapter 27: *Effective leadership and accountability for the mental health system—new system-level governance* will be responsible for system performance oversight. This includes monitoring and reporting on system-wide outcomes, and on the Victorian Government's progress in implementing the Commission's recommendations and delivery of reforms.

The Department of Health will remain accountable for monitoring and evaluating the performance and outcomes of mental health and wellbeing service providers. This must include ensuring that new service and program funding depends on clearly communicated and appropriate levels of spending on evaluation, and on independent evaluation findings being shared to promote system learning.

The Commission also recommends that the Department of Health:

- develops a rolling three-year evaluation program (similar to the Productivity Commission's proposal for the National Mental Health Commission to publish a rolling three-year schedule for evaluation[253]) and commissions appropriately qualified and independent experts to carry out evaluations of mental health and wellbeing programs, initiatives and reforms
- carries out or commissions the evaluation of innovation projects funded from the mental health and wellbeing innovation fund, or through targeted investment by Regional Mental Health and Wellbeing Boards in local innovation or translation initiatives
- in partnership with the workforce development coordinating function of the collaborative centre (described in Chapter 33: *A sustainable workforce for the future*), builds evaluation capability across the system, including raising the profile of consumers and carers as evaluators
- sets an expectation that adequate evaluation is a condition of funding for all new mental health and wellbeing programs, initiatives and innovations, and that this expectation extends to the sharing of evaluation findings for wider system learning
- establishes processes to share information from evaluations and innovation learning through the collaborative centre and other research centres, to promote and scale proven approaches across the system.

The Commission notes that the Centre for Evaluation and Research in the former Department of Health and Human Services carries out evaluation activities across a range of programs. This supports policy and program development, as well as the continued improvement of services. However, due to the scale of mental health and wellbeing system reforms, and the need for extensive evaluation activity in the future, the Commission recommends resourcing dedicated capacity for mental health and wellbeing evaluation.

More systematic evaluation is needed to understand how to apply models of care in widely varying cultures and settings.[254] Without this, evaluation activity may create inequity in the mental health and wellbeing system. For example, trials of a program at limited sites could give different results in different areas. This may lead to some services being discontinued and others continued, causing inconsistency in access.[255]

As a result, the Department of Health should report evaluation findings publicly.[256] It should ensure that processes are in place to use them proactively in system and policy design.

The Institute for Safety, Compensation and Recovery Research provides a model for how government and service providers can partner with expert evaluators and researchers to inform continued review, refinement and implementation of what works (refer to Box 36.12).

Box 36.12: Institute for Safety, Compensation and Recovery Research

The Institute for Safety, Compensation and Recovery Research is a joint initiative established and funded by Monash University, WorkSafe Victoria and the Transport Accident Commission (TAC). The purpose of the Institute is to lead exploratory and translational research that can inform real-life policy and service improvements for member organisations.

Working closely with WorkSafe and the TAC, Monash University co-develops its research approach and questions to understand the issues they face and how to answer them. One of the major services that WorkSafe, the TAC and Monash University provide is the development and implementation of evaluation frameworks and activities to assess the effectiveness, outcomes, and effects or lessons for any government program and initiative that WorkSafe and TAC use, and for the outputs of the evaluations to inform policy and investment decisions.

The benefits of this model are that government has a large network of experts who can inform evaluation and continuous improvement. The TAC and WorkSafe do not have major in-house evaluation capabilities or ethics functions. Therefore, this approach ensures that all programs and services are properly and independently assessed. Evaluation outcomes can also be fed back into research to improve future service design and outcomes.

Source: Institute for Safety, Compensation and Recovery Research, Our partners and Governance, <www.iscrr.com.au/who-we-are/our-partners-and-governance/>, [accessed 20 August 2020].

The Commission also notes the Productivity Commission's recommendation in its *Mental Health Inquiry Report* that a national body should be responsible for promoting a culture of evaluation, commissioning program evaluations, and building evaluation capacity and capabilities.[257] This body—recommended to be the National Mental Health Commission—would build and maintain partnerships with research institutes, and state and territory partners:

> the [National Mental Health Commission] is expected to evaluate aspects of the system that are of national significance or that relate to multiple jurisdictions. This would involve close consultation with jurisdictions to discern where and when the [National Mental Health Commission] could best add value.[258]

There would be an opportunity for a dedicated mental health and wellbeing evaluation function in Victoria to form a strong relationship with the national body, and access funding to undertake program evaluations that would have national interest.

Support provided for practice translation by the clinical academic leaders' network, and local innovation and trials by the innovation body should include helping to establish models of ongoing testing, reflection and adaptation within teams—reflecting structured processes such as the RISE rapid improvement model. They should also build the skills of workers and consumers to reflect on and evaluate different approaches and implications for their practice.

Intelligence gathered from evaluations, consumer-led research and leading grassroots practice should also be used by the workforce development coordination function of the collaborative centre to inform the design and development of capacity building and professional development.

36.6.4 Integrating consumers and the workforce in system learning

In Chapter 27: *Effective leadership and accountability for the mental health system—new system-level governance*, the Commission recommends that the new Mental Health and Wellbeing Commission develops and implements strategies to support the leadership, and the full and effective participation, of people with lived experience of mental illness or psychological distress in decision-making processes about policies and programs, including those directly concerning them.

The collaborative centre, other research bodies, the Department of Health, and the innovation body should all ensure that consumers have a meaningful and influential role in research and evaluation, and that consumer expertise is built into research efforts, service innovation and workforce capability development.

Consumer leadership will be integral to networked collaboration. The collaborative centre will employ leaders with lived experience in influential positions in many of its functions, to help grow the body of consumer-led research, and ensure that promising findings are put into practice for the benefit of consumers, families, carers and supporters.[259]

Proactive efforts must be undertaken to support and build the capabilities of consumers as leaders of research and evaluation.

Consumer leaders must have a senior presence in the governance of innovation, implementation and evaluation responsibilities. They should influence how funding is shared and encourage lived experience experts as partners in the innovation networks.

As described in Chapter 33: *A sustainable workforce for the future*, the collaborative centre will work with existing learning and development providers, and statewide services to coordinate and increase access to high-quality workforce training and development. This will be for all staff in the Victorian mental health and wellbeing system, including consumer and peer workforces. It will include:

- developing leaders to support adaptive thinking and practice
- building workforce capabilities for reflective practice, collaborative inquiry and evaluation, focused on improving consumer experiences
- building best-practice guidance and evidence-based approaches into training programs
- supporting the workforce to participate in knowledge distribution and evidence-based practice approaches.

Associate Professor Stafrace argues that '[t]he techniques of adaptive thinking can be taught and learnt.'[260] In his view, the 'ability to recruit adaptive leaders or develop adaptive leadership capability will be crucial in building the capacity for reform in our mental health sector'.[261]

36.6.5 Research priorities and opportunities for innovation

Research and innovation activities that receive Victorian Government funding should be clearly linked to system reforms, and consumer needs and preferences. It is the Commission's view that directing research and investment to focus on these areas, summarised in Box 36.13, will support implementation, and advance new and improved approaches to treatment, care and support.

Overall, the system should have the capacity to respond to breakthroughs that may not be part of the formal research agenda, but that have the potential to add considerable value for consumers. This includes responding to unexpected events or needs within the Victorian community.

The Commission is confident that, by taking these steps to strengthen research, innovation, practice translation and evaluation, Victoria's mental health and wellbeing system will be set up to learn, adapt and improve into the future, and regain its status as a world-leader in mental health treatment, care and support.

Box 36.13: Research and innovation priorities for the Victorian mental health and wellbeing system

Community-based models of care: as a foundational reform, it will be critical that research supports the investment and expansion that will be required, and builds evidence on approaches to particular service delivery modalities, peer support methodologies, supports for particular groups in communities (for example, refugees), and opportunities for supporting mental wellbeing, particularly relating to isolation and loneliness.[262]

Children and young people: the future system will provide treatment, care and support earlier in life, and earlier in an individual's experience of mental illness—including increasing wellbeing and preventing poor mental health. Research into the role of psychosocial factors early in life, and effective wellbeing and treatment interventions, will help to improve outcomes for young people. In particular, a stronger understanding of the links between substance use and mental health, and effective interventions for children and young people who have experienced trauma, will help the system to better respond to those most at risk of mental illness.[263]

Digital technologies and innovations: there is significant potential to improve access and service delivery through the integration of digital technologies into clinical services, but more translational research is needed to realise this potential. Research into digital interventions that enhance clinical services, mechanisms that influence take up and adoption, and effectiveness of digital tools and interventions, will be foundational to achieving a contemporary system and responding to the needs of regional and rural communities.[264]

Diverse communities: The Commission has made a number of recommendations that target the mental health and wellbeing of people who are at greater risk of poor mental health, trauma and suicide than the general population. Research is needed to develop and adapt culturally appropriate and safe models of care and interventions to meet the particular needs of Aboriginal people,[265] culturally diverse communities including migrants and refugees from different backgrounds,[266] and LGBTIQ+ communities.[267]

Families, carers and supporters: the future system will respond to the significant role that relationships of care and support play in promoting mental health and wellbeing for people living with mental illness or psychological distress. Research will provide a stronger understanding of the crucial role that parents, families and other carers and supporters play, the challenges they face, and how their experiences can strengthen how services are offered and delivered. It will also inform the development of dedicated supports that the system will offer to families, carers and supporters.

Older Victorians: the collaborative centre will create research capacity in Victoria that is dedicated to developing the evidence base for improving the mental health and wellbeing of older adults. This will enable the system to provide more effective interventions aimed at improving help-seeking, facilitating diagnosis and increasing participation in enjoyable and meaningful activities.[268]

Pharmacology: further research is needed to make meaningful progress on new treatments and drug therapies for mental illness (see Box 36.6 above for a detailed assessment).[269]

Rights and interests of consumers: the Commission's recommendations make the rights of consumers paramount. Services will be required to significantly reduce the use of compulsory treatment, and work towards eliminating seclusion and restraint. They must be supported to develop a stronger understanding of alternative interventions and strategies that are safe and effective.[270] More broadly, additional research will inform approaches and initiatives that effectively deal with stigma and change attitudes towards mental illness.

Suicide prevention and support: suicide prevention research has been effective in describing risk factors, but the Commission understands there is still much to learn about the effectiveness of suicide prevention interventions. Research will be critical in helping the system to reduce the rates of self-harm and suicide, particularly among younger people. It is also important to better understand family and carer experiences of caring for someone who is suicidal, and how the system can help people who provide this support.[271]

Trauma: along with suicide prevention, trauma-informed practice and services are prioritised in the immediate actions recommended by the Commission. The establishment of a statewide specialist trauma service auspiced by the collaborative centre (refer to Chapter 15: *Responding to trauma*) creates an opportunity for more translational research into responses and interventions for survivors of torture and traumatic events, and to develop holistic, culturally adapted approaches suitable for diverse communities and consumers.[272]

Treatment and services for people with mental illness needing ongoing intensive treatment, care and support: there are some people whose mental health outcomes are substantially worse than the general population, and who would benefit from accelerated research and new care models to support them. The Commission considers that the needs of these Victorians should be a paramount concern, as evidence indicates that many experience high levels of coercion, poor physical health, and personal recovery outcomes and social exclusion.[273]

1 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, pp. 98 and 385.

2 *Evidence of Dr Ravi Bhat*, 15 July 2019, p. 988.

3 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 391–393.

4 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, 2020, p. 1246.

5 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, pp. 1244 and 1246.

6 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1246.

7 Australian Bureau of Statistics, 4159.0 General Social Survey: Summary Results, Australia, 2014, 2015, <www.abs.gov.au/statistics/people/people-and-communities/general-social-survey-summary-results-australia/latest-release>, [accessed 25 September 2020]; Australian Bureau of Statistics, 1370.0 Measures of Australia's Progress, 2013, <www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1370.0~2013~Main%20Features~Homepage~1>, [accessed 25 September 2020].

8 Commonwealth Department of Infrastructure and Transport, *State of Australian Cities*, 2013, pp. 7–8 and 271–272.

9 Australian Council of Social Service, *Inequality in Australia: A Nation Divided*, 2015 Part 1: Income Inequality; Australian Council of Social Service Part 2: Wealth Inequality; Vinson, Rawsthorne, Beavis and Ericson, *Dropping Off the Edge 2015: Persistent Communal Disadvantage in Australia*, 2015, p. 11.

10 Department of Health and Human Services, *Victoria's 10–Year Mental Health Plan*, 2015, p. 10; John Mendoza, Kathleen Margaret Griffiths and Sebastian Pascal Rosenberg, *Obsessive Hope Disorder: Reflections on 30 Years of Mental Health Reform and Visions for the Future: Summary Report*, 2013, p. 41; *Witness Statement of Kym Peake*, 24 July 2019, paras. 57 and 74; Victorian Auditor-General's Office, *Access to Mental Health Services*, 2019, p. 8; Mercy Mental Health, *Submission to the RCVMHS: SUB.0002.0029.0267*, 2019, p. 4; *Witness Statement of Dr Neil Coventry*, 28 June 2019, para. 118.

11 *Witness Statement of Angus Clelland*, 5 June 2020, paras. 15–20; *Witness Statement of Associate Professor Alessandra Radovini,* 10 June 2020, para. 54; *Witness Statement of Dr Hila Haskelberg*, 13 July 2020, paras. 84 and 100; *Witness Statement of Georgie Harman*, 2 July 2020, para. 59; *Witness Statement of Professor Mario Alvarez-Jimenez*, 10 June 2020, paras. 159 and 167.

12 Monash Sustainable Development Institute, *Correspondence to the RCVMHS: CSP.0001.0102.0001, Final Outcomes Report*, 2020, pp. 13–14.

13 Monash Sustainable Development Institute, p. 14; *Witness Statement of Dr Hila Haskelberg*, para. 84.

14 *Witness Statement of Angus Clelland*, para. 143.

15 *Witness Statement of Professor Ian Hickie* AM, 11 August 2020, paras. 185–186; *Witness Statement of Angus Clelland*, para. 14.

16 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, pp. 20–21.

17 LaunchVic, About LaunchVic, <launchvic.org/about-launchvic>, [accessed 6 October 2020].

18 Better Care Victoria, Better Care Victoria Innovation Fund, <www.bettercare.vic.gov.au/our-work/innovation-fund>, [accessed 6 October 2020].

19 Victorian Council of Social Service, *Social Impact Bonds Briefing Paper*, 2017, pp. 1–2.

20 Department of Treasury and Finance, Partnerships Addressing Disadvantage, <www.dtf.vic.gov.au/funds-programs-and-policies/partnerships-addressing-disadvantage>, [accessed 3 March 2020]; *Witness Statement of Georgie Harman*, 2020, para. 80.

21 Victorian Government, *Victorian Budget 2020–21: Service Delivery: Budget Paper No. 3*, 2020, p. 118.

22 Shubham Singhal and Stephanie Carlton, *The Era of Exponential Improvement in Healthcare?*, 2019, p. 4.

23 Fiona McKenzie and Mark Cabaj, *Changing Systems, Power and Potential*, 2020, p. 9.

24 Harvard Business Review, Disruptive Technologies: Catching the Wave, <hbr.org/1995/01/disruptive-technologies-catching-the-wave>, [accessed 26 October 2020].

25 Australian Institute of Family Studies, Collective Impact: Evidence and Implications for Practice, <aifs.gov.au/cfca/publications/collective-impact-evidence-and-implications-practice/what-collective-impact>, [accessed 20 October 2020].

26 Forbes, What Is A Startup?, <www.forbes.com/sites/natalierobehmed/2013/12/16/what-is-a-startup/>, [accessed 26 October 2020].

27 Productivity Commission, *Draft Indigenous Evaluation Strategy*, 2020, p. 5.

28 Monash Sustainable Development Institute, Monash University, p. 4.

29 Monash Sustainable Development Institute, Monash University, p. 26; Ministry of Health, Ontario, *Ontario Health Teams: Guidance for Health Care Providers and Organizations*; K.A. Moat, K. Waddell and J.N. Lavis, *RISE Brief 11: Accountable-Care Organizations*, 2019.

30 Ministry of Health, Ontario, p. 5.

31 McMaster University, Rapid-Improvement Support and Exchange, <www.mcmasterforum.org/rise/learn-about-rise/overview>, [accessed 6 October 2020].

32 *Witness Statement of Associate Professor Simon Stafrace*, 14 August 2020, paras. 143 (a–e).

33 *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 109.

34 *Witness Statement of Dr Hila Haskelberg*, para. 81.

35 Lynne Maher and others, *Creating the Culture for Innovation: A Practical Guide for Leaders*, 2010, p. 9.

36 *Witness Statement of Associate Professor Jo-An Atkinson*, 29 April 2020, para. 92; Jo-An Atkinson, Andrew Page, Ante Prodan, Geoff McDonnell and Nathaniel Osgood, 'Systems Modelling Tools to Support Policy and Planning', *The Lancet*, 391.10126, (2018), 1158–1159 (p. 1159).

37 *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 111.

38 Alison Faulkner, 'Survivor Research and Mad Studies: The Role and Value of Experiential Knowledge in Mental Health Research', *Disability and Society*, 32.4, 2017, 1–21 (pp. 10 and 12).

39 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 410.

40 *Witness Statement of Cath Roper*, 2 June 2020, para. 34.

41 Louise Byrne and Til Wykes, 'A Role for Lived Experience Mental Health Leadership in the Age of COVID-19', *Journal of Mental Health*, 29.3, 2020, 243–246 (p. 244).

42 Michelle Banfield and others, 'Lived Experience Researchers Partnering with Consumers and Carers to Improve Mental Health Research: Reflections from an Australian Initiative', *International Journal of Mental Health Nursing*, 27.4, (2018), 1219–1229 (p. 1220).

43 Cath Roper, Flick Grey, and Emma Cadogan, *Co-Production: Putting Principles into Practice in Mental Health Contexts*, 2018, p. 6.

44 *Witness Statement of Georgie Harman*, 2020, para. 77.

45 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, pp. 1113 and 1249.

46 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 410.

47 *Witness Statement of Associate Professor Simon Stafrace*, 2020, paras. 51 and 53, citing Heitetz R Grashow A and Linsky M, *The Practice of Adaptive Leadership. Tools and tactics for changing your organisation the world* (Harvard Business Press, 2009).

48 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 433.

49 Dr Stephanie Allen, 2020 *Global Health Care Outlook: Laying a Foundation for the Future*, 2019, p. 4.

50 Singhal and Carlton, p. 6.

51 Melbourne Connect, Access Leading Researchers, Talent and Entrepreneurs, <melbconnect.com.au/people/access/>, [accessed 2 November 2020].

52 RCVMHS, *Innovation Roundtable: Record of Proceedings*, 2020.

53 Monash Sustainable Development Institute, Monash University, pp. 21 and 24.

54 Victorian Government, *Melbourne Biomedical Precinct: From Research Engine to Economic Powerhouse*, 2018, p. 7.

55 Victorian Government, *Melbourne Biomedical Precinct: From Research Engine to Economic Powerhouse*; Monash Health, Monash Health Translation Precinct, <monashhealth.org/research/translation-precinct/>, [accessed 14 October 2020]; Garvan Institute of Medical Research, About the Garvan Institute, <www.garvan.org.au/about-us/about-the-garvan-institute/>, [accessed 14 October 2020].

56 Jeffrey Braithwaite and others, 'Accomplishing Reform: Successful Case Studies Drawn from the Health Systems of 60 Countries', *International Journal for Quality in Health Care*, 29.6, (2017), 880–886 (p. 883).

57 The University of Melbourne and Lendlease, Melbourne Connect: Creating a Connected Innovation Ecosystem in the Heart of Melbourne Brochure, 2020, p. 2.

58 Mariana Mazzucato, *The Entrepreneurial State*, 2011, pp. 70–71.

59 Deloitte Center for Health Solutions, *Top 10 Health Care Innovations: Achieving More for Less*, 2016, p. 3; Singhal and Carlton, p. 4.

60 Singhal and Carlton, p. 8.

61 Victorian Government, *Healthier Lives, Stronger Economy: Victoria's Health and Medical Research Strategy 2016–2020*, 2016, pp. v–vii.

62 Government of South Australia, Department for Innovation and Skills, <innovationandskills.sa.gov.au/>, [accessed 6 October 2020].

63 RCVMHS, *BCA Digital Fireside Chat—Roundtable: Record of Proceedings*, 2020.

64 Black Dog Institute, *Submission to the Productivity Commission Inquiry into Mental Health*, 2019, p. 23.

65 RCVMHS, *Innovation Roundtable: Record of Proceedings*, 2020.

66 *Witness Statement of Dr Hila Haskelberg*, para. 76.

67 Buenos Aires Times, Edmund Phelps: "It's Important to Get a Debt Agreement That Is Feasible for Argentina", <www.batimes.com.ar/news/economy/edmund-phelps-its-important-to-get-a-debt-agreement-that-is-feasible-for-argentina.phtml>, [accessed 6 October 2020].

68 *Witness Statement of Associate Professor Jo-An Atkinson*, para. 92; *Witness Statement of Georgie Harman*, 2020, paras. 76 and 80.

69 Braithwaite and others, p. 883.

70 William D. Eggers and Mike Turley, *The Future of Regulation: Principles for Regulating Emerging Technologies*, 2018, pp. 9–10.

71 Eggers and Turley, p. 11.

72 RCVMHS, *Innovation Roundtable: Record of Proceedings*.

73 *Witness Statement of Frank Quinlan*, 25 May 2020, para. 39.

74 *Witness Statement of Dr Hila Haskelberg*, para. 79.

75 *Witness Statement of Angus Clelland*, para. 144.

76 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 393.

77 Translational Cancer Research Network, Translational Research—Defining the "T's", <www.tcrn.unsw.edu.au/translational-research-definitions>, [accessed 6 October 2020].

78 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 392–394.

79 The Florey Institute of Neuroscience and Mental Health, *Submission to the RCVMHS: SUB.0002.0029.0209*, 2019, pp. 5–6; Dana-Farber Cancer Institute, Basic, Clinical and Translational Research: What's the Difference?, <blog.dana-farber.org/insight/2017/12/basic-clinical-translational-research-whats-difference/>, [accessed 6 October 2020].

80 RCVMHS, *Innovation Roundtable: Record of Proceedings*.

81 *Witness Statement of Mary-Ann O'Loughlin AM*, 28 July 2020, para. 58.

82 RCVMHS, *Innovation Roundtable: Record of Proceedings*.

83 Australian Evaluation Society, Talking About Evaluation, <aes.asn.au/talking-about-evaluation>, [accessed 12 October 2020].

84 Department of Treasury and Finance, *Performance Management Framework: For Victorian Government Departments March 2016*, 2017, p. 32; Australian Psychological Society, *Submission to the RCVMHS: SUB.0002.0029.0349*, 2019, p. 77.

85 Department of Treasury and Finance, *Performance Management Framework: For Victorian Government Departments March 2016*, p. 37.

86 Department of Health and Human Services, *Victorian Health Services Performance Monitoring Framework 2019–20*, 2019, p. 28.

87 Catherine Althaus, Peter Bridgman and Glyn Davis, Chapter 11: Evaluation, in *The Australian Policy Handbook: A Practical Guide to the Policy-Making Process*, 6th Edition (Allen and Unwin Academic, 2017), pp. 200–214 (p. 201).

88 *Witness Statement of Professor David Castle*, 29 May 2020, para. 62.

89 Althaus, Bridgman and Davis, p. 209.

90 Department of Treasury and Finance, *Performance Management Framework: For Victorian Government Departments March 2016*, p. 32.

91 Mental Health Victoria and Mental Health Legal Centre, *Submission to the RCVMHS: SUB.0002.0029.0006*, 2019, p. 31; Mental Health Victoria and Victorian Healthcare Association, *Submission to the RCVMHS: SUB.0002.0029.0005*, 2019, p. 55.

92 *Witness Statement of Vrinda Edan*, 10 July 2019, para. 33; Victorian Council of Social Service, *Submission to the RCVMHS: SUB.0002.0029.0282*, 2019, p. 20.

93 *Witness Statement of Robyn Kruk AO*, 4 May 2020, para. 29.

94 Althaus, Bridgman and Davis, p. 212.

95 Productivity Commission, *Mental Health Inquiry Report*, Volume 3, p. 1239.

96 Productivity Commission, *Mental Health Inquiry Report*, Volume 3, p. 1236.

97 Productivity Commission, *Mental Health Inquiry Report*, Volume 3, p. 1236.

98 Productivity Commission, *Mental Health Inquiry Report*, Volume 3, p. 1237.

99 Productivity Commission, *Mental Health Inquiry Report*, Volume 3, pp. 1131 and 1234.

100 Productivity Commission, *Mental Health Inquiry Report*, Volume 3, p. 1123.

101 RCVMHS, *Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings*, 2020; RCVMHS, *Nurses Workforce Human-Centred Design Focus Group: Record of Proceedings*, 2020; ORIMA Research, *Mental Health Workforce Survey*, 2020, pp. 8, 24–28 and 67.

102 Bianca Albers, Mary Abdo and Robyn Mildon, *Implementing the Commission's Recommendations: Prepared by the Centre for Evidence and Implementation for the Royal Commission into Victoria's Mental Health System*, 2020, pp. 7–8.

103 *Witness Statement of Professor Alexander McFarlane AO*, 14 May 2020, para. 107.

104 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 393; Victorian Government, *Healthier Lives, Stronger Economy: Victoria's Health and Medical Research Strategy 2016–2020*, p. 5; Orygen, The National Centre of Excellence in Youth Mental Health, *Submission to the RCVMHS: SUB.2000.0001.0741*, 2019, pp. 16 and 46; The Florey Institute of Neuroscience and Mental Health, p. 4.

105 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 400, 407 and 411.

106 *Public Health and Wellbeing Act 2008* (Vic) sec. 5; Department of Health and Human Services, *Victorian Health Services Performance Monitoring Framework 2019–20*, p. 4; *Witness Statement of Kym Peake*, 2019, paras. 224.4 and 229.5.

107 18 per cent of Victoria's start-up firms operating in 2020 are health-focused, indicating that entrepreneurial interest is consolidating in the sector. LaunchVic, *Victorian Start-up Ecosystem Mapping*, 2020, p. 17.

108 Royal Commission into Victoria's Mental Health System, *Interim Report*, p.403.

109 Alfred Health, *Submission to the RCVMHS: SUB.0002.0028.0157*, 2019, p. 17.

110 *Witness Statement of Professor Robert Thomas OAM*, 12 May 2020, para. 16.

111 Nev Jones, Louise Byrne and Sarah Carr, 'If Not Now, When? COVID-19, Lived Experience, and a Moment for Real Change', The Lancet Psychiatry, 2020, 1–2 (p. 1); *Witness Statement of Cath Roper*, para. 17.

112 RCVMHS, *Consumer Foundations Working Group, 14 August 2020: Record of Proceedings*, 2020.

113 *Witness Statement of Cath Roper*, para. 42.

114 *Witness Statement of Cath Roper*, paras. 21 and 31.

115 Consumer Foundations Working Group, *Correspondence to the RCVMHS: Consumer Leadership and Mobilisation*, 2020, p. 25.

116 *Witness Statement of Indigo Daya*, 12 May 2020, para. 106.

117 Future Generation, *Australia's Mental Health Crisis: Why Private Funders Are Not Answering the Call*, 2019, p. 13; *Witness Statement of Associate Professor Jo-An Atkinson*, paras. 92–93.

118 *Witness Statement of Associate Professor Jo-An Atkinson*, para. 93.

119 RCVMHS, *Innovation Roundtable: Record of Proceedings*.

120 RCVMHS, *Innovation Roundtable: Record of Proceedings*.

121 *Witness Statement of Professor Ian Hickie AM*, para. 180.

122 Department of Human Services, Policy Framework: Clinical Academic Positions and Activity 2004–09, 2004, <www.yumpu.com/en/document/read/9047501/policy-framework-clinical-academic-positions-and-activity-2004>, [accessed 26 October 2020].

123 Orygen, The National Centre of Excellence in Youth Mental Health and Brown, p. 47.

124 *Witness Statement of Professor Suresh Sundram*, 19 May 2020, paras. 176–179.

125 Department of Human Services, p. 5; Dr Louise Byrne, *Promoting Lived Experience Perspective: Discussion Paper Prepared for the Queensland Mental Health Commission*, p. 5.

126 Witness Statement of Matt Jones, 29 July 2020, para. 28; *Witness Statement of Frank Quinlan, para. 39; Witness Statement of Professor Graham Meadows*, 26 June 2020, para. 84.

127 Association of Australian Medical Research Institutes, *Submission to the Productivity Commission Inquiry into Mental Health*, 2019, p. 43.

128 Prevention United, *Submission to the RCVMHS: SUB.0002.0028.0412*, 2019, p. 11.

129 Orygen, The National Centre of Excellence in Youth Mental Health, p. 47; Monash Health, *Submission to the RCVMHS: SUB.7000.0003.0001*, 2019, pp. 65–66.

130 Philip J Batterham and others, 'NHMRC Funding of Mental Health Research', *Medical Journal of Australia*, 205.8, 2016, 348–349, (p.348); *Witness Statement of The Hon. Robert Knowles AO*, 16 July 2019, para. 30.

131 Australian Institute of Health and Welfare, *Mental Health Services in Australia: Expenditure on Mental Health Services 2016–17,* EXP.31; Australian Government Department of Health, Cancer Fact Sheet, 9 July 2018, <www1.health.gov.au/internet/main/publishing.nsf/Content/A091E85A15E4F93DCA25814E0005C8EE/$File/20180709%20Cancer%20Fact%20Sheet.pdf> [accessed 22 January 2021].

132 National Health and Medical Research Council, Research Funding Statistics and Data, <www.nhmrc.gov.au/funding/data-research/research-funding-statistics-and-data>, [accessed 7 November 2019]; Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1242.

133 Future Generation, p. 21.

134 Future Generation, p. 24.

135 Orygen, The National Centre of Excellence in Youth Mental Health, pp. 46–47.

136 The University of Melbourne, Submission to the *RCVMHS: SUB.0002.0029.0263*, 2019, p. 6; *Witness Statement of Dr Gerard Naughtin*, 24 July 2019, para. 17; Mental Health Victoria and Victorian Healthcare Association, p. 5.

137 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, pp. 1242–1243; National Health and Medical Research Council, Research Funding Statistics and Data, <www.nhmrc.gov.au/funding/data-research/research-funding-statistics-and-data>, [accessed 7 November 2019].

138 *Witness Statement of Professor Patrick McGorry AO*, 2 July 2019, paras. 15 and 34; The University of Melbourne, p. 6; Orygen, The National Centre of Excellence in Youth Mental Health, pp. 46–47.

139 *Evidence of Professor Patrick McGorry AO*, 5 July 2019, pp. 333–334.

140 Brianna Jade Chesser, *Criminal Courts and Mental Illness: The Emergence of Specialist Problem Solving Courts in Australia* (Thomson Reuters (Professional) Australia Limited, 2016), pp. 25–26.

141 Professor Arthur Christopoulos, Faculty of Pharmacy and Pharmaceutical Sciences, Monash University, *Correspondence to the RCVMHS: CSP.0001.0131.0001*, 2020.

142 *Evidence of Professor Patrick McGorry AO*, p. 334.

143 St Vincent's Hospital Melbourne, *Submission to the RCVMHS: SUB.0002.0030.0106*, 2019, p. 18; Joseph Firth and others, 'The Lancet Psychiatry Commission: A Blueprint for Protecting Physical Health in People with Mental Illness', *The Lancet Psychiatry*, 6 (2019), 675–712 (p. 685).

144 *Witness Statement of Dr Neil Coventry*, 29 July 2020, para. 363(e).

145 Mental Health Complaints Commissioner, *Submission to the RCVMHS: SUB.4000.0001.0179*, 2019, p. 25.

146 Mental Health Complaints Commissioner, p. 34.

147 Mental Health Complaints Commissioner, pp. 17 and 64; Lisa Brophy and others, *People Making Choices: The Support Needs and Preferences of People with Psychosocial Disability* (Mind, 2014), p. 29; Firth and others, pp. 1 and 12–13.

148 Dr Stuart Thomas, Kaisha Corkery-Lavender, Dr Michael Daffern and Dr Danny Sullivan, Centre for Forensic Behavioural Science, School of Psychology & Psychiatry, Monash University, *Disability, Mental Health and Medication: Implications for Practice and Policy*, 2010, p. 7.

149 Mental Health Complaints Commissioner, p. 49.

150 Association of Counselling Psychologists, *Submission to the Productivity Commission Inquiry into Mental Health*, 2019, p. 6.

151 Andrea Cipriani and others, 'Comparative Efficacy and Acceptability of 21 Antidepressant Drugs for the Acute Treatment of Adults with Major Depressive Disorder: A Systematic Review and Network Meta-Analysis', *The Lancet*, 391, 2018, 1357–1366 (p. 1358).

152 John Ioannidis, 'Effectiveness of Antidepressants: An Evidence Myth Constructed from a Thousand Randomized Trials?', *Philosophy, Ethics, and Humanities in Medicine*, 3:14, 2008, 1–9 (p. 1).

153 Pat Bracken and others, 'Psychiatry beyond the Current Paradigm', *British Journal of Psychiatry*, 201.6, (2012), 430–434 (p. 432).

154 Paul J Harrison, 'Recent Genetic Findings in Schizophrenia and Their Therapeutic Relevance', *Journal of Psychopharmacology*, 29.2, (2015), 85–96 (p. 92).

155 Productivity Commission, *Mental Health Inquiry Report, Volume 1*, 2020, p. 38.

156 Centre for Mental Health, Swinburne University of Technology, *Submission to the RCVMHS: SUB.0002.0030.0009*, 2019, p. 5; The Florey Institute of Neuroscience and Mental Health, p. 5.

157 The Florey Institute of Neuroscience and Mental Health, p. 5.

158 *Witness Statement of Professor Shitij Kapur*, 8 May 2020, para. 50.

159 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, pp. 1242–1243.

160 Royal Commission into Victoria's Mental Health System, *Interim Report,* p.476; *Evidence of Dr Graham Gee*, 16 July 2019, p. 1120; NorthWestern Mental Health (A Division of Melbourne Health), *Submission to the RCVMHS: SUB.0002.0030.0061*, 2019, p. 6.

161 Productivity Commission, Me*ntal Health Inquiry Report*, Volume 3, p. 1233.

162 Australian Psychological Society, pp. 76–77.

163 Foundation House, *Submission to the RCVMHS: SUB.1000.0001.0868*, 2019, p. 39.

164 *Witness Statement of Matt Jones*, para. 28; *Witness Statement of Frank Quinlan*, para. 39; *Witness Statement of Professor Graham Meadows*, para. 84.

165 *Witness Statement of Honor Eastly*, 14 September 2020, para. 63b.

166 RCVMHS, *Innovation Roundtable: Record of Proceedings*.

167 *Witness Statement of Graham Panther*, 6 July 2020, paras. 170–171.

168 *Witness Statement of Dr Hila Haskelberg*, para. 77.

169 *Witness Statement of Georgie Harman*, 2020, para. 80.

170 RCVMHS, *Innovation Roundtable: Record of Proceedings*.

171 *Witness Statement of Professor Lisa Brophy*, 29 April 2020, para. 35.

172 RCVMHS, *Innovation Roundtable: Record of Proceedings*; *Witness Statement of Alan Woodward*, 18 July 2019, para. 39.

173 RCVMHS, *Innovation Roundtable: Record of Proceedings*.

174 Black Dog Institute, *Submission to the Productivity Commission Inquiry into Mental Health*, p. 24.

175 *Witness Statement of Alan Woodward*, para. 39.

176 *Witness Statement of Georgie Harman*, 2020, para. 79.

177 Zoë Slote Morris, Steven Wooding and Jonathan Grant, 'The Answer Is 17 Years, What Is the Question: Understanding Time Lags in Translational Research', *Journal of the Royal Society of Medicine*, 104.12 (2011), 510–520 (p. 510); The Florey Institute of Neuroscience and Mental Health, p. 5.

178 *Witness Statement of Professor Mario Alvarez-Jimenez*, para. 96.

179 The Florey Institute of Neuroscience and Mental Health, p. 5.

180 RCVMHS, *Innovation Roundtable: Record of Proceedings*.

181 Black Dog Institute, *Submission to the Productivity Commission Inquiry into Mental Health*, p. 23.

182 *Witness Statement of Kym Peake*, 4 October 2020, para. 279.

183 *Witness Statement of Georgie Harman*, 2020, para. 21.

184 Black Dog Institute, *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health*, 2020, p. 2.

185 *Witness Statement of Dr Hila Haskelberg*, para. 101.

186 *Witness Statement of Dr Hila Haskelberg*, para. 101.

187 *Witness Statement of Kym Peake*, 2020, para. 282.

188 *Witness Statement of Graham Panther*, para. 9.

189 *Witness Statement of Professor Shitij Kapur*, para. 60.

190 *Witness Statement of Professor Shitij Kapur*, para. 61.

191 Victorian Government, *Submission to the RCVMHS: SUB.5000.0001.0001*, 2019, p. 35.

192 LaunchVic, *State of HealthTec Victoria*, pp. 25–26.

193 RCVMHS, I*nnovation Roundtable: Record of Proceedings*.

194 *Witness Statement of Kym Peake*, 2019, paras. 86–89; Council on the Ageing, *Submission to the RCVMHS: SUB.1000.0001.0789*, 2019, p. 20; Mind Australia, *Submission to the RCVMHS: SUB.0010.0029.0372*, 2019, p. 48; Perinatal Anxiety and Depression Australia, S*ubmission to the RCVMHS: SUB.0002.0030.0055*, 2019, p. 27.

195 *Witness Statement of Kym Peake*, 2019, paras. 86–87.

196 *Witness Statement of Professor Patrick McGorry AO*, 2019, para. 14.

197 *Witness Statement of Dr Tim Moore*, 2 June 2020, para. 62.

198 Future Generation, p. 13.

199 RCVMHS, *Allied Health Workforce Human-Centred Design Focus Group: Record of Proceedings*.

200 Department of Health and Human Services, *Mental Health Research and Knowledge Translation Plan: Discussion Paper*, 2017, pp. 12–14.

201 *Witness Statement of Dr Shaymaa Elkadi*, 25 May 2020, para. 48.

202 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 394.

203 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, pp. 1189–1190.

204 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1233.

205 Centre for Evaluation and Research, Department of Health and Human Services, E*valuation Guide*, 2017.

206 Victorian Auditor-General's Office, p. 34.

207 Department of Health and Human Services, *Chief Psychiatrist Guideline and Practice Resource: Family Violence*, 2018; Cherrie Galletly and others, 'Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Management of Schizophrenia and Related Disorders', *Australian and New Zealand Journal of Psychiatry*, 50.5 (2016), 1–117; Gin S Malhi and others, 'Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for Mood Disorders', *Australian & New Zealand Journal of Psychiatry*, 49.12 (2015), 1087–1206; Jasmin Grigg and others, *Methamphetamine Treatment Guidelines: Practice Guidelines for Health Professionals (Second Edition)*, 2018; The Bouverie Centre, *Guidelines for Trauma-Informed Family Sensitive Practice in Adult Health Services*, 2013; Safer Care Victoria, *Caring for People Displaying Acute Behavioural Disturbance: Clinical Guidance to Improve Care in Emergency Settings–Draft for Consultation*, 2020; The Australian College of Mental Health Nurses, *Mental Health Practice Standards for Nurses in Australian General Practice*, 2018.

208 RCVMHS, *Innovation Roundtable: Record of Proceedings*.

209 Victorian Government, *Submission to the RCVMHS: SUB.5000.0001.0001*, p. 22.

210 Prevention Coalition in Mental Health, *Primed for Prevention: A Consensus Statement on the Prevention of Mental Disorders*, 2020, p. 23.

211 RCVMHS, *Mentally Healthy Workplaces Roundtable: Record of Proceedings*, 2020.

212 Alfred Health, p. 23.

213 Alfred Health, p. 23.

214 *Evidence of Dr Ravi Bhat*, pp. 989–990.

215 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 391.

216 Melbourne Children's Campus, *Submission to the RCVMHS: SUB.0002.0030.0152*, 2019, p. 2.

217 Murdoch Children's Research Institute, Creating a System of Care for Child Mental Health, <www.mcri.edu.au/users/mcri-administrator/blog/creating-system-care-child-mental-health-0>, [accessed 24 November 2020].

218 Department of Education and Training, Help Develop Mental Health Support and Resources for Primary Schools, <www.education.vic.gov.au/school/teachers/classrooms/Pages/approachesmentalhealthsupportprimary2020.aspx>, [accessed 24 November 2020].

219 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 400.

220 Orygen, The National Centre of Excellence in Youth Mental Health, p. 9.

221 Orygen, Annual Report 2018–19, 2019, p. 74.

222 Orygen, p. 75.

223 Orygen, p. 9; International Association for Youth Mental Health, The 5th International Conference on Youth Mental Health; United for Global Change,<www.iaymh2019.com/>, [accessed 11 January 2021].

224 Orygen, pp. 8 and 60.

225 Orygen, *Annual Report 2018–19*, 2019, p. 13.

226 Orygen, Orygen Welcomes Victorian Government's COVID-19 Mental Health Support Package, <orygen.org.au/About/News-And-Events/2020/Orygen-welcomes-Victorian-Government%E2%80%99s-COVID-19-me>, [accessed 26 October 2020].

227 Orygen, $33 Million Grant for Psychosis Research Sets Australian Record for Medical Research Funding, <www.orygen.org.au/About/News-And-Events/2020/$33-million-grant-for-psychosis-research-sets-Aust>, [accessed 24 November 2020].

228 *Witness Statement of Professor Suresh Sundram*, para. 179; *Witness Statement of Professor Emeritus Bruce Singh AM*, para. 70.

229 *Witness Statement of Professor Suresh Sundram*, para. 157.

230 *Witness Statement of Professor Suresh Sundram*, para. 158.

231 Orygen, The National Centre of Excellence in Youth Mental Health, p. 47.

232 Debbie Carrick-Sen, Alison Richardson, Anne Moore and Shelley Dolan, *Transforming Healthcare through Clinical Academic Roles in Nursing, Midwifery and Allied Health Professions: A Practical Resource for Healthcare Provider Organisations* (The Association of UK University Hospitals, 2016), p. 9.

233 Department of Human Services, p. 2.

234 *Witness Statement of Professor Emeritus Bruce Singh AM*, 23 July 2020, para. 14.

235 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 401.

236 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, pp. 1131 and 1234.

237 Better Care Victoria, Better Care Victoria Innovation Fund, <www.bettercare.vic.gov.au/our-work/innovation-fund>, [accessed 6 October 2020].

238 *Witness Statement of Honor Eastly*, para. 63(c).

239 Monash Sustainable Development Institute, p. 19.

240 LaunchVic, About LauncVic.

241 LaunchVic, *Annual Report 2018–19*, 2019, p. 5.

242 Eggers and Turley, p. 11.

243 Harvard Business Review, How the Japanese Government's New "Sandbox" Program Is Testing Innovations in Mobility and Technology, <hbr.org/sponsored/2020/02/how-the-japanese-governments-new-sandbox-program-is-testing-innovations-in-mobility-and-technology>, [accessed 6 October 2020].

244 Alfred Health, p. 24.

245 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].

246 Department of Health and Wellbeing, South Australia, *Mental Health Services Plan 2020–2025*, 2019, p. 15.

247 health.vic, Evidence and Evaluation, <www2.health.vic.gov.au/public-health/population-health-systems/evidence-and-evaluation>, [accessed 6 October 2020].

248 health.vic, Evidence and Evaluation.

249 Mental Health Victoria and Mental Health Legal Centre, *Submission to the RCVMHS: SUB.0002.0029.0006*, p. 18.

250 *Witness Statement of Alan Woodward*, para. 39.

251 Austin Health, *Submission to the RCVMHS: SUB.0003.0001.0001*, 2019, p. 5.

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

253 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1129.

254 *Witness Statement of Professor Helen Herrman AO*, 1 July 2019, p. 193.

255 *Witness Statement of Dr Ravi Bhat*, 4 July 2019, paras. 73–75.

256 The Royal Australian and New Zealand College of Psychiatrists, *Submission to the RCVMHS: SUB.0002.0029.0227*, 2019, p. 15.

257 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, pp. 1118–1119.

258 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1234.

259 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 406.

260 *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 56.

261 *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 51.

262 *Witness Statement of Professor Neil Rees*, 15 June 2020, paras. 56 and 75; Foundation House, *Submission to the RCVMHS: SUB.1000.0001.0868*, p. 39; *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 95.

263 MacKillop Family Services, *Submission to the RCVMHS: SUB.0002.0029.0174*, 2019, p. 17; *Evidence of Professor Louise Newman AM*, 23 June 2020, p. 20; *Evidence of Professor David Coghill*, 23 June 2020, pp. 55–56; Jenny Welsh, Laura Ford, Lyndall Strazdins and Sharon Friel, *Evidence Review: Addressing the Social Determinants of Inequities in Mental Wellbeing of Children and Adolescents*, 2015, pp. 35–36; Paola Pedrelli, Ben Shapero, A Archibald and Chelsea Dale, 'Alcohol Use and Depression During Adolescence and Young Adulthood: A Summary and Interpretation of Mixed Findings', *Current Addiction Reports*, 3.1, 2016, 91–97 (p. 96); Yasmin L. Hurd and others, 'Cannabis and the Developing Brain: Insights into Its Long-Lasting Effects', *The Journal of Neuroscience*, 39.42, (2019), 8250–8258 (p. 8258).

264 *Witness Statement of Dr Piers Gooding*, 25 June 2020, paras. 32(d) and 32(f); *Witness Statement of Professor Mario Alvarez-Jimenez*, paras. 31, 33 and 180; *Witness Statement of Associate Professor Simon Stafrace*, 2020, paras. 190 and 199.

265 National Mental Health Commission, *Contributing Lives, Thriving Communities: Report of the National Review of Mental Health Programmes and Services, Volume 2: Every Service Is a Gateway Response to Terms of Reference*, 2014, p. 138; Victorian Aboriginal Children and Young People's Alliance, *Submission to the RCVMHS: SUB.0002.0028.0546*, 2019, p. 13; *Witness Statement of Andrew Jackomos PSM*, 11 July 2019, para. 97; *Witness Statement of Andrew Jackomos PSM,* 6 July 2019, para. 97 and p. 325; Pat Swan, Professor Beverley Raphael, and National Aboriginal Community Controlled Health Organization, *Ways Forward: National Aboriginal and Torres Strait Islander Mental Health Policy: National Consultancy Report*, 1995, p. 38.

266 Centre for Multicultural Youth, *Submission to the RCVMHS: SUB.0002.0032.0067*, 2019, pp. 6–7; Multicultural Centre for Women's Health, *Submission to the RCVMHS: SUB.0002.0030.0303*, 2019, pp. 9–10.

267 Department of Premier and Cabinet, *Discussion Paper for the Victorian LGBTIQ Strategy*, 2020, pp. 13–14; RCVMHS, *LGBTI Roundtable: Record of Proceedings*, 2019.

268 Mental Health Victoria and Council on the Ageing, *Correspondence to the RCVMHS: CSP.0001.0101.0001, Priorities to support the mental health of older Victorians*, 2020, p. 19; National Ageing Research Institute, *Submission to the RCVMHS: SUB.0002.0024.0049*, 2019, pp. 2 and 6.

269 *Evidence of Professor Patrick McGorry AO*, p. 334; Patrick McGorry and others, '"Is 'Early Intervention' in Bipolar Disorder What It Claims to Be?" Malhi et al', *Bipolar Disorders*, 20.3 (2018), 181–183 (p. 182); Harrison, p. 92.

270 *Witness Statement of Professor Lisa Brophy*, para. 75; *Witness Statement of Professor Penelope Weller*, 27 August 2020, para. 30; *Witness Statement of Professor David Castle*, para. 72; *Witness Statement of Professor David Copolov AO*, 7 July 2020, paras. 253 and 273; Graham Thornicroft and others, 'Evidence for Effective Interventions to Reduce Mental-Health-Related Stigma and Discrimination', *The Lancet*, 387 (2016), 1123–1132 (p. 1129); Amy J. Morgan and others, 'Interventions to Reduce Stigma towards People with Severe Mental Illness: Systematic Review and Meta-Analysis', *Journal of Psychiatric Research*, 103 (2018), 120–133 (pp. 130–131); Nisha Mehta and others, 'Evidence for Effective Interventions to Reduce Mental Health-Related Stigma and Discrimination in the Medium and Long Term: Systematic Review', *British Journal of Psychiatry*, 207.5 (2015), 377–384 (p. 383); Claire Henderson and others, 'Mental Health-Related Stigma in Health Care and Mental Health-Care Settings', *The Lancet Psychiatry*, 1 (2014), 467–482 (p. 479); Bruce G. Link and Jo C. Phelan, 'Conceptualizing Stigma', *Annual Review of Sociology*, 27 (2001), 363–385 (pp. 365 and 382).

271 *Witness Statement of Professor Jane Pirkis*, 18 July 2019, para. 28; *Evidence of Professor Jane Pirkis*, 22 July 2019, p. 1469; Department of Health and Human Services, *Victorian Suicide Prevention Framework 2016–25,* 2016, p. 24; Orygen, The National Centre of Excellence in Youth Mental Health, p. 42; Jo Robinson and others, 'What Works in Youth Suicide Prevention? A Systematic Review and Meta-Analysis', *EClinicalMedicine*, 4–5, (2018), 52–91 (pp. 52–91); Sarah Coker and others, *Better Support: Understanding the Needs of Family and Friends When a Loved One Attempts Suicide*, 2019, p. 4.

272 *Witness Statement of Professor Alexander McFarlane AO*, paras. 20, 79 and 101; Foundation House, *Integrated Trauma Recovery Service Model*, 2016, pp. 8–9.

273 *Witness Statement of Professor Patrick McGorry AO*, 2019, para. 11; *Witness Statement of Professor Lisa Brophy*, para. 97; David Castle and others, *Submission to the RCVMHS: SUB.0002.0002.0118*, 2019, p. 3; National Institute for Health and Care Excellence, United Kingdom, *Rehabilitation for Adults with Complex Psychosis (NG181): NICE Guideline*, 2020, pp. 46–49; Carol Harvey and others, *Models of Care for Victorians Living with Severe and Persistent Mental Illness and Complex Multiagency Needs: Literature Review and Key Reform Considerations. Report Prepared for the Royal Commission into Victoria's Mental Health System by the University of Melbourne*, 2020, p. 6; E Sally Rogers, 'Recovery-Oriented Practices Need Innovative Research', *The Lancet Psychiatry*, 6.2, (2019), 82–83 (p. 82).

Chapter 37

Implementation

37.1 The work ahead

The Royal Commission has reached its end, delivering 74 recommendations spanning two reports.

During the two years of its operation, the Commission engaged widely with the community, collected a wealth of knowledge and evidence and undertook a comprehensive systems design process to set the reform agenda. Collectively, the recommendations contained in this report present the Commission's aspirations for a reimagined and compassionate mental health and wellbeing system.

While much has already been done, and the foundations for reform are set, considerable work lies ahead to realise the Commission's ambitions. Promisingly, the Commission has observed an encouraging level of public discourse, community-wide interest and open communication about mental health and wellbeing. The Commission's inquiry benefited enormously from this collective momentum, which must now be harnessed to support implementation efforts.

The recommendations made in the Commission's interim report are currently being implemented. Those reforms focused on responding to pressing challenges within the system and preparing for the extensive changes to come.[1] This report puts forward the Commission's final directions on how to transform the mental health system so that all Victorians 'can experience their best mental health, now and into the future'.[2]

Although this report is a major milestone, it is only the start of the reform process. The Commission has created a plan of action—however, 'a strategy is only as good as its execution'.[3] Putting the Commission's ambitious reform agenda into practice is what will make the hopes held by many in the Victorian community become a reality. Implementation is not about repeating the work of the Commission or revisiting its decisions; it is about taking definitive action and fulfilling the solutions presented in this report.[4]

If history is any indication, reform will not be easy. Despite best endeavours, previous efforts to redesign the mental health system in Victoria, and across Australia more broadly, have not been realised.[5] As a result, the state's mental health system has catastrophically failed to live up to expectations and is unprepared for current and future challenges.[6] This persistent gap between the rhetoric of past inquiries and the reality for people living with mental illness or psychological distress, families, carers and supporters as well as the mental health workforce, has been described by some as devastating.[7]

The Victorian Mental Illness Awareness Council articulated its hopes that implementation of the Commission's recommendations will be different:

> There is a history of reviews and inquiries making recommendations about reform of the mental health sector with little follow through and the reforms come to nothing. This would be tragic given the amount of work that has gone into the Royal Commission.[8]

The Commission agrees with this sentiment—that this time, the results must lead to transformational change.

Implementation, however, is rarely a straightforward activity. Many service systems, not just mental health systems, have faced challenges in implementing inquiry recommendations.[9] Evidence from past reviews suggests that a substantial number of recommended actions or programs are never implemented.[10] The factors that hamper implementation efforts are complex, but failures in implementation may be attributed in part to a lack of preparedness, loss of momentum due to changes in leadership, shifting policy agendas or insufficient funding, people and expertise.[11]

Reforming Victoria's mental health system brings its own unique challenges. One factor contributing to this is the lack of priority given to the mental health system over the years, partly fuelled by stigma and discrimination.[12] The system's many intersections with other health, justice and social supports services, including, for example, physical health, alcohol and other drug services and housing, is another. Now, the COVID-19 pandemic and its far-reaching impacts have combined with these historical factors, further affecting the process of reform.

Despite this, it is imperative to get implementation right. Witnesses Mary Corbett and her brother and carer Jacob Corbett expressed what this would look like for them:

> **change that comes as result of the Royal Commission needs to be felt mainly at the patient/consumer level—the level where people enter the mental health system and are treated and discharged. There is no point doing a good analysis and good report, if it does not effect change at the ground level; it becomes only a bureaucratic shuffle.**[13]

Delivering on these aspirations requires strong leadership across the Victorian Government, the workforce, service providers and, importantly, from people with lived experience of mental illness or psychological distress, families, carers and supporters. Leaders must be equipped with the knowledge, skills and attributes—with their development supported—to lead and push change forward. Those already working in the system must be supported to engage with and enable the reform process. Deliberate and sustained collaboration from all levels of government, related systems and the Victorian community is also required. While there is much at stake, all those involved in implementing the Commission's recommendations must rise to the challenge and work together to build a new mental health and wellbeing system.

There will be obstacles along the way. Ensuring all partners in delivering this reform remain connected and committed to the change process will be imperative to success. The Commission has presented a clear and compelling vision for profound change that incorporates ways of maintaining these connections.

Implementing the reforms effectively will also require learning from past experiences, including identifying and preventing unintended consequences and developing new ways of thinking and doing. Some research encourages learning from the past as a means to prepare for effective change in the future:

> **The incremental, incomplete and inconsistent approach to mental health reform over the past twenty years is demonstrably inadequate and unaffordable for the challenges now confronting our nation.**
>
> **We can and must do better. To do better we have to accept the baggage from the past, identify the barriers to reform and map out strategies for change based on these experiences and those from overseas.**[14]

Establishing the foundational structures that will promote and enable large-scale change will not be a straightforward or sequential process; it will be dynamic and evolving, with many reforms occurring in parallel. The Victorian Government will need to actively manage this process, helping implementers to stay the course.

In announcing this inquiry, the current Victorian Government committed to implementing every recommendation made by the Commission.[15] The significance of this opportunity is not lost on the Commission.

To achieve substantial policy change, royal commissions may need to adopt effective 'influencing strategies', involving problem framing, coalition building, and making recommendations that are implementable.[16] In this respect, the Commission has sought to frame the narrative around the challenges facing the mental health system, made efforts to strengthen the consensus for change and tested ideas for reform and implementation with a wide range of actors. In line with its letters patent, it has also endeavoured to make recommendations 'to achieve practical, prioritised, efficient and sustainable outcomes'[17] to improve the lives of people living with mental illness or psychological distress, families, carers and supporters.

In its recommendations, the Commission has expressed its hopes for a reimagined mental health and wellbeing system and suggested how to implement reforms to achieve these aspirations. This chapter takes a broad view. It aims to help prepare the Victorian Government and all partners involved in implementation for success by exploring the requirements needed for enduring and profound change across Victoria's mental health system—as well as potential pitfalls. This chapter therefore complements the Commission's recommendations and chapters in both its interim and final reports, and should be read alongside them.

37.2 Requirements for transforming the system

In preparing to implement the Commission's recommendations, it is essential to appreciate the scale of the task at hand. The changes envisaged in this report are enormous. Not only will successful reform require a great deal of investment, it will also rely on the establishment of trust between all implementation partners[18] involved in the reform process. All partners will need to work together to follow the clear vision the Commission has set and stay focused on implementing the recommendations.

The Commission acknowledges this will be challenging in a highly complex reform environment. There are several major forces shaping Victoria's future that will no doubt influence implementation. Population and demographic changes, rising inequality and social isolation and large-scale disruptions—such as the severe bushfires and the COVID-19 pandemic experienced during the Commission's inquiry—will all have an impact. Chapter 1: *The reform landscape,* explains what these issues mean for the Commission's reform agenda and presents critical features that are essential to the reform process: re-established confidence through prioritisation and collaboration; a responsive and integrated system with community at its heart; contemporary and adaptable services; and a system attuned to promoting inclusion and addressing inequities.

How to deliver the reimagined mental health and wellbeing system is a fundamental consideration. Informed by evidence collected throughout the course of its inquiry, the Commission has chosen to share its reflections on several key requirements for successful implementation, with a view to assisting with implementation efforts. These reflections are outlined below.

37.2.1 A clear and shared vision

The Commission has presented a compelling vision for a new mental health and wellbeing system. It is a system that will deliver the best outcomes and experiences for individuals and communities through an elevated focus on the prevention of mental illness and the promotion of good mental health and wellbeing. It is a system that provides treatment, care and support in the community, close to people's homes and in line with their needs and preferences.

The Commission has set out the structure of its report to cover the essential features of a reformed mental health and wellbeing system:

- Volume 1 sets out the Commission's vision for a responsive and integrated system that centres on a community-based model of care that provides people with dependable access to services when and where it would make the most difference to them.

- Volume 2 sets an expectation of collaboration in the future system supporting good mental health and wellbeing in the settings in which people live, learn and work, with improved treatment, care and support for Victorians of all ages, as well as collaborative responses to: support people who have experienced trauma; increase access to safe and secure housing; and improve suicide prevention and responses.
- Volume 3 recognises that the attainment of good mental health and wellbeing among Victoria's diverse communities requires responses that extend beyond purely the mental health and wellbeing system to other supports that address inequities and promote inclusion.
- Volume 4 creates new structures for enduring reform to support a contemporary and adaptive system that provides high-quality and safe services, including a new approach to leadership, system governance and oversight.
- Volume 5 provides advice regarding the collection and distribution of expertise to support continuous improvement and implementation efforts across Victoria's mental health and wellbeing system, as well as an overview of the Commission's work to assist future royal commissions.

The Commission's reform approach is not about making isolated improvements. It seeks to build a new system to meet the evolving needs and expectations of individuals and communities now and into the future. Delivering this transformational change requires that all recommendations established in this report are read collectively. Implementers must take a long and broad view to understand how all the components of the redesigned system fit together and reinforce each other.

The momentum for change generated by this report, and the reforms to come, will be substantial. But this ambition relies on the continued prioritisation of good mental health and wellbeing. In particular, it depends on a future in which good mental health and wellbeing is rightly recognised as a fundamental tenet of a well-functioning and compassionate society.

At the time of finalising this report, there is an encouraging level of support across the Victorian and Commonwealth governments for change. The Commission recognises, however, that changes to government leadership, competing priorities and a reluctance to commit to long-term reform are all potential barriers to the enduring success of its agenda.[19]

As explored throughout this report, mental health has been a low priority of successive governments and the community.

Community attitudes towards people living with mental illness or psychological distress have influenced funding decisions, detracting from investment in mental health.[20] This lack of prioritisation may have also been influenced by competing advocacy priorities, making it difficult for governments to work out where the priority for reform lies and diminishing accountability.[21] As Professor Bruce Bonyhady AM, Executive Chair of the Melbourne Disability Institute at the University of Melbourne, stated in a personal capacity:

> Based on my own observation, the mental health sector has been deeply divided along clinical mental health and community mental health lines. There has been conflict and envy between these groups regarding who should receive funding—and at times this has led them to undermine each other's claims and this has made it easy for governments to ignore both.[22]

Ensuring mental health is a priority, and that there is a shared and clear vision for the future at all levels of government decision making, will be critical to successfully implementing the Commission's recommendations. This will be particularly important in light of the many reviews and planned reforms that are underway across comparable systems such as the aged care and disability sectors. Maintaining a genuine commitment at the highest political spheres at the local, state and national levels will be integral to achieving long-lasting and successful reform. As discussed in Chapter 29: *Encouraging partnerships,* governance arrangements between the Commonwealth and state governments have recently evolved, with decision making now occurring through the newly established National Cabinet Reform Committee. These new arrangements have the advantage of streamlining decision making,[23] yet the Commission holds concerns that these structures may limit the influence of the Victorian Government and indeed other states and territories in progressing an ambitious mental health and wellbeing agenda. It will therefore be vital that the Victorian Government works closely with the Commonwealth Government and the National Cabinet Reform Committee to ensure mental health and wellbeing remains a priority.

A bipartisan commitment to implementing the Commission's recommendations will also be important for implementation.[24] Ms Georgie Harman, CEO of Beyond Blue, said that without a bipartisan commitment, people will continue to miss out on the treatment, care and support they deserve, '[w]ithout concerted, long-term and bipartisan action—and addressing broader social determinants and equity—people with the greatest needs will continue to miss out.'[25]

Associate Professor Ruth Vine, then Executive Director of NorthWestern Mental Health, Melbourne Health at the time of giving evidence, noted the importance of a bipartisan approach in overcoming the current system's challenges:

> Mental health used to be deemed to be 'above politics' but it seems to have become increasingly politicised with successive governments wanting to make their mark. This is not good for system development, the clinical workforce and the end users. The government must be bipartisan in relation to mental health as it was in the 1990s and has to be for many years, as the challenges in the system cannot be overcome in a single term of government or by switching between partisan policies.[26]

In some ways, the COVID-19 pandemic has strengthened collaborative approaches to reform, demonstrating the value of bipartisanship between levels of government. The Commission hopes these efforts continue and that they may sustain momentum for reform as the mental health system is reshaped. The Hon. Julia Gillard AC, Chair of Beyond Blue, noted the benefits of bipartisanship during times of significant change, '[t]he collaborative, bipartisan response to the mental health challenges posed by this crisis has been swift and decisive and reminds us of what we can achieve by working together.'[27]

Professor Rob Moodie, Deputy Head of School and Professor of Public Health at the University of Melbourne, shared similar thoughts:

> If you can forge bipartisanship, then you can generally forge more effective interventions. Those interventions are the responsibility of government. For example, in the case of COVID-19, we have seen significant bipartisan interventions around controlling COVID-19 and stimulating the economy.[28]

The attitudes and perceptions of the community also play an important role, given 'the public hold[s] the key to transformational change'.[29]

When there is strong community support for recommendations, this can help overcome objections in other sections of the community and give government 'licence' to implement difficult changes.[30] This has been demonstrated with successful reforms in the past. For example, while Medicare was originally met with mixed reviews, those opposed to its introduction were persuaded in part by strong community support for universal access to health care.[31]

Professor David Copolov AO, Professor of Psychiatry and Pro Vice Chancellor of Major Campuses and Student Engagement at Monash University, shared similar observations, reflecting on lessons from the National Disability Insurance Scheme:

> In particular, the early history of the [National Disability Insurance Scheme] teaches us that we need … recognition that we cannot expect politicians to support reforms unless there is already clear, visible and unified community support …[32]

There is such evidence of strong community support for the types of changes the Commission is recommending. There is certainly much more public conversation about and interest in mental health and wellbeing. The work of this Commission, alongside national efforts for reform—including the Productivity Commission's *Mental Health Inquiry Report* and the work of the Prime Minister's Suicide Prevention Adviser—have contributed to this. This heightened level of community awareness presents a unique opportunity that must be capitalised on to achieve momentum in implementation.

The community's interest in and connection to reform will also shore up continued efforts to raise awareness of mental health and wellbeing and to tackle the stigma and discrimination associated with poor mental health and mental illness, and should therefore be harnessed. Indeed, those implementing the reforms must bring the Victorian community with them. Being clear about the broad vision and principles underpinning reform, and ensuring they resonate with the public, will help with this.[33] As Ms Kym Peake, the former Secretary of the then Department of Health and Human Services, said:

> it is important to inspire a commitment to reform by presenting a compelling vision for the future and anchoring change back to the values that matter for the sector. This vision and an agreement on the direction for change can encourage buy in, help focus collective efforts and keep people engaged in the face of challenges and set-backs.[34]

As a starting point, implementers should draw inspiration from the Commission's guiding principles (refer to Figure 37.1), which outline the Commission's aspirations for a reformed mental health and wellbeing system. They should build on these principles to convey to the public the vision and direction for the change ahead in an open and clear way. Implementers also need to offer the public opportunities to genuinely engage and participate in reform.

Figure 37.1: The Commission's guiding principles for a future mental health and wellbeing system

Guiding principles for Victoria's mental health and wellbeing system

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

It envisages a mental health and wellbeing system in which:

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

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

37.2.2 The importance of leadership

The Parenting Research Centre pointed out that the more complex the reform process, the more important leadership is.[35] Therefore, leadership across all aspects of Victoria's mental health and wellbeing system will be critical in implementing change. It will also be vital that all those delivering reform embrace it. As Professor Patrick McGorry AO, Executive Director of Orygen and Professor of Youth Mental Health at the University of Melbourne stated in a personal capacity, '[t]he leadership team needs to share the same inspirational vision and commitment to transformational change.'[36]

As highlighted in the Commission's interim report and described in Figure 37.2, there are five different but equally important leadership types that are essential to a reformed mental health and wellbeing system: policy and system stewardship; organisational leadership; clinical and academic leadership; operational leadership; and emerging leaders across all areas.[37]

Figure 37.2: Leadership types across the new mental health and wellbeing system

Effective implementation of the Commission's recommendations will therefore require strong leadership dispersed across different places and positions. This includes leadership from all tiers of government and from service providers, the workforce, related systems, advocacy organisations and peak bodies, people with lived experience of mental illness or psychological distress, families, carers, supporters and the Victorian community more broadly.

Dispersed leadership across organisations, services, disciplines and locations will pave the way for collaboration and collective learning opportunities. It will also embed consistency and accountability, ensuring there is always someone responsible for reform. This will mitigate the risk of leadership turnover, ensuring reform momentum is not lost with changes in personnel.[38]

The type of collaborative leadership required to transform Victoria's mental health system is different from traditional hierarchical leadership; it guides rather than controls and inspires rather than directs.[39] Other leadership theories are continuing to emerge. Ensemble leadership theory, for example, describes leadership from an Indigenous world view that is: collective rather than individual; dynamic, rather than static; based on a social structure that is fluid and flexible; and encompasses multiple intersecting hierarchies.[40]

All partners involved in implementing the Commission's recommendations must be willing to collaborate and take collective responsibility for reforming the system. Building collective support by empowering leaders, both within and outside the formal boundaries of the mental health and wellbeing system, including interrelated service systems, will be essential to maintaining the reform momentum.[41]

In its evaluation of the factors that contribute to successful implementation, the Parenting Research Centre reflected on the importance of strong unified leadership in driving broader organisational change:

> Reform may be impeded where agencies or departments are not open to new practices or agendas. This can be perpetuated by organisational leaders entrenched in the old culture. By contrast, new leadership may scrutinise the situation from an external standpoint and accommodate change. This needs to be matched with retaining expertise and corporate memory in the organisation. Either way, it can be argued that senior management needs to be united in its commitment to change, and middle management needs to directly manage cultural change as its leadership shapes organisational behaviour.[42]

All leaders involved in the change process must be empowered to make decisions and take risks, with an eagerness to learn and collaborate and share their knowledge and power.[43] These traits must be complemented by strong systems knowledge and the skills and capabilities to lead and drive change. Passion and belief in the change process have also been identified as integral to effective leadership.[44] Providing evidence in a personal capacity, Associate Professor Simon Stafrace, Chief Adviser of Mental Health Reform Victoria, described some of the distinguishing features of effective leadership:

> If the goal of mental health reform is to transform Victoria's mental health system into a public asset valued by the community, then leadership will be the key activity through which this will be delivered. And if located at its heart is a capacity for driving change, then the distinguishing features of effective leadership must surely be an ability to see the world from multiple perspectives, a vision for what might be possible, an openness to learning, and the courage to fail.[45]

It is therefore essential that all new and emerging leaders involved in reform are supported to develop and maintain the core attributes, skills, system knowledge and competencies required. They must also be enabled to make decisions and continue to develop and improve by learning from previous experiences.

To strengthen and sustain leadership, the Commission's interim report recommended establishing a leadership network to provide for strong personal capabilities and organisational cultures and system-wide collaboration and oversight.[46] These reforms will be integral to preparing future leaders to develop the reformed mental health and wellbeing system.

Alongside these reforms, the Commission has made several recommendations to strengthen the leadership of people with lived experience of mental illness or psychological distress, families, carers and supporters across the reimagined mental health and wellbeing system. In addition to these roles, it is imperative that the Victorian Government continue efforts to identify and develop key lived experience leadership roles as new and emerging opportunities and challenges arise throughout implementation. For this to occur, implementers must make proactive efforts to dismantle the power imbalances that are inhibiting people with lived experience of mental illness or psychological distress from leading and influencing change. Strategies for distributing power more evenly across the reimagined mental health and wellbeing system are discussed in Chapter 18: *The leadership of people with lived experience of mental illness or psychological distress*. Co-production is one example of how power can be shared more evenly. This is discussed more in the following section.

Continued efforts must be made to strengthen, sustain and empower leaders across different places and positions in the sector. Nurturing and developing the skills and capabilities of leaders so they can thrive and champion reform will support this. Supports should reflect the needs and strengths of individuals and organisations but may include providing mentorship and opportunities to gain technical skills, as well as role-sharing arrangements, executive coaching, training and professional development.[47] Leaders must also be encouraged to take risks, with the opportunity to learn from their experiences and continue to adapt and evolve their approach throughout the reform process.

Leadership must stem from within the sector, noting that leadership from the Victorian Government alone will not be enough to drive reform. For example, fostering the leadership capabilities of advocacy organisations and peak bodies, including the Victorian Mental Illness Awareness Council and Tandem, will be crucial. These organisations play a pivotal role in supporting individuals and other organisations to engage, advocate and implement reform. Through times of major change, these organisations will be an important source of guidance and support. It is likely that their role will also intensify as government and implementers look to partner with them to harness their expertise and relationships across the sector. The Commission encourages the Victorian Government to support these organisations through adequate and stable resourcing, tailored supports and opportunities for professional development and training.

37.2.3 Co-production and partnering with people with lived experience

This section describes approaches to partnering with people with lived experience of mental illness or psychological distress, as well as with families, carers and supporters. Section 37.2.5 reflects on the importance of supporting and involving the workforce and service providers in the delivery of reform. Section 37.2.8 takes a broad view, describing strategies to support collaboration across all the partners involved in the delivery of reform.

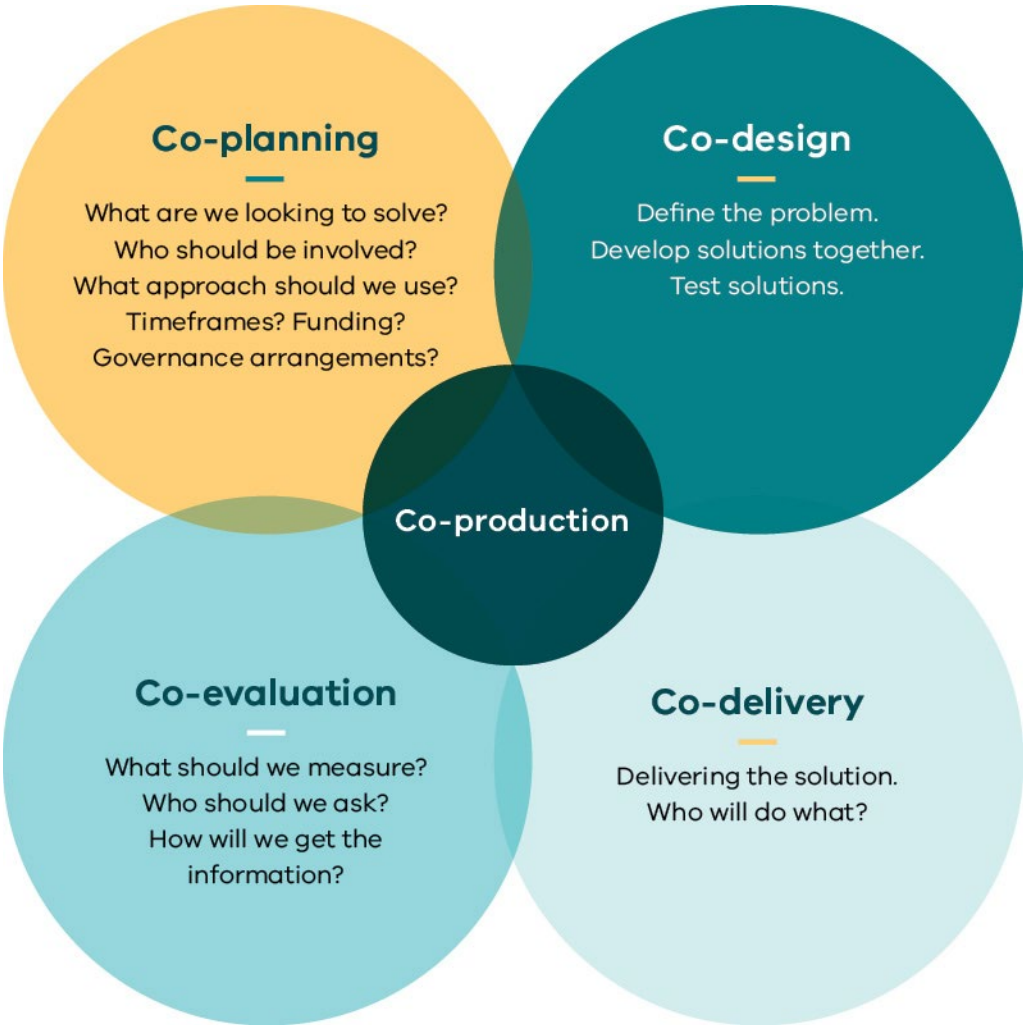
Redesigning Victoria's mental health system must involve meaningful partnerships with people with lived experience of mental illness or psychological distress, families, carers and supporters. It is only through this process that the ambitions of the Commission's recommendations will be realised. As Ms Janet Meagher AM, an advocate for people with lived experience of mental illness, stated, '[t]he mental health system can only assist people to live contributing lives when the principles of involvement, genuine partnership and empowerment are central to its operation.'[48]

Ms Rachel Bateman, a witness before the Commission, made similar observations:

> In order to strengthen service improvement and ensure that services are designed in a way that genuinely meets the needs of consumers and their families and carers, organisations need to engage in co-production. Co-production includes consumers being a central part of the co-planning, co-design, co-delivery and co-evaluation of service improvement activities. Co-production processes should include genuine opportunities for consumers to feel heard as equals, and opportunities for organisations to reflect upon the power held by them and by clinical professions.[49]

As described in Figure 37.3, co-production 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. Each of these phases can stand alone as a collaborative activity in and of itself, but taken together they represent true co-production.[50]

Figure 37.3: Defining co-production



Source: Cath Roper, Flick Grey and Emma Cadogan, *Co-Production: Putting Principles into Practice in Mental Health Contexts*, 2018, p.2.

Co-production involves equal partnerships between those involved in the project or initiative, allowing for negotiation and compromise.[51] Co-production is different from other partnership approaches because it values the expertise and knowledge of those most affected by the problem and actively responds to power differentials within partnerships. In light of the power imbalances that permeate the current system, co-production cannot occur without leadership from people with lived experience of mental illness or psychological distress, with real opportunities and supports for these roles to flourish.[52] As described in Chapter 18: *The leadership of people with lived experience of mental illness or psychological distress*, advisory groups with limited influence will not be able to deliver on this ambition. Elevating the leadership of people with lived experience of mental illness or psychological distress requires that they have decision-making authority, with influence over policy and resourcing decisions.[53]

There are great benefits in co-producing the planning, design, delivery and evaluation of reform initiatives so they are based on people's lived knowledge, values, needs and preferences. These include improved outcomes and experiences for individuals as well as increased capacity and impact of services, and return on investment.[54] Yet, as explored throughout this report, co-production is often poorly understood. There are tokenistic approaches to participation, meaning that many of the benefits of co-production are missed.[55]

Ms Erandathie Jayakody, a witness before the Commission, explained:

> **Instead what often happens is that agenda, budget and timelines are set up without consumer involvement and half way through the project consumers will be consulted but only in a very limited way (often citing budgetary and time constraints). The consultation will often occur in a very superficial way such as with respect to the colours of a building or the name of a service.**[56]

Dr Melissa Petrakis, Chair of Tandem, shared similar thoughts when providing evidence to the Commission in a personal capacity:

> **[Consumer, carer and family workers] are expected to provide 'the' consumer or carer perspective when asked, as if there is only one and as though representativeness can be delivered without time to consult others with lived experience about the matter at hand.**[57]

The Commission undertook a range of activities with people with lived experience of mental illness or psychological distress, families, carers and supporters to understand their experiences and to design a system that reflects their needs and perspectives. The Commission has also engaged widely across the Victorian community, drawing on the expertise, experiences and perspectives of many to inform its recommendations. It is imperative that implementers do not repeat the consultative work of the Commission or revisit the decisions behind its reform agenda. To do so would be a disservice to those who have generously shared their experiences, analysis and ideas for reform with the Commission. Implementers must not delay; they must start building on the work of the Commission, focusing their efforts on implementing the solutions in this report. The time for action is now.

Co-production in implementing the Commission's recommendations may not always be suitable or appropriate. Where true co-production is not possible, partnering with people with lived experience should nevertheless occur across as many phases as possible—for example, in co-planning, co-design, co-delivery and co-evaluation. Depending on the purpose of the project or initiative, there are different techniques and tools that can be used to support these approaches.[58]

For example, a contributor to the Commission explained:

> the nature of co-design and co-production is that you work with people as partners, to understand what the problem is to design a solution to deliver and implement it. But the Royal Commission has been doing the work of understanding the problem, and also the beginning of designing solutions.[59]

The Commission has included guidance and recommendations throughout this report to support implementers to partner with people in this way. In addition to this guidance, there are other important factors that should be considered.

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 sets of experiences, perspectives and expertise. While at times these groups may have shared interests, they speak from their own perspectives and experiences and at times may have different views.[60] Approaches to partnering with these two groups must therefore be designed to account for these varied perspectives and experiences. To this end, there are times where the Commission has provided specific guidance to implementers on which group to partner with. For example, in Chapter 19: *Valuing and supporting families, carers and supporters*, family and carer-led centres will be developed in partnership with families and carers. Similarly, as described in Chapter 18*: The leadership of people with lived experience of mental illness or psychological distress*, a new agency to help the emergence of organisations led by people with lived experience of mental illness or psychological distress will be implemented in co-production with people with lived experience of mental illness or psychological distress.

It is important that implementers are honest and transparent about the level and types of participation they intend to use from the outset, including establishing clear roles and responsibilities and expectations about the process ahead.[61] This is critical to accountability, building trust, managing expectations and to the integrity of the implementation processes.

As Ms Cath Roper, Consumer Academic with the Centre for Psychiatric Nursing at the University of Melbourne, advised:

> we need to be honest about the level of consumer participation we are achieving: if you're consulting with consumers, then call it consultation, not co-production. There is nothing worse than calling something co-production when actually the parameters have already been set and there is no genuine possibility for moving further up the decision-making ladder.[62]

Full co-production and other partnering approaches take time and resources. Implementers should therefore ensure project and strategic planning efforts build in enough time to support these approaches. Implementers must plan effectively across the various stages of a project or initiative including factoring in the costs of remuneration and reimbursement.[63]

This will ensure approaches to co-production and partnering with people with lived experience are authentic and avoid the risk of being sidelined by budget and time constraints. With sound planning, there should always be a capacity to meaningfully partner with people with lived experience of mental illness or psychological distress and families, carers and supporters.

Approaches to partnering with people with lived experience of mental illness or psychological distress and families, carers and supporters must also be relevant and fit for purpose. Implementers should think about who to engage with, ensuring a diversity of perspectives that are relevant to the context and purpose. This includes engaging with people who may not have been heard before. Different people may also be required to participate at various stages of the project or initiative.[64] In a 2020 article published in the *International Journal of Mental Health Nursing,* staff from the Centre for Psychiatric Nursing at the University of Melbourne advised that partnering with people with lived experience of mental illness or psychological distress can be supported by:

- ensuring a diversity of relevant perspectives, including partnering with Aboriginal people, culturally diverse people, people living with disability, LGBTIQ+ people and people with different experiences of treatment, care and support
- applying critical reasoning to who is selected
- involving more people
- seeking out the views of those who may have challenging perspectives.[65]

Importantly, power differentials between all those involved in the implementation process must be explored and continually dismantled. This can be supported by identifying and openly exploring power imbalances before responding. Strategies to actively shift power to those who have traditionally held less include:

- ensuring people are provided with the supports they need to participate and lead in meaningful ways
- setting aside time to reflect and improve partnership approaches
- outlining clear roles and responsibilities and expectations of those involved in the partnership
- providing opportunities for people with lived experience of mental illness or psychological distress to lead and make decisions, with real operational responsibilities and powers to affect change
- providing opportunities to elevate the expertise, experiences and perspectives of those who hold less power.[66]

37.2.4 Providing opportunities for people to share their stories and experiences

As outlined in this report, the Commission has sought to create a reflective and evolving mental health and wellbeing system that adapts to the changing needs and preferences of individuals. As outlined in Chapter 36: *Research, innovation and system learning*, there are many ways in which system adaptation can be supported. A further approach includes providing opportunities for people to share their stories and experiences.

Throughout its inquiry, the Commission has engaged with people from across Victoria and Australia and internationally. It has been privileged to hear the deeply personal experiences of people living with mental illness or psychological distress, and those of families, carers and supporters, and the experiences of those working in and managing the system. Many have shared their painful memories of the past, in the hope of shaping a better future. As one person said:

> **thank you for the opportunity to tell a small part of our story and [I] look forward to the outcomes of this much needed Royal Commission. If we can help prevent one person from experiencing what we have gone through, I will feel it has all been worthwhile.**[67]

People have willingly shared their powerful and deeply moving experiences. These contributions have left a lasting impact and have provided the impetus for profound change.

While it is not the role of the Commission to substantiate the claims of individual people, hearing these personal stories has helped the Commission to explore what lies at the heart of individual experiences and, importantly, what needs to change. The sharing of people's personal experiences also played an important role in raising awareness of mental health and wellbeing and tackling the stigma and discrimination that continues to have a pervasive influence on the lives of people with lived experience of mental illness or psychological distress. In many ways, this sharing has raised the level of public conversation about mental illness.

Mr Al Gabb, a witness before the Commission, hoped that openly talking about his experiences would help others:

> **for me speaking out and openly talking about it—and I'll talk about it to anybody that asks—it's about helping. If I can help one person, that's a win, that's all that matters to me, is to give back.**[68]

For some, engagement with the Commission was the first opportunity they have had to share their story formally, giving those who had not been listened to before the chance to have their voices heard and acknowledged. As one person shared, '[t]hank you so much for listening. No one ever has before.'[69]

While the time for consultation on what needs to be done is over, opportunities for people to share their experiences and stories must continue throughout the implementation process. Continued dialogue and opportunities for sharing and reflection on implementing the Commission's reforms will be integral to generating system-wide change. This could include local and tailored engagement approaches such as gathering places, discussion groups, forums, programs and events, supported by online and digital approaches. Implementers should use these stories and experiences to sustain commitment across the Victorian community by making the impact of reform 'real'.[70]

Providing evidence in a personal capacity, Mr David Pearl, Innovator, Author and Public Speaker of The Studios, London, suggested that sharing individual experiences can help people envisage a changed world, which will be critical in encouraging and inspiring all partners throughout the reform process, 'I think the stories that are really helpful … are stories that generate change, that make a future state real to people.'[71]

Implementers should also look to share people's stories and experiences to help bring about broad cultural change, countering the false assumptions and discriminatory beliefs held by some Victorians about people with lived experience of mental illness or psychological distress. Efforts to respond to and challenge stigma will be essential to successfully implementing the Commission's recommendations, ensuring good mental health and wellbeing remains a priority in government decision-making and for the community. As one person shared with the Commission:

> For a lot of people mental ill health, especially on an extreme level hasn't been experienced. It is hard for people to identify with others who do experience it if they can't quite understand the feelings themselves. Being able to connect with personal stories makes it less clinical and encourages a level of connection between those who do and don't experience it.[72]

Creating opportunities for continued dialogue and discussion will also ensure an evolving and adaptable mental health and wellbeing system that responds to the needs and perspectives of individuals. As the National Mental Health Commission reflected:

> Mental health consumers and carers hold vital knowledge about what is needed from the system, both for individual care and at broader levels. Engagement of consumers and carers in recovery focussed services can lead to healing of historical traumatisation within services and promote cultural change.[73]

Actively engaging with and listening to the experiences of individuals will provide implementers with early warning signs about where reform is falling short of community expectations. This will ensure approaches to implementation can be refined and adapted, responding to emerging challenges.

The Commission acknowledges that some people have called for a formal process through which they can have their experiences and their stories heard, including, for example, a consumer-led truth telling and reconciliation process.[74] While it is outside the remit of the Commission to formalise processes such as this, the experiences, perspectives and expertise of people with lived experience of mental illness or psychological distress, families, carers and supporters have been central to its work. These contributions underpin the narrative, reform agenda and recommendations outlined in this report.

As reform progresses, the Commission envisages that the mental health and wellbeing system will continue to create opportunities for people to share their individual stories and experiences. The recommended strategies for enabling the leadership of people with lived experience of mental illness or psychological distress outlined in Chapter 18: *The leadership of people with lived experience of mental illness or psychological distress*, will support this endeavour.

Creating the space for people to share their stories and have their experiences heard and acknowledged, however, will be the responsibility of all those involved in implementing the recommendations contained in this report—this includes the entities created by the Commission, and the existing agencies, organisations and individuals involved in the mental health and wellbeing system. This will involve enquiring into and engaging with the individual experiences and perspectives of those who use and work within the system, and seeking out diverse views and perspectives, including those of people who have previously been silenced or excluded.

Continued dialogue, reflection and the sharing of individual experiences and stories is essential to rebuilding the Victorian community's trust in the mental health and wellbeing system and to creating a system that is flexible and respects people's needs and experiences.

37.2.5 Supporting and involving service providers and the workforce

The perspectives of the workforce, including the leadership of a range of service providers, are also integral to successful implementation. The workforce—as the heart of the Victorian mental health and wellbeing system—will play a crucial role in translating the Commission's vision into action. The workforce must be supported and involved in implementation from the very start.

There is considerable optimism and readiness for change within the workforce. A workforce survey that the Commission engaged ORIMA Research to undertake suggests that almost all respondents personally felt ready for changes to the mental health system, with 90 per cent of respondents indicating they believed change was necessary in the mental health setting where they worked.[75]

When asked what would help to prepare them for changes to the system, '[r]eceiving clear communication and being kept informed throughout the changes' was rated as the most important factor, followed by '[a]ccess to relevant training, professional development, and practice support.'[76] Some specific suggestions for improving how change is managed across the mental health system included an 'opportunity to collaborate in the proposed changes, necessary resources and positive workplace culture'[77] as well as 'being consulted about how to best implement changes locally'.[78] These results suggest there is an opportunity to capitalise on the enthusiasm and expertise amongst the workforce by involving them in the implementation of reforms.

Leaders from a range of organisations involved in service delivery will also play a pivotal role, steering their own organisations, including individuals, teams and associated systems, through a substantial period of change and innovation. Associate Professor Stafrace described how leaders of organisations can influence outcomes for the better by shaping 'the pattern of beliefs, values, and behavioural norms that represents the shared learning of the organisation as it solves the problems it confronts'.[79] In this way, their support for implementation will be critical. Garnering that support will require the Department of Health to actively seek and involve leaders from a range of organisations involved in service delivery throughout the implementation process. This will also help to ensure that the translation of the Commission's reforms and enablement of change across the system is informed by a deep understanding of what works on the ground, at the point of service delivery.

37.2.6 Evaluation throughout reform

As discussed in Chapter 36: *Research, innovation and system learning*, an adaptive mental health and wellbeing system relies on research and evaluation to inform the design and delivery of effective and innovative treatment, care and support. While the importance of evaluation is detailed elsewhere in this report, it is brought to the fore here as an essential component of ongoing implementation efforts.

Evaluation is a critical part of ensuring reform implementation can adapt to changing needs. It indicates what works and what does not work, and for whom, in what context and why. Evaluation can also shift power to people whose voice might otherwise not be heard by giving them a say about decisions and services that affect their lives.[80]

Evaluation should be included from the beginning of implementation,[81] using success measures that are established during the planning stage.[82] This allows for an iterative development and implementation process where evidence is collected and used to make adjustments along the way, and to ensure changes are implemented effectively.

The balance between planning and responding to feedback 'on the go' was discussed in an essay published in *Delivering Policy Reform: Anchoring Significant Reforms in Turbulent Times:*

> We also know … that policy reforms cannot anticipate all factors and contingencies; there will inevitably be a great deal of learning and adjustment in order to meet these realities. [Implementation must manage] the tensions between seeking durability in policy reforms and making improvements or adjustments in light of feedback from those responsible for implementation and evidence on the performance of the policy and programs without losing the integrity and momentum of the original reforms.[83]

Rigorous evaluation also builds momentum for change by indicating the benefits of the approach—when people can see that what they are doing is having a positive impact, and achieving an aim, it helps them to keep up their commitment. Exemplifying how reforms will make a difference to individuals' experiences and outcomes, as well as for service providers, governments and the public, helps to build people's confidence and engagement in the change effort.[84] This is particularly important because reform efforts will take time to deliver. For example Joannah Luetjens of Utrecht University, Professor Michael Mintrom of Monash University and Professor Paul 't Hart of Utrecht University made the following observations about reforms to make Melbourne more 'liveable' in *Successful Public Policy, Lessons from Australia and New Zealand*:

> In the case of the drive to make Melbourne a more liveable city, there were various challenges that meant implementation occurred in a slow, incremental fashion … When people started to see the benefits of the implementation efforts, assessments of the overall initiative became far more positive.[85]

Continually evaluating the impact of reforms and sharing the knowledge obtained not only gives people visibility of how well new approaches are working (thus building confidence in reforms). It also enables better decisions at the system and service levels—for example, about what initiatives to invest in and at what scale. Therefore, evidence plays a crucial role in guiding the expansion of what works so the full benefits can be understood and realised.[86]

In thinking about what constitutes evidence, the Commission encourages implementers to adopt a broad approach. Data collection, research and the perspectives of people with lived experience of mental illness or psychological distress, families, carers and supporters as well as the workforce must be actively sought, considered and acted on.

It is important to note, however, that scaling up and expanding effective approaches must be tailored to and reflect the local context.[87] When expanding programs or initiatives, implementers must take care to strike the balance between ensuring efforts respond to the identity and culture of communities while maintaining a level of consistency and fidelity to the model.[88]

Continuous evaluation implicitly acknowledges one important fact: not all efforts will be successful on their first attempt. Implementation of substantial reform necessarily involves new and innovative ways of doing, including approaches and initiatives that have never been attempted before. To innovate and take these risks, implementers must have both the permission and the courage to try, with the opportunity to learn from their experiences and adapt future approaches. This is also important to achieving momentum. Delaying decisions and progress towards a reformed mental health and wellbeing system may compromise Victorians' trust in reform—in some ways, perhaps, more than unsuccessful first attempts would.

In Chapter 36: *Research, innovation and system learning,* the Commission has recommended an approach to build evaluation activity and capability across the redesigned mental health and wellbeing system, including developing a rolling three-year evaluation program to promote system learning. The Commission notes the Productivity Commission's *Mental Health Inquiry Report* recommendation that a national body be established to promote a culture of evaluation, commissioning program evaluations, and building evaluation capacity and capabilities.[89] This body would build and maintain partnerships with research institutes and state and territory partners and 'evaluate aspects of the system that are of national significance or that relate to multiple jurisdictions'.[90] But this 'does not obviate the responsibility for all governments' to monitor and evaluate programs.[91] A dedicated mental health evaluation function in Victoria should form a strong relationship with the national body and receive funding to undertake program evaluations that would have national interest. These collaborative activities will enable Victoria to assess, grow and extend approaches so Victorians can connect with high-quality treatment, care and support.

37.2.7 Financial commitment

In recent decades, Victoria's mental health system has suffered from marked underinvestment and deprioritisation, contributing to increasing unmet demand for mental health services.[92] As a result, many people do not get the treatment, care and support they seek, when it would make the most difference.

The Commission recognises that the Victorian Government will be implementing its recommendations within a fiscally constrained environment, particularly as a result of the COVID-19 pandemic. For the first time since 1991, in July 2020 Australia found itself in recession.[93] While technically it has since 'emerged', the federal Treasurer, the Hon. Josh Frydenberg MP, has warned that Australia's economic recovery is far from over.[94]

While this context is important, it is the firm view of the Commission that the impacts of the COVID-19 pandemic on individuals and communities—including social isolation and unemployment rates—necessitates a strong focus on mental health and wellbeing and its prioritisation in future budgets.

The costs of poor mental health are borne by everyone; people living with mental illness or psychological distress are most affected, but families, carers, supporters, governments and employers also incur costs. In its interim report, the Commission estimated that poor mental health costs Victoria $14.2 billion a year.[95] Australia-wide, too, the costs of poor mental health are enormous. The Productivity Commission's *Mental Health Inquiry Report* estimates the economic costs to the country of poor mental health and suicide in 2018–19 to range from $43 billion to $70 billion. It anticipates that these costs are likely to increase in response to the COVID-19 pandemic and the 2019–20 severe bushfire season, with predicted widespread implications for the mental health and wellbeing of all Australians.[96]

Investment in good mental health and wellbeing has been at the fore of the Commission's thinking throughout the conduct of its inquiry. Anticipating the considerable work needed to redesign the system, the Commission's interim report recommended a new approach to mental health investment to both deliver a substantial funding increase and ensure that funding is best distributed and used throughout the reformed mental health and wellbeing system—a new levy and a dedicated capital investment fund.[97] The design and implementation of this new approach to investment will be critical to ensuring sustainable and enduring reform. Should the new levy and dedicated capital investment fund be delayed, the Commission expects the Victorian Government to demonstrate its commitment by allocating investment from general revenue as part of the annual budget process, to pave the way for major, sustained investment in good mental health and wellbeing.

The Victorian Government has recently shown it is willing to invest in the good mental health and wellbeing of Victorians. Through the 2020–21 State Budget, it has announced measures to rebuild the economy and to respond to the 'cracks' exposed by the COVID-19 pandemic. This includes a commitment of almost $870 million to implement the recommendations made by the Commission in its interim report to repair a 'frail mental health system'.[98] As the Hon. Tim Pallas MP, Treasurer of Victoria articulated:

> **this year has tested us emotionally and it has revealed the very deep cracks in our mental health system. This year's Budget invests nearly $870 million to ensure Victorians have the mental health support they need as we get on with fixing a broken system.**[99]

The Commission is encouraged by the way the Victorian Government made mental health a priority in response to the COVID-19 pandemic. This investment, however, is just the beginning. The scale of funding required to redress historical underinvestment and meet the future needs of the Victorian community is enormous. Yet, as explored in the Commission's interim report there is a compelling case for increasing investment in mental health. Increased funding in Victoria's mental health and wellbeing system would provide a range of benefits including: opportunities to tackle inequity and design a system that is fair and just for all; improved social and economic participation that will boost the economy; and health benefits, including improvements to Victorians' quality of life and life expectancy.[100]

While increased funding alone will not fix all the problems in the mental health system, strong and sustained investment will be vital to delivering on the reforms outlined in this report and to ensuring future savings.

The Productivity *Commission Mental Health Inquiry Report* reached similar conclusions, suggesting that if Commonwealth, state and territory governments spent $3.5–$4.2 billion to deliver major reform across the system, this would result in estimated savings due to increased productivity and good quality of life of $1.7 billion, and increases to total income earned of up to $1.3 billion per year.[101] The Commission believes that these investment estimates are modest for Victoria, given the historical underinvestment in the mental health system in the state. The reality of past underinvestment means there will need to be substantial spending put in place for the fundamental elements that will enable large-scale change across the state. Only once that has happened will the Victorian community and economy see the benefits the Productivity Commission envisages for Australia.

The Victorian Government will need to continue making the mental health and wellbeing of the Victorian community a priority as it makes funding decisions. It should also explore ways to coordinate investments with other levels of government—for example, by forming new partnerships—to best meet Victorians' mental health and wellbeing needs and preferences.

37.2.8 Collaboration

The scale and complexity of the task ahead, and the fact that implementation of many reforms will occur in parallel, means that government, service providers, the workforce, people with lived experience of mental illness or psychological distress, families, carers, supporters and the Victorian community will need to collaborate effectively.

Successful collaboration 'require[s] a shared vision, objectives and methodology, utilising the skills and expertise of all parties'.[102] It involves 'creating new structures within which to embed authority, developing a common mission, engaging in comprehensive and shared planning, and in which formal communication across multiple levels occurs'.[103]

Effective collaboration also requires a willingness to be transparent so that 'both sides understand each other and are able to align vision of the partnership with their shared goals'.[104] It needs a commitment to regular and direct communication and mutual trust, which is especially crucial when challenges emerge.[105]

Dr Tricia Szirom, the then CEO of the Victorian Mental Illness Awareness Council, reflected on the benefits of collaborative efforts in solving complex problems:

> **when you bring people with diverse backgrounds together, you can solve complex problems, particularly as you are able to bounce your ideas off one another and you all bring with yourself a different perspective.**[106]

A report by the Australian New Zealand School of Government made similar observations about the importance of collective problem solving:

> **public problem-solving skills are directed not at convincing others that one is right, but at harnessing the collective intelligence of others to develop a deeper and more realistic understanding of both problem and solution, and to evolve along with them. We cannot be as smart alone as we are together, taking advantage of our diverse intelligence.**[107]

Collaboration can also help to ease the transition to new arrangements. For example, at the Commission's public health roundtable, participants highlighted strong potential to improve public health efforts for mental health in Victoria through collaborative efforts, but that the transition to new arrangements and managing new complexities may be challenging.[108]

As described earlier, Victoria's mental health sector has been divided and at times has struggled to achieve a consistent and unified voice.[109] The Commission considers that this may be partly explained by the historical and structural pressures facing the system. While the Commission's aspiration is for a unified mental health and wellbeing system where collaboration can flourish, in reality there are several pressures—in particular, demand for services and a shortage of workers—that will continue to test collaborative efforts.

Over the past 30 years, demand for mental health services has increased, and this is only likely to continue.[110] It is also anticipated that as community awareness and understanding of mental health and wellbeing continues to develop, in part due to this inquiry, so too will demand for services. This has been evident with comparable reforms; for example, the Implementation Monitor of the Royal Commission into Family Violence acknowledged the increasing demand when the sector was reformed:

> **Demand for services continues to grow, likely due in part to the increased community awareness of family violence the reforms have supported. The existing system needs to simultaneously grow and reform while meeting the immediate needs of victim survivors. This is a pressure being felt across all areas of government and community organisations ...**[111]

The Implementation Monitor of the Victorian Bushfires Royal Commission made similar observations, suggesting that recent inquiries into the sector had increased public interest and expectation:

> **The public conduct of the [Victorian Bush Fires Royal Commission] and [other] inquiries ... show that the community is interested in what is going on and has an expectation that if problems or failures in response to a disaster or emergency event are identified, then these will be swiftly rectified to ensure the ongoing protection of the community.**[112]

Increasing demand places pressure on all aspects of the mental health and wellbeing system, with flow-on effects to interrelated service systems. This in turn places considerable pressure on the workforce and those managing the system. Responding to increasing demand for mental health and wellbeing services cannot be the responsibility of one part of the system alone. Effectively responding to demand requires collaboration between all parts of the system—governments and service providers alike. Collaboration can help ensure the needs of a population are well understood by Victorian and Commonwealth governments and that subsequent investments are complementary and coordinated towards the areas of greatest need—minimising duplication of effort and the risk of service gaps. At the service delivery level, collaboration between service providers can help ensure people receive the right services when it would make the most difference to them, reducing the need for higher intensity service responses.

Responding to demand and reforming the mental health and wellbeing system simultaneously will be a major challenge. Faced with these pressures, there may be a temptation for implementers to respond to demand in isolation of the Commission's recommended system-wide approach—for example, by resourcing existing mental health services based on historical approaches. Yet this would be a missed opportunity, given responding to demand cannot be done by simply more investment. New and innovative approaches to mental health and wellbeing must be explored concurrently and collaboratively.

Alongside increasing demand, the mental health workforce will also continue to face substantial resourcing challenges, with shortfalls across professional groups in specialist public mental health services expected to worsen over time.[113] As explored in Chapter 33: *A sustainable workforce for the future*, proactive efforts to substantially expand the workforce, develop new roles and support new and enhanced capabilities will be essential to effectively implementing the future mental health and wellbeing system.

In light of these pressures, proactive efforts must be made to unite and strengthen the sector so all partners involved in delivering reform can work together to achieve systemic change. Recognising the importance of collaboration to reform, the Commission's interim report recommended establishing the Victorian Collaborative Centre for Mental Health and Wellbeing to bring together people with lived experience of mental illness, families, carers and supporters, researchers, academics and clinicians to improve service delivery and research. As a contemporary facility with statewide leadership and delivery functions, the Collaborative Centre will encourage greater collaboration. But it is only one entity within a broad system. It is essential that the entire system has an equally strong focus on collaboration.

Fostering collaborative efforts across the sector, while at the same time responding to emerging and historical pressures, will be supported by defined objectives, roles and responsibilities,[114] with ongoing efforts to acknowledge, explore and confront power imbalances.[115] Implementers must also take care to develop decision-making structures in which the different needs and perspectives of individuals and groups can be considered, including through regular consultation and clearly defined accountability. Dr Peter Shergold, former Secretary of the Department of the Prime Minister and Cabinet and current Chair of the Centre for Social Impact, 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'.[116]

Implementers should employ a range of strategies to enable effective collaboration. This could include, for example undertaking appropriate planning to build in enough time to support collaborative approaches and developing tailored engagement strategies and communication channels.[117] It is important, however, that these activities are designed to aid implementation—not delay it.

Because the Victorian public will be partners in delivering reform, it will be important to create a shared sense of purpose with them to maintain momentum. As described earlier, there is a strong appetite in the Victorian community for system-wide change. Presenting a compelling vision for reform, using the media effectively and identifying champions to lead reform will help to capitalise on this desire for a new system.[118]

Making sure the public has visibility over the reform process can help maintain trust, including the trust of people with lived experience of mental illness or psychological distress. This can be achieved by regularly updating people on the reform work such as through regular progress updates via a dashboard or website and monthly reports, which can also include information on opportunities for participation.[119]

37.2.9 Strong governance structures

Strong governance structures will be integral to implementing reform; they can clearly define the intended scope of reform and clarify the roles and responsibilities of all those involved in implementing it, helping them to work together.[120]

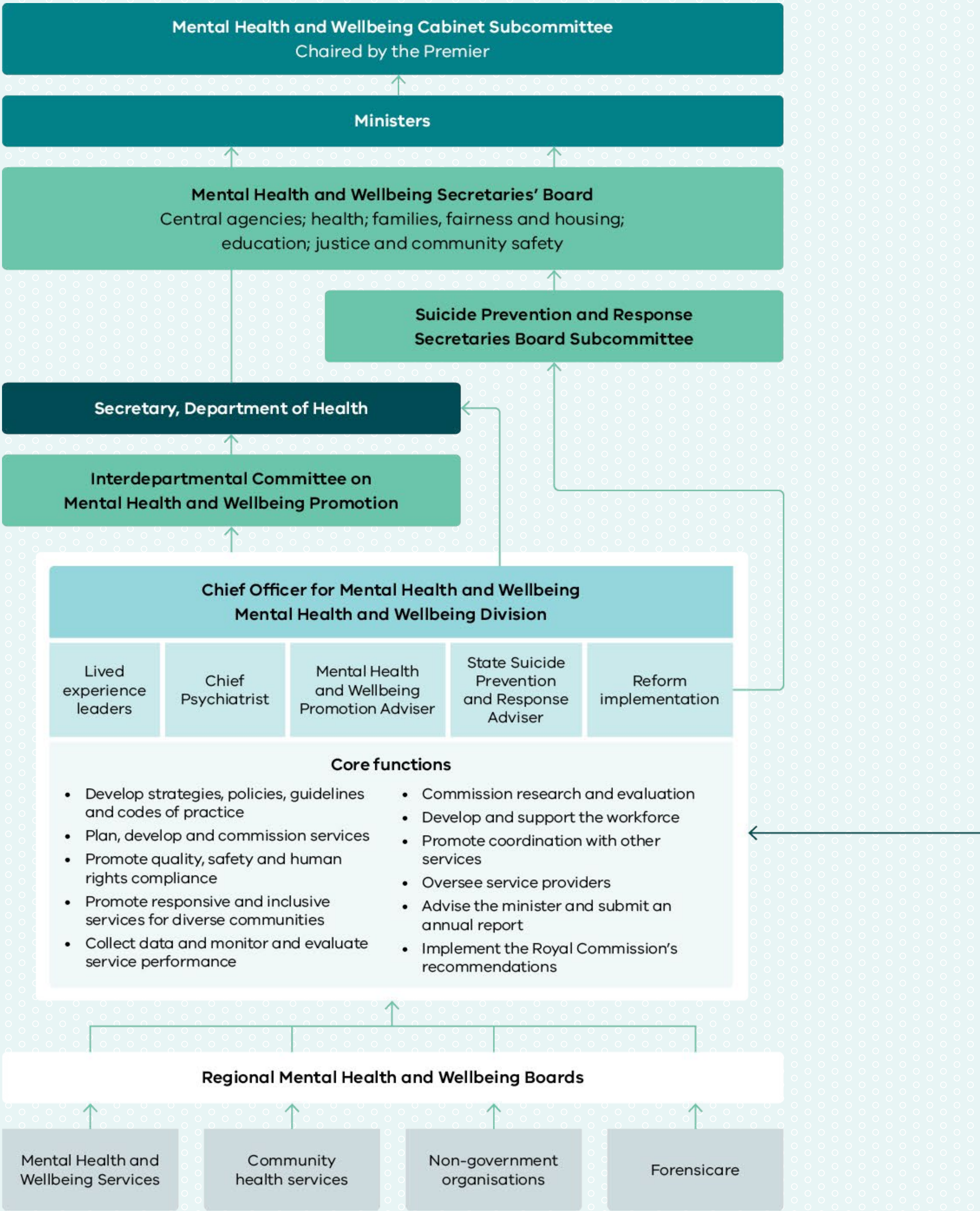
The Family Violence Implementation Monitor described the risks of not having clear governance structures:

> **Clear governance arrangements are critical to the successful implementation of any major reform. Without these, there is a significant risk that accountability will be blurred—meaning it is unclear who is ultimately responsible for a particular decision or risk. Consequently, implementation decisions may be poorly informed and possibly taken at the wrong level of government, without adequate input from relevant agencies. Alternatively, gaps in decision making and risk management may arise as groups are unsure of their responsibilities, or decisions may be made in isolation in different agencies.**[121]

Alongside establishing accountability for reform, governance structures also play a critical role in ensuring it is clear who has authority over what, therefore enabling decision-making. An independent review of the Australian Public Service made the following observations about good governance in enabling and supporting the change process, '[i]t empowers and guides … leaders to make good decisions without unnecessary delay, and ensures public resources are deployed properly and effectively. It supports the organisation to act with integrity.'[122]

To support implementation, the Commission has established a range of governance structures which are summarised in Figure 37.4. As outlined in Chapter 27: *Effective leadership and accountability of the mental health and wellbeing system—new system-level governance*, this includes establishing government-wide and community-wide approaches to improving mental health and wellbeing, including a Mental Health and Wellbeing Cabinet Subcommittee, and a Mental Health and Wellbeing Secretaries' Board, a Suicide Prevention and Response Secretaries' Board Subcommittee and an Interdepartmental Committee on Mental Health and Wellbeing Promotion, which will oversee implementation of the Commission's recommendations. These structures, which include leadership from the Premier and senior ministers, should be established as a priority to ensure there are clear arrangements in place to support effective decision making and enable the timely implementation of the Commission's recommendations. It is also anticipated that governance arrangements will continue to mature and evolve as reform progresses and the system is redesigned. This is evident, for example, in the Commission's recommended approach to establishing Regional Mental Health and Wellbeing Boards, which will adopt their functions through a staged approach to implementation. This approach will support development of new capabilities and skills, allowing for trusting partnerships between the Department of Health, the new entities, service providers and the community to be developed as reform progresses.

Figure 37.4: Summary of new system architecture



Mental Health and Wellbeing Cabinet Subcommittee
Chaired by the Premier

Ministers

Mental Health and Wellbeing Secretaries' Board
Central agencies; health; families, fairness and housing; education; justice and community safety

Suicide Prevention and Response Secretaries Board Subcommittee

Secretary, Department of Health

Interdepartmental Committee on Mental Health and Wellbeing Promotion

Chief Officer for Mental Health and Wellbeing
Mental Health and Wellbeing Division

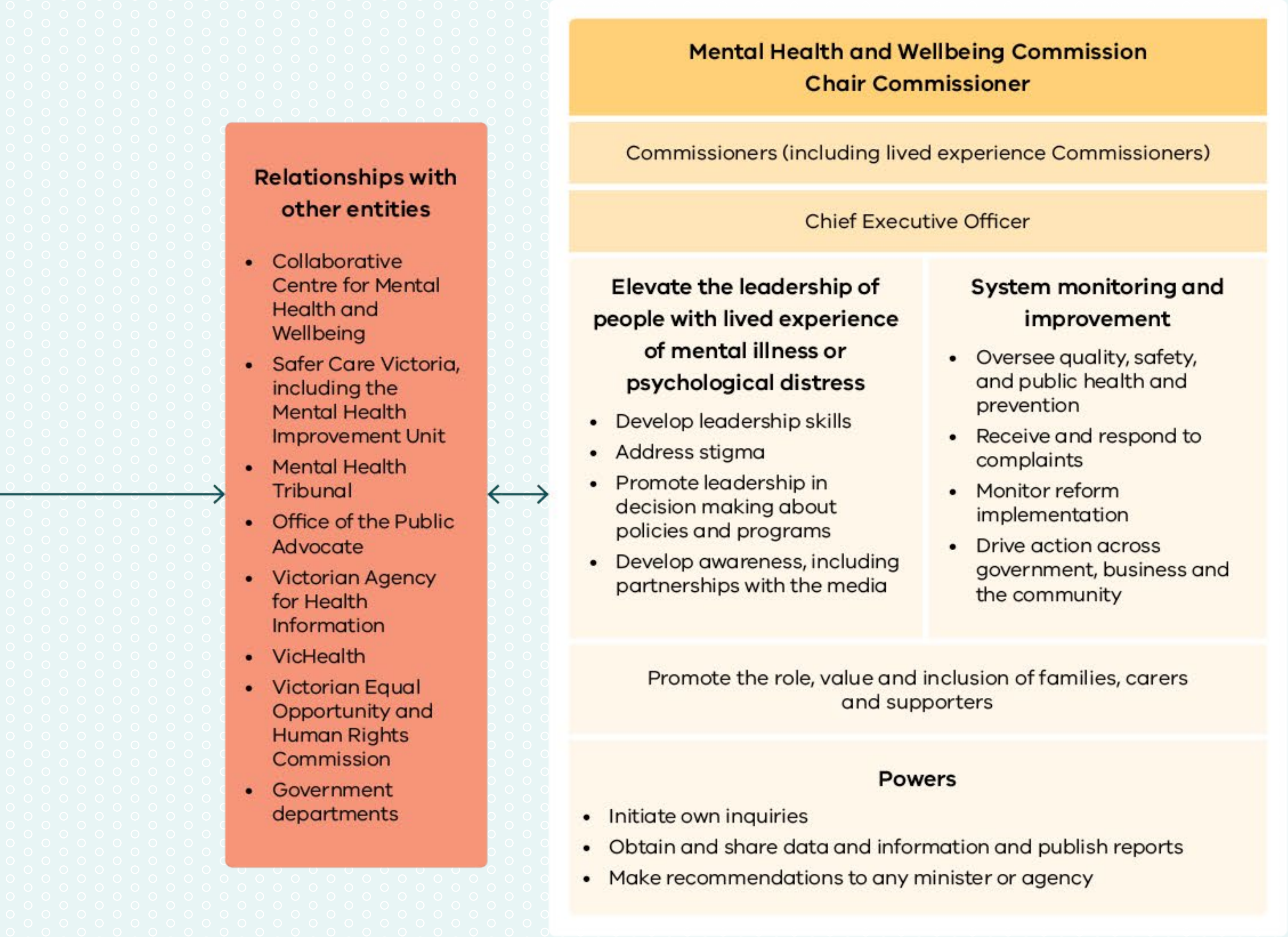
- Lived experience leaders
- Chief Psychiatrist
- Mental Health and Wellbeing Promotion Adviser
- State Suicide Prevention and Response Adviser
- Reform implementation

Core functions

- Develop strategies, policies, guidelines and codes of practice
- Plan, develop and commission services
- Promote quality, safety and human rights compliance
- Promote responsive and inclusive services for diverse communities
- Collect data and monitor and evaluate service performance
- Commission research and evaluation
- Develop and support the workforce
- Promote coordination with other services
- Oversee service providers
- Advise the minister and submit an annual report
- Implement the Royal Commission's recommendations

Regional Mental Health and Wellbeing Boards

- Mental Health and Wellbeing Services
- Community health services
- Non-government organisations
- Forensicare



Relationships with other entities

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

Mental Health and Wellbeing Commission
Chair Commissioner

Commissioners (including lived experience Commissioners)

Chief Executive Officer

Elevate the leadership of people with lived experience of mental illness or psychological distress

- Develop leadership skills
- Address stigma
- Promote leadership in decision making about policies and programs
- Develop awareness, including partnerships with the media

System monitoring and improvement

- Oversee quality, safety, and public health and prevention
- Receive and respond to complaints
- Monitor reform implementation
- Drive action across government, business and the community

Promote the role, value and inclusion of families, carers and supporters

Powers

- Initiate own inquiries
- Obtain and share data and information and publish reports
- Make recommendations to any minister or agency

Implementing the Commission's recommendations will require a collective approach across different parts of the Victorian Government. This reflects that there are a range of circumstances that contribute to people's experiences of mental health and wellbeing, including social and cultural characteristics, environmental events and neighbourhood, economic and demographic factors.[123] A collective and coordinated effort across government portfolios, such as education, justice and community services, is therefore required to ensure people are supported to experience their best mental health and wellbeing. The importance of a collaborative governance approach in delivering complex reform was emphasised in an independent review of the Australian Public Service, which states that 'single agencies working relatively independently of each other can miss opportunities to deliver seamless services to Australia or robust advice to government on complex challenges that cut across portfolio boundaries'.[124] The scale of reform ahead will therefore require collaboration and leadership across many government departments. This is particularly pertinent in the context of recent changes that saw the Department of Health and Human Services separated into the Department of Health and the Department of Families, Fairness and Housing.[125] As outlined in Chapter 3: *A system focused on outcomes*, accountability and collaboration across government departments and agencies will be fostered through a *Mental Health and Wellbeing Outcomes Framework*.

The Victorian Mental Illness Awareness Council advocated for an integrated system-wide approach to governance:

> changes to the mental health system will require strong integrated system-wide governance to ensure that the vision of the Commission for consumer-centred and consumer-acknowledged leadership is implemented and maintained over future years.[126]

This approach to governance will bring with it a number of challenges. But with the right structures, funding, people expertise, and accountabilities in place, governance arrangements that involve a number of parties will play a critical role in driving and implementing change and improving outcomes for people living with mental illness or psychological distress, families, carers and supporters.

As Ms Lin Hatfield Dodds, Associate Dean for the Australian and New Zealand School of Government of the Crawford School at Australian National University stated in a personal capacity:

> Collaboration is hard, grinding, and resource intensive. If it were easy, our federation would work more efficiently and consistently deliver seamless service systems for citizens. When properly resourced, collaboration across types of organisations and levels of government is generally highly effective in delivering outcomes and value for communities.[127]

Alongside the structures recommended by the Commission, implementers should also consider whether other arrangements are necessary to ensure a coordinated and collaborative approach to implementing specific recommendations. While governance arrangements will vary depending on the purpose and scope of the reform agenda, the Centre for Evidence and Implementation identified the following principles for good governance in facilitating collaboration for reform:

- legitimacy and voice—ensuring those who should and need to be represented are supported to actively participate and collaborate
- strategic vision—stating a clear direction and strategic vision with goals and objectives, ensuring all partners understand their role in achieving change
- performance—monitoring and reporting on progress towards reform and making necessary adaptations
- accountability—facilitating a culture of openness and transparency and ensuring clarity about the accountabilities of different individuals and the collective
- fairness and equity—ensuring all those involved get value from the process and applying the principles of equity, inclusion and diversity across all aspects of governance.[128]

Lessons should also be drawn from comparative reforms. For example, an interdepartmental committee was established to oversee all of the reforms planned by the Royal Commission into Family Violence. However, there were several problems identified with its structure, including that it lacked clear purpose and decision-making authority.[129] These challenges emphasise the importance of putting in place strong decision-making structures with defined roles for each governance body and guidance on how they intersect. Past challenges also show the importance of having a single point of accountability for system reform.[130] For governance structures to be successful, it will be essential to establish clear priorities and ways of working together, including information-sharing protocols to ensure work programs are coordinated.

37.2.10 Monitoring implementation of the Commission's recommendations

Effective monitoring is essential to implementation, playing an important role in: maintaining momentum for reform; embedding accountability for change; ensuring progress is transparent; mitigating and avoiding unintended consequences; and continuously improving and adapting reform efforts.[131]

The Parenting Research Centre identified three important features of effective monitoring for successful implementation—transparency; independence and sustainability[132]—suggesting that, '[a]n external oversight body may be necessary for the effective monitoring and evaluation of implementation, ensuring accountability.'[133]

In line with these features, as described in Chapter 27: *Effective leadership and accountability of the mental health and wellbeing system – system-level governance*, the Commission recommends that the new Mental Health and Wellbeing Commission will be responsible for examining and overseeing implementation of the Commission's recommendations. As an independent statutory authority, the Mental Health and Wellbeing Commission is best placed to provide independent scrutiny and oversight, holding implementers to account for fulfilling the aspirations of the Victorian community. This includes annual public reporting to parliament while the Commission's recommendations are being implemented. Importantly, the new Mental Health and Wellbeing Commission will also include leadership from people with lived experience of mental illness or psychological distress and families and carers, ensuring lived experience oversight over the implementation of the Commission's recommendations.

A transparent and independent approach to monitoring reflects similar approaches adopted to oversee large-scale reforms. For example, the Victorian Bushfires Royal Commission recommended establishing an independent implementation monitor to ensure 'government and the community have access to transparent, independently verified information on the response to the Commission's recommendations'.[134]

The Royal Commission into Family Violence took a similar approach, recommending an independent statutory agency be established to, among other things, monitor and report on the implementation of its recommendations.[135]

Effective monitoring must go beyond providing a 'scorecard' or a 'tick the box' exercise. For example, while information on output measures or analysis of how much money has been invested is important, it does not reflect whether the reform has had the intended impacts.[136] The Mental Health and Wellbeing Commission must therefore engage widely across the sector to gather information and assess whether implementation efforts are meeting the needs and preferences of people with lived experience of mental illness or psychological distress, families, carers and supporters.

It is important too that approaches to monitoring implementation efforts do not solely focus on finding fault or attributing blame. Instead, a positive and supportive approach will motivate, guide and help implementers to learn and adapt their approach. As one participant told the Parenting Research Centre in an in-depth interview about their experience of implementation,[137] '[implementers needed to see that monitoring is] there to help, not to beat them up … so that together we could work in a collaborative way to create change'.[138] To this end, the Mental Health and Wellbeing Commission must provide advice to improve the effectiveness of the implementation process and suggest strategies to tackle emerging risks and problems.

Monitoring and publicly reporting on implementation of the Commission's recommendations is vital to ensuring real progress is made to improving the experiences and outcomes of people with lived experience of mental illness or psychological distress, families, carers and supporters. It is also critical for making sure governments and implementers are accountable to the public.

37.3 Implementing the reimagined mental health and wellbeing system

As explored throughout this chapter, large-scale transformation requires partnerships with people with lived experience, as well as effective collaboration, strong governance structures and collective leadership. It also requires a strategic approach to planning over time, not just a 'project plan'. This could be achieved by developing detailed, staged implementation plans, with clear explanations of responsibilities, engagement processes, timelines, costs and evaluation points.

Because of the complexities associated with implementation, the reform activity following this Commission should be staged or sequenced. As Associate Professor Stafrace stated, '[r]eform takes time. The most successful examples involved building momentum over time.'[139] Associate Professor Vine also encouraged an incremental approach to implementation:

> improvement needs to be incremental—as a big part of reversing the decline involves developing new services, improving amenity and re-invigorating a workforce that in places has become de-skilled and dis-engaged. Such improvement will take time.[140]

A planned approach to implementation can help facilitate a measured and achievable process.[141] A well-considered pace of change can also enable improvements and adaptations to be made over time, accommodating new information and intelligence as reform progress.[142]

Implementers must strike the balance, however, between the pace and scale of reform and the urgency required to deal with the depth of the problems in the existing mental health system. There is a moral imperative for implementers to capitalise on the opportunities afforded by this inquiry. Timely, deliberate and sustained actions are therefore required to ensure all Victorians can benefit from the changes described in this report, both now and into the future.

Implementation generally occurs in stages or phases[143] including sequencing across time horizons or 'waves' of reform over the short, medium and longer term. Generally, these approaches begin by implementing the critical enablers of reform first—processes and policies that must be in place before further changes or initiatives can be introduced. As described in Chapter 26: *Rebalancing mental health laws—a new Mental Health and Wellbeing Act*, in the context of the Commission's recommendations this includes immediate legislative reforms via a new Mental Health and Wellbeing Act, which should be introduced into parliament as soon as possible, ideally by the end of 2021. Early implementation of priority recommendations is also important to maintaining the reform momentum, ensuring the problems these recommendations seek to rectify are front and centre in public discourse.[144]

When considering the staging of reform, it is important to identify and plan for what skills and capacity will be needed to implement reforms, not just in the short-term but over many years.[145] The Royal Commission into Institutional Responses to Child Sexual Abuse, for example, acknowledged the importance of a phased approach in achieving long-term cultural change, providing institutions, regulatory bodies and governments with time to build their capabilities and capacity for large scale change.[146]

When sequencing reform activities, then, implementers should consider the time required to build sufficient capacity and readiness for reform while also allowing for the evaluation needed to adapt and scale up successful approaches.

The Commission has consistently considered the potential resourcing, time and effort required to implement the changes it has recommended. It also considered the sequencing of its reform agenda, identifying the main steps or activities that may form the basis of an implementation plan. This section provides a consolidated overview of the Commission's reform agenda and indicative sequencing.

37.3.1 Waves of reform: main steps and sequencing

The Commission's terms of reference direct it to develop recommendations that are 'appropriate for the short, medium and long term'.[147] The Commission has articulated a 10-year reform agenda, comprising three waves of reform at Table 37.1:

- short term—by the end of 2022
- medium term—by the end of 2026
- long term—by the end of 2031.

This section provides an overview of the reform agenda. Table 37.1 presents the main components of each recommendation and provides an overview of associated timeframes for implementation. The timeframes depicted in Table 37.1 are the period within which implementation processes will commence and the major steps associated with the delivery of each component of the recommendation undertaken. It is noted that some recommendations include a specific and articulated deadline against componentry (for example, 'by the end of 2022'), which means all major steps must be complete by this date. Some timeframes in the table extend through to the end of 2031, noting they are in the main associated with ongoing governance arrangements. The presentation of the Commission's recommendations in this way is intended to provide the Victorian Government with a starting point to aid the implementation process. It also serves to illustrate what reforms the Commission considered are priorities, and what may take more time.

It is important to acknowledge, however, that system-wide reform will not be achieved simply by implementing the Commission's recommendations. The Family Violence Implementation Monitor described the key deficiencies of this assumption:

> The emphasis on acquittal means the recommendations are driving reform implementation. This is problematic because, while the recommendations of the Royal Commission are a critical input to the design of the reform and the implementation plan, and acquitting them is an important accountability exercise, they are not sufficient to drive the implementation of the reform. They provide neither sufficient detail nor the necessary systemic approach.[148]

Instead, implementers must take a systemic approach and consider how recommendations work in parallel to achieve the changes envisaged by the Commission, including how all of the components of the redesigned system will fit together[149] and the impacts of recommendations on other parts of the system and interrelated services. As described earlier, the recommended Mental Health and Wellbeing Commission will also assist by monitoring implementation efforts and supporting implementers to learn and adapt their approach.

It is important to note that while the Commission has articulated a 10-year reform agenda, implementation is not a static or linear process; reform will be ongoing and dynamic, requiring 'consistency, resilience, and perseverance'[150] from all those involved in implementation.

37.3.2 The time to act is now

While the Commission has reached its end, its ambitions for a reimagined mental health and wellbeing system are far from realised. Next, the Commission's recommendations must be effectively implemented, and this will require unwavering commitment from government and all partners involved in its reform.

While the work ahead will not be easy, there is hope that this time will be different—that all possible efforts will be made to give the recommended reforms the best chance of success. The Commission calls on implementers to make the hopes of people with lived experience of mental illness or psychological distress, families, carers and supporters a reality.

The Victorian public's optimism and desire for change gives implementers a unique opportunity to create enduring reform. All partners in delivering profound change must rise to the challenge. The Commission's inquiry is over; the time for decisive and deliberate action is now.

Table 37.1: Implementation table

Recommendation 1:

Supporting good mental health and wellbeing

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. build on the interim report's nine recommendations and develop a *Mental Health and Wellbeing Outcomes Framework* to drive collective responsibility and accountability for mental health and wellbeing outcomes across government portfolios.	○—○		
2. through a newly established Mental Health and Wellbeing Cabinet Subcommittee, chaired by the Premier (refer to recommendation 46(2)(a)), use the *Mental Health and Wellbeing Outcomes Framework* to monitor outcomes to inform planning and policy decisions.	○——	———	——○
3. use the *Mental Health and Wellbeing Outcomes Framework* as a mechanism to inform government investment processes and assess the benefits, including the economic benefits, of early intervention.	○——	———	——○
4. update the *Mental Health and Wellbeing Outcomes Framework* and publicly report on progress against outcomes at a service, system and population level, every year.	○——	———	——○

Recommendation 2:

Governance arrangements for promoting good mental health and preventing mental illness

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. establish within the Mental Health and Wellbeing Division, a Mental Health and Wellbeing Promotion Office, led by a Mental Health and Wellbeing Promotion Adviser, who reports to the Chief Officer for Mental Health and Wellbeing (refer to recommendation 45(1)).	○—○		
2. enable the Mental Health and Wellbeing Promotion Office to develop and coordinate a statewide approach to the promotion of good mental health and wellbeing and the prevention of mental illness which: a. delivers the economic and social benefits of good mental health and wellbeing across the population; b. is informed by public health principles; c. promotes and is informed by human rights; and d. focuses on reducing inequities in mental health and wellbeing outcomes.	○—○		

Recommendation 3:

Establishing a responsive and integrated mental health and wellbeing system

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. establish a responsive and integrated mental health and wellbeing system, in which people receive most services locally and in the community throughout Victoria, close to their families, carers, supporters and networks.	●	●	
2. establish service delivery across Victoria at local, area-based and statewide levels comprising:			
a. between 50 to 60 new Adult and Older Adult Local Mental Health and Wellbeing Services that operate with extended hours and are delivered in a variety of settings;	●	●	
b. 22 Adult and Older Adult Area Mental Health and Wellbeing Services delivered through partnerships between public health services or public hospitals and non-government organisations that deliver wellbeing supports;	●		
c. 13 Infant, Child and Youth Area Mental Health and Wellbeing Services delivered through partnerships between public health services or public hospitals and non-government organisations that deliver wellbeing supports; and	●		
d. statewide services that are delivered in a way that minimises the need for people to travel far to access services.	●	●	
3. for planning and governance purposes, realign existing boundaries and organise mental health and wellbeing services across eight regions (refer to recommendation 4).	●		
4. remove rigid boundaries (or catchments) for service delivery based on where people live.	●	●	
5. establish the requirements for each service and the links between them through a 'service capability framework'.	●	●	

Recommendation 4:

Towards integrated regional governance

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. by mid-2021, establish eight interim regional bodies to provide advice to the Mental Health and Wellbeing Division in the Department of Health as it plans, develops, coordinates, funds and monitors a range of mental health and wellbeing services in each region.	○—○		
2. by no later than the end of 2023, replace interim regional bodies with legislated Regional Mental Health and Wellbeing Boards to: a. undertake workforce, service and capital planning for mental health and wellbeing services; and b. lead engagement with their respective communities.	○——	——○	
3. from the end of 2023 and by no later than the end of 2026, enable each Regional Mental Health and Wellbeing Board also to: a. commission mental health and wellbeing services; and b. hold individual providers to account to improve the outcomes and experiences of people who use their services.	○——	——○	
4. in parallel with the establishment process, ensure that Regional Mental Health and Wellbeing Boards: a. acquire and maintain the required skills and capabilities to perform the above functions; b. are accountable for the delivery of agreed outcomes through new accountability arrangements; and c. are skills-based and include at least one person with lived experience of mental illness or psychological distress and one person with lived experience as a family member or carer.	○——	——○	
5. with the assistance of the interim regional bodies, establish a multiagency panel in each region to coordinate as required the delivery of multiple mental health and wellbeing services for people living with mental illness or psychological distress, including children and young people, who may require ongoing intensive treatment, care and support.	○——○		

Recommendation 5:

Core functions of community mental health and wellbeing services

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. commission and ensure that Adult and Older Adult Local Mental Health and Wellbeing Services and Adult and Older Adult Area Mental Health and Wellbeing Services referred to in recommendation 3(2)(a) and (b) work in collaboration to deliver in each of the 22 service areas short-term, ongoing and intensive services as required and include the following core functions: a. Core function 1: integrated treatment, care and support that comprises: • a broad range of treatments and therapies; • a broad range of wellbeing supports (formerly called psychosocial supports) for those who require them, including those who are unable to access the National Disability Insurance Scheme; • education, peer support and self-help; and • care planning and coordination. b. Core function 2: services to help people find and access treatment, care and support and, in Area Mental Health and Wellbeing Services, respond to crises 24 hours a day, seven days a week. c. Core function 3: support for primary and secondary care and related services through primary consultation with consumers, secondary consultation with providers of those services and a formal model of comprehensive shared care.	○──	──○	
2. commission and ensure that Adult and Older Adult Local Mental Health and Wellbeing Services and Adult and Older Adult Area Mental Health and Wellbeing Services referred to in recommendation 3(2)(a) and (b) work in collaboration to deliver multidisciplinary, holistic and integrated treatment, care and support through a range of delivery modes including: a. site-based care (such as centres or clinics); b. telehealth; c. digital technologies; and d. visits to people's homes and other places (including targeted assertive outreach).	○──	──○	
3. ensure Adult and Older Adult Local Mental Health and Wellbeing Services and Adult and Older Adult Area Mental Health and Wellbeing Services are accessible and responsive to the diversity of local communities.	○──	──○	

Recommendation 6:

Helping people find and access treatment, care and support

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. ensure people can access Local Mental Health and Wellbeing Services through a referral from a general practitioner or any other service provider, or through a discussion with the relevant service's access and navigation support worker.	●	●	
2. ensure people can access Area Mental Health and Wellbeing Services through a referral from a Local Mental Health and Wellbeing Service or through direct referral from a medical practitioner.	●	●	
3. ensure people can access Statewide Mental Health and Wellbeing Services through a referral from an Area Mental Health and Wellbeing Service.	●		
4. promote, and co-produce with people with lived experience, a website that provides clear, up-to-date information about Victoria's mental health and wellbeing system that helps users to: a. understand their mental health needs; b. identify services and supports across all relevant provider types; and c. access online self-help resources.	●		
5. collaborate with its funded non-government helpline services to improve helplines' connections with mental health and wellbeing services and to assist people to find and access treatment, care and support.	●		

Recommendation 7:

Identifying needs and providing initial support in mental health and wellbeing services

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. ensure mental health and wellbeing services provide three 'needs identification and initial support' functions: a. access and navigation support; b. initial support discussions; and c. comprehensive needs assessment and planning discussions.	○	○	
2. ensure these functions are delivered based on a philosophy of 'how can we help?' to enable people to be supported from their first to their last contact with mental health and wellbeing services.	○	○	

Recommendation 8:

Responding to mental health crises

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. ensure each Adult and Older Adult Area Mental Health and Wellbeing Service delivers a centrally coordinated 24-hours-a-day telephone/telehealth crisis response service accessible to both service providers and to members of the community of all ages that provides: a. crisis assessment and immediate support; b. mobilisation of a crisis outreach team or emergency service response where necessary; and c. referral for follow-up by mental health and wellbeing services and/or other appropriate services.	●	●	
2. expand crisis outreach services in each Adult and Older Adult Area Mental Health and Wellbeing Service to provide treatment, care and support from a clinician and nonclinical worker such as a peer worker.	●	●	
3. improve emergency departments' ability to respond to mental health crises by: a. establishing a classification framework for all emergency departments and urgent care centres, based on their capability to respond to people experiencing mental health crises;	●	●	
b. using the classification framework to ensure that health services are appropriately resourced to perform their role in a regional network of emergency departments and urgent care centres; and	●	●	
c. ensuring there is at least one highest-level emergency department suitable for mental health and alcohol and other drug treatment in each region.	●		

Recommendation 9:

Developing 'safe spaces' and crisis respite facilities

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. invest in diverse and innovative 'safe spaces' and crisis respite facilities for the resolution of mental health and suicidal crises which are consumer-led and, where appropriate, delivered in partnership with non-government organisations.	○——	—○	
2. in collaboration with the new agency led by people with lived experience of mental illness or psychological distress (refer to recommendation 29) and non-government organisations that deliver wellbeing supports, establish: a. one drop-in or crisis respite facility for adults and older Victorians per region (refer to recommendation 3(3)); and	○——	—○	
b. four safe space facilities across the state, comprising a mix of drop-in spaces and crisis response services, co-designed with and for young people.		○—○	
3. establish a crisis stabilisation facility, in consultation with people with lived experience, led by a public health service or public hospital in partnership with a non-government organisation that delivers wellbeing supports.	○——	—○	

Recommendation 10:

Supporting responses from emergency services to mental health crises

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. ensure that, wherever possible, emergency services' responses to people experiencing time-critical mental health crises are led by health professionals rather than police.	●	●	
2. support Ambulance Victoria, Victoria Police and the Emergency Services Telecommunications Authority to work together to revise current protocols and practices such that, wherever possible and safe: a. Triple Zero (000) calls concerning mental health crises are diverted to Ambulance Victoria rather than Victoria Police; and b. responses to mental health crises requiring the attendance of both ambulance and police are led by paramedics (with support from mental health clinicians where required).	●		
3. ensure that mental health clinical assistance is available to ambulance and police via: a. 24-hours-a-day telehealth consultation systems for officers responding to mental health crises; b. in-person co-responders in high-volume areas and time periods; and c. diversion secondary triage and referral services for Triple Zero (000) callers who do not require a police or ambulance dispatch.	●	●	

Recommendation 11:

New models of care for bed-based services

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. review, reform and implement new models of multidisciplinary care for bed-based services that are delivered in a range of settings, including in a person's home and in fit-for-purpose community and hospital environments.	○—	—○	
2. deliver a broad range of bed-based services, including as a matter of immediate priority: a. expanding Hospital in the Home services as an alternative to acute hospital-based treatment, care and support where appropriate;	○—○		
b. investing in a wide range of time-limited and flexible residential respite services informed by local priorities, including establishing a peer-led residential respite service at a demonstration site; and	○—	—○	
c. developing new bed-based rehabilitation services (refer to recommendation 12).	○—	—○	
3. build on the interim report's recommendation 2 about the need for the expansion of acute mental health services and deliver at least 100 additional beds in settings that reflect optimal allocation and distribution across Victoria.	○—	—○	
4. periodically review the allocation of new beds as part of the statewide and regional planning processes recommended by the Royal Commission (refer to recommendation 47) and audit the outcomes.	○—	—	—○

Recommendation 12:

Developing new bed-based rehabilitation services

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. implement the new whole-of-system rehabilitation pathway described by the Royal Commission in its final report, which includes two new bed-based rehabilitation models of care, for people living with mental illness who require ongoing intensive treatment, care and support.	○──	──○	
2. consistent with the 'design and quality features' described by the Royal Commission in its final report, co-design with consumers, clinicians and relevant non-government organisations and services: a. the new community rehabilitation model of care and deliver it at a community care unit demonstration site; and	○──	──○	
b. the new intensive rehabilitation model of care and deliver it at a secure extended care unit demonstration site.	○──	──○	
3. subject to the evaluation and required adaptation of the new rehabilitation models of care, apply these models to existing community care and secure extended care units and enhance and expand infrastructure accordingly.			○──○

Recommendation 13:

Addressing gender-based violence in mental health facilities

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. ensure that all new mental health inpatient facilities: a. are built and designed with the necessary scale and flexible infrastructure to enable gender-based separation in all bedrooms and bathrooms; and b. provide separate communal spaces as required.	○——	——	——○
2. by mid-2022, ensure that existing high dependency units in inpatient facilities allow for gender-based separation.	○—○		
3. review and retrofit existing inpatient facilities on a case-by-case basis to: a. achieve gender-based separation where possible; and b. as a matter of priority, ensure that each facility meets the minimum standards for gender safety set out in the Chief Psychiatrist's guideline: Promoting sexual safety, responding to sexual activity and managing allegations of sexual assault in adult acute inpatient units.	○——	——○	
4. ensure that the Mental Health and Wellbeing Division supports mental health and wellbeing services to eliminate sexual and gender-based violence in bed-based service settings.	○——	——	——○

Recommendation 14:

Supporting mental health consultation liaison services

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. work with the Independent Hospital Pricing Authority and the Commonwealth Government to: a. ensure mental health consultation liaison services for consumers admitted for physical health reasons are formally recognised and adequately funded as part of routine care; and b. ensure mental health consultation liaison services are incorporated, costed and priced in the relevant classifications and standards.	○—	—○	
2. ensure public health services and public hospitals: a. receive adequate temporary funding to embed and deliver in-hospital mental health consultation liaison services as part of routine care until joint funding arrangements between the Commonwealth and Victorian governments are established;	○—	—○	
b. are accountable for delivering in-hospital mental health consultation liaison services and, whenever required, provide such services to consumers admitted for physical health reasons; and	○—	—	—○
c. are accountable for providing the sustained delivery of high-quality integrated mental health treatment, care and support across the hospital system.	○—	—	—○

Recommendation 15:

Supporting good mental health and wellbeing in local communities

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. establish and recurrently resource 'community collectives' for mental health and wellbeing in each local government area.	●	●	
2. support each community collective to bring together a diversity of local leaders and community members to guide and lead efforts to promote social connection and inclusion in Victorian communities.	●	●	
3. test and develop a range of initiatives that support community participation, inclusion and connection.	●	●	
4. by the end of 2022, establish one social prescribing trial per region (refer to recommendation 3(3)) in Local Mental Health and Wellbeing Services to support healthcare professionals to refer people, particularly older Victorians, living with mental illness, into community initiatives.	●		

Recommendation 16:

Establishing mentally healthy workplaces

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. as an initiative of the Mental Health and Wellbeing Cabinet Subcommittee (refer to recommendation 46(2)(a)): a. foster the commitment of employers to create mentally healthy workplaces; b. advise on, develop and provide resources to assist employers and employees across Victorian businesses to: • promote good mental health in workplaces; • address workplace barriers to good mental health; • promote inclusive workplaces that are free from stigma and discrimination; and • support people experiencing mental illness at work.	○—○		
2. sponsor industry-based trials to demonstrate how to adapt and implement comprehensive mentally healthy workplace approaches in an industry context.		○—○	

Recommendation 17:

Supporting social and emotional wellbeing in schools

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. fund evidence-informed initiatives, including anti-stigma and anti-bullying programs, to assist schools in supporting students' mental health and wellbeing.	○——	———	——○
2. develop a digital platform that contains a validated list of these initiatives.	○—○		
3. develop a fund, modelled on School Readiness Funding for kindergartens, to support schools, with priority given to those in rural and regional areas, to select the most appropriate suite of initiatives for them.	○—	———	——○

Recommendation 18:

Supporting the mental health and wellbeing of prospective and new parents

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. expand and reform the community perinatal mental health teams in each Adult and Older Adult Area Mental Health and Wellbeing Service across Victoria to adapt and deliver the core functions as set out in recommendation 5, including by providing consultation to primary and secondary care and related services for prospective and new parents, including maternal and child health nurses.	○——	——○	
2. review approaches to perinatal mental health screening.	○—○		

Recommendation 19:

Supporting infant, child and family mental health and wellbeing

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. establish one responsive and integrated infant, child and youth mental health and wellbeing system to provide developmentally appropriate mental health and wellbeing treatment, care and support for newborns to 25-year-olds.	○—○		
2. by the end of 2022, establish a dedicated service stream for infants, children and their families, consisting of Infant, Child and Family Area Mental Health and Wellbeing Services, within the 13 Infant, Child and Youth Area Mental Health and Wellbeing Services (refer to recommendation 3(2)(c)) to: a. provide developmentally appropriate mental health and wellbeing treatment, care and support services for newborns to 11-year-olds and their families; and b. adapt and deliver the core functions of community mental health and wellbeing services (refer to recommendation 5), including through a range of delivery modes, ensuring services are accessible and responsive to the diversity of local communities.	○—○		
3. by the end of 2022, and in partnership with the Commonwealth, establish three infant, child and family health and wellbeing multidisciplinary community-based hubs.	○—○		
4. deliver evidence-informed online parenting programs and group-based parenting sessions.	○—○		
5. establish two statewide subacute residential family admission centres located in the community.	○——	——○	

Recommendation 20:

Supporting the mental health and wellbeing of young people

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. by the end of 2022, establish a dedicated service stream for young people, consisting of Youth Area Mental Health and Wellbeing Services, within the 13 Infant, Child and Youth Area Mental Health and Wellbeing Services (refer to recommendation 3(2)(c)) to: a. appropriately adapt and deliver the core functions of community mental health and wellbeing services set out in recommendation 5, including through a range of delivery modes and ensuring services are accessible and responsive to the diversity of local communities; and b. provide both short-term and ongoing treatment, care and support to young people, including those who require ongoing intensive treatment, care and support.	●		
2. ensure Youth Area Mental Health and Wellbeing Services are available for young people aged 12 to 25 (until a person's 26th birthday), with age boundaries and transitions to be applied flexibly by services in partnership with young people and their families, carers and supporters.	●	●	
3. support the development of formal partnerships, step-up and step-down referral pathways, shared staff and infrastructure and co-location between headspace centres and Infant, Child and Youth Area Mental Health and Wellbeing Services.	●	●	
4. work with the Commonwealth Government, headspace National and Primary Health Networks to ensure that Infant, Child and Youth Area Mental Health and Wellbeing Services become the preferred providers of headspace centres where they exist or are established in Victoria.	●		

Recommendation 21:

Redesigning bed-based services for young people

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. review, reform and implement new models of multidisciplinary care for bed-based services for young people that are delivered in a range of settings, including in young people's homes and in fit-for-purpose community and hospital environments.	○────	────○	
2. deliver a broad range of bed-based services, including as a matter of immediate priority: a. ensuring every region has a Youth Prevention and Recovery Centre for young people aged 16 to 25, supported through a common and consistent model of care;	○────	────○	
b. creating a new stream of inpatient beds across Victoria for young people aged 18 to 25 by reconfiguring existing inpatient beds for adults and using an allocation of the 100 new beds referred to in recommendation 11(3); and	○────	────○	
c. ensuring Hospital in the Home services are available for young people as an alternative to acute hospital-based treatment, care and support where appropriate.	○──○		
3. formally review the Youth Residential Rehabilitation Program in consultation with young people, as well as families, carers and supporters.	○──○		

Recommendation 22:

Supporting the mental health and wellbeing of older Victorians

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. establish a responsive and integrated mental health and wellbeing service stream for older Victorians that focuses on improving their mental health and wellbeing outcomes.	○——○		
2. ensure older Victorians have access to the same mental health treatment, care and support as the rest of the adult population.	○——	——○	
3. establish older adult mental health and wellbeing specialist multidisciplinary teams in Adult and Older Adult Area Mental Health and Wellbeing Services (refer to recommendation 3(2)(b)), to: a. provide specialist mental health treatment, care and support for people with complex and compounding mental health needs generally related to ageing; and b. assist primary and secondary care and related services that support older Victorians, including aged care, through primary consultation, secondary consultation and shared care.	○——	——○	

Recommendation 23:

Establishing a new Statewide Trauma Service

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. by the end of 2022, establish a Statewide Trauma Service hosted within the Collaborative Centre for Mental Health and Wellbeing, to deliver the best possible mental health and wellbeing outcomes for people of all ages with lived experience of trauma.	○—○		
2. fund the Statewide Trauma Service to bring together mental health practitioners, trauma experts, peer workers and consumers with lived experience of trauma to: a. conduct multidisciplinary and translational trauma research; b. develop and deliver education and training that supports Victoria's mental health and wellbeing workforce to deliver trauma-informed care; c. develop and oversee digital peer-led support platforms offering consumers access to peer support networks; and d. coordinate and facilitate access to specialist trauma expertise, including secondary consultation for mental health practitioners and peer workers across Victoria's mental health and wellbeing system.	○—○		

Recommendation 24:

A new approach to addressing trauma

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. in collaboration with the Statewide Trauma Service (refer to recommendation 23), enable each of the 22 Adult and Older Adult Area Mental Health and Wellbeing Services and each of the 13 Infant, Child and Youth Area Mental Health and Wellbeing Services (refer to recommendation 3(2)(b) and (c)) to employ up to three specialist trauma practitioners to: a. work with peer support workers in Local Mental Health and Wellbeing Services to provide and facilitate access to a broad range of trauma supports for consumers of all ages and backgrounds; and b. contribute to the ongoing learning and professional development of the mental health and wellbeing workforce through supervision, consultation and shared clinical care.	○—	—○	

Recommendation 25:

Supported housing for adults and young people living with mental illness

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. recognise people who are living with mental illness as a priority population group as part of Victoria's 10-year strategy for social and affordable housing and ensure that, during the next decade, people living with mental illness are allocated a continuing substantial proportion of social and affordable housing.	●	●	●
2. revise the Victorian Housing Register's Special Housing Needs 'priority access' categories to include people living with mental illness, including people who need ongoing intensive treatment, care and support.	●		
3. ensure that the 2,000 dwellings assigned to Victorians living with mental illness in the Big Housing Build are delivered as supported housing and are prioritised for people living with mental illness who require ongoing intensive treatment, care and support, with Area Mental Health and Wellbeing Services assisting with the selection process.	●	●	
4. in addition to the 2,000 dwellings, invest in a further 500 new medium-term (up to two years) supported housing places for young people aged between 18 to 25 who are living with mental illness and experiencing unstable housing or homelessness.		●	
5. ensure that the supported housing homes for adults and young people living with mental illness are: a. delivered in a range of housing configurations including standalone units, self-contained units with shared amenities and various forms of clustered independent units on a single-site property; b. appropriately located, provide for the requirements of people living with mental illness and are co-designed by Homes Victoria, representatives appointed by the Mental Health and Wellbeing Division and people with lived experience of mental illness; and c. accompanied by an appropriate level of integrated, multidisciplinary and individually tailored mental health and wellbeing treatment, care and support.	●		
6. periodically review the allocation of supported housing homes as part of the statewide and regional planning processes recommended by the Royal Commission (refer to recommendation 47) and audit the outcomes.	●	●	●

Recommendation 26:

Governance arrangements for suicide prevention and response efforts

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. establish in the Mental Health and Wellbeing Division, a Suicide Prevention and Response Office, led by a State Suicide Prevention and Response Adviser who reports to the Chief Officer for Mental Health and Wellbeing (refer to recommendation 45(1)).	○—○		
2. enable the Suicide Prevention and Response Office to: a. establish a system-based approach to suicide prevention and response efforts; b. work with people with lived experience of suicidal behaviour, family members and carers, and people with lived experience of bereavement by suicide to co-produce, implement and monitor a new suicide prevention and response strategy for Victoria; c. work closely with the Commonwealth Government to ensure suicide prevention and response efforts in Victoria are coordinated with, and complement, national approaches; d. facilitate a community-wide and government-wide approach to suicide prevention and response efforts; e. work within governance structures that encompass all government departments and relevant agencies, with Deputy Secretary and Secretary-level membership; and f. employ people with lived experience of suicidal behaviour, family members and carers, and people with lived experience of bereavement by suicide.	○——	———	——○

Recommendation 27:

Facilitating suicide prevention and response initiatives

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. build on the interim report's recommendation 3 on suicide prevention and response and develop initiatives to support people experiencing suicidal behaviour including: a. providing training in appropriate responses for members of workforces likely to come into contact with people experiencing suicidal behaviour; b. providing free, online, evidence-informed 'community gatekeeper training' for Victorians to develop suicide awareness and prevention skills; c. enabling Aboriginal people to design culturally safe 'community gatekeeper training' for Aboriginal people; and d. facilitating Victorian industries and businesses to invest in evidence-informed workplace suicide prevention and response programs, with an initial focus on forming partnerships with high-risk industries.	●	●	
2. develop initiatives to support people at risk of experiencing suicidal behaviour, by: a. co-producing an aftercare service for lesbian, gay, bisexual, trans and gender diverse, intersex, queer and questioning people following a suicide attempt; and	●	●	
b. in partnership with the Commonwealth Government, implementing statewide postvention bereavement support, so that every person bereaved by suicide is automatically referred to a postvention bereavement provider.	●	●	
3. develop an intensive 14-day support program for adults who are experiencing psychological distress, modelled on Scotland's Distress Brief Intervention program	●		

Recommendation 28:

Developing system-wide roles for the full and effective participation of people with lived experience of mental illness or psychological distress

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. in addition to the nominated roles specified in other recommendations, develop key roles across the mental health and wellbeing system for people with lived experience of mental illness or psychological distress.	○———	————	———○
2. enable the Mental Health and Wellbeing Commission (refer to recommendation 44) to: a. elevate the leadership and support 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 affecting them; b. develop and support the leadership capabilities of people with lived experience of mental illness or psychological distress through learning and development opportunities; c. design and deliver initiatives to prevent and address stigma towards people living with mental illness or psychological distress; and d. design and deliver initiatives to develop awareness and understanding of the experiences and perspectives of people with lived experience of mental illness or psychological distress.		○———	———○

Recommendation 29:

A new agency led by people with lived experience of mental illness or psychological distress

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. build on the interim report's recommendation 5 and establish 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, to:	○────	────○	
a. deliver accredited training and resources to aid the development of organisations led by people with lived experience of mental illness or psychological distress;	○──	────○	
b. develop and deliver mental health and wellbeing services led by people with lived experience of mental illness or psychological distress; and	○──	────○	
c. facilitate co-location, shared resourcing, learning opportunities and the creation of new partnerships and networks between people with lived experience of mental illness or psychological distress and the organisations they lead.	○──	────○	

Recommendation 30:

Developing system-wide involvement of family members and carers

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. in addition to the nominated roles specified in other recommendations, develop key roles across the mental health and wellbeing system for people with lived experience as family members and carers.	●	●	●
2. enable the Mental Health and Wellbeing Commission (refer to recommendation 44) to: a. elevate the leadership and promote the valued role of family members and carers of people living with mental illness or psychological distress throughout the mental health and wellbeing system; and b. develop and support the leadership and governance capabilities of families and carers of people living with mental illness or psychological distress through learning and development opportunities.	●	●	●
3. ensure that: a. in commissioning mental health and wellbeing services, expectations are set for working with families, carers and supporters; b. families, carers and supporters are included in a range of therapeutic interventions in each Area Mental Health and Wellbeing Service; and c. working with families, carers and supporters is part of system-wide workforce training.	●	●	
4. in addition to reforms to improve information sharing outlined in other recommendations, develop standards for services and practitioners to guide the sharing of appropriate information with families, carers and supporters.	●		

Recommendation 31:

Supporting families, carers and supporters

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. by the end of 2022, commission non-government organisations to use consistent branding and deliver one family and carer-led centre in each of the eight regions (refer to recommendation 3(3)) to: a. provide tailored information and supports for families, carers and supporters in the region; b. work with families, carers and supporters to help identify their needs and connect them to the supports that will best respond to those needs; c. provide access to increased funds for immediate practical needs including short-term respite (brokerage); and d. deliver support for family and carer peer support groups in the region.	○—○		
2. establish a statewide peer call-back service for families, carers and supporters caring for people experiencing suicidal behaviour.	○—○		
3. ensure there is tailored information for families, carers and supporters, such as on the new statewide mental health website (refer to recommendation 6(4)).	○—	—○	

Recommendation 32:

Supporting young carers

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. by the end of 2022, fund a non-government organisation such as the Satellite Foundation to co-design and expand the range of supports across Victoria for young carers and children and young people who have a family member living with mental illness or psychological distress.	○—○		
2. by the end of 2022, broaden the scope and reach of the Families where a Parent has a Mental Illness program, including by: a. enabling each Area Mental Health and Wellbeing Service to employ new workers to support young carers in their local environment; and	○—○		
b. increasing the funding available to young carers to help with practical needs (brokerage).	○—○		
3. strengthen identification and referral pathways for young carers through the mental health and education systems.	○—○		

Recommendation 33:

Supporting Aboriginal social and emotional wellbeing

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. build on the interim report's recommendation 4 to support Aboriginal social and emotional wellbeing, and resource the Social and Emotional Wellbeing Centre to establish two co-designed healing centres.	○—○		
2. resource Infant, Child and Youth Area Mental Health and Wellbeing Services to support Aboriginal community-controlled health organisations by providing primary consultation, secondary consultation and shared care.	○—○		
3. resource Aboriginal community-controlled health organisations to commission the delivery of culturally appropriate, family-oriented, social and emotional wellbeing services for children and young people.	○—○		
4. resource the Victorian Aboriginal Community Controlled Health Organisation, in partnership with an Infant, Child and Youth Area Mental Health and Wellbeing Service, to design and establish a culturally appropriate, family-oriented service for infants and children who require intensive social and emotional wellbeing supports.	○———	—○	

Recommendation 34:

Working in partnership with and improving accessibility for diverse communities

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. ensure the active engagement of Victoria's diverse communities throughout the process of planning, implementing and managing the reformed mental health and wellbeing system.	●	●	●
2. legislatively provide that the Secretary of the Department of Health is responsible for the delivery of a mental health and wellbeing system that responds to the needs of Victoria's diverse communities and promotes access and equity of outcomes, with this function able to be delegated to the Chief Officer for Mental Health and Wellbeing (refer to recommendation 45(1)).	●		
3. ensure that the Mental Health and Wellbeing Division: a. collects, analyses and reports on data on the mental health and wellbeing of Victoria's diverse communities for planning and funding purposes and to improve transparency in mental health and wellbeing outcomes for diverse communities;	●	●	●
b. ensures that Victorians, regardless of first or preferred language, hearing, literacy or neurocognitive ability, have access to appropriate mental health and wellbeing information and means of communication throughout the mental health and wellbeing system;	●	●	
c. enables Victoria's diverse communities and community-led organisations to: • design and deliver mental health and wellbeing information and awareness campaigns; and • assist their communities to navigate the mental health and wellbeing system.	●	●	
4. by the end of 2021, provide recurrent funding to Switchboard Victoria to deliver its Rainbow Door program, at scale, to support people who identify as lesbian, gay, bisexual, trans and gender diverse, intersex, queer and questioning to navigate and access the mental health and wellbeing system.	●		
5. enable the development of digital technologies to support the delivery of language services that assist access to and engagement with mental health and wellbeing services.	●	●	

Recommendation 35:

Improving outcomes for people living with mental illness and substance use or addiction

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. by the end of 2022, in addition to ensuring there is at least one highest-level emergency department suitable for mental health and alcohol and other drug treatment in every region (refer to recommendations 3(3) and 8(3)(c)), ensure that all mental health and wellbeing services, across all age-based systems, including crisis services, community-based services and bed-based services: a. provide integrated treatment, care and support to people living with mental illness and substance use or addiction; and	○—○		
b. do not exclude consumers living with substance use or addiction from accessing treatment, care and support.	○—○		

Recommendation 36:

A new statewide service for people living with mental illness and substance use or addiction

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. establish a new statewide specialist service, built on the foundations established by the Victorian Dual Diagnosis Initiative, to: a. undertake dedicated research into mental illness and substance use or addiction; b. support education and training initiatives for a broad range of mental health and alcohol and other drug practitioners and clinicians; c. provide primary consultation to people living with mental illness and substance use or addiction who have complex support needs; and d. provide secondary consultation to mental health and wellbeing and alcohol and other drug practitioners and clinicians across both sectors.	○———	—○	
2. as a matter of priority, increase the number of addiction specialists (addiction medicine physicians and addiction psychiatrists) in Victoria.	○———	———○	
3. work with the Commonwealth Government to explore opportunities for funded addiction specialist trainee positions in Victoria.	○——○		

Recommendation 37:

Supporting the mental health and wellbeing of people in contact with, or at risk of coming into contact with, the criminal and youth justice systems

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. expand the Assessment and Referral Court to each of the 12 headquarter Magistrates' Courts to meet demand at both existing and new locations.	●	●	
2. expand the existing forensic community model to: a. enable Adult and Older Adult Area Mental Health and Wellbeing Services and Infant, Child and Youth Area Mental Health and Wellbeing Services (refer to recommendation 3(2)(b) and (c)) to provide consistency in treatment, care and support to people in contact with, or at risk of coming into contact with, the criminal justice system; and b. establish the specialist behaviour response team described by the Royal Commission in its final report.	●		
3. establish a program for people in prison living with mental illness who require ongoing intensive treatment, care and support to transition the delivery of supports from correctional settings to the mainstream mental health and wellbeing system upon their release.	●		
4. expand specialist youth forensic mental health programs to a statewide model, including across the 13 Infant, Child and Youth Area Mental Health and Wellbeing Services (refer to recommendation 3(2)(c)), to provide consistent and appropriately specialised treatment, care and support to children and young people in contact with, or at risk of coming into contact with, the youth justice system.	●	●	

Recommendation 38:

Providing safe and appropriate mental health treatment, care and support at Thomas Embling Hospital

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. in line with master planning for Thomas Embling Hospital and the proposal of the Victorian Health and Human Services Building Authority: a. refurbish the existing 136 beds; and b. by the end of 2026, provide an additional 107 beds, a small number of which should be allocated for people living with mental illness whose treatment, care and support requirements cannot be safely and appropriately met in acute inpatient settings or through the forensic community model (refer to recommendation 37(2)).	○——	——○	
2. provide up to 20 beds, in addition to the 107 beds referred to in recommendation 38(1) (b) and the additional beds in recommendation 11(3), to support people living with mental illness whose treatment, care and support requirements cannot be, or are unlikely to be, safely and effectively met in other extended rehabilitation settings.	○——	————	——○

Recommendation 39:

Supporting the mental health and wellbeing of people in rural and regional Victoria

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. in addition to ensuring rural and regional communities receive the benefits of the Royal Commission's recommended responsive and integrated mental health and wellbeing system: a. provide additional resources to enable mental health and wellbeing services operating in regional Victoria to deliver services to small or geographically isolated rural communities; and	●	●	
b. by the end of 2022, trial two new digital service delivery initiatives in rural and regional areas that meet the needs of local communities.	●		

Recommendation 40:

Providing incentives for the mental health and wellbeing workforce in rural and regional areas

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. address mental health and wellbeing workforce supply needs in rural and regional areas and establish an incentive scheme to: a. attract mental health and wellbeing workers to rural and regional mental health and wellbeing services; and b. retain mental health and wellbeing workers in such services.	○——	———	——○

Recommendation 41:

Addressing stigma and discrimination

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. fund and support the Mental Health and Wellbeing Commission (refer to recommendation 44) to work with a network of partners, including research organisations, to lead the design and delivery of anti-stigma programs that: a. continue on a long-term basis; and b. aim to reduce the impact of stigma in a range of settings including, but not limited to, healthcare settings, workplaces and schools.	○—	—	—○
2. design and deliver an anti-stigma grants program to: a. support community-led organisations and community members to deliver projects that challenge stigma in Victorian settings and communities; and b. focus, as an immediate priority, on communities and social groups at increased risk of stigma.	○—	—○	
3. conduct a comprehensive evaluation of anti-stigma efforts to: a. develop evidence about effective ways to address mental health stigma across Victoria; and b. inform the design and delivery of anti-stigma programs.	○—	—	—○
4. support and establish mechanisms to: a. address systemic issues of mental health discrimination; b. enhance individual access to legal protection from mental health discrimination; and c. enable one or two independent legal services with a demonstrated connection or ability to connect with people with lived experience of mental illness or psychological distress to initiate legal claims, including test cases relating to systemic mental health discrimination.	○—	—	—○

Recommendation 42:

A new Mental Health and Wellbeing Act

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
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

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
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.			○—○

Recommendation 44:

A new Mental Health and Wellbeing Commission

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
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

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
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

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
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.	○—○		

Recommendation 47:

Planning the new mental health and wellbeing system

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
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

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
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

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
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.	○—○		

Recommendation 50:

Encouraging national partnerships

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
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

Recommendation component	**Time horizon**		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
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*.		○	○

Recommendation 52:

Improving the quality and safety of mental health and wellbeing services

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
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

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
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.	○──	────	──○

Recommendation 54:

Towards the elimination of seclusion and restraint

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
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.	○———	———	———○

Recommendation 55:

Ensuring compulsory treatment is only used as a last resort

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
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

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
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.			●

Recommendation 57:

Workforce strategy, planning and structural reform

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
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

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
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

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
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, and 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.	○——	————	——○

Recommendation 60:

Building a contemporary system through digital technology

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. develop new statewide digital service requirements for all publicly funded mental health and wellbeing service providers that outline the consistent minimum digital functionality every provider should offer to consumers, families, carers and supporters.	●		
2. support mental health and wellbeing service providers to adopt digital technologies, where safe and appropriate to do so, through: a. developing regulatory arrangements; b. providing funding; and c. building the ability of mental health and wellbeing service providers to integrate digital technologies.	●	●	
3. enable mental health and wellbeing services to offer people living with mental illness or psychological distress access to devices, data and digital literacy support, where it is their preference to use digital services but they are otherwise unable to do so.	●	●	

Recommendation 61:

Sharing mental health and wellbeing information

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. develop policies, standards and protocols to enable the effective, safe and efficient collection and sharing of mental health and wellbeing information.	○—○		
2. set expectations that mental health and wellbeing services will provide opportunities for consumers to contribute to the information held about them and gain easy access to it.	○—○		
3. collaborate with consumers to introduce a consent-driven approach to information sharing with mental health and wellbeing services and individuals outside of the mental health and wellbeing system.	○—○		

Recommendation 62:

Contemporary information architecture

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. develop, fund and implement modern infrastructure for Information and Communications Technology (ICT) systems, including: a. a new statewide Electronic Mental Health and Wellbeing Record for mental health and wellbeing services to replace the current Client Management Interface/Operational Data Store (CMI/ODS) system;	○——	——○	
b. a review of data items currently required for service delivery and system administration, the removal of unused items and the addition of new items that accurately reflect mental health service activity and consumer outcomes;	○—○		
c. a new Mental Health Information and Data Exchange that allows interoperability between the proposed Mental Health and Wellbeing Record and other services' major ICT systems to support information sharing in real-time within and across services and sectors;		○——	——○
d. a new user-friendly online consumer portal (web and mobile) connected to the Mental Health Information and Data Exchange that allows consumers to view key information about themselves and authorise sharing of information with members of their care team, including families, carers and supporters; and		○—○	
e. a comprehensive data repository and associated clinical registries for mental health (within the recommended Mental Health Information and Data Exchange) that will support outcome measurement, future service planning, continuous improvement and mental health research.		○—○	

Recommendation 63:

Facilitating translational research and its dissemination

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. building on the interim report's recommendation 1, by the end of 2023, enable the Collaborative Centre for Mental Health and Wellbeing to: a. facilitate translational research throughout the mental health and wellbeing system, including in collaboration with other research centres and institutes; b. ensure new research aligns with initial reform priorities identified by the Royal Commission; c. strengthen and support a formal network of academic service leaders responsible for sharing and applying research in service settings; d. ensure that evidence informs workforce education and training, and promotes cultures of inquiry, innovation and learning; e. provide a 'clearing house' to collect, combine and share information from research, innovation projects and evaluations; and f. provide authoritative advice on evidence-informed approaches to treatment, care and support to inform policy development, planning and investment.	○───	───○	
2. identify and promote opportunities to increase collaboration in translational research on the mental health and wellbeing of infants, children and young people.	○───	───○	

Recommendation 64:

Driving innovation in mental health treatment, care and support

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. commission an existing entity to provide dedicated support and resources for innovation in mental health treatment, care and support.	○——	———	——○
2. fund this entity to: a. administer a dedicated mental health innovation fund for projects selected by an expert panel; b. establish and promote collaborative networks to drive and facilitate innovation in mental health treatment, care and support; and c. provide practical support to services to implement and test new approaches to mental health treatment, care and support.	○——	———	——○

Recommendation 65:

Evaluating mental health and wellbeing programs, initiatives and innovations

Recommendation component	Time horizon		
	Short (by end of 2022)	**Medium** (by end of 2026)	**Long** (by end of 2031)
1. set an expectation that adequate evaluation is a condition of funding for all new mental health and wellbeing programs, initiatives and innovations.	●		
2. develop and fund a strategy to ensure evaluation routinely informs the implementation of reforms and ongoing decision making about policies and investment.	●	●	
3. promote and improve evaluation practices throughout the mental health and wellbeing system by issuing guidance and facilitating access to evaluation expertise.	●	●	●

1 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 385.

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

3 Dr Dahle Suggett, *Occasional Paper No. 15: The Implementation Challenge: Strategy Is Only as Good as Its Execution*, 2011, p. 3.

4 Implementation is about putting decisions into practice, refer to: Bianca Albers, Mary Abdo and Robyn Mildon, *Implementing the Commission's Recommendations: Prepared by the Centre for Evidence and Implementation for the Royal Commission into Victoria's Mental Health System*, 2020, p. 2. The Commission arranged this report from the Centre for Evidence and Implementation to inform development of this chapter. The Commission acknowledges Bianca Albers, Mary Abdo and Robyn Mildon for this work.

5 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 568–570.

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

7 John Mendoza, Kathleen Margaret Griffiths and Sebastian Pascal Rosenberg, *Obsessive Hope Disorder: Reflections on 30 Years of Mental Health Reform and Visions for the Future: Summary Report*, 2013, p. 11.

8 The Victorian Mental Illness Awareness Council, *Correspondence to the RCVMHS: Governance in Mental Health*, 2020, p. 13.

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

10 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, pp. xiv and 22.

11 Albers, Abdo and Mildon, p. 1; Parenting Research Centre, pp. xv–xvi.

12 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 121.

13 *Joint Witness Statement of 'Mary Corbett' and 'Jacob Corbett' (pseudonyms)*, 25 June 2020, para. 119.

14 Mendoza, Griffiths and Rosenberg, p. 43.

15 Victorian Government, Announcement: Royal Commission into Mental Health Speech, 24 October 2018, p. 4.

16 Michael Mintrom, Deirdre O'Neill and Ruby O'Connor, 'Royal Commissions and Policy Influence', *Australian Journal of Public Administration*, 2020, 1–17 (pp. 4 and 15).

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

18 Throughout this chapter, the Commission defines 'implementation partners' or 'implementers' as all those involved in implementing the Commission's reform agenda. This includes the Victorian Government, the workforce, service providers, people with lived experience of mental illness or psychological distress, families, carers, supporters and the Victorian community more broadly. It also extends to involvement from the Commonwealth Government and other human services systems.

19 Parenting Research Centre, p. 90.

20 *Witness Statement of Dr Chris Groot*, 4 September 2019, para. 16; Professor Patrick McGorry, Mental Illness Is More Ubiquitous Than Cancer. How Can We Help the "Missing Middle"?, *The Guardian*, 25 April 2019, p. 2.

21 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 3 December 2020].

22 *Witness Statement of Professor Bruce Bonyhady AM*, 16 June 2020, para. 33.

23 Royal Commission into National Natural Disaster Arrangements, *Transcript of Proceedings, Day 29*, 5 August 2020, p. 2595.

24 Parenting Research Centre, p. 93.

25 *Witness Statement of Georgie Harman*, 1 July 2019, para. 106.

26 *Witness Statement of Associate Professor Ruth Vine*, 27 June 2019, para. 97.

27 Beyond Blue, Media Release: Beyond Blue Backs National Mental Health and Wellbeing Pandemic Response Plan, 15 May 2020, p. 1.

28 *Witness Statement of Professor Rob Moodie*, 9 June 2020, para. 15.

29 Patrick D McGorry and Matthew P Hamilton, 'Broken Promises and Missing Steps in Mental Health Reform', *Medical Journal of Australia*, 206.11 (2017), 487–489 (p. 488).

30 *Witness Statement of Kym Peake*, 24 July 2019, para. 188; Parenting Research Centre, p. 94.

31 Anne-marie Boxall, Chapter 11: Medicare: The Making and Consolidation of an Australian Institution, in *Successful Public Policy: Lessons from Australia and New Zealand* (Canberra: ANU Press, 2019), pp. 257–278 (p. 260); *Witness Statement of Kym Peake*, 2019, paras. 188–190.

32 *Witness Statement of Professor David Copolov AO*, 7 July 2020, para. 296(b).

33 Parenting Research Centre, p. 154.

34 *Witness Statement of Kym Peake*, 4 October 2020, para. 132.

35 Parenting Research Centre, p. 138.

36 *Witness Statement of Professor Patrick McGorry AO*, 22 June 2020, para. 143.

37 Royal Commission into Victoria's Mental Health System, I*nterim Report*, pp. 535–536.

38 Parenting Research Centre, pp. 138–139.

39 Madeline M Carter, *The Importance of Collaborative Leadership in Achieving Effective Criminal Justice Outcomes* (Center for Effective Public Policy, Department of Justice National Institute of Corrections, 2006), p. 3.

40 Grace Ann Rosile, David M Boje and Carma M Claw, 'Ensemble Leadership Theory: Collectivist, Relational, and Heterarchical Roots from Indigenous Contexts', *Leadership*, 14.3 (2018), 307–328 (pp. 309–311).

41 *Witness Statement of Kym Peake*, 2020, para. 138.

42 Parenting Research Centre, p. 158.

43 Carter, p. 3.

44 *Witness Statement of Professor Patrick McGorry AO*, para. 144.

45 *Witness Statement of Associate Professor Simon Stafrace*, 14 August 2020, para. 13.

46 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 535–536.

47 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 537; *Witness Statement of Associate Professor Simon Stafrace*, 2020, paras. 60–61.

48 *Witness Statement of Janet Meagher AM*, 1 July 2019, para. 36.

49 *Witness Statement of 'Rachel Bateman' (pseudonym)*, 16 June 2020, para. 56.

50 Cath Roper, Flick Grey and Emma Cadogan, *Co-Production: Putting Principles into Practice in Mental Health Contexts*, 2018, p. 2.

51 Roper, Grey and Cadogan, p. 4.

52 *Witness Statement of Cath Roper*, 2 June 2020, paras. 8–9; Roper, Grey, and Cadogan, pp. 5–6.

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

54 Julie Slay and Lucie Stephens, *Co-Production in Mental Health: A Literature Review*, 2013, p. 16; Mike Spencer, Ruth Dineen and Andrew Phillips, *Co-Producing Service—Co-Creating Health: Tools for Improvement*, 2013, p. 10.

55 *Witness Statement of Cath Roper*, para. 17; *Witness Statement of 'Rachel Bateman' (pseudonym)*, para. 59.

56 *Witness Statement of Erandathie Jayakody*, 4 June 2020, para. 69.

57 *Witness Statement of Dr Melissa Petrakis*, 11 May 2020, para. 50(b).

58 Roper, Grey and Cadogan, p. 5.

59 RCVMHS, *Consumer Foundations Working Group Meeting Summary*, October 2020, p. 19.

60 *Witness Statement of Indigo Daya*, 12 May 2020, para. 86.

61 Albers, Abdo and Mildon, p. 16.

62 *Witness Statement of Cath Roper*, para. 33.

63 Albers, Abdo and Mildon, pp. 16–17.

64 Roper, Grey and Cadogan, p. 5.

65 Indigo Daya, Bridget Hamilton and Cath Roper, Authentic Engagement: A Conceptual Model for Welcoming Diverse and Challenging Consumer and Survivor Views in Mental Health Research, Policy, and Practice, *International Journal of Mental Health Nursing*, 29.2 (2020), 299–311 (pp. 300 and 309).

66 Roper, Grey and Cadogan, pp. 6 and 10; *Witness Statement of Erandathie Jayakody*, para. 72(c).

67 Anonymous, *Brief Comments to the RCVMHS: SUB.0001.0003.0021*, 2019, p. 5.

68 *Evidence of Al Gabb*, 15 July 2019, p. 950.

69 Anne-Marie Skegg, *Submission to the RCVMHS: SUB.0002.0028.0623*, 2019, p. 2.

70 *Witness Statement of Kym Peake*, 2020, para. 139.

71 *Witness Statement of David Pearl*, 11 May 2020, para. 21.

72 Anonymous 419, *Submission to the RCVMHS: SUB.0002.0013.0002*, 2019, p. 5.

73 National Mental Health Commission, *Consumer and Carer Engagement: A Practical Guide*, 2019, p. 4.

74 Consumer Foundations Working Group, *Correspondence to the RCVMHS: Consumer Leadership and Mobilisation*, 2020, p. 8.

75 ORIMA Research, *Mental Health Workforce Survey*, 2020, p. 37.

76 ORIMA Research, p. 40.

77 *Commission Analysis of ORIMA Research, Mental Health Workforce Survey, 2020*.

78 *Commission Analysis of ORIMA Research, Mental Health Workforce Survey, 2020*.

79 *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 45.

80 Australian Evaluation Society, Talking About Evaluation, <aes.asn.au/talking-about-evaluation>, [accessed 12 October 2020].

81 Catherine Althaus, Peter Bridgman and Glyn Davis, Chapter 11: Evaluation, in *The Australian Policy Handbook: A Practical Guide to the Policy-Making Process*, Sixth Edition (Allen and Unwin Academic, 2017), pp. 200–214 (p. 209).

82 Department of Treasury and Finance, *Performance Management Framework: For Victorian Government Departments March 2016*, 2017, p. 32.

83 Evert A. Lindquist and John Wanna, Chapter 1: Delivering Policy Reform: Making It Happen, Making It Stick, in *Delivering Policy Reform: Anchoring Significant Reforms in Turbulent Times* (Canberra: ANU E Press, 2011), pp. 1–12 (p. 8).

84 Parenting Research Centre, pp. 99 and 137.

85 Joannah Luetjens, Michael Mintrom and Paul 't Hart, *Successful Public Policy: Lessons from Australia and New Zealand* (Canberra: ANU Press, 2019), p. 19.

86 Nina Hemmings and others, *Achieving Scale and Spread: Summary of Learning for Innovators and Policy-Makers*, 2020, p. 6.

87 Albers, Abdo and Mildon, p. 10.

88 Hemmings and others, p. 9.

89 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, 2020, pp. 1118–1119.

90 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1234.

91 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1123.

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

93 The Honourable Josh Frydenberg MP, Treasurer of the Commonwealth of Australia, National Accounts June Quarter Statement Speech, 2 September 2020, <ministers.treasury.gov.au/ministers/josh-frydenberg-2018/speeches/national-accounts-june-quarter-statement>, [accessed 21 December 2020].

94 ABC News, Australia "Emerges from Recession" After GDP Figures Show Economy Growing for the First Time This Year, 2 December 2020, <www.abc.net.au/news/2020-12-02/australia-september-quarter-economic-growth-gdp-figures/12934336>, [accessed 3 November 2020].

95 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 361–362.

96 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, 2020, p. 153.

97 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 543–544.

98 The Honourable Daniel Andrews MP, Premier of Victoria, Media Release: Putting The Mental Health of Victorians First, 12 November 2020, <www.premier.vic.gov.au/putting-mental-health-victorians-first>, [accessed 12 November 2020]; Victorian Government, *Victorian Budget 2020–21: Treasurer's Speech: Budget Paper No. 1*, 2020, p. 11.

99 Victorian Government, *Victorian Budget 2020–21: Treasurer's Speech: Budget Paper No. 1*, p. 11.

100 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 374–378

101 Productivity Commission, *Mental Health Inquiry Report*, Volume 2, p. 172.

102 Elaine Henry, 'Chapter 11: Perspectives of Community Organisations: The Smith Family Experience', in Collaborative Governance: A New Era of Public Policy in Australia? (Canberra: ANU E Press, 2008), pp. 113–120 (p. 117).

103 Janine O'Flynn, Chapter 17: Elusive Appeal or Aspirational Ideal? The Rhetoric and Reality of the "Collaborative Turn" in Public Policy, in Collaborative Governance: A New Era of Public Policy in Australia? (Canberra: ANU E Press, 2008), pp. 181–195 (p. 185).

104 *Witness Statement of Dr Hila Haskelberg, 13 July 2020*, para. 35(a).

105 *Witness Statement of Dr Hila Haskelberg*, para. 35.

106 *Witness Statement of Dr Tricia Szirom*, 12 May 2020, para. 36.

107 Beth Noveck and Rod Glover, *Today's Problems, Yesterday's Toolkit (Australia and New Zealand School of Government* (ANZSOG), 2019), p. 15

108 RCVMHS, *Public Health Roundtable: Record of Proceedings*, 2020.

109 *Witness Statement of Associate Professor Ruth Vine*, 2019, para. 111.2; Jennifer Doggett, The Personal and the Political, Inside Story, 15 June 2019.

110 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 172–177; Victorian Auditor-General's Office, Access to Mental Health Services, 2019, p. 25.

111 Family Violence Reform Implementation Monitor, *Report of the Family Violence Reform Implementation Monitor as at 1 November 2019*, 2020, p. 46.

112 *Bushfires Royal Commission Implementation Monitor: Final Report, 2012*, p. 224.

113 Commission analysis of the Department of Health (Commonwealth), National Mental Health Service Planning Framework, 2018; Department of Environment, Land, Water and Planning, Victoria in Future 2019, 2019; Australian

Institute of Health and Welfare, Mental Health Services in Australia: Specialised Mental Health Care Facilities 2017–18 Tables Table FAC.3.

114 Albers, Abdo and Mildon, p. 20.

115 Roper, Grey and Cadogan, p. 7.

116 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).

117 Albers, Abdo and Mildon, pp. 13–15; *Witness Statement of Kym Peake*, 2020, paras. 141–142 and 145(d).

118 Parenting Research Centre, p. 91; *Witness Statement of Kym Peake*, 2020, para. 132.

119 RCVMHS, *Consumer Foundations Working Group Meeting Summary*, p. 18.

120 Albers, Abdo and Mildon, p. 20.

121 Family Violence Reform Implementation Monitor, *Report of the Family Violence Reform Implementation Monitor as at 1 November 2017*, 2017, p. 12.

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

123 Crick Lund and others, Social Determinants of Mental Disorders and the Sustainable Development Goals: A Systematic Review of Reviews, *The Lancet Psychiatry*, 5 (2018), 357–369 (p. 357).

124 Commonwealth Government, p. 278.

125 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].

126 The Victorian Mental Illness Awareness Council, p. 13.

127 *Witness Statement of Lin Hatfield Dodds*, 15 June 2020, para. 47.

128 Albers, Abdo and Mildon, pp. 20–21.

129 Family Violence Reform Implementation Monitor, *Report of the Family Violence Reform Implementation Monitor as at 1 November 2018*, pp. 11–12.

130 Family Violence Reform Implementation Monitor, *Report of the Family Violence Reform Implementation Monitor as at 1 November 2018*, p. 14.

131 Parenting Research Centre, pp. 142–143.

132 Parenting Research Centre, p. 144.

133 Parenting Research Centre, p. xvii.

134 Victorian Bushfires Royal Commission, *Volume 2, Chapter 12: Monitoring Implementation*, 2010, p. 404.

135 Royal Commission into Family Violence, *Report and Recommendations, Volume VI*, 2016, p. 133.

136 Parenting Research Centre, p. 146.

137 Parenting Research Centre, p. 87.

138 Parenting Research Centre, p. 147.

139 *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 67(d).

140 *Witness Statement of Associate Professor Ruth Vine*, 2019, para. 125.

141 Parenting Research Centre, p. 157.

142 *Witness Statement of Associate Professor Simon Stafrace*, 2020, para. 67(d).

143 Albers, Abdo and Mildon, p. 18.

144 Parenting Research Centre, p. 157.

145 Albers, Abdo and Mildon, p. 19.

146 Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report: Making Institutions Child Safe, Volume 6*, 2017, p. 19.

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

148 Family Violence Reform Implementation Monitor, *Report of the Family Violence Reform Implementation Monitor as at 1 November 2017*, p. 4.

149 Family Violence Reform Implementation Monitor, *Report of the Family Violence Reform Implementation Monitor as at 1 November 2017*, p. 4.

150 Albers, Abdo and Mildon, p. 18.

A note from the CEO

A message from the CEO

Working on a royal commission is an extraordinary privilege. From the first days of this Commission, in which the Chair and I met with commissioners and CEOs of previous royal commissions, through to preparing the final report for printing and delivery to the Governor, it has been clear that this opportunity was different to many others.

As royal commissions before us showed, the most rewarding part of conducting a commission is engaging with people and learning from the experiences they share. Thousands of people—people with lived experience of mental illness or psychological distress, families, carers and supporters, and people who work in and manage the system—gave their time and wisdom to the Commission. From all over Victoria, and indeed other parts of Australia and overseas, people came forward, voluntarily, to contribute, and the Commission encouraged them to do so in many different ways. The experience of listening to people's thoughts and aspirations, and the collective desire to create a better future, gave meaning and purpose to the Commission. This sense of shared hope is reflected in this report.

There were many special moments during the course of our work, in the sharing of stories, that went to the heart of human experience. Indeed, a royal commission is really a series of these special moments. Some of them were shared publicly, in community consultations, in which many people, sitting in deep grief, were comforted by strangers. Some contributions were more private, sent anonymously to the Commission. For many, it took a lot of courage to take part. Commission staff will long remember the strength of the people who stood to take the microphone, or even a seat at a table, at the community consultations. There were many occasions at our public hearings too, where formality gave way to emotion—not just for the witnesses sharing their experience, but also for Commission staff and Commissioners. Finally, people said they felt 'heard', and for some this was the first time they felt their ideas and aspirations were valued. Many carers and family witnesses told us a heavy weight they had carried was lifted by the public acknowledgment that it was not them who had failed their loved one, but the system.

Moments like these highlighted the importance of a royal commission as a vehicle for engagement and change. There is no doubt that the lives of all Commission staff have been enriched by the experiences shared, and by the community's generosity towards our work.

Establishing a royal commission

From the outset, how the Commission was constituted was deemed just as important as its policy and legal work. Selecting staff with the right skillsets and characteristics was a priority. We were guided by previous royal commissions, and paid attention not only to the formal requirements of a royal commission, but also to what was needed to respect and harness the goodwill demonstrated by the community.

The Chair and I focused on the qualities we required for a diverse, yet united team. We were influenced in particular by the knowledge of the executives of the Royal Commission into Institutional Responses to Child Sexual Abuse, whom we consulted in our formative stages.

They advised that we would require staff with endurance and, in equal measure, the nature to treat people engaging with the Commission with kindness and respect. They spoke of the importance of gestures that made witnesses feel valued—opening their car door when they arrived at a hearing, making a follow-up call afterward—as being critical to the process, and to how those involved would remember their experience. This wisdom guided us in building our team, and we selected every staff member with these characteristics in mind.

We were also encouraged to ensure that the diversity of skills and teams present did not result in division. A royal commission is a pressured environment, united by purpose but presented with many pathways to reach the end point, all of them unrelenting and exhausting. It was necessary to ensure all teams, legal and policy, and the community engagement team, worked together and recognised the separate but critical contributions each made.

I am proud to say that despite the difficulty and operational demands of forming a royal commission, we did have the team we wanted: people committed to the purpose of the Commission, with respect for its process, each other and the community. The Commission worked harmoniously, and it was a privilege to work alongside all staff, the Counsel Assisting appointed by the Chair, our contractors, the Expert Advisory Committee and Consumer Foundations Working Group, and our legal firm, Herbert Smith Freehills.

The operations of the Commission

The Commission operated during 2019 and 2020, years that will long be marked in Victoria's history for two devastating events: the 2019–20 summer bushfires and the COVID-19 pandemic.

The impacts of these events, and the related uncertainties, tragedies and losses, influenced our work. These forces shaped the mental health system, and the wellbeing of communities, as the Commission deliberated. As explained throughout this report, the focus of our work became how to best support people through crisis and tragedy and bolster the system's long-term adaptability.

The pandemic also changed the way we worked, with staff spending most of 2020 working remotely. This presented challenges. Some, like the cancellation of our final round of public hearings, were visible, while others were less so, such as the personal isolation staff felt and the challenge of connecting ideas at a distance. Yet, undeterred and motivated to ensure the Commission delivered on its commitment to transform the Victorian mental health system, staff adapted to the new arrangements and worked tirelessly to ensure the Commission's work was done.

Leading the staff through the Commission's enormous work program, including the unexpected challenges 2020 brought, was a remarkably talented and thoughtful executive leadership group. Listed in the order they started at the Commission, and noting some stayed for the duration while others gave the time they could, they are: Maria Perera, Luke Horwill, Phil Ames, Fayyaz Khan, Nicola Farray, Rhys Benny, Kerin Leonard, Phuong Nguyen, Luke Bo'sher, Tessa Piper, Charlotte Frew, James Lavery, Erica Grundell and Caroline Aebersold. I also acknowledge the contribution of Dan Jefferson, who stood in briefly as Interim CEO while

I was seconded to the Department of Health and Human Services to assist with the response to the COVID-19 pandemic.

I also acknowledge the persistence and talents of my Strategic Adviser, Shane Robertson, and the deliberate and reflective work of both Cath Roper, Lived Experience Adviser, and the Commission's Aboriginal Adviser, Nicole Cassar.

The Department of Health and Human Services and the Department of Premier and Cabinet were critical in the Commission's establishment phase, deploying key staff to assist in its early weeks. In particular I want to thank Greg Wilson, Emma Fenby and Alison Rutherford. I am also grateful for the early support of Ben Rimmer, who joined briefly as a strategic adviser, and the ongoing support of Ross Broad, Director, Royal Commission Engagement Branch, Department of Health and Human Services. Mr Broad coordinated responses to the Commission's Notices to Produce and numerous requests it made for information from multiple government departments.

The operational aspects of the Commission and the work of its leadership team and other staff are presented in the following chapters. These provide a formal record in the hope it supports future royal commissions as we have been supported by those before us. The chapters also explain the expectation we set to work to the highest standards of transparency and integrity and as prescribed by the *Inquiries Act 2014* (Vic). The Commission's policies and protocols now form part of the public record.

Innovation in royal commissions

Each royal commission is established in unique circumstances, and each pushes new frontiers. These efforts often pave the way for those that come after them. Because the 2009 Victorian Bushfires Royal Commission reached into communities, holding gatherings in town halls, for example, this Commission did not feel that its inquiry should be confined to a hearings room.

The 2015 Royal Commission into Family Violence showed how royal commissions could focus on policy with an eye to the future, rather than only on past events. This example, too, encouraged us to think differently, and this is evident in the 'systems design' approach that informed our work.

This Commission chose to harness the licence its letters patent gave it to go beyond system improvement and to look forward to the future—and deliver a complete redesign of Victoria's mental health system. In many respects, the Commission was a leader of systems change practice. It sought the input of people with experience in diverse areas of business, academia, systems engineering and design, implementation science, public policy, regulation, digital services and social innovation. Many of these people had no direct expertise in mental health, but enriched the Commission's ability to 'think in systems'. In particular, they helped the Commission to see and understand the complexity of Victoria's mental health system and identify ways to transform it. The Commission particularly acknowledges those who advised it through its systems advisory function.

The Commission has also reflected on the Victorian Government's commitment to implement its recommendations. This commitment, along with the Commission's focus on the future system, has been instrumental in shaping the work. The focus shifted away from changing individual services and programs, toward the full system—its structures, practices, services, policies, resources, power dynamics, relationships and connections, values and beliefs—that, collectively reformed, will deliver better outcomes for Victorians.

We hope that in some small way, we opened up new possibilities for royal commissions to come.

Final words

All royal commissions will unfold differently, yet every CEO who establishes one will be challenged by the rapid momentum they generate, the expectations they set, and the pressing need for integrity of process in the face of tight timelines and significant legal and policy questions.

The work of the Commission, as described in this report, speaks to the dedication of the staff and the rigorous processes followed. It is an important record for Victoria.

The Commission's task—to redesign a mental health system—was enormous. Despite searching, we could not find an example of where an inquiry had been given a comparable challenge.

To undertake this momentous work with the Commission staff, to work alongside the Chair of the Commission and with the other Commissioners, and with Counsel Assisting and the legal team—and to meet so many of the people who shared their stories—has been an honour.

Jodie Geissler
Chief Executive Officer,
Royal Commission into
Victoria's Mental Health System

Chapter 38

The establishment of the Commission

38.1 Inquiry announced

On 24 October 2018, the Victorian Premier, the Hon. Daniel Andrews MP, announced that, if re-elected, the government would commit to a royal commission into mental health.[1] Reflecting on the personal mental health experiences of Victorians that he had heard, the Premier said the 'royal commission would be for everyone in this state—and ultimately, this country—who has ever felt like they had nowhere to turn, no one to rely on and nothing to hope for',[2] and that it would 'bring mental health out of the darkness into the blinding light'.[3]

On 22 February 2019, Her Excellency, the Hon. Linda Dessau AC, the Governor of the State of Victoria, formally established the Royal Commission into Victoria's Mental Health System.

The same day, the Premier said the mental health system is 'a broken system and until we acknowledge that and set a course to find those answers and a practical plan for the future, people will continue to die, people will continue to be forever diminished'.[4]

The Premier had previously committed to implementing all of the Commission's recommendations.[5] The letters patent required the Commission to report on 'how Victoria's mental health system can most effectively prevent mental illness, and deliver treatment, care and support, so that all those in the Victorian community can experience their best mental health, now and into the future'.[6] The letters patent were critical in guiding the work of the Commission over the life of the inquiry.

The work of the Commission was also bound by the *Inquiries Act 2014* (Vic) which outlines the conduct of royal commissions.[7] The Commission conducted the inquiry in line with the requirements of procedural fairness, letters patent and the Inquiries Act.[8] The Commission was supported by the Department of Premier and Cabinet, which assisted with the establishment phase, and some operational and corporate functions.

Appendix A.1 shows the Commission's letters patent.

38.2 Interim report delivered

The Commission delivered an interim report on 27 November 2019. The report outlined the challenges facing Victoria's mental health system, and made nine recommendations in response to some of the most immediate challenges faced by Victorians with poor mental health, by families, carers and supporters, and those working in the sector.[9]

38.3 Inquiry extended

The letters patent required the Commission to deliver a final report by 31 October 2020.[10] However, as a result of the impact of COVID-19—and the need to find alternative ways of working with health services, government departments and people with lived experience—the Commission requested a three-month extension.[11]

On 26 May 2020, the Governor formally extended the Commission's final report deadline to 5 February 2021.[12]

Appendix A.2 shows the Commission's amended letters patent granting the extension.

The extension allowed the Commission to explore mental health and wellbeing issues that became increasingly prominent during the COVID-19 pandemic, such as loneliness and social isolation and the importance of telehealth.

38.4 Impact of COVID-19

In March 2020, Victoria began adopting measures to prevent the transmission of COVID-19. The Premier recommended that Victorians who were able to work from home should do so to limit their exposure to the virus. Accordingly, Commission staff began working from home from 23 March 2020.

The pandemic had an impact on the Commission's operations. Like many Victorians, Commissioners and the Commission staff had to adapt quickly. They continued to engage with the community, meet with interested parties, workshop ideas, collaborate, research and write—all remotely. One important impact of the pandemic on the Commission was cancelling the second round of public hearings, which were to take place in April 2020. The Commission announced the cancellation of the hearings on 19 March 2020, during the early stage of the COVID-19 pandemic.[13] This was in response to government health advice to protect the health and safety of participants and the general public.

A COVIDSafe Plan was established in the Commission under the direction of a small committee. This plan outlined the measures to be put in place to minimise the risk of transmitting COVID-19 in the workplace, and appropriate procedures to ensure the health and safety of Commissioners and staff while working in the office and remotely.

To support staff wellbeing during their 10 months of remote working, and at a time of such uncertainty, the Commission put a number of measures in place. These included regular counselling sessions for staff, and wellbeing workshops to help staff deal with challenges such as change, social isolation and balancing work with caring responsibilities. This was complemented with flexible working arrangements, regular discussions among the leadership team, and updates from the Chair and CEO to staff, including about how to best manage the impacts of COVID-19.

The Commission also implemented security measures to ensure documents were protected and processes were maintained during remote working. This included the delivery of information management and security training, and regular communication to staff about risk management, confidentiality and document security protocols.

To ensure calls from the public were being attended to, phone lines were redirected to staff working from home, making sure all calls from the public could be answered, and that support was provided when required.

38.5 Commissioners appointed

The Governor appointed four Commissioners to lead the inquiry, based on their expertise in public policy and the mental health sector.[14]

Penny Armytage AM (Chair)

Penny Armytage AM has held senior executive positions in the Victorian public service, including Secretary of the former Department of Justice.

Penny has overseen major policy and service delivery reforms in the justice and human services sectors. She has worked extensively with ministers, department and agency leaders, and heads of jurisdiction across the Victorian public sector and nationally.

Penny conducted the *Youth Justice Review and Strategy: Meeting Needs and Reducing Offending* review and was chair of the Independent Inquiry into the Environment Protection Authority.

She has also been the chair of the Transport Accident Commission board and president of the board of Berry Street, an independent family services organisation. She was the National President of the Institute of Public Administration Australia.

Dr Alex Cockram (Commissioner)

Dr Alex Cockram is a psychiatrist, a clinician and a leader in mental health and acute health care. Alex is an advocate for workforce training and development that supports better patient and community outcomes.

Alex has advised government in areas including mental health, alcohol and other drug service system reform, and on the interface between the National Disability Insurance Scheme and the health system.

She has helped improve outcomes for consumers, families and carers, working with key stakeholders to develop regional strategies that better integrate mental health and alcohol and other drug service systems in primary, community and specialist care settings.

Alex was previously the CEO of Western Health, before she joined the board of Epworth HealthCare group, one of Australia's largest not-for-profit healthcare providers. She is also a board director of the Central Adelaide Local Health Network.

Professor Allan Fels AO (Commissioner)

Professor Allan Fels AO has held several senior chair positions throughout his career, including chair of the Australian Competition and Consumer Commission, chair of the National Mental Health Commission and chair of the Haven Foundation, which provides accommodation, care and support for people with lived experience of mental illness.

Allan is on the board of Mind Australia and a patron of Mental Health Victoria. He also has a daughter with schizophrenia and is a carer.

Allan is an honorary professor at the University of Melbourne, Monash University and Oxford University.

Professor Bernadette McSherry (Commissioner)

Professor Bernadette McSherry is an internationally recognised legal academic in criminal law and mental health law. Bernadette is the Foundation Director of the Melbourne Social Equity Institute and Professor of Law at the University of Melbourne.

Throughout her career, Bernadette has held many senior positions such as the Louis Waller Chair of Law and Associate Dean (Research) in the Faculty of Law, Monash University. She was appointed an Australian Research Council Federation Fellow and established the Centre for the Advancement of Law and Mental Health as part of this prestigious fellowship.

The Victorian Government appointed Bernadette to the Complex Adult Victim Sex Offender Management Review Panel. She has also served as a member of the Victorian Government's Criminal Law Justice Statement Advisory Group and the Expert Advisory Panel, Victorian Government Courts and Programs Development Unit.

Bernadette is the immediate past president of the Australian and New Zealand Association of Psychiatry, Psychology and Law. For seventeen years, she was a legal member of the Mental Health Tribunal of Victoria. She is currently a Commissioner of the Victorian Law Reform Commission.

38.6 Staff at the Commission

Commission staff came from a variety of backgrounds with a vast array of skills and experience. They joined the Commission from the Victorian public sector, the health sector, non-government organisations and the private sector. They brought a depth of skill in policy and research, working with the community, corporate operations and in legal, data management and support functions.

Many staff had lived experience of mental illness or psychological distress, including as consumers and carers. The Commission also employed Ms Cath Roper as a special adviser on consumer lived experience, and Ms Nicole Cassar as a special adviser on Aboriginal engagement.

There was a high level of flexibility in work arrangements due to the nature of the Commission's work. Some staff members worked for the full length of the Commission and some joined for short-term engagements; work ranged from part to full-time. This level of flexibility occurred across all teams.

Led by Jodie Geissler, CEO, and supported by the Executive Leadership Group, Commission staff were organised into four branches: the Policy and Research branch, the Community Engagement branch, the Advisors and Executive Support branch, and the Corporate Services branch.

The Commissioners thank all staff for their contribution.

Table 38.1 lists all the staff who contributed to the Commission's work.

Table 38.1: Commission staff

Name	Name	Name
Dr Caroline Aebersold	Stephen Gow	Lisa Orth
Phil Ames	Miriam Greig	Mandy Pateras
John Argyropoulos	Robert Gruhn	Maria Perera
David Arkell	Erica Grundell	Julie Petering
Rhys Benny	Christian Habla	Deirdre Pinto
Madelaine Blomfield	Heather Harding	Tessa Piper
Jane Blurton	Matthew Haworth	Estelle Polevoy
Troy Bogaart	Sarah Jane Haywood	Dr Sarah Pollock
Luke Bo'sher	Claire Hopkins	Shane Robertson
Daizee Boucher	Luke Horwill	Louise Robinson
Teresa Calabria	Karen Hutchinson	Joanna Rolfe
Nicole Cassar	Renee Imbesi	Cath Roper
Gavin Chandra	Laura Irving	Mark Rosales
Rebecca Clark	Melissa Iskov	Theresa Russo
Sarah Cohen	Chelsea Ives	Alison Rutherford
Nicholas Coxon	Fayyaz Khan	Georgie Scanlon
Megan Ault Cullen	Julia Lambert	John Schauble
Emily Debney	Timothy Lambert	Gajan Selvarajah
Louise De Gannes	Laura Lane	Alanna Symons
Ken De Vries	James Lavery	Gemma Tiernan
Matthew Downey	Kerin Leonard	Dr Emma Tinning
Adam Duke	Samantha Loff	Alanna Trembath
Rebecca Duke	Grace McCoy	Dr George Vasilev
Indhia Duncan	Cosima McRae	Ruth Ward
Nicola Farray	Emma Moffatt	Phil Watson
Emma Fenby	L Gopika Murthy	Janet Westwood
Haylea Fitzsimmons	Archana Naidu	Ben Whitton
Dr Holly Foster	Jacinta Nancarrow	Greg Williamson
Charlotte Frew	Dr Phuong Nguyen	Claire Wong
Jenny Galloway	Ilona Nicola	Christopher Woodall
Naomi Goldwater	Rebecca Olsen	

Note: The Commission had a core contingent of 45 staff. This is an exhaustive list and includes staff who worked for the Commission for short engagements and on a part-time basis. It also includes secondees who were engaged to assist the Commission for a period of time.

38.7 Expert Advisory Committee appointed

As the letters patent directed, the Commission established an eight-member Expert Advisory Committee.[15] The committee brought a wealth of knowledge to the Commission, including lived experience, and professional and sector experience with Victoria's mental health system.

Professor Patrick McGorry AO (Chair)

Patrick is the Executive Director of Orygen and Professor of Youth Mental Health at the University of Melbourne. He is a world leader in mental health innovation, advocacy and reform. In 2010, Patrick was selected as Australian of the Year. As a psychiatrist, Patrick has worked in mental health for the past 40 years and is a prominent researcher in early psychosis, youth mental health and clinical research more broadly.

Anne Doherty

Anne has extensive experience in leading and managing clinical mental health services, and has a deep knowledge of clinical and corporate governance. Anne has worked in a range of senior executive roles and has been a member of boards and state committees. She has held leading executive portfolios at Monash Health and is a board member at the Butterfly Foundation.

Honor Eastly

Honor is a mental health advocate who specialises in consumer engagement, lived experience and peer workforce initiatives. Honor is a critically acclaimed podcaster and co-founder of The Big Feels Club, a public-facing mental health resource and peer support initiative.

Julian Gardner AM

Julian has held several senior positions within the Victorian mental health sector and public sector. Most recently, Julian was chair of the Mind Australia board, and has previously held positions as the chair of advisory and consultation groups for the review of the Victorian Mental Health Act. From 2000 to 2007, he was the Public Advocate for Victoria.

Erandathie Jayakody

Erandathie has a lived experience of mental ill health and recovery. Erandathie is a member of the Mental Health Tribunal and an Assistant Director, Strategic Advice, Psychosocial Disability at the National Disability Insurance Agency. She is the co-editor of the book *Peer Work in Australia: a new future for mental health*.

Dr Gerry Naughtin

Gerry has had an extensive career in human services in the disability and aged care sectors, and has a strong history of promoting consumer and carer participation in sector reform. Gerry is the strategic adviser for mental health in the Strategic Advisers and Research Division of the National Disability Insurance Agency, and was previously the CEO of Mind Australia.

Distinguished Professor James Ogloff AM

James is a clinical and forensic psychologist, academic, researcher and practitioner with extensive experience in clinical and forensic mental health. He is Executive Director of Psychology Services and Research at the Victorian Institute of Forensic Mental Health (Forensicare) and a Distinguished Professor and Director of the Centre for Forensic Behavioural Science at Swinburne University.

Jim Williamson

Jim started his career as a secondary school teacher and lecturer, and has worked as a senior policy manager and consultant in public policy. He holds several advocacy roles impacting on local government areas in the western region of Melbourne and has an interest in developing a mental health system with a stronger community focus.

38.8 Counsel Assisting appointed

Lisa Nichols QC was appointed Senior Counsel Assisting the Commission in March 2019. She served until 22 October 2019, when she was appointed as a Judge of the Supreme Court of Victoria. Stephen O'Meara QC was engaged as Senior Counsel Assisting the Commission from 23 December 2020 until the end of the Commission. Junior Counsel Assisting, Georgina Coghlan SC and Fiona Batten, supported the Commission for its duration.

1 Victorian Government, Announcement: Royal Commission into Mental Health Speech, 24 October 2018, p. 4.

2 Victorian Government, Announcement: Royal Commission into Mental Health Speech, p. 5.

3 Victorian Government, Announcement: Royal Commission into Mental Health Speech, p. 4.

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

5 Victorian Government, Announcement: Royal Commission into Mental Health Speech, p. 4.

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

7 *Inquiries Act 2014* (Vic), Part 2, Division 3.

8 *Inquiries Act 2014* (Vic), sec. 12.

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

10 Victorian Government, Royal Commission into Victoria's Mental Health System—Letters Patent, para. II(b).

11 The Honourable Daniel Andrews MP, Premier of Victoria, Media Release: Statement On Extension For Royal Commission, 5 May 2020, <www.premier.vic.gov.au/statement-extension-royal-commission>, [accessed 29 October 2020].

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

13 RCVMHS, Statement on Public Hearings, 19 March 2020.

14 The Honourable Daniel Andrews MP, Premier of Victoria, Media Release: Experts to Lead the Mental Health Royal Commission, 24 February 2019, <www.premier.vic.gov.au/experts-lead-mental-health-royal-commission>, [accessed 1 September 2020].

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

Chapter 39

The work of the Commission

39.1 The Royal Commission

The Commission's task was a policy-based inquiry, with recommendations to inform the future design of the mental health system, rather than an investigation into individual cases or particular events. This policy focus meant the Commission could gather evidence in ways that extended beyond traditional hearings and submissions.

The Commission's approach to its inquiry was also informed by the complexity of its task and the level of change to the mental health system that is required. As outlined in Chapter 2: *The Commission's approach to reform*, the Commission applied a systems change framework to its work. Within this context, the Commission used a range of processes to develop its understanding of the existing mental health system and to inform its recommendations about the future system design. These processes included formal inquiry mechanisms, such as gathering evidence through submissions and public hearings, drawing on academic research and literature, and community engagement.

The Commission's letters patent, which were informed by more than 8,000 community contributions,[1] asked it to 'engage widely'.[2] The letters patent also identified major population groups for the Commission to consider in making its recommendations: in particular, people who are at greater risk of experiencing poor mental health.[3] In considering this, the Commission committed to hear and take into account the needs of diverse communities in Victoria.

As the Premier stated at the announcement of the extension of the Commission, '[f]rom the outset of the Royal Commission, we understood that the voices of Victorians must be at the heart of our reform.'[4]

The Commission made it possible for new insights about the mental health system to be heard and incorporated into the future system's design, by supporting continued conversations with people with diverse perspectives, expertise and experience throughout its inquiry.

39.1.1 The voice of people with lived experience

The Commission's letters patent required it to have regard to the 'evidence of people with lived experience'[5] and directed the Commission to 'follow best practice approaches to engagement with people with lived experience, including the provision of opportunities for them to share their experiences while recognising that many of them will need support to disclose trauma'.[6]

While the Commission understands that the term lived experience is used and understood in different ways by different people, for the purpose of this report, the Commission builds on its interim report and refers to people with lived experience to include:

- 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.[7]

The Commission recognises that the needs of each group can be different, that one individual can be in both groups, and that individuals identify in many ways.

It also recognises that there is a power imbalance when it comes to involving people with lived experience in policy reform and system design, as described in more detail in Chapter 2: *The Commission's approach to reform*.

Ms Janet Meagher AM, an advocate for people with lived experience of mental illness, highlighted in her witness statement that:

> **Often people with personal experience of mental illness have been taught that others are the experts, that there is a professional who has 'the answer', knows what is best and that there are only limited, rigid versions of the way forward.**[8]

The Commission went further than the requirements of its letters patent to have 'regard to … the evidence of people with lived experience'.[9] It continued to draw on the perspectives and analysis of people with lived experience throughout all phases of its system design work, through carefully designed engagement opportunities.

39.2 Overview of the Commission's engagement

As described above, the Commission engaged widely to gather evidence to inform its findings and recommendations, including contact with the Victorian community to hear their experiences of and suggestions for the future of the mental health system. The Victorian community has made more than 12,500 contributions to inform the Commission's work, in addition to more than 8,000 submissions that shaped the terms of reference before the work began.

All inputs the Commission has received will be delivered to the Public Record Office Victoria at the end of the Commission. This record of the Commission's work and contributions made to it will include submissions, witness statements and records of meeting proceedings.

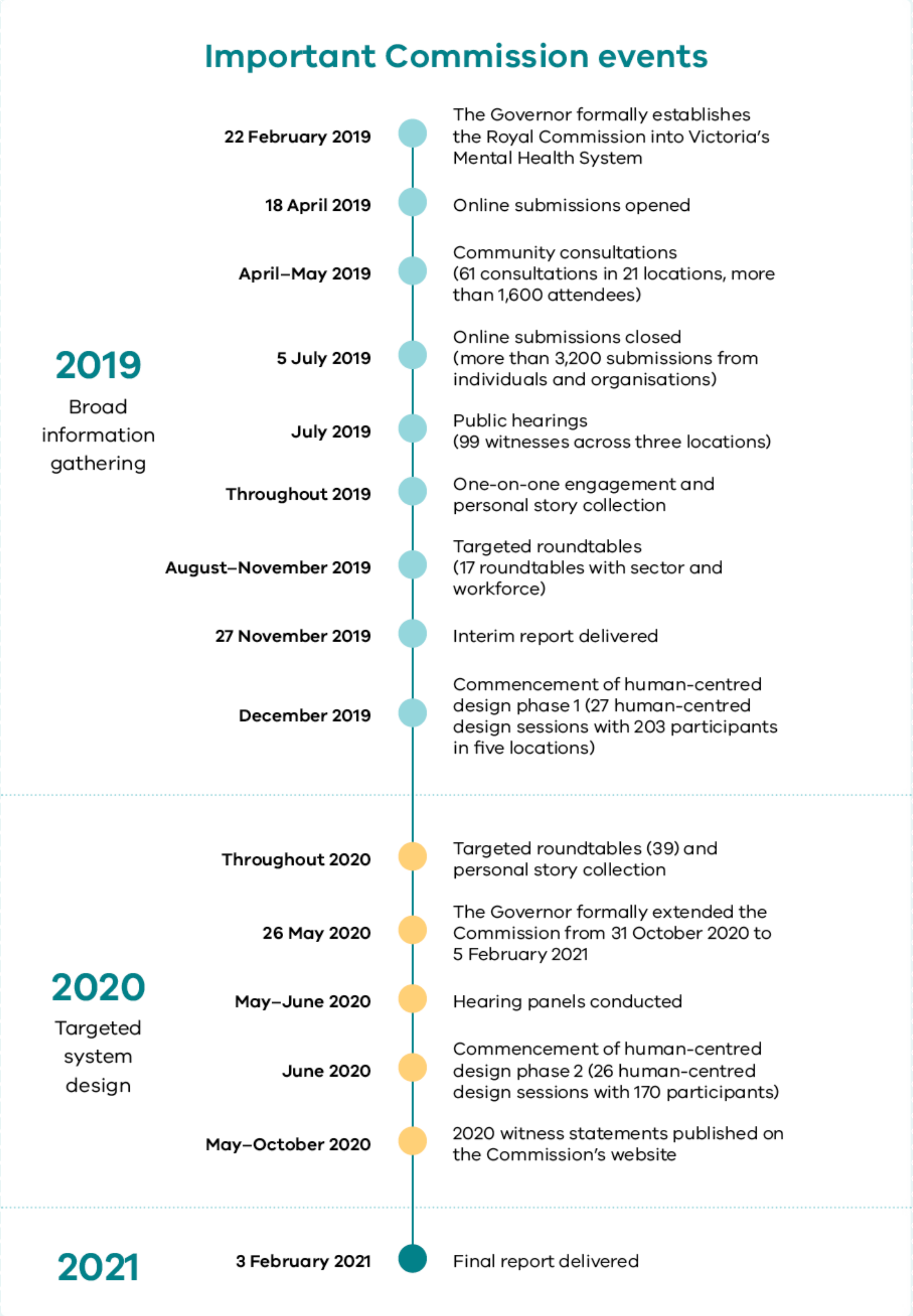
Figure 39.1 shows some of the Commission's important event milestones.

Figure 39.2. is an overview of the Commission's key facts and figures.

Figure 39.3 shows the Commission's engagement across Victoria.

From late March 2020, when the COVID-19 pandemic worsened in Australia, engagements were quickly adapted and held in various online formats. Shifting to virtual engagement benefited many participants by removing several barriers to taking part, including eliminating travel time and increasing the flexibility for people to participate from their homes.

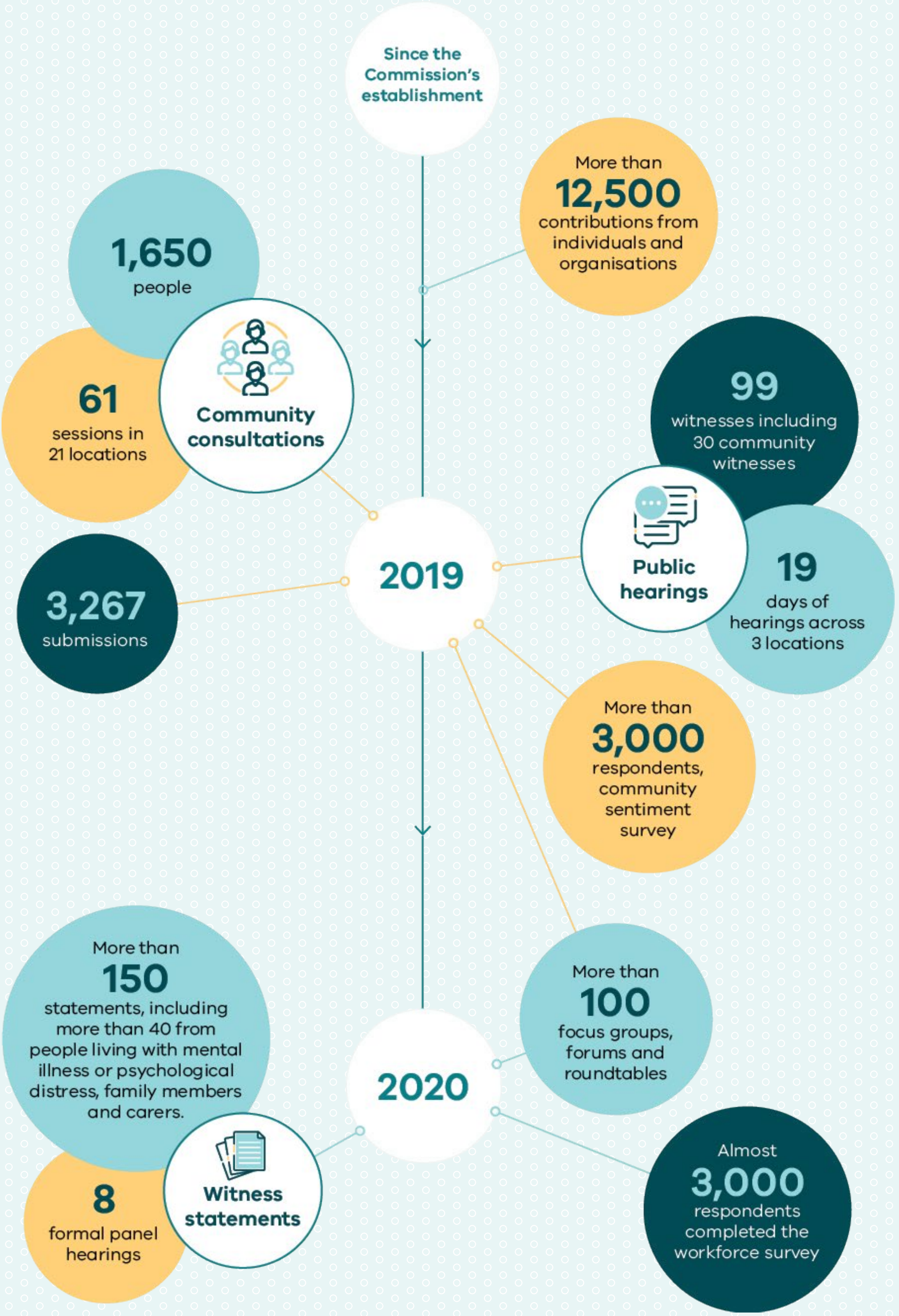
Figure 39.1: Important Commission events



Important Commission events

Period	Date	Event
2019 Broad information gathering	22 February 2019	The Governor formally establishes the Royal Commission into Victoria's Mental Health System
	18 April 2019	Online submissions opened
	April–May 2019	Community consultations (61 consultations in 21 locations, more than 1,600 attendees)
	5 July 2019	Online submissions closed (more than 3,200 submissions from individuals and organisations)
	July 2019	Public hearings (99 witnesses across three locations)
	Throughout 2019	One-on-one engagement and personal story collection
	August–November 2019	Targeted roundtables (17 roundtables with sector and workforce)
	27 November 2019	Interim report delivered
	December 2019	Commencement of human-centred design phase 1 (27 human-centred design sessions with 203 participants in five locations)
2020 Targeted system design	Throughout 2020	Targeted roundtables (39) and personal story collection
	26 May 2020	The Governor formally extended the Commission from 31 October 2020 to 5 February 2021
	May–June 2020	Hearing panels conducted
	June 2020	Commencement of human-centred design phase 2 (26 human-centred design sessions with 170 participants)
	May–October 2020	2020 witness statements published on the Commission's website
2021	3 February 2021	Final report delivered

Figure 39.2: Facts and figures



Since the Commission's establishment

More than **12,500** contributions from individuals and organisations

Community consultations

1,650 people

61 sessions in 21 locations

2019

3,267 submissions

Public hearings

99 witnesses including 30 community witnesses

19 days of hearings across 3 locations

More than **3,000** respondents, community sentiment survey

More than **100** focus groups, forums and roundtables

2020

Witness statements

More than **150** statements, including more than 40 from people living with mental illness or psychological distress, family members and carers.

8 formal panel hearings

Almost **3,000** respondents completed the workforce survey

Figure 39.3: The Commission's engagement across Victoria

Engagement across Victoria

The Commission has run significant engagement activities across the state, including:

61 **community consultations** across 21 locations including 11 rural and regional locations

19 days **of public hearings** across three locations, and **1 at an Aboriginal community-controlled organisation**

6 face-to-face **human-centred design focus groups**, across regional and rural locations

4 place-based **online roundtables** and **community workshops**

Rural and regional consultations

- Swan Hill
- Bendigo
- Ballarat
- Geelong
- Hamilton
- Mildura
- Sale
- Seymour
- Shepparton
- Warragul
- Warrnambool

Metropolitan consultations

- Box Hill
- Dandenong
- Healesville
- Melbourne
- Pakenham
- Preston
- St Kilda
- Sunshine
- Werribee
- Whittlesea

Human-centred design focus groups

- Bairnsdale
- Frankston
- Melbourne
- Traralgon
- Wangaratta

Public hearings

- Maryborough
- Melbourne
- Thornbury

Regional roundtables

- Maryborough
- Traralgon

Online roundtables and community workshops

- East Gippsland
- North Eastern Victoria
- South Eastern metropolitan Melbourne
- Wangaratta

39.2.1 Expert Advisory Committee

The Commission was supported throughout its inquiry by the Expert Advisory Committee, chaired by Professor Patrick McGorry AO. The Committee advised the Commission on a range of topics, including engagement, how to raise awareness of mental health, and the likely impact of the Commission's findings and recommendations. The Commission held 14 Expert Advisory Committee meetings and presented papers covering more than 30 topics for discussion through this forum. The Committee also provided advice through individual member meetings with Commissioners and policy staff.

39.3 Community consultations

One of the Commission's first acts was to listen to people in communities throughout the state. The consultations, held from 5 April to 22 May 2019, were open to everyone. More than 1,650 people attended 61 sessions in 21 locations in regional, rural and metropolitan Victoria.

A wide variety of people attended the consultations to share their experiences of living with mental illness or psychological distress, caring for someone living with mental illness, or of working in the mental health sector. Some came to tell of losing someone they loved to suicide. Some had described their experiences in previous forums, while others were taking part in a formal consultation process for the first time.

The Commission heard from people working in acute, community and specialist services, general practitioners, private psychiatrists, allied health and other professionals, youth workers and numerous staff working in intersecting fields, such as community health services, housing and homelessness services, family violence, and alcohol and other drug services. There were also people from legal and justice services, financial counselling organisations, local councils, schools, emergency services and gambling services, as well as state and federal members of parliament, library staff and academics.

Many participants had their own lived experience of mental illness or psychological distress, or were families, carers or supporters. The Commission noted that people often brought multiple perspectives, and it appreciated the diversity this brought to the consultations.

Each session ran for about 90 minutes and was guided by a facilitator, allowing Commissioners to move around the tables and listen directly to community members. Each table had eight to ten people, and had a Commission staff member listening and taking detailed notes while the participants discussed three questions:

- Reflecting on mental health services, what is working well?
- Reflecting on mental health services, what is not working well?
- What needs to change to improve Victoria's mental health services?

The level of interest in the community consultations often meant that multiple sessions were held in one day, and that extra rooms were required to accommodate the number of attendees. An example of this was the Box Hill community consultation on 20 May 2019. Three sessions were held in Box Hill, with more than 170 people coming to share their contributions with the Commission. The pictures at Figure 39.4 and Figure 39.5 show two of the rooms at the Box Hill Town Hall where people gathered to have their say at the consultation.

Figure 39.4: Box Hill Consultation Room 1, 20 May 2019

Figure 39.5: Box Hill Consultation Room 2, 20 May 2019

The consultations were designed to give participants an opportunity to share their experiences and ideas. Participants listened to each other and added different perspectives. They supported each other in informal ways—making a cup of tea for someone, or offering a tissue or a kind smile—and they often shared a sense of frustration and desperation, along with a commitment to and hope for a better future for the mental health system.

Box 39.1: Advice on social media ahead of attending a community consultation

During the Commission's consultations in 2019, a community member was a bit unsure about coming along to one of the sessions. She took to social media and sent a tweet to say she was booked in to attend a community consultation but was nervous, and asked if anyone else had been involved. Several people responded with messages of support, letting her know what to expect, describing Commission staff as warm and welcoming and encouraging her to participate and share her voice.

Conversations at tables allowed participants to share their experience with a smaller group, before joining in a plenary discussion inviting participants to share their insights and ideas for change, including any new ideas they had, with the whole group. No topic was off limits in the small groups or in plenary sessions.

Some participants also chose to share supporting information and documentation for the Commission to consider. These contributions became part of the Commission's evidence base.

Following the community consultations, the notes Commission staff had taken were combined and analysed, and a report was produced for Commissioners describing common experiences and important issues participants had raised in response to the three questions outlined previously. The Commission used this information to shape its work and help it decide on topics for the 2019 public hearings.

The Commission received feedback from participants about the community consultations, which was taken into account as it developed further engagement activities. Specifically, the Commission heard from some participants that they wanted a more private opportunity to provide input, and they did not always feel safe to openly share when they were in the same space as others. For example, some consumers provided feedback that having dedicated 'consumer-only' sessions would support sharing lived experience from a consumer perspective and would go some of the way to addressing the power imbalance outlined earlier. People attending the consultations could also make private and confidential submissions.

When planning other engagements, the Commission provided a range of options that included consumer-only, family and carer-only and workforce-only spaces for conversation.

The Commission received a range of feedback on the consultation process, with some participants saying they felt their experiences were acknowledged by the process. For some, this was the first time they have felt this in the context of the mental health system:

> [The Royal Commission] is the first time I've felt like I could use my intelligence and my experience to add to the picture.[10]

Participation in the consultations was supported by:

- Commission staff, who were clearly identified
- peer workers from the Victorian Mental Illness Awareness Council (VMIAC), the peak Victorian non-government organisation for people with direct lived experience of mental health issues or emotional distress, and Tandem, the peak body for families and friends supporting people living with mental health issues
- a professional counsellor
- a document outlining what people could expect at the consultation sessions
- an information sheet with the contact details of support services for people to take with them after the session
- a short video of Commissioners talking about their aspirations for the Commission
- details about how to stay up to date with the work of the Commission.

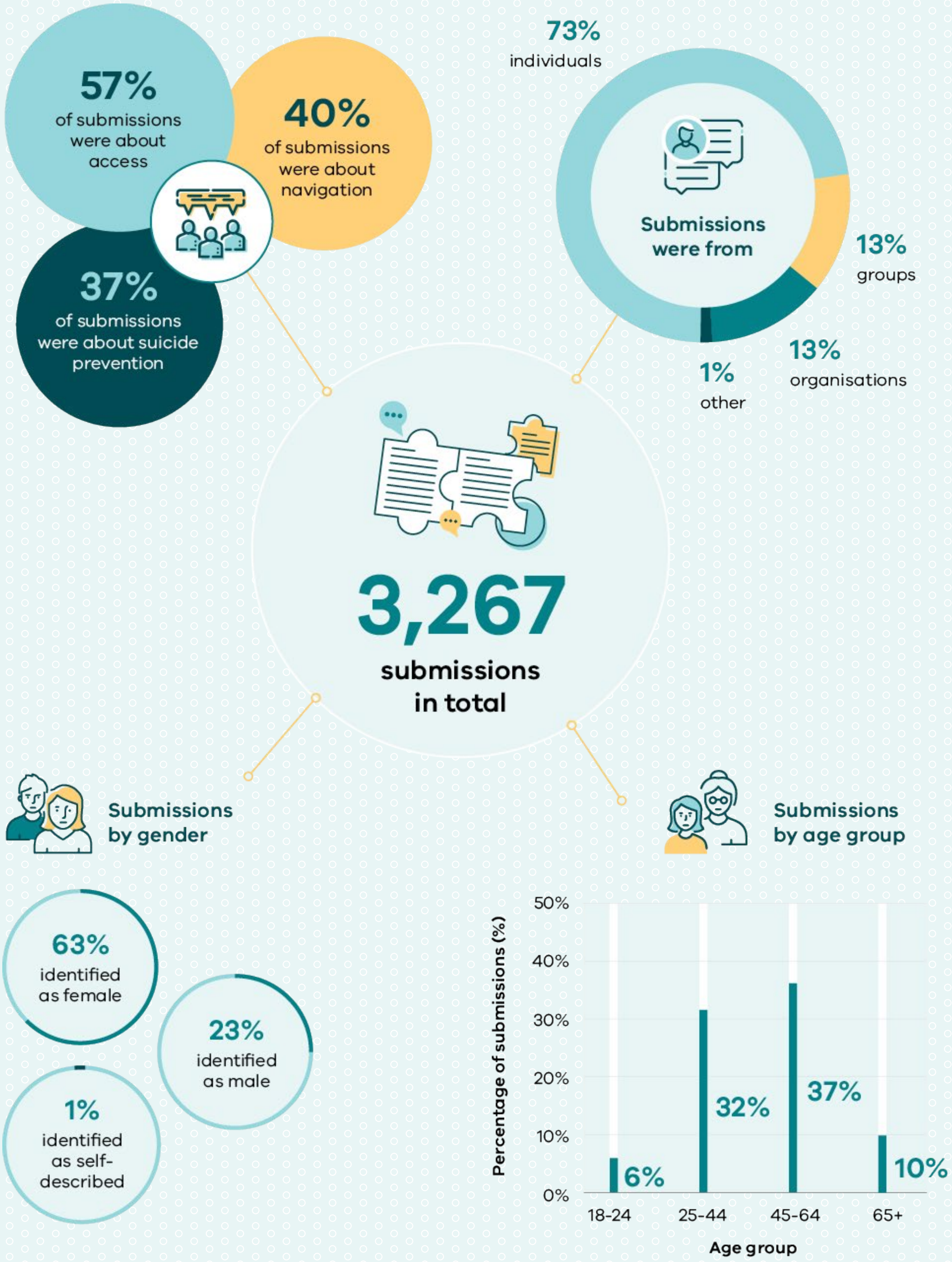
39.4 Submissions

The Commission issued a media release on 17 April 2019 calling for submissions until 15 July 2019. The call for submissions was open for 11 weeks and the Commission received 3,267 submissions.[11]

Input was sought from the general public, and all views and ideas for change were welcomed. Those who shared their experiences included people who had lived experience of mental illness or psychological distress, families, carers and supporters, people who worked in the mental health or related sectors, services, academics and members of the public with a general interest in mental health. Many submissions covered multiple topics, concerns and suggestions.

Figure 39.6 provides an overview of the submissions the Commission received.

Figure 39.6: Submissions received by the Commission



Note: Totals may not add to 100 per cent due to invalid/unknown responses. Where totals exceeded 100 per cent, these have been adjusted to 100 per cent.

People could make submissions in a range of formats, so they could tell the Commission about their experience or perspective in the way that best suited them. Box 39.2 describes one example of the flexible options for people to share their stories with the Commission. Submissions could be made online, via mail or email, by phone, or with audio or visual content. They could also be made by telephone with an interpreter service.

Information about how to make a submission was provided in English, Easy English and in 16 languages other than English, with priority given to the most commonly spoken languages in Victoria and the languages of newly arrived communities.

All submissions were read and reviewed. Where people agreed to their submissions being public, the Commission published them on its website.

Box 39.2: The Commission provided flexible options for people to make submissions

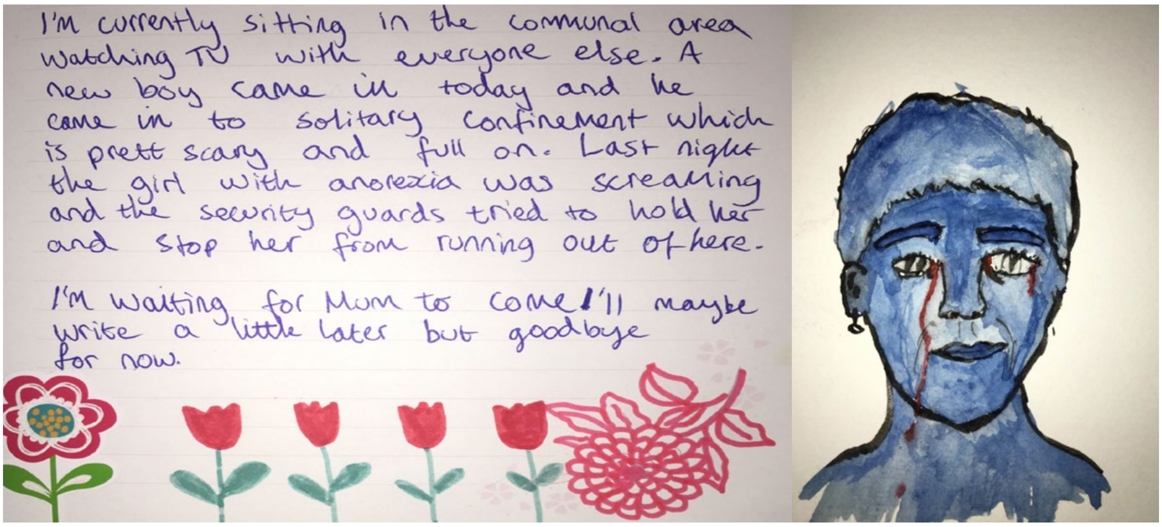
An older person wanted to share her story and ideas with the Commission as part of the submission process. She said she was unable to handwrite her experience and there was no one else to support her to do this. She did not have a computer or the internet. Her only form of communication was her mobile phone, which she regularly used to contact the Commission for updates.

The Commission worked with the person to find a way of making a submission that suited her. It offered her options for listening to her story, such as talking with a Commission staff member over the phone, coming to the Royal Commission office to speak with someone in person, and having a Commission staff member visit her at home. However, because she did not want to talk about her experience in a concentrated period of time, she decided that she preferred to call after business hours and leave her story on the Commission’s voicemail, in multiple messages. This allowed her to make her submission over a number of evenings, and to call at times that suited her. The Commission then transcribed the audio recordings to capture her submission, which it published anonymously on its website with her permission.

This process supported the person to make a submission. She was able to choose a way to engage in the process that was flexible, accessible and made her feel comfortable.

Some people chose to provide visual content, as a way of strengthening the points in their written submission, as shown in Figure 39.7.

Figure 39.7: An anonymously published submission with pictures and diary excerpts from when the writer was in an inpatient unit[12]



I'm currently sitting in the communal area watching TV with everyone else. A new boy came in today and he came in to solitary confinement which is prett scary and full on. Last night the girl with anorexia was screaming and the security guards tried to hold her and stop her from running out of here.

I'm waiting for Mum to come I'll maybe write a little later but goodbye for now.

Diary entry 29th April: 'I'm currently sitting in the communal area watching TV with everyone else. A new boy came in today and he came in to solitary confinement which is pretty scary and full on. Last night the girl with anorexia was screaming and the security guards tried to hold her and stop her from running out of here. I'm waiting for Mum to come I'll maybe write a little later but goodbye for now'.

The Commission's long-form submission process took people through a structured online questionnaire consisting of 11 questions about reducing stigma and discrimination, preventing suicide, early intervention, and how people access, use and experience care, treatment and support. People could answer the questionnaire alone or attach their submission to the online form. The Commission also provided the option for people to complete brief comments via a shorter online questionnaire that included a subsection of the long-form submission questions.

Some submissions did both—they responded to the questions and provided additional information for the Commission's consideration. One submission provided a written response, links to videos and an invitation for the Commission to attend a theatre performance, which is described in Box 39.3.

Box 39.3: Innovative submission from Listening to Voices Theatre

The Commission welcomed innovative submissions to support people to share their experiences and ideas for a future mental health system. One particularly innovative submission came from Listening to Voices Theatre, based out of Gateway Health in Wodonga. Listening to Voices Theatre is a program in which people with lived experience use theatre methods to both discover the need to speak, and to speak about things often unspoken. The performers are also advocates in this way, working hard to support those watching in the community and the workforce to have a better understanding of lived experience. In addition to their written submission, Listening to Voices Theatre invited the Commission to watch a performance created and performed by people with lived experience, called *Hero of Myself*.

On 6 December 2019, a Commission staff member went to Wodonga to attend *Hero of Myself*.

The performance aimed to show audiences the many realities of living with mental health challenges, in the hope that the audience will gain a better understanding of people's lived experiences, build empathy and reduce stigma.

The performance included several short scenes on themes such as:

- accessing and navigating the mental health system
- trauma
- understanding and listening to voices that other people cannot hear
- diagnosis
- stigma.

The performance showed different experiences and perspectives to give a sense of how lived experience is unique to an individual. While the focus was on people experiencing mental illness or psychological distress, families and carers were also portrayed in the performance.

Listening to Voices Theatre explained the philosophy behind the performance in its submission to the Commission.

> The work honours the lived experiences of the performers, placing them as the experts and exploring what works and what urgently needs attention. Through their storytelling, powerful and confronting, they are stimulating very important dialogue.[39]

After the performance, the Artistic Director asked the audience to call out words that reflected their impressions of the performance and how it made them feel. Some of the reflections and words called out were 'inspired', 'amazed', 'strength', 'encouraged' and 'talented'.

Listening to Voices Theatre has been using this unique creative form of advocacy since 2016.

Photo credit: Irene Metter

39.4.1 Processing and publication of submissions

All submissions were read and handled in accordance with a protocol on processing and publication of submissions. If a submission indicated that someone may be distressed and without other supports, and they had provided their contact details, the Commission's community engagement team reached out to offer them help in connecting to services and supports in their local area. This work also included connecting people with peer and other supports, such as VMIAC or Tandem.

The Commission also supported people sharing their experience with the Commission to connect with the Mental Health Complaints Commissioner, if they wanted to seek an individual remedy for a complaint about a mental health service.

Names of people other than the person who made the submission were generally redacted—removed—to protect privacy. The protocol also detailed the Commission's strict checking process. Before publishing any submission, two different staff members checked the content to make sure the file title matched the contents of the submission. They also checked the submission against a list that outlined which category each submission belonged to—public, anonymous or restricted—to prevent the accidental publication of confidential material. People were notified about the publication of their submission in advance.

39.5 Site visits

Commissioners visited services and organisations across Victoria including inpatient units, community health settings, prisons, courts and Aboriginal health services. These visits gave Commissioners opportunities to see the diversity of physical environments where mental health treatment, care and support is provided and the range of service models in practice, and were valuable inputs into the Commission's deliberations. The Commission's Chair also visited New Zealand to examine more innovative environments for treatment, care and support. Figure 39.8 was taken during the Chair's visit to Piri Pono, New Zealand in 2019.

There were some site visits planned for the later stages of the Commission's work in 2020, but these could not occur due to COVID-19 restrictions. Instead, Commissioners had online meetings with a range of different service providers to discuss practice and service delivery models, and the benefits and limitations of particular facilities. Box 39.4 describes one of these online meetings.

A list of site visits is at Appendix C.

Figure 39.8: Piri Pono, New Zealand

39.6 Individual meetings

The Commission held numerous meetings with a range of Victorian, national and international professionals, including lived experience experts, during its engagement process. It sometimes met with individuals more than once, where further examination of issues was required. These meetings helped the Commission to develop and refine its thinking, and informed its decision making.

Academics, leading professionals and consumer leaders also provided input to the Commission in various ways, including through public hearings and witness statements, roundtable meetings, and by contributing information and supplementary submissions. The Commission benefitted greatly from this expertise.

Box 39.4: Adult Mental Health Rehabilitation Unit – Secure Extended Care Unit

One of the Commission's meetings was with people at the Adult Mental Health Rehabilitation Unit – Secure Extended Care Unit (AMHRU–SECU) in Sunshine. Due to COVID-19 restrictions, the meetings took place via video conference. The Commission met with the unit's senior leadership team in a meeting chaired by a Commissioner. The Commission also met with three people using the AMHRU's services and two AMHRU carers.

The meetings with the service users and carers focused on what they liked about the environment and what they thought could be improved. The conversations helped the Commission understand how both groups of people experience such an environment.

A nurse attended with the service users to provide support and service users were given the opportunity to speak to Commission staff without the nurse present. The sessions were recorded with the service users' and carers' consent.

39.7 Public communications

The Chair of the Commission led its public communications, engaging with media at distinct points during its inquiry—at the commencement of the Commission, at the point of calling for submissions, at the tabling of its interim report, at the announcement of the Commission's extension, and at the tabling of its final report. While the Commission monitored media, including social media, daily, so that it maintained an understanding of the public discourse, the Commission did not itself run public commentary on issues that may pre-empt its consideration of all the evidence and its final deliberations.

To help people to stay informed about the Commission's work, it developed and distributed its own communications and updates to the public through a range of digital formats. Its website, for example, featured the most important information about the Commission, including its letters patent, the interim report, and submissions and witness statements that contributors had agreed to let the Commission publish.

Figure 39.9 shows that the Commission's website received more than 488,400 views and 195,800 visits from more than 98,200 users as at 31 December 2020.

Figure 39.9: Visitors to the Commission's website as at 31 December 2020

As well as keeping its website up to date, the Commission used Twitter to communicate and promote its work, including giving details about its public hearings, live-tweeting important events, and publishing witness statements and other content, including videos, media statements and updates.

The Commission also published and promoted more than 25 different videos on its YouTube channel, gaining more than 10,000 views.

People interacted with and shared content the Commission published on social media with enthusiasm, particularly for milestones such as public hearings, the publication of submissions and statements, and the launch of the interim report. The Commission had more than 1,800 Twitter followers at the end of its inquiry.

Another way the Commission updated the public on its work was through regular digital newsletters. People could subscribe to the newsletter on the Commission's website or by calling the 1800 number, and many did: the newsletter went out to almost 2,000 subscribers.

The Commission continued to interact with people with lived experience by holding Q&A (question and answer) sessions with VMIAC, Tandem and the Youth Affairs Council Victoria (YACVic). During these sessions, Commissioners responded directly to questions from people with lived experience from across Victoria, and detailed the Commission's work to date. The shift to digital meant that sessions held after April 2020 were able to be easily recorded and made available online for viewing by a wider audience.

Figure 39.10 was taken during a Q&A forum with VMIAC in 2020.

Figure 39.10: VMIAC Q&A forum in February 2020

39.7.1 Correspondence

The Commission received a range of correspondence, which supported it in all stages of its work. This included correspondence from people providing or seeking extra information from the Commission. In total, the Commission received more than 1,300 items of correspondence.

All correspondence was read by a Commission staff member. The Commission valued the time and care people took to send correspondence. By responding with a similar amount of time and care, the Commission hoped people would feel they had been heard and that their contribution would continue to inform the Commission's work.

39.7.2 Telephone support line

The Commission also staffed a 1800 telephone support line, which:

- gave people information about the Commission
- connected people to services and bodies, including to the Mental Health Complaints Commissioner if people wanted to complain about services or treatment they had received
- gave people an opportunity to talk the Commission through extra information they wanted to provide
- enabled the Commission to update people on its work, including how to obtain information and connect further with the Commission.

Commission staff also provided a supportive contact point if people wanted to talk about their concerns or experiences with mental health and the mental health system.

In total, the Commission received more than 2,000 telephone calls.

Commission staff managed and responded to correspondence and calls to the support telephone line by following Commission protocols that included the:

- Referral protocol between the Commission, the Department of Health and Human Services, Melbourne Health and Monash Health
- Referral protocol between the Commission and the Victorian Fixated Threat Assessment Centre
- Personal story collection protocol
- Protocol on public communications
- Privacy policy.

39.8 Public hearings

In July 2019, the Commission conducted 19 days of public hearings across three locations to understand the important issues within Victoria's mental health system. All four Commissioners were present to hear the witnesses' evidence. A list of witnesses is at Appendix C.

While this Royal Commission was asked to run a policy-focused inquiry, the public hearings took a legal format, and had the benefit of allowing evidence to be publicly presented and tested through examination by Counsel Assisting. The Commission's policy staff worked closely with Counsel Assisting to ensure the hearings were able to effectively explore important policy questions.

Witness statements provided background, history and context, allowing for a depth of understanding that could be explored during the hearings. Counsel Assisting's questions enabled further analysis of the evidence. The approach Counsel Assisting took to questioning supported witnesses to put their views forward.

On the first day of the hearings, the Commission showed a short animated video it had prepared about the current Victorian mental health system. The video provided Commissioners, Counsel Assisting, witnesses and those attending the hearings or watching remotely, with a shared context for what would be covered in the hearings and why. This video was also shared through social media channels and viewed more than 1,500 times.

Figure 39.11 is of the public hearings taking place at the Melbourne Town Hall in July 2019.

Figure 39.11: Public hearings at Melbourne Town Hall in July 2019

During the hearings, the Commission heard from witnesses about issues and questions relevant to its terms of reference contained in the letters patent. As noted above, hearing topics were informed by what the Commission had previously heard. Witnesses included consumers and carers, service providers, and workforce and government representatives.

The topics covered were:

- stigma
- prevention and early intervention
- accessing and navigating the mental health system
- carers and family
- supports for and the needs of particular groups, including rural communities, Aboriginal people, LGBTIQ+ people, and culturally and linguistically diverse communities
- community resilience
- suicide prevention
- prioritisation and delivery of mental health services.

To support the Commission's focus on rural and regional mental health needs, a regional hearing day was held in Maryborough in the Central Goldfields. A day-long hearing that focused on the needs of Aboriginal people in Victoria was held at the Aborigines Advancement League in Thornbury.

Witness statements and transcripts from the hearings are available on the Commission's website.

Although most of the hearings were open to the public and livestreamed, the evidence of some witnesses was the subject of a restricted publication order. This meant that identifying information about a witness could not be published on the Commission's website. On a small number of occasions, the hearings were closed to the public to protect the privacy of witnesses and their families.

39.8.1 Witnesses

The Commission heard from 99 witnesses during the 2019 hearings. Thirty community witnesses spoke about their lived experience—18 from personal experience and 12 from the perspective of being family members, carers and supporters of people living with mental illness or psychological distress. The Commission heard from mental health professionals, police officers, paramedics and leaders in research, service management and education.

Witnesses outside of government and mental health services were also supported by the Commission's Counsel Assisting to make their statements.

As with the community consultations, several witnesses brought multiple perspectives to their evidence, having worked in the mental health system and also having lived experience. Witnesses prepared written statements, apart from one witness, who prepared a video.

This video statement reflected the Commission's commitment to supporting people—whether they were making submissions or attending hearings as witnesses—to have their voices heard in whatever way suited them best.

The support that the Commission gave witnesses extended to interactions with the media. Throughout the hearings, there was considerable media interest and coverage. Metropolitan and regional media attended each day and were given a dedicated space with screens and audio feeds. Commission staff acted as a liaison between witnesses and media to support individuals to share their stories, and to encourage consistent and accurate media coverage about mental health.

The Commission also created some short videos featuring witnesses to promote and highlight content from the public hearings, and to give a sense of the evidence received to those who did not watch the hearings. These videos were promoted on social media and online, and shared with those involved for distribution.

39.8.2 Supporting community witnesses

The Commission took particular steps to support community witnesses who were sharing their lived experience. These steps were:

- sharing videos about what it was like for witnesses to give evidence before the Royal Commission into Family Violence in formal hearings, featuring the generous contribution of two witnesses with lived experience of family violence

- allocating a consistent point of contact in the Commission's community engagement team to the greatest extent possible. The community engagement team's role included providing witnesses with information about what to expect, giving them an opportunity to walk through the hearing venue in advance where possible, meeting them on the day, and checking in with them afterwards
- offering witnesses support when dealing with media enquiries
- offering a session with counsellors engaged by the Commission
- developing factsheets for witnesses about what to expect, and about things to consider for carers and supporters, so that witnesses had written information to take away with them
- explaining options for community witness statements to be published under a pseudonym, in the person's first name only, or kept confidential to the Commission, to protect the person's privacy, or to protect sensitive information
- providing dedicated seating so that support people, including family and friends, could sit closest to the witness while they were giving their evidence.

The Commission's efforts to support witnesses were well received, with the Commission continuing communications with community witnesses throughout its duration:

> **Thank you for your wonderful words and thank [you] for all of your wonderful support. [Y]our team had been so good to me throughout this whole experience. It is what any mother would do and by knowing how painful it is for another mother to go through a mental health journey and suicide, that is why I did the Royal Commission.**[13]

39.8.3 Accessibility of hearings

To support the accessibility and inclusivity of the public hearings, they were held at accessible venues and were open for the public to attend. They were also streamed online and transcripts were published on the website within 24-hours after each hearing. The Commission invited those who required additional supports to make these known to the Commission beforehand so that they could be arranged.

The Commission took care to provide detailed information on its website for those who wanted to attend the hearings, putting thought and care into trying to make people feel safe and welcome.

Actions to support this included:

- preparing a factsheet for the general public that outlined what to expect at a Royal Commission hearing and a sense of what would happen on the day
- developing a protocol outlining how the Commission wanted people to be treated and welcomed and discussed this with venues in advance of hearings
- having Commission staff present to welcome and guide people at access points
- providing physical security to ensure everyone's safety, while maintaining a welcoming atmosphere
- allocating an extra, less-formal space for people to watch the livestream, without having to be in the hearing room: this was a room where people could talk to each other and help themselves to refreshments—colouring books for children were also provided

- providing a dedicated space for media, which allowed Commission staff to act as a liaison with witnesses first to confirm their wishes to speak with media, and to provide support before and after any interviews
- providing trained counsellors, and a private area for conversations with them at the hearing venues: this included counsellors from the Victorian Aboriginal Health Service at the hearing day at the Aborigines Advancement League
- providing childcare support at the Aborigines Advancement League
- providing refreshments, ranging from tea, coffee and biscuits at the Melbourne Town Hall, through to a catered lunch at Maryborough and the Aborigines Advancement League, in recognition that food outlets were not always available or accessible.

39.8.4 Hearing incident management protocols

Hearing incident management protocols were established to support the conduct of the Commission's public hearings. The protocols set out that the Commission's primary duty was to the safety of participants at its hearings, and to provide people with the opportunity to give and hear the evidence before the Commission.

The protocols set out procedures to de-escalate situations; for example, if there was violence or threat of violence. The procedures outlined circumstances under which the Commissioners and audience would be removed from the hearing venue, and when police would be called (this would only be if there was an emergency, not if someone merely disturbed proceedings).

In line with the Commission's commitment to support people to express their opinions, the protocol specified that while people may be asked to leave a hearing if they were disrupting it, there should be no intent to limit people's ability to express themselves in a way they chose.

39.9 Community sentiment survey

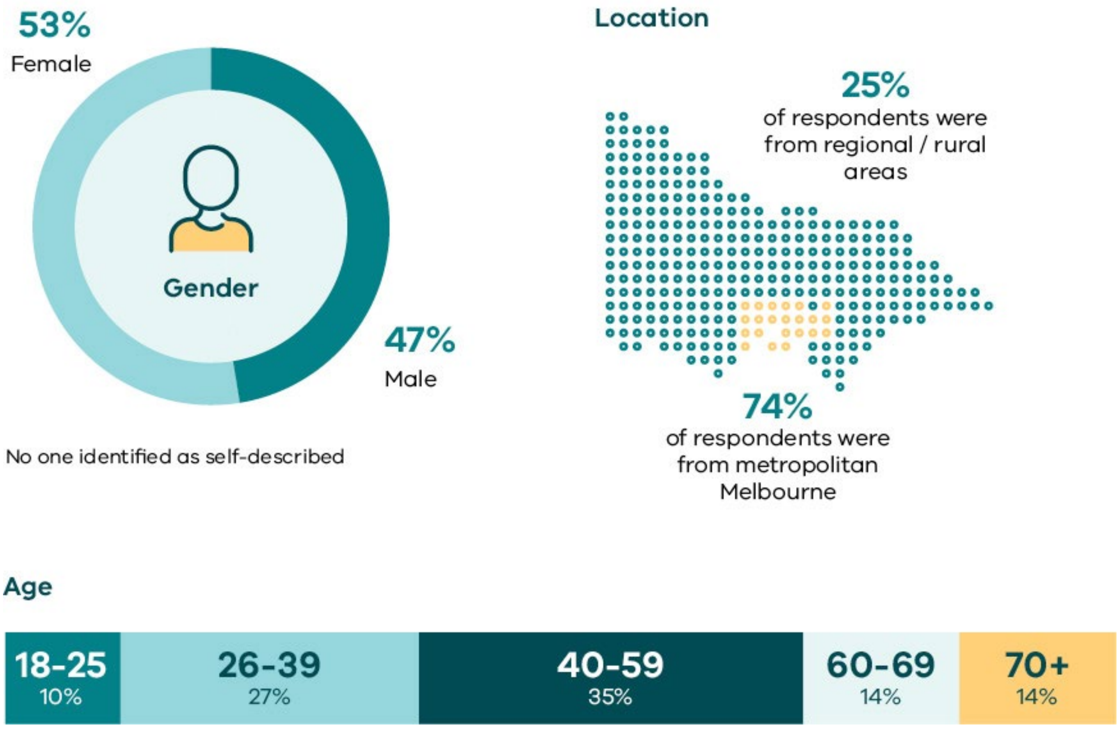
The Commission engaged a market research company to conduct a community sentiment survey. The survey was conducted to help the Commission understand current attitudes and perceptions about people living with mental health challenges, and about Victoria's mental health system.

The company surveyed more than 3,000 Victorians in July 2019. The survey was complemented by five focus group discussions across Victoria, involving 46 people: two groups in Richmond, and one each in Frankston, Traralgon and Warrnambool.

A summary of the findings was published on the Commission's website and Figure 39.12 details the survey respondent characteristics.

The information from this survey informed the Commission's assessment of issues outlined in its interim report. The content also helped to shape the Commission's work in 2020 on stigma, discrimination and the role of communities, places and sectors in supporting better mental health.

Figure 39.12: Survey respondent characteristics



39.10 Targeted roundtables

The Commission held 17 targeted roundtable meetings, chaired by a Commissioner, from May to December 2019.

These roundtable meetings were used to explore the diverse needs of Victorians, with a focus on the needs of Aboriginal people, LGBTIQ+ people, culturally and linguistically diverse communities, people with neurodiversity and intellectual disabilities, older people and young people. They were also used to examine intersecting service systems, including housing, alcohol and other drugs, and the justice system. A full list of roundtables and attendees is at Appendix C.

Box 39.5: Rural and regional input

The Commission valued the contribution and voices of rural and regional Victorians, and hearing about the unique challenges and opportunities these communities face. The Commission visited specific communities and connected with services, community leaders and people with lived experience, supporting its commitment to rural and regional perspectives.

Consultations were held in Mildura, Swan Hill, Bendigo, Ballarat, Hamilton, Warrnambool, Geelong, Warragul, Sale, Seymour and Shepparton. These consultations helped the Commission to understand the mental health needs and experiences of the mental health system from people living in rural and regional communities, and how these differ between large regional centres, smaller country towns and dispersed rural farming communities.

In mid-2019, the Commission held two regional roundtables in Traralgon and Maryborough, where Commissioners connected with local organisations, including health services, councils, schools, police and Aboriginal services. The local roundtable in Maryborough was followed by a hearing day on 15 July 2019 that was dedicated to examining the mental health needs and the operation of the mental health system in rural and regional communities across the state. The Commission heard from multiple witnesses across 2019 and 2020 providing regional and rural perspectives. In addition, more than 15 per cent of all submissions received by the Commission were from people in regional and rural Victoria.

While COVID-19 restrictions meant that plans for more hearing days and roundtables in rural and regional locations in 2020 had to be revised, arrangements were made to continue with online roundtables with communities in East Gippsland and north-eastern Victoria.

Rural and regional communities were involved in the Commission's human-centred design activities—detailed later in this chapter—with focus groups held in Wangaratta and Bairnsdale. A number of people with lived experience from rural and regional areas were supported to attend human-centred design activities held in the Melbourne CBD.

Participants from rural and regional services were invited to attend topic-based roundtables by travelling into the city, using technology to participate, or responding to written questions, instead of attending. Moving to digital delivery also removed travel as a barrier for participation in focus groups, and enabled people who may not otherwise be able to be involved to take part—the same was true for roundtables.

39.11 Personal story collection

Personal stories focus on real-life experiences of individuals, families, carers and supporters, and the mental health workforce, and help build understanding of the challenges of the current mental health system and aspirations for the future.

Commissioners and Commission staff read personal stories to understand the current system and develop recommendations. Personal stories provided important input into the Commission's policy design and research, by detailing the realities of service delivery from a variety of perspectives and the practical implications of existing policy decisions. The Commission collected stories from more than 100 people from August 2019 to November 2020 and documented what people would like to see changed in the system.

A selection of personal stories was published in the Commission's interim report and personal stories are an important feature of this final report. To ensure that people were comfortable with the final form of any story selected for publication in one of the Commission's reports, the personal stories protocol outlined a process for checking this with them.

The Commission also collected personal stories from a range of other sources. For example, the Commission received stories directly from community members, and from peak bodies and services. In addition, the Victorian Government provided funding to several organisations to assist them to provide stories to the Commission, including VMIAC, Tandem, Victorian Aboriginal Community Controlled Health Organisation (VACCHO), Mental Health Legal Centre and Victoria Legal Aid.

These materials have been shared with Commissioners and policy staff to inform their analysis of current issues, and to test whether ideas for change may have made a difference to their situation:

> It was good to talk to you. We had the sense that you were really listening to us, which was most heartening as it hasn't happened much with the health professionals whose job has been to help our son. So we appreciated it.[14]
>
> I'm only just learning the power of my story, I thought it was just very ordinary … Somebody said to me once … 'once you are heard, you begin to heal' and I think that is really important because a lot of these experiences are very isolating … So to finally be heard and listened to, I can now heal.[15]

39.12 Interim report

The Commission's interim report was presented to the Governor of Victoria on 27 November 2019 and tabled in the Victorian Parliament on 28 November 2019. While policy analysis and research continued throughout the Commission's inquiry, the core writing for the interim report took place from August to October 2019.

The interim report was accompanied by an executive summary, Easy English outline and a short animated video outlining the purpose of the report and key recommendations. The video received more than 2,200 views.

The interim report was an important first step towards reforming the mental health system, making a number of priority recommendations. These changes were aimed at addressing urgent problems and preparing the foundations for further reform. The interim report highlighted the scale of change required and foreshadowed that a comprehensive set of recommendations for transforming Victoria's mental health services will be presented in this final report.

On 28 November 2019, the Commissioners led a media doorstop event on the steps of Parliament House to launch the interim report. On the same morning, the Commission held a public launch at the Melbourne Town Hall with almost 200 attendees, including community witnesses and representatives from mental health services, peak bodies and government departments.

The Commission wanted the interim report launch to replicate the feel of the public hearings: welcoming and inclusive. Therefore, similar thought and care went into preparations for the launch. The Commission formally presented the report and answered attendees' questions. The launch was recorded and made available online, along with the Chair's opening remarks and presentation slides. The event shown in Figure 39.13 was also live-tweeted via the Commission's Twitter account.

Figure 39.13: Interim report launch at Melbourne Town Hall on 28 November 2019

Box 39.6: Hearing from Aboriginal people, communities and services

The Commission engaged Ms Nicole Cassar to advise on its consultation with Aboriginal people, services and communities, and to help examine how the social and emotional wellbeing of Aboriginal people throughout Victoria can be improved.

On 16 July 2019, the Commission held a day of hearings at the Aborigines Advancement League, which focused on the needs of Aboriginal people. The Commission heard about the importance of understanding that Aboriginal concepts of mental health and wellbeing are holistic, and shaped by connections to culture, land, extended kinship, ancestors and spirituality.

Aunty Di Kerr on 16 July 2019

The Commission is grateful to have been welcomed to country by Aunty Di Kerr, an Elder of the Wurundjeri people of the Kulin nation.

Aunty Nellie Flagg, an Elder and a Taylor-Charles, whose traditional countries are Wemba Wemba, Dja Wurrung and Boonwurrung, was the first witness to appear before the Commission that day. She reflected that, 'when Aboriginal people talk about our health, we don't do it in isolation. Mental, physical and spiritual health is holistic. We need not only to treat the person who is being damaged, but their families too.'[16]

Before publication of the Commission's interim report, the Chair of the Commission hosted several roundtables with leaders of Aboriginal services and people who had appeared before the Commission as witnesses at the Aborigines Advancement League. The Commission received compelling evidence from Aboriginal witnesses and services, which recommended expanding multidisciplinary models of care that apply the Aboriginal concept of social and emotional wellbeing. Social and emotional wellbeing means being resilient, being and feeling culturally safe and connected, having and realising aspirations, and being satisfied with life.[17]

Aboriginal leaders and senior representatives from Aboriginal organisations told the Commission that communities have been calling for self-determined social and emotional wellbeing models of care for decades so that Aboriginal people themselves can provide services promoting their social and emotional wellbeing. It was action, not more consultation, that was needed.

These conversations led to the Commission bringing forward its recommendation about Aboriginal social and emotional wellbeing to its interim report.

In that report, the Commission recommended that the Victorian Government expand social and emotional wellbeing teams throughout Victoria, and that these teams be supported by a new Aboriginal Social and Emotional Wellbeing Centre.

The Commission appreciated the attendance of Aboriginal services and organisations at a range of roundtables, as it explored the broader mental health system design, including:

- examinations of housing
- the needs of older Victorians
- mental health services for children and young people in the youth justice system
- courts
- criminal justice services
- forensic justice services
- practitioner regulation.

The Commission was grateful for the attendance of Aboriginal organisations and community members at regional roundtables in Traralgon, East Gippsland and north-eastern Victoria.

The Commission also held dedicated focus groups with carers who identify as Aboriginal, and appreciated the assistance of the Victorian Aboriginal Legal Service in identifying Aboriginal participants who have experience of mental illness and the criminal justice system for the focus groups.

The Victorian Government also funded VACCHO to consult and support the Commission's work. This consultation took place in 2020 and resulted in *Balit Durn Durn: Strong brain, mind, intellect and sense of self*, a report to the Commission that was delivered in October 2020.

Jill Gallagher AO, CEO of VACCHO, said of the *Balit Durn Durn* report:

> **For the first time in history, Aboriginal leaders, organisations, people, families, carers, and communities were given the opportunity to have their voices and experiences included in a redesign of the mental health system through the Royal Commission into Victoria's Mental Health System.**
>
> **This report explores the power of Aboriginal culture. It outlines ways to build strength, resilience, connectedness and identity in Aboriginal people and communities to create essential pathways for fostering positive mental health and wellbeing.**[18]

The Commission thanks the many Aboriginal people who contributed to its consultations and to the *Balit Durn Durn* report. People contributed with courage and generosity, often sharing their difficult experiences during the COVID-19 pandemic, and over periods of mourning in the community.

39.13 Phase 1 of human-centred design

Many royal commissions end their public engagement after community consultations, submissions and public hearings. However, the Commissioners gave deep consideration to three important factors:

- the transparency of process expected of royal commissions conducted under the *Inquiries Act 2014* (Vic) to ensure public confidence in its findings and recommendations
- the Commission's commitment to elevating and keeping the voice of people with lived experience at the centre of its work
- the nature of this Commission—making recommendations for the future of Victoria's mental health system.

To support the nature and ambition of its task, Commissioners expanded the typical royal commission model of engagement to include participation in the process of designing the new mental health and wellbeing system.

The Commission engaged an external consultant to adapt elements of a method called human-centred design to support the Commission's engagement process. The Commission undertook two phases of human-centred design.

Human-centred design is about defining and solving problems. It puts those experiencing a problem at the heart of the design process by working with them to come up with solutions. It provides a 'powerful alternative philosophy for systems design, and broader educational and societal development'.[19]

From November 2019 to June 2020, the Commission undertook the first stage of its human-centred design approach. The focus groups were held in Wangaratta, Bairnsdale, Traralgon, Frankston and Melbourne. The Commission organised and ran focus groups in November and December, which were facilitated by the external consultant who had adapted the methodology. From December to June, Commission staff ran focus groups, with external facilitation engaged at times to support participation.

The Commission worked closely with VMIAC, Tandem and a range of other services, to identify and support participants for the human-centred design sessions. In response to feedback from community consultations, and in discussion with Cath Roper, Consumer Adviser to the Commission's CEO, focus groups were split into separate consumer and carer sessions. This was intended to provide a dedicated and safe space for open discussion about the difficulties with the current system and aspirations for the future.

To assist participation, the Commission had a support person at every session and—depending on whether the session was for consumers, families, carers or supporters—a peer support worker from VMIAC or Tandem. Participants were also welcome to bring their own support person.

Participants and focus group locations were chosen to reflect a mix of experiences of mental illness or psychological distress and caring, ages and geographic location. The range of experiences covered included experience in inpatient services, clinical settings, youth mental health services, aged mental health services, and experience of mental illness and alcohol and other drug services.

The Commission also held a series of dedicated human-centred design focus groups with people who had experience of mental health illness or psychological distress and the justice system:

- adults with experience of forensic or justice mental health services
- Forensicare Consumer Advisory Group
- men over 25 years old with experience of mental illness and recent experience of the justice system
- young men over 16 years old with experience of mental illness and recent experience of the justice system, including youth justice
- women over 25 years old with experience of mental illness and recent experience of the justice system
- young women over 16 years old with experience of mental illness and recent experience of the justice system, including youth justice.

Box 39.7: Justice focus groups

The Commission heard from 36 people across six focus groups, who had experience of mental illness and recent experience of the criminal justice system. The sessions were interactive and accessible—a high level of literacy was not required, participants could request interpreters and bring their own support people, and venues were in central locations close to transport. A graphic recorder captured the conversation using a range of pictures, images and key words. Refreshments were provided, and created an informal and welcoming feel.

Nicole Cassar, the Commission's Aboriginal community engagement adviser, led participants through the sessions. A male facilitator supported the sessions with men. A female facilitator supported the sessions with women.

By using human-centred design methods the expertise of people with lived experience, their lived knowledge and analysis was highlighted for the Commission.

> I don't have complex needs ... I just have to navigate a complex system![20]
>
> In jail, the psychiatrist changed every six months. So, every six months, you'd have to go through your backstory, your origin story. Again. I wouldn't do that. I tell them, read the files. I got sick of repeating my life story.[21]

The Commission brought various materials that summarised some of what it had already heard to these focus groups, to test its understanding of the issues and barriers people had experienced in the mental health system. The materials included diagrams of the current system experience, and statements about challenges consumers and carers had shared about their experience with the mental health system.

The Commission wanted the focus groups to be a positive experience for participants, despite the conversations centring on difficulties and challenges with the existing mental health system. The Commission worked hard to adapt and deliver the methodology in a way that was respectful and considerate of people's differences, experiences and circumstances.

Figure 39.14 shows participants in human-centred design activities in Wangaratta and Melbourne in 2019:

> I found the HCD [human-centred design] session last year incredibly powerful and gained some new friends from that group of people. I was terrified of participating but found the participants, Royal Commission staff … and the whole process incredibly supportive, so the experience was a very positive one.[22]

Figure 39.14: Participants in human-centred design activities, Wangaratta and Melbourne, 19 November 2019 and 10 December 2019.

Each session ran for up to two and a half hours, and were audio recorded and transcribed.

Focus group conversations were captured by a graphic recorder who used a variety of pictures, words and symbols to create a record of the key things that were discussed on a big piece of paper, referred to as a canvas. The canvases, detailed notes and transcripts were provided to Commissioners and Commission staff to support the development of ideas and decision making.

Stories and quotes used by the Commission from the session were kept anonymous.

A list of phase 1 and 2 human-centred design activities is at Appendix C.

Box 39.8: Informal supports and the Commission's activities

Participants in the human-centred design focus groups were most often strangers to each other, coming together to share their stories, commonly about how the mental health system had let them down. While this can be a confronting experience, it was also an opportunity for people to connect and provide informal peer support. This happened in several ways over the two phases and 53 sessions. The following is a description of some of those moments.

On a Saturday morning, a group of young carers from across the state came together in the Melbourne CBD to talk about their specific challenges and aspirations. For some of these young people, it was their first time being part of focus group, while others were young leaders in the advocacy space. The group was a revelation for some participants, who exclaimed that they did not know there were so many others with the same or similar experience as them. The planned two-hour focus group went for closer to three hours, with conversations continuing after the session formally ended. The young participants made connections and started a WhatsApp group to continue the conversations and support to each other.

Another group created a virtual book club while connecting in an online focus group. Participants were able to quickly get their favourite books from their bookshelves and make recommendations to each other. They used the technology to show the covers of the books, and the chat function to share book titles and author names. They shared their thoughts on the books they were recommending and created reading lists for each other.

An insights report from the phase 1 human-centred design process was prepared and presented to the Commissioners by external consultants in January 2020. It provided detailed analysis of themes from the focus groups held in November and December 2019. The analysis in the report was used by the Commission to inform and shape options for the design of the future mental health system.

Frontline workforce human-centred design sessions complemented phase 1 of the design process. Four separate sessions were held with a total of 31 frontline staff, from the peer and lived experience workforce, nurses, psychiatrists and clinical psychologists, and allied health professionals. These sessions, facilitated by Commissioner Dr Alex Cockram, took a similar approach to the consumer and carer sessions, using the same tools and a survey, to reflect and refine what the Commission had heard from across the mental health and supporting workforces.

The session with the peer and lived experience workforces was co-facilitated by a lived experience expert. The Commission engaged an independent peer support person to sit in on the session and provide supervision and debriefing as needed for those attending the focus group. One participant observed:

> **I am very impressed with the integrity of the Royal Commission and it gives me a lot of hope for the future of mental health. I hope this process will enable us to help many people, to overcome barriers and prepare Australia for future challenges. I am grateful for everyone's efforts. Thank you.**[23]

Box 39.9: Impact of COVID-19 and how the Commission moved to digital engagement

On 19 March 2020, the Commission took the precaution of cancelling or postponing planned in-person engagement activities due to the COVID-19 pandemic. This included cancelling its second and final round of public hearings.

The public hearings had been scheduled to start in late-April 2020 and to run for four weeks—during the anticipated peak of the first wave of COVID-19 in Melbourne. The scheduled commencement of the Commission's hearings, a few weeks after isolation measures were first introduced, did not allow time for alternative hearing formats to be put in place that would both ensure safety and support the smooth participation of Commissioners, Counsel Assisting, witnesses, lawyers for witnesses and support staff.

This was not a decision made lightly. Consideration was given to a range of options to progress the second round of public hearings, while also managing the logistics and risks associated with COVID-19, which were still emerging, including:

- how isolation measures and restrictions would impact the various organisations and individuals required to progress the hearings
- access to and availability of reliable technology
- availability of key witnesses working on critical responses to COVID-19 in government and in health services
- the implications for meeting the Commission's original timeline for delivery of the final report of 31 October 2020.

The Commission considered the level of uncertainty and heightened caution across the community and decided it was possible for the Commission to obtain the evidence required without the second round of public hearings.

As well as cancelling the hearings, the Commission cancelled four focus groups with lived experience participants. All participants were invited to share their personal story with the Commission via a one-on-one phone call with a Commission staff member, or via email or mail.

Four focus groups planned with workforce participants were postponed and delivered via an online format in May and June 2020.

Within a week of cancelling or postponing face-to-face engagements, the Commission had committed to, and begun planning for, engagement to continue in a digital format. This involved researching and testing online platforms, while considering IT access and equity.

The Commission also put in place a digital process to collect witness statements from people who had been scheduled to give evidence at the Commission's 2020 hearings. This process is outlined in section 39.14.

The move to digital delivery extended to Commissioner meetings, which were adapted to an online format. More than 30 Commissioner meetings were held online during a peak period of decision making. Commissioners moved to online meetings from Thursday 26 March 2020.

Commission staff rapidly and creatively found ways to continue participation remotely. Within five weeks of cancelling or postponing face-to-face activities, invitations were sent to participants for engagements taking place from May 2020. Through the shift to digital engagement, the Commission identified new ways of working together and new opportunities for engaging with people.

Between May and October 2020, the Commission held:

- 37 online roundtables with 372 participants
- four online Q&A sessions with more than 300 participants
- 32 online focus groups with 200 participants
- 26 online meetings between community witnesses and Commissioners to discuss their witness statements
- eight online panel hearings with 25 participants
- two online community workshops with 31 participants.

The move to more flexible, online participation helped many people engage with the Commission. For example, Q&A sessions between Commissioners and families and carers were attended by 70–90 people, rather than the 30 or so who may have been able to attend a similar meeting in the Melbourne CBD.

While physically distanced, many witnesses with lived experience had one-on-one conversations with a Commissioner that were more personal and direct than the experience at a public hearing.

The Commission assisted people to build their skills and knowledge using digital technology, offering every person invited to an online lived experience focus group and workshop the opportunity to test the technology with Commission staff prior to the session. This meant that participants entered sessions confident that they could actively take part. If technology or an internet connection failed during online engagements, the Commission contacted participants to offer technical support, and to invite them to share anything they may not have been able to share in the session.

All participants were offered an opportunity to send through any other thoughts or information related to the session in the days after their involvement, via phone, email or mail.

While online participation is not suitable or accessible to everyone, the Commission observed that these processes made participation easier for some people, who could take part from the comfort of their own homes. It also made access to focus groups, roundtable and workshops more equitable for those in rural and regional Victoria, and for those living with physical disabilities.

39.14 Collection of witness statements

The Commission collected a total of 154 witness statements from people who had been scheduled to give evidence at the Commission's 2020 hearings, including statements from 43 people with lived experience—29 people with lived experience of mental illness or psychological distress and 14 family members, carers or supporters.

Community witness statements were collected with the support of a Commission staff member as a consistent point of contact. This support evolved based on feedback from the 2019 hearings: for the 2020 hearings, the Commission gave witnesses the option of having a preparatory or debriefing session with a counsellor or allied health support person of their choice. This was in addition to the offer of support from a psychologist engaged by the Commission.

People giving evidence from the perspective of their lived experience and lived expertise were offered a one-on-one online meeting with a Commissioner to talk about their witness statement in more detail. The online meetings showed the ways that people adapted to and used digital formats.

Through the online meetings, witnesses and Commissioners shared parts of their lives, meeting from their homes, which brought a personal flavour to the conversations. There were pictures hanging on walls, shelves of books and boardgames, and the sights and sounds of daily life continuing: children and pets in the background, ringing doorbells and cats walking in front of the camera. There was also the odd technical difficulty that participants worked through with support from a Commission staff member. A number of these videos have been published on the Commission's website.

Community witnesses reflected on the process of discussing their statements, and how it felt speaking to Commissioners from their homes, as opposed to the more formal hearings forum:

> Thank you again for assisting in bringing my meeting with your Chair, Penny Armytage to life—it was an incredible opportunity for me that I am still very grateful for ... So much appreciation for what we have created as a team.[24]
>
> Thanks for giving me this platform and opportunity to share my experiences with Commissioner McSherry to possibly help others.[25]
>
> Just a note to say how grateful we are to you for arranging a chat with Professor Fels. We had a great time and he seemed genuinely interested.[26]
>
> That meeting with Commissioner Cockram was great![27]
>
> I actually preferred to be in my own home. It helped me feel that the power was more equal. And it was surprisingly comforting to have Angus [the cat] there with me.[28]

The lists of witnesses who provided statements in 2020 is at Appendix C.

Miss Denna Healy, witness and spoken word poet, provided a poem as part of her witness statement. The poem was recorded and the video was published on the Commission's website. Following is an excerpt from the poem.

Box 39.10: Excerpt from a poem written by community witness Denna Healy[29]

I see you.

Your mind ruminating about what you could have done differently,
how you could have shown up, who you would rather be …
You're in a constant state of disconnect.
With every day flowing into the next.
Anxiety engraved within your being like it's your middle name.
Mind racing.
Heart thumping; breaking, and growing with every beat.

I hear you.

You cry yourself to sleep most nights, exhausted after long days of
wearing a facade and keeping your truth held close to your chest.
It feels hard to trust.
To open up.
To love.
To risk being hurt yet again.
Vulnerability is a strength disguised as a weakness within
society—opening the door to connection when fully embraced.

I forgive you.

For starving yourself—physically, mentally, emotionally and spiritually.
You weren't as present as you could have been in life because you didn't
believe that you had a place in the world.
Your eyes were closed off from the beauty that has always lived within you.

39.15 Panel hearings

The Commission conducted eight panel hearings that had been scheduled to take place as part of the Commission's 2020 public hearings. Panels involved three to four witnesses giving evidence before Commissioners at the same time. This method allowed Commissioners to examine a range of areas where there were different views among witnesses. Counsel Assisting led the questioning. These panel discussions were recorded, and the videos and transcripts were published on the Commission's website.

The topics for the panel hearings were:

- community-based mental health
- early intervention in adolescence and youth for good mental health throughout life
- compulsory treatment
- supporting the next generation through good infant and child mental health
- supporting young people and adults living with mental illness who are in contact with the justice system
- supporting people living with mental illness and alcohol and drug use
- enabling a contributing life
- service configuration.

A list of panel witnesses is at Appendix C.

39.16 Consumer Foundations Working Group

In July 2020, the Commission established the Consumer Foundations Working Group which comprised seven members who together brought a range of skills, expertise, experiences and perspectives to the Commission's work. A list of members is provided at Appendix C. The Commission is grateful for Sarah Jane Haywood's facilitation of this group.

Working Group members provided advice on reforms related to the leadership of people with lived experience of mental illness or psychological distress, with a view to creating an enduring foundation for a future mental health system that is grounded in consumer expertise. They were invited to consider and provide expert advice on policy proposals. Members were encouraged to be bold and innovative in their ideas for reform.

The Commission also provided informal opportunities for members to gather and network online, to ensure they had the space to share ideas, prepare for and debrief after meetings, and develop their own ideas.

The Commission appreciated the advice, thoughtfulness and generosity of Working Group members who provided input to the Commission. This input informed the deliberation of Commissioners who are responsible for the recommendations of the Commission as a whole. The Commission acknowledges that many members, like many other people with lived experience of mental illness or psychological distress, have contributed to similar processes before, sharing their hopes and aspirations to little or no avail. Like the Working Group members, the Commission hopes this process will be different—that it will lead to a reformed mental health and wellbeing system that meets the evolving needs and desires of consumers, and people living with mental illness and psychological distress.

39.17 Phase 2 of human-centred design

From June to September 2020, the Commission conducted a second and final phase of human-centred design. During this phase of focus groups, consumers and carers met online separately and, on a small number of topics, together, to discuss and develop specific reform ideas that had been identified in the Commission's work to date. This was an opportunity to understand the practical implications of potential policy directions and system design from a range of lived experience perspectives.

A total of 139 consumers and carers with a range of experiences and backgrounds attended 24 virtual focus groups hosted by the Commission, with policy staff in attendance. Topics covered during the focus groups included core components of the future service model, such as crisis responses, entry pathways, community integrated mental health services, primary care, alcohol and other drugs, suicide prevention, bereavement by suicide, perinatal mental health, housing, bed-based services, information sharing, services for young people, carers of young people, restrictive practices and compulsory treatment.

In most focus groups, a visual prompt was used to illustrate a range of policy options that had been raised with the Commission. This tool helped to bring previous contributions into the room, and supported people with lived experience to share in the analysis of potential policy directions and provide feedback directly to the Commission's policy staff.

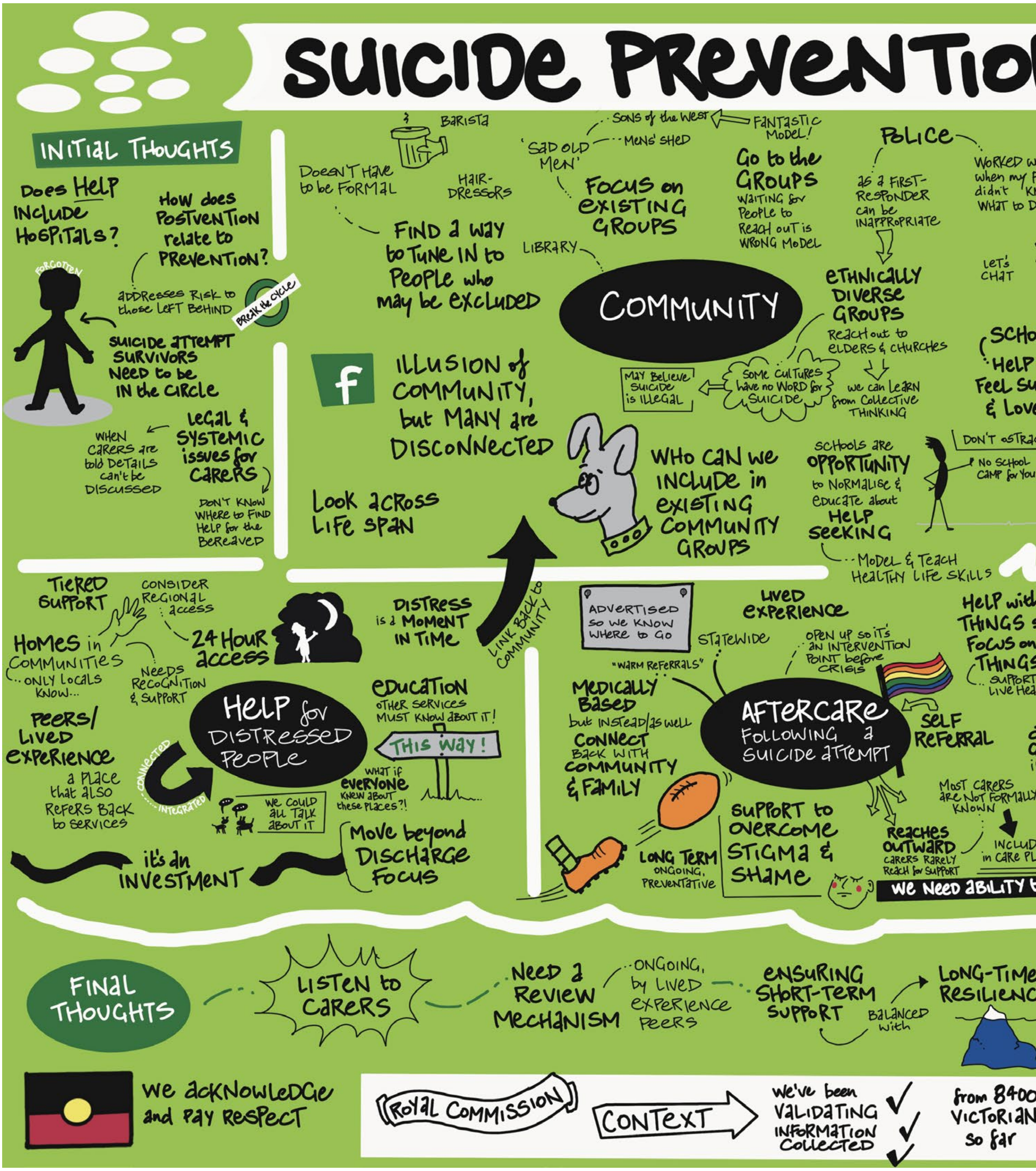
Focus groups were held online, and most were led by a facilitator with lived experience. The shift to online engagements, while reducing geographic barriers to participation, did require participants to use an internet-enabled device. In light of the changed delivery, the format was adapted. Participants were invited to log into the session to meet the facilitator and support staff, and settle into the online 'room' before the Commission's policy staff joined.

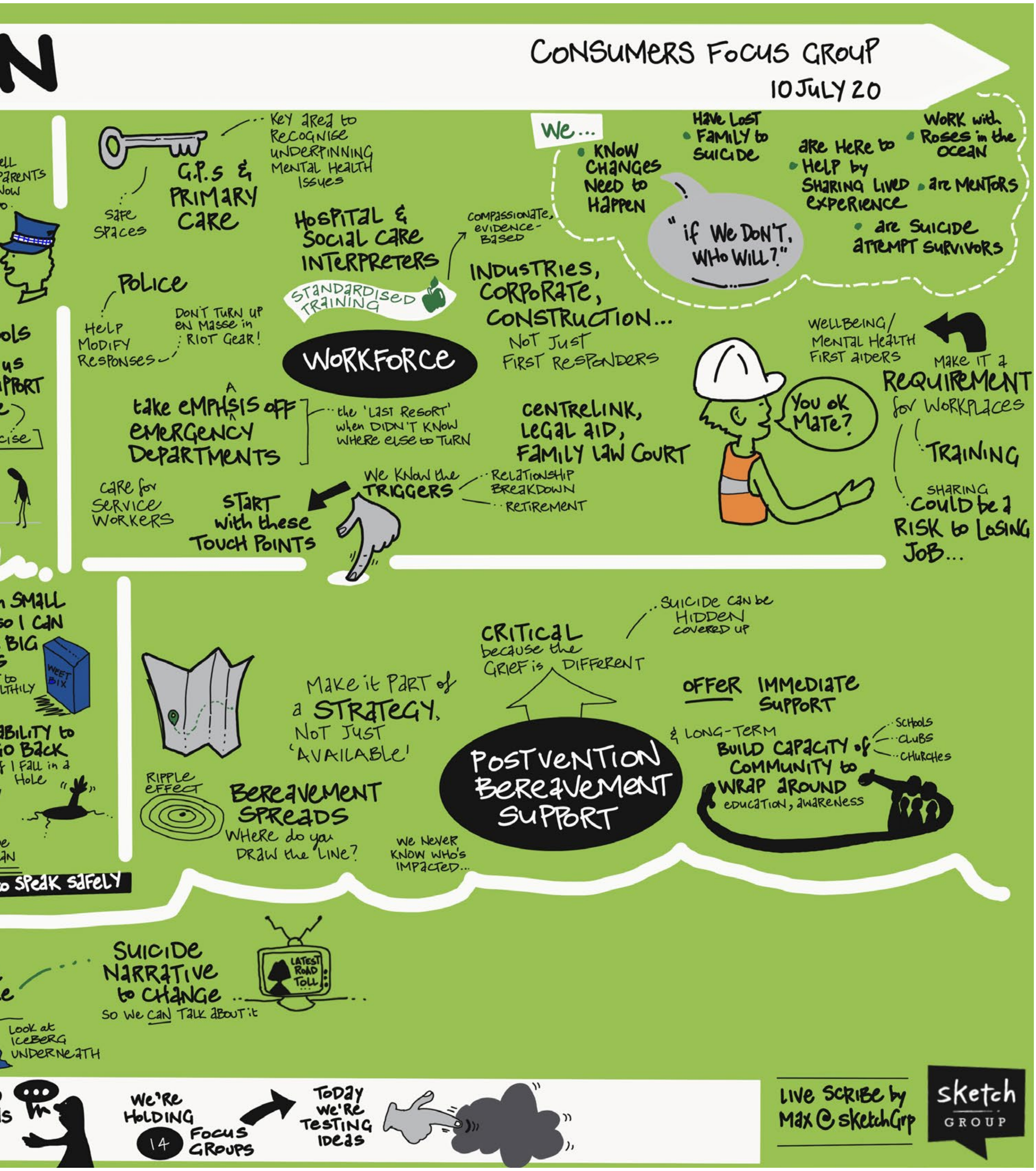
Many participants positively reflected on their experience participating in the focus groups, speaking of how they felt heard, and hoped for positive change in the future:

> Thank you all for the experience and opportunity to speak of our humanity and solutions to power over problems ... It was cathartic in terms of seeing that someone sees our humanity. Thank you.[30]
>
> Thanks for allowing me the chance to be involved in the focus group. I hope I brought something valuable to the table/discussion ... Anyway I had a great experience and hope for some positive change for my local mental health system.[31]

A graphic recorder captured a visual representation of the conversations using pictures, words and symbols, so the Commission could confirm with participants that important points had been understood and documented. The visual canvas and notes taken by Commission staff were provided to Commissioners. An example is provided at Figure 39.15.

Figure 39.15: Canvas capturing a focus group conversation about suicide prevention on 10 July 2020




N
CONSUMERS FOCUS GROUP
10 JULY 20
Key area to recognise underpinning mental health issues
G.P.s & PRIMARY CARE
Safe spaces
HOSPITAL & SOCIAL CARE INTERPRETERS
STANDARDISED TRAINING
COMPASSIONATE, EVIDENCE-BASED
POLICE
Help modify responses
Don't turn up en masse in riot gear!
WORKFORCE
INDUSTRIES, CORPORATE, CONSTRUCTION...
Not just first responders
We...
• Know changes need to happen
• Have lost family to suicide
are here to
• Help by sharing lived experience
• Work with Roses in the Ocean
• are mentors
• are suicide attempt survivors
"if we don't, who will?"
take A emphasis off emergency departments
the 'last resort' when didn't know where else to turn
CENTRELINK, LEGAL AID, FAMILY LAW COURT
Wellbeing/mental health first aiders
Make it a REQUIREMENT for workplaces
TRAINING
SHARING could be a risk to losing job...
You ok mate?
Care for service workers
START with these TOUCH POINTS
We know the TRIGGERS
Relationship breakdown
Retirement
small so I can BIG
WEET BIX
BILITY to go back if I fall in a hole
Make it part of a STRATEGY, not just 'available'
CRITICAL because the grief is different
Suicide can be hidden covered up
OFFER IMMEDIATE SUPPORT
& LONG-TERM
BUILD CAPACITY of COMMUNITY to WRAP AROUND
Schools
Clubs
Churches
education, awareness
RIPPLE EFFECT
BEREAVEMENT SPREADS
Where do you draw the line?
We never know who's impacted...
POSTVENTION BEREAVEMENT SUPPORT
speak safely
SUICIDE NARRATIVE to CHANGE
so we can talk about it
LATEST ROAD TOLL
Look at iceberg underneath
We're holding 14 FOCUS GROUPS
Today we're testing ideas
Live scribe by Max @ sketchGrp
sketch GROUP

39.18 Targeted roundtables

The Commission continued to hold roundtables, this time online, from June to October 2020. This series of 37 roundtables was designed to help the Commission explore important design questions. A Commissioner attended every roundtable and most roundtables were chaired by a Commissioner, with an external facilitator or host leading the other sessions. As with similar sessions, the discussion was recorded and notes were taken. A list of roundtable attendees is at Appendix C.

Box 39.11: Mentally healthy workplaces, mentally healthy Victoria roundtable

In recognition of the important role that business and workplaces play in promoting good mental health for their employees, customers and the broader communities in which they operate, the Commission invited a range of representatives from the business sector to attend a roundtable.

The mentally healthy workplaces, mentally healthy Victoria roundtable sought insights from the business sector about:

- where there are opportunities to make use of existing expertise in addressing mental health in their own organisation or industry
- their reach across the community
- an innovation mindset to support new ways of working and doing business.

This topic was particularly important in the context of COVID-19, which saw changes to, and in some cases the closure of, various industries.

The roundtable, facilitated by Professor Rod Glover from Monash Sustainable Development Institute, provided the Commission with an opportunity to learn from the work that businesses are doing. This information was of interest to the Commission, as it may support workplaces across Victoria to both fulfil their legal duties as an employer to provide a safe workplace, and to create an environment where employees thrive.

The important contribution business makes to the broader community, beyond the scope of their own staff and workplaces, was also discussed and considered as an important input for the Commission's deliberations. The roundtable was a distinctive event in that it reached beyond mental health services to gather evidence about responding to and preventing barriers to good mental health.

> It was a privilege to join the roundtable and to hear and learn from others.[32]

Box 39.12: Regional roundtables

The COVID-19 restrictions saw the Commission adjust its plans, including cancelling public hearing days planned for East Gippsland and north-eastern Victoria, areas that had been significantly affected by the 2019–20 summer bushfires. The Commission instead held regional roundtables in these areas, once management of COVID-19 restrictions within those communities had been well established, and people and organisations were in a position to talk with the Commission again.

An online roundtable helped the Commission get a better understanding of the unique perspectives and experiences of services and consumers in East Gippsland and north-eastern Victoria. The Commission worked with, and was hosted by, local partners in bringing together a range of services and people with lived experience. Participants shared their experiences and ideas, and the Commission considered these in its deliberations.

Each area was unique in what they brought to the roundtable, with themes such as:

- trauma and bushfire impacts
- experiences of farmers
- isolation and implications for service access
- the needs of Aboriginal and culturally and linguistically diverse communities
- the realities for service delivery in regional and rural areas.

Case studies and personal experiences were presented to the Commission. For example the story of a primary-school-aged boy living with family conflict, who was evacuated from two houses during the fires in early 2020. The school noted changes in his behaviour, including a decline in his schooling, suicidal ideation, self-harm, destructive behaviour at school and threats of harm to others. The school and family both tried to access child and youth mental health services, but were told there were no services available for him. The child was without mental health support services until a hospital admission.

Another personal story was from a local farming couple who lost their home and a large amount of their farming crop in early 2020. They spoke about the realities of farming life: drought, fire, flood and succession planning.

> it was a very, very stressful period like for probably 18 months to two years having to make phone calls every month on who we can pay and who we can’t pay and how we’re going to hang on is very difficult and then dealing with a young family at the same time.[33]

These roundtables echoed what the Commission had heard about the differences between regional and rural living, and what this means for people living with psychological and emotional distress. A common theme that came up was the importance of local knowledge and service providers.

> **It was totally useless; I spent all my time trying to explain to the counsellor/mental health worker about the farm or why what they were suggesting wouldn't work or that the referral they gave me was to a service that is miles away.**[34]
>
> **Our community that we look after is quite diverse and it's from farming, small industry, small business professionals, environmental groups and it's quite a low socioeconomic area.**[35]

The Commission was grateful for the work of the hosting organisations and those who gave presentations to the Commission to demonstrate the distinctive barriers and opportunities in their areas.

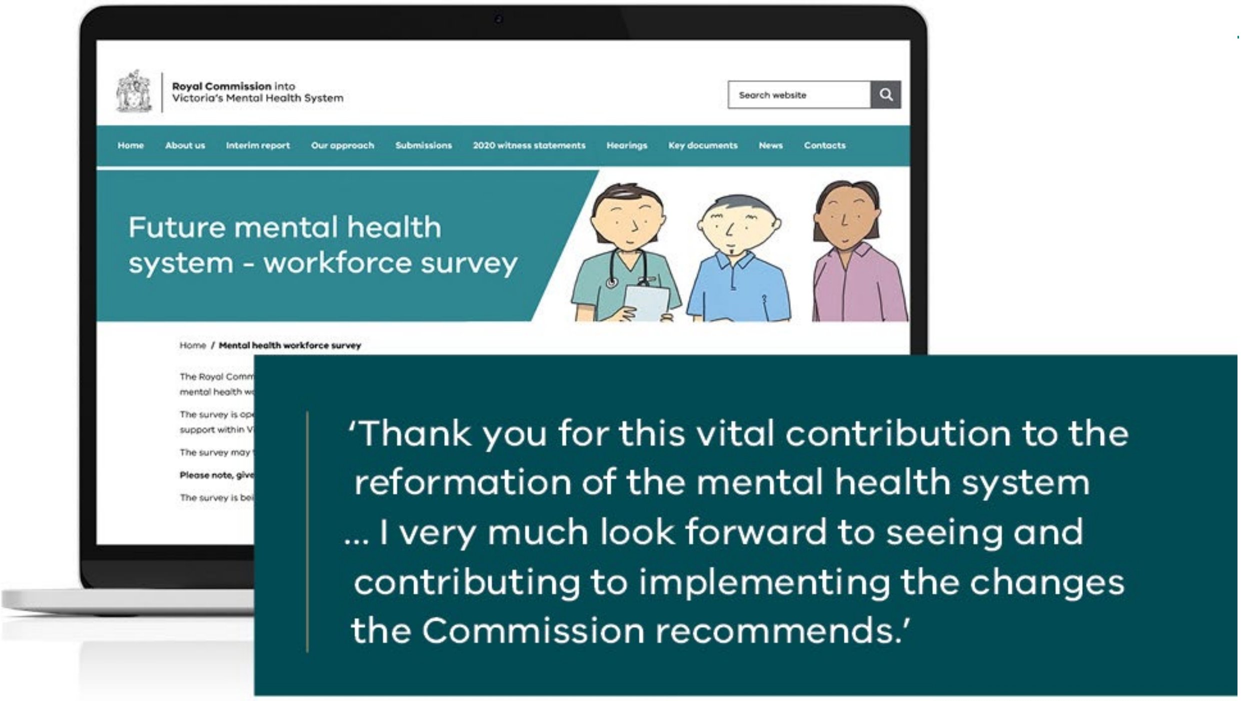
39.19 Workforce survey

The Commission engaged independent consultants to conduct a survey of frontline mental health workers to gain an understanding of Victoria's mental health workforce and to hear their ideas for change. Almost 3,000 people participated in the survey, which was a good response rate, also noting the increased pressure on the workforce as they responded to the COVID-19 pandemic and remote working arrangements.

The Commission worked with organisations and unions across the mental health sector to promote the survey and encourage participation.

Responses were collected across a wide range of professions, roles and workplace settings, broadly reflecting the diversity of the mental health workforce across Victoria. While just under 5 per cent of survey responses received were from workers primarily in a lived experience role, the majority of respondents across diverse professional roles and settings reported having lived experience of mental illness, or of caring for a friend or family member living with mental illness. This illustrates the breadth of lived experience in the current mental health workforce. Many respondents expressed their appreciation of the opportunity to contribute to the Commission. The workforce survey, as shown in Figure 39.16 was open from 27 July to 12 August 2020.

Figure 39.16: Future mental health system – workforce survey[36]



'Thank you for this vital contribution to the reformation of the mental health system ... I very much look forward to seeing and contributing to implementing the changes the Commission recommends.'

39.20 Community workshops

The Commission closed its public engagement the same way it commenced: by inviting the general public to connect and have conversations about mental health and wellbeing. Two virtual workshops marked the end of the Commission's formal public engagement in October 2020.

Local community members in Wangaratta and south eastern metropolitan Melbourne met with the Commission on 6 and 7 October 2020 respectively in two separate online workshops to talk about what communities can do at a grassroots level to strengthen wellbeing and promote good mental health. The workshops were not looking at the mental health system specifically, but focused on prevention and promotion. Involvement in this conversation, unlike human-centred design focus groups, was not limited to people with lived experience. In fact, the invitation was broad to encourage any member of the public with an interest in prevention and promotion to attend.

Attendees included parents, young people, older people, workers in the health and human services systems, artists and playwrights, school teachers and principals, faith leaders, tradespeople and sporting club members. While lived experience of mental illness or familiarity with the mental health system was not required, participants brought a range of experiences, some of which included lived experience.

The workshops were interactive and ran for two and a half hours, with participants allocated to smaller groups to discuss social connectedness and the roles that communities can play in promoting good mental health and wellbeing. The Commission heard that social isolation and loneliness in communities are associated with poor mental health and are increasing in Victoria, particularly among older Victorians.

Conversations in the workshops spanned definitions of good mental health and wellbeing, promoting good mental wellbeing in day-to-day activities, and opportunities to strengthen these from a grassroots perspective. People spoke about the importance and the difficulty of building community connections, as well as supporting wellbeing, particularly where people are adapting to new environments:

> The young kids, especially the young men, really are developing their bonding with the soccer teams. They love it, they engage with it; I have a client, a kid who's lost three to four years in the detention camp now back to school. And he's thriving in that environment, connecting, developing bonding with other culture voices from the other cultures. So I think outdoor activities definitely helped them.[37]

Commission staff attended to hear from participants directly, help guide discussion and take notes of the proceedings. A graphic recorder captured the conversation using a variety of words and pictures as shown in Figure 39.17.

Figure 39.17: Canvas recording of the conversation held with members of the south eastern metropolitan Melbourne community as part of a community workshop on 7 October 2020


N METRO
NE 7 OCTOBER '20
GRASSROOTS PROMOTION
"WE ACKNOWLEDGE the TRADITIONAL OWNERS..."
SENSE of BELONGING
NEIGHBOURHOOD HOUSE
SOCIAL CONNECTIONS
LEARN NEW THINGS
CITIZENS' ADVICE BUREAU
A PLACE to FIND LOCAL INFORMATION
REDUCE ISOLATION
PETS
ART
NOW KNOW AS: COMMUNITY SUPPORT & INFORMATION
PROMOTE THIS!
RECOVERY & ENGAGEMENT COACH
'BUDDY' to HELP INTRODUCE into COMMUNITY GROUPS
CHECK OUT LIVINGWORKS.com.au
INCLUSION
EDUCATE
ZOOM
BROADER CONNECTION
COMMUNITY
SOCIAL INCLUSION
RECOGNISE VALUE of PLACES of WORSHIP
ENDORPHINS
TEER
MULTI-CULTURAL
WOMEN'S CAFE
TALK
KNOWLEDGE
CHILD FRIENDLY
SPORT as a GATEWAY to POSITIVE MINDSET
AND SHARE STORIES
LIVED EXPERIENCE
MEDIA
POSITIVE MESSAGES
CLEAR PATHWAYS
GET
EMS
WRAP AROUND SERVICES
SAFETY
CHOICE
HOUSING
VISITS
TRUST
TARGET the ISOLATED
EARLY INTERVENTION
INPUT FROM YOUNG PEOPLE
COLOUR
FONT
EMOTIONAL INTELLIGENCE
RESPECTFUL RELATIONSHIPS
MENTAL HEALTH LITERACY at HIGH SCHOOL
GOOD ROLE MODELS
TAFE: TALK ABOUT FINANCE, GRIEF, RELATIONSHIP
(ALL the things that can LEAD to SUICIDE)
COMMUNITY GATEKEEPER TRAINING
HAIRDRESSER
COULD BE ANYONE
FOCUS NEEDED ON MIGRANT MEN
HUBS for SELF-HELP + EXERCISE + NON-CLINICAL HELPERS
LOW-COST
MATCH LESS WELL PEOPLE with WELL PEOPLE
"IF YOU JOIN A GOOD CHOIR, SOON YOU'LL SING WELL"
VOLUNTEERING
TELL us the WORDS to USE
GRAPHIC RECORDING by Max @ sketchGrp
sketch GROUP

39.21 Final report

The final report marks the close of the Commission's work. While the interim report set the foundations, this report contains an ambitious blueprint for transforming Victoria's mental health system, and improving the lives of people living with mental illness or psychological distress, families, carers and supporters, and the Victorian community now and in the future.

All of the information the Commission has received throughout its inquiry has informed the final report and the Commission's recommendations.

While policy analysis and research proceeded across the Commission's inquiry, the core writing for the final report took place from October to December 2020, after the Commission closed its public engagements at the beginning of October 2020.

The final report is accompanied by a summary and recommendations, Plain Language and Easy Read outlines, and a short animated video.

39.22 Acknowledgements

The Commission would like to thank all those who made contributions to this inquiry—people with lived experience, members of the workforce, academics, government officials and those in related fields—for sharing their time, perspectives and ideas. The fact that engagement with the Commission continued at pace during the COVID-19 pandemic was a testament to the considerable interest and dedication of so many in the Victorian community to building a better mental health and wellbeing system. The Commission is particularly grateful for the many contributions from people with lived experience, and recognises that these contributions were often deeply personal and sometimes difficult for people to share.

The Commission acknowledges that many people shared personal, sometimes tragic experiences in the generous hope of improving treatment, care and support for others:

> It is my hope that by sharing some of my experiences, I can help be part of the process of change, so that no other child or adolescent has to go through what I went through in an attempt to recover from a mental illness.[38]

The Commission was supported by strong connections with key lived experience peak bodies, VMIAC and Tandem, and also by VACCHO. The Commission acknowledges the support of these organisations and thanks them for the commitment they showed to the Commission's work, and for supporting a wide range of people with lived experience to engage with the Commission.

The Commission would like to acknowledge several people who assisted the Commission with its policy work and processes, often over many months: Chris Kotur; Gemma Varley; Shane Solomon; Professor Hal Swerissen; Professor Rod Glover; James Mansell; Gareth Edwards; Dr Nina Terrey; Max Harman; Simon Katterl; Cathy Balding and Lesley Thornton. While all of the work in this final report is that of the Commission, these individuals supported legal, engagement and policy processes.

The Commission appreciated engagement with the Productivity Commission during the course of its inquiry into mental health, including with its Commissioners and staff. In addition, the Commission is grateful for the time given by Christine Morgan, CEO of the National Mental Health Commission and National Suicide Prevention Adviser to the Prime Minister, and the Department of the Prime Minister and Cabinet as well as the Commonwealth Department of Health, in progressing conversations about mental health and system design. These connections provided the Commission with a deeper understanding of issues and opportunities from a national perspective, including opportunities for collaboration and partnership.

1 The Honourable Daniel Andrews MP, Premier of Victoria, Media Release: Experts to Lead the Mental Health Royal Commission, 24 February 2019, <www.premier.vic.gov.au/experts-lead-mental-health-royal-commission>, [accessed 1 September 2020].

2 Victorian Government, Royal Commission into Victoria's Mental Health System—Letters Patent, 2019, para. IV(i).

3 Victorian Government, Royal Commission into Victoria's Mental Health System—Letters Patent, para. I(4).

4 The Honourable Daniel Andrews MP, Premier of Victoria, Media Release: More Time to Design a Better Mental Health System for Victoria, 27 May 2020, <hnb.dhs.vic.gov.au/web/pubaff/medrel.nsf/AllDocs/ABA0B5C3D6194D D5CA2585750006C1BB/$FILE/200527-More-Time-To-Design-A-Better-Mental-Health-System-For-Victoria.pdf>, [accessed 7 January 2021].

5 Victorian Government, Royal Commission into Victoria's Mental Health System—Letters Patent, para. III(a).

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

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

8 *Witness Statement of Janet Meagher AM*, 1 July 2019, para. 35.

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

10 RCVMHS, *Seymour Community Consultation—May 2019*.

11 RCVMHS, Media Release: Have Your Say to Improve Victoria's Mental Health System, 17 April 2019, <rcvmhs.vic.gov.au/news/have-your-say-improve-victorias-mental-health-system>, [accessed 28 October 2020].

12 Anonymous 107, *Submission to the RCVMHS: SUB.0002.0032.0056*, 2019, pp. 3 and 9.

13 *Correspondence from 'Susan Trotter' (pseudonym)*, July 2019.

14 *Correspondence from Anonymous*, April 2020.

15 RCVMHS, *Interview with Julie Rickard*, August 2020.

16 *Witness Statement of Aunty Nellie Flagg*, 9 July 2019, para. 35.

17 Department of Health and Human Services, *Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework 2017–2027*, 2017, p. 50.

18 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001. Balit Durn Durn Report*, 2020, p. 10.

19 Mike Cooley, Chapter 4: Human Centred Design, in *Information Design* (Massachusetts Institute of Technology: MIT Press, 1999), pp. 59–82 (p. 64).

20 RCVMHS, *Youth Female Criminal Justice Human-Centred Design Focus Group: Record of Proceedings*, 2020.

21 RCVMHS, *Adult Female Criminal Justice Human-Centred Design Focus Group: Record of Proceedings*, 2020.

22 *Correspondence from a Human-Centred Design Participant*, August 2020.

23 RCVMHS, *Workforce Focus Group: Record of Proceedings*, 2020.

24 *Correspondence from Denna Healy*, August 2020.

25 *Correspondence from 'Nathan Turner' (pseudonym)*, November 2020.

26 *Correspondence from 'Mary and Jacob Corbett' (pseudonyms)*, August 2020.

27 *Correspondence from Kiba Reeves*, September 2020.

28 ABC News, How Angus the Cat Helped a Mental Health Royal Commission Witness Feel More Equal Giving Her Testimony, 27 May 2020, <www.abc.net.au/news/2020-05-27/mental-health-royal-commission-coronavirus/12288698>, [accessed 5 November 2020].

29 *Correspondence to the RCVMHS—Poem of Denna Healy: CSP.0001.0123.0001*, 2020.

30 *Correspondence from a Human-Centred Design Participant*, September 2020.

31 *Correspondence from a Human-Centred Design Participant*, July 2020.

32 *Correspondence from a Roundtable Participant*, September 2020.

33 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*, 2020.

34 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*, 2020.

35 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

36 ORIMA Research, *Mental Health Workforce Survey*, 2020.

37 RCVMHS, *Southern Metro Community Workshop (Dandenong / Frankston): Record of Proceedings*, 2020.

38 Anonymous 60, *Submission to the RCVMHS: SUB.0002.0022.0023*, 2019, p. 1.

39 Listening to Voices Theatre Group, *Submission to the RCVMHS: SUB.0002.0032.0032*, 2019, pp. 21–22

Chapter 40

The operations of the Commission

40.1 Commission operations

The Commission began operating in February 2019. It occupied a small separate space and used some information technology (IT) equipment and systems at the Department of Premier and Cabinet's office.

The initially small Commission team reviewed previous royal commission reports and spoke to government contacts who had set up similar operations, and came up with a set of priorities that comprised:

- developing the budget needed to support the Commission
- recruiting the staff and contractors required to do the Commission's work
- acquiring and moving into an independent office
- establishing and operating a separate, protected IT environment.

The team then set up processes to ensure the Commission could operate effectively, independent of government, including:

- governance, decision-making and risk-management processes
- planning and project-management functions
- financial management and delegations
- procurement and contract-management processes
- people and culture policies and processes
- records-management protocols.

Where possible, the team sought support from other entities, including from:

- the Department of Premier and Cabinet—for initial accommodation, IT and advertising for staff and recruitment
- the Shared Service Provider within the Department of Treasury and Finance—for finding suitable long-term accommodation
- a range of Victorian public service departments and agencies—these entities allowed some of their people with much-needed capability to join the Commission's staff on short notice.

The team used established operational processes wherever possible. For example, they used State Purchase Contracts to secure providers quickly and on standard government-approved terms to achieve value for money.

The Commission was able to set up its operations quickly using a combination of these processes and support.

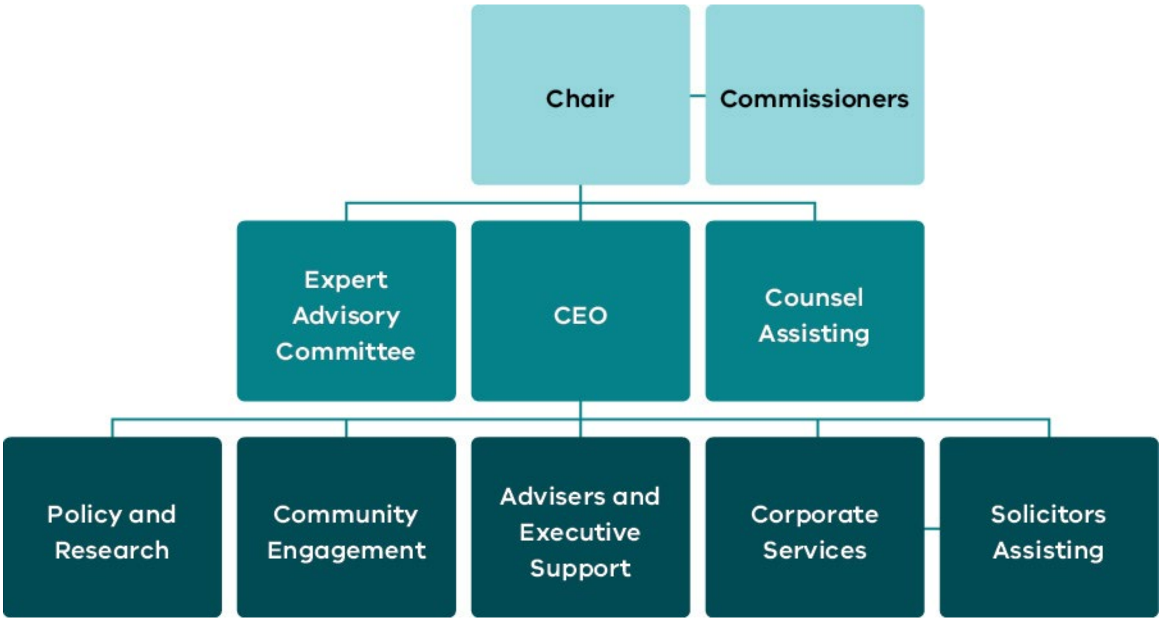
40.2 Governance and decision making

In setting up its operations, the Commission considered how it would be organised and how decisions would be made. A structure was developed with functions that comprised:

- **Commissioners**—the Chairperson had overall accountability for the Commission's activities—such as overseeing its program of work, inquiries, engagement, reports and recommendations—to meet the terms of reference. A Commissioners' Charter set out the respective responsibilities of the Chairperson and Commissioners. Commissioners shared strategic oversight of key activities, whereas the Chairperson was responsible for the Commission's operations.
- **Staff of the Commission**—led by the CEO and supported by the Executive Leadership Group, the staff of the Commission were organised into four branches:
  - **Policy and Research**—teams of policy and research experts with primary responsibility for managing and analysing data, evidence and other information the Commission obtained; developing work packages and policy directions for Commissioner consideration; and writing and producing the Commission's reports
  - **Community Engagement**—teams that managed the Commission's programs of engagement with stakeholders; provided support to the public in their contact with the Commission; and ran the Commission's media relations, and internal and external communications activities
  - **Advisers and Executive Support**—a small team that supported and advised the CEO and Commissioners
  - **Corporate Services**—a team that managed services for the Commission, including finance and procurement, people and culture, IT and records management, legal, governance, risk management and accommodation.
- **Counsel Assisting**—facilitated the inquiry by advising on the Commission's powers, duties, functions and obligations; conducting hearings; supporting report writing and the presentation of evidence; and helping to manage and administer inquiry processes and procedures.
- **Solicitors Assisting**—a contracted legal services firm, Herbert Smith Freehills, was appointed to provide legal advice as the Commission's solicitors; support Counsel Assisting and the hearings process; work with parties' legal representatives; and help manage evidence.
- **Expert Advisory Committee**—an eight-member expert committee was established as requested by the letters patent, to advise the Commission on all matters it considered appropriate during the inquiry. Members had a wealth of knowledge in lived experience and professional and sector experience with Victoria's mental health system.

Figure 40.1 shows the structure of the Commission.

Figure 40.1: Commission structure

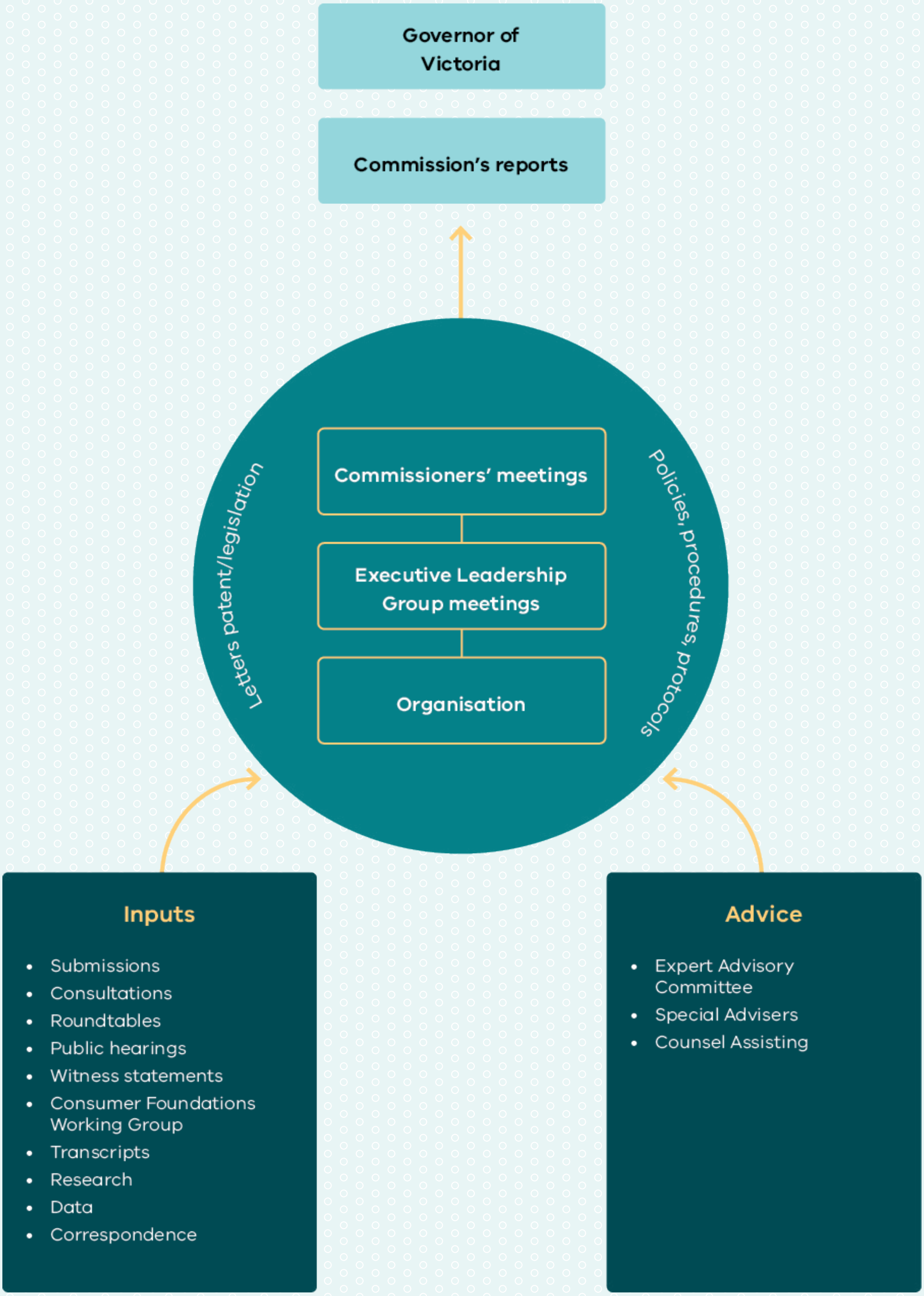


The Commission implemented a governance framework to support this structure, oversee the delivery of its work and guide decision making. This comprised:

- **Commissioners' meetings**—formal meetings of the Chairperson and Commissioners were held and attended by the CEO and staff. These meetings were the main forum for considering the Commission's work.
- **Expert Advisory Committee meetings**—during formal committee meetings, the Commission and the committee discussed and tested the Commission's work.
- **Executive Leadership Group meetings**—formal meetings of the Leadership Group discussed important issues and risks associated with the Commission's work program and operations.

Figure 40.2 shows the Commission's governance.

Figure 40.2: Commission governance



Inputs

- Submissions
- Consultations
- Roundtables
- Public hearings
- Witness statements
- Consumer Foundations Working Group
- Transcripts
- Research
- Data
- Correspondence

Advice

- Expert Advisory Committee
- Special Advisers
- Counsel Assisting

40.3 Practice directions and protocols

Under the *Inquiries Act 2014* (Vic) a Royal Commission may issue practice directions.[1]

The Commission made two practice directions. Practice direction number 1 related to the conduct of the Commission's public hearings.[2] Practice direction number 2 related to the production of material and document management protocol for providing information under a Notice to Produce to the Commission.[3]

The Commission also entered into a protocol with the State of Victoria to set out the process of timely access to documents and data.[4] The protocol established a mechanism for dealing with claims of public interest immunity made over documents produced by the State.[5] This protocol was read in conjunction with practice direction number 2.

40.4 Notices to produce

The Inquiries Act provides a royal commission with the power to compel the production of documents to a royal commission.[6] This power allows a royal commission to gather a strong and broad evidence base to underpin its work and receive information that is not ordinarily publicly available.

The Commission issued 217 Notices to Produce (Table 40.1). Documents and data produced to the Commission had to comply with the Document Management Protocol set out in Practice direction number 2.

The Commission received 8,243 documents through the Notice to Produce process. Some documents provided by agencies were subject to the following claims:

- public interest immunity
- personal information
- legal professional privilege
- statutory secrecy or statutory confidentiality.

Table 40.1: Notices to Produce issued by the Commission

Agency	Number of NTPs	Number of documents produced
Albury Wodonga Health	1	12
Alfred Health	2	38
Ambulance Victoria	3	25
Austin Health	2	13
Ballarat Health Services	1	9
Barwon Health	2	86
Bendigo Health	2	48
Department of Education and Training	8	100
Department of Environment, Water, Land and Planning	1	4
Department of Health and Human Services	110	4,987
Department of Jobs, Precincts and Regions	6	41
Department of Justice and Community Safety	16	1,504
Department of Premier and Cabinet	11	137
Department of Treasury and Finance	5	120
Doveton College	1	1
Eastern Health	3	13
Emergency Services Telecommunication Authority	2	18
Goulburn Valley Health	1	1
Kalinda Primary School	1	1
Latrobe Regional Hospital	2	18
Melbourne Health	5	233
Mental Health Complaints Commission	3	50
Mental Health Reform Victoria	1	1
Mental Health Tribunal	1	20
Mercy Health	1	17
Monash Health	2	2
Northern Health	1	1
Peninsula Health	1	69
Southwest Healthcare	2	45
St Vincent's Hospital Melbourne	1	48
The Royal Children's Hospital	2	32
Victoria Police	7	88
Victoria Workcover Authority	4	204
Victorian Institute of Forensic Mental Health	4	247
Victorian Public Sector Commission	1	4
Western Health	1	9
Total	**217**	**8,246**

Note: Includes Notices to Produce issued for the production of witness statements. The number of documents produced is an approximate number due the reproduction of some documents.

40.5 Finance and procurement

The Victorian Government allocated $37.1 million to cover the Commission's operations, over three financial years from 2018-19 to 2020–21. This includes funds to extend the Commission's final report deadline from 31 October 2020 to 5 February 2021.

The Commission's estimated total expenditure is $35.7 million. This estimate of all costs associated with the Commission reflects actual costs incurred to 31 December 2020 as well as an estimate of costs for the final period of operation from 1 January to 5 February 2021 and expected wind-down and decommissioning costs to 31 March 2021.

Costs incurred by the Commission for the period 22 February 2019 to 30 June 2020 were included in the audit by the Victorian Auditor-General's Office as part of its annual financial audits of the Department of Premier and Cabinet, which processed all Commission expenses. The costs incurred for the period 1 July 2020 to 31 March 2021 will be included in the audit by the Victorian Auditor-General's Office as part of its annual financial audit of the Department of Premier and Cabinet at the end of the 2020–21 financial year.

40.5.1 Internal controls

The Commission was committed to providing value for money and good financial governance when spending public funds. Accordingly, it was careful to ensure it had internal controls in place for its financial management.

Corporate Services coordinated the Commission's funding requirements and financial management in conjunction with the CEO and Chairperson of the Commission.

Although the Commission managed its own financial decisions and processes, the Department of Premier and Cabinet's finance team supported the Commission with reporting and accounts payable.

Using the powers conferred in the letters patent and in accordance with the Inquiries Act, the Chairperson issued delegations to several executive staff to support the Commission's effective operation.[7] This permitted directors to approve expenditure up to $25,000 and the CEO to approve up to $150,000. The Chairperson authorised expenditure above those delegations.

The Commission also used the internal controls built into the finance system, such as position-controlled delegations, as well as segregation of duties for approving payments.

Corporate Services provided staff with advice and support to ensure they had the knowledge and expertise to follow policies and processes regarding Commission expenditure.

The lead of Finance and Procurement and the director of Corporate Services undertook regular reviews of financial transactions and ensured there was correct documentation to support financial decisions.

40.5.2 Financial management

As noted above, a budget was constructed early in the Commission's establishment.

The budget was divided into cost categories, and these formed the basis for the Commission's financial reporting framework, which assisted the Commission to plan and manage its expenditure.

Each month, the Corporate Services director and Finance and Procurement lead worked together to create a financial reporting package. The package was approved by the CEO and was distributed to and discussed with the Executive Leadership Group. High-level financial reporting was also provided monthly to the Commissioners as part of their meetings, so the Commission was aware of how the budget was tracking overall.

In addition to this reporting, Corporate Services, as well as the cost category and contract managers, were in regular contact so they could identify any financial risks and issues early.

As the Commission progressed, Corporate Services undertook several budget reviews to realign the budget with the Commission's shifting priorities and needs.

The onset of the COVID-19 pandemic was one major example of this. As outlined in Chapter 39: *The work of the Commission*, the pandemic resulted in the cancellation of in-person activities, such as hearings, which reduced expenditure in this area. However, it led to an increase in other expenditure because resources needed to be reallocated to collect evidence and interact virtually with interested parties. Corporate Services worked closely with the Executive Leadership Group and the Commission to provide visibility over the Commission's finances and to support these decisions.

40.5.3 Procurement

The Commission adopted standard policies and processes in line with Victorian public sector guidelines to manage procurement. Consistent with Victorian public service procurement practice, the Commission at times applied exemptions whilst maintaining competitive procurement processes. The procurement processes included:

- testing the market based on the value of the proposed procurement
- signing off and appropriately delegating and managing conflicts of interest for all involved in the procurement processes
- recording assessments of value for money
- using State Purchasing Contracts.

40.6 Information technology, records management and data management

Given the volume and sensitivity of the information the Commission received, great importance was placed on ensuring this information was efficiently managed and kept safe. This meant implementing an independent protected-level IT system and a strong approach to records and data management.

Corporate Services was responsible for designing and managing the Commission's IT environment, supported by a partnership of managed services providers Citadel (Kapish) and SXIQ. The Commission engaged these providers within the first few months of its operations from a select tender process using the Victorian Government eServices register for IT services.

This team was supported by electronic document and evidence management services from three sources—the Commission's Solicitors Assisting firm, an independent IT security firm (Trusted Impact) and a team in the Policy and Research Branch dedicated to managing Commission data.

40.6.1 Information technology

The Commission's IT environment needed to comply with Australian Cyber Security Centre guidelines and Victorian Protective Data Security Framework controls to a 'protected level' in order to maintain a high level of security for the Commission's information and data.

Other requirements included a standard operating environment and intuitive software applications so the system could be set up quickly and easily used by Commission staff. It also needed to be adaptable over the life of the Commission to ensure information flowed smoothly and the Commission's engagement activities were supported.

The ability to have good information flow and the need to support virtual engagement activities became more important as the COVID-19 pandemic resulted in staff working remotely and the Commission's engagement activities moving to an online format rather than face-to-face. The Commission quickly mobilised to use collaboration software such as Zoom and Microsoft Teams, which enabled staff to conduct activities online. Staff and contractors were provided with portable devices to help them work flexibly, and Commission contractors provided desktop support via an onsite technician and an after-hours number in peak periods. IT help guides were also developed so staff could resolve issues independently where possible.

The Commission placed great emphasis on regular maintenance, backup and security of systems and devices to protect information and the Commission's work. Staff were given information security training and the environment was managed in accordance with a range of policies, procedures and protocols. This included monthly service delivery meetings between Commission staff and its managed service providers, as well as regular IT risk assessment meetings and security testing.

40.6.2 Records management

The Commission's electronic document records management system was first set up on the Content Manager platform, but moved to the Microsoft SharePoint platform as part of its standard operating environment for its working documents. The Commission needed the usability and flexibility of SharePoint, including the ability for multiple users to work on documents together in real time. While this was a new platform for many staff, SharePoint provided much-needed efficiency. Staff adapted to the platform and it proved to be vital in producing the final report, which staff largely wrote working from home due to COVID-19 restrictions.

The Commission chose the NVivo platform to host its source documentation and reference materials. This database became the main repository for research materials, submissions, hearings materials such as transcripts and exhibits, correspondence, responses to Notices to Produce, and formal records of engagement activities.

The NVivo platform also allowed staff to sort, search, code and extract information, helping them to analyse the suite of information, to inform findings and write reports and recommendations.

As mentioned above, the Commission was supported by the document management arm of its Solicitors Assisting firm. The firm processed, catalogued and stamped formal evidence and then provided it to the Commission to upload into NVivo.

While the Commission valued flexibility and usability in its records management approach, it was mindful that documentation would ultimately become part of the public record. Accordingly, the Commission worked with the Department of Premier and Cabinet and Public Record Office Victoria to set up a records management framework that would comply with the archive requirements in the Inquiries Act and the Retention and Disposal Authority under the *Public Records Act 1973* (Vic).[8]

40.6.3 Data management

The Commission established an in-house data analytics team to manage the data it received. The team helped ensure the data was used effectively and that the Commission's findings and recommendations were evidence-informed.

The Commission sought and received datasets from a range of Victorian Government departments, agencies and funded services including:

- Ambulance Victoria
- Coroners Court of Victoria
- Department of Education and Training
- Department of Health and Human Services
- Department of Justice and Community Safety
- Emergency Services Telecommunications Authority
- Mental Health Complaints Commissioner
- Mental Health Tribunal
- Victoria Police

- Victorian public health services and public hospitals
- WorkSafe Victoria.

The Commission also received the Victorian Social Investment Integrated Data Resource, which is an enduring linked data resource combining information on Victorian health care, community care, education, crime and safety. The dataset enabled the Commission to not only investigate a population at a specific time (cross-sectional data) but also changes over time (longitudinal data). Longitudinal data provides valuable insights over an individual's life course—insights that are not usually available in standalone datasets.

The Commission is grateful to these departments and agencies for providing these datasets and supporting the Commission to use and analyse their content appropriately.

The Commission also created a merged dataset that included the:

- Victorian Admitted Episodes Dataset
- Victorian Emergency Minimum Dataset
- Victorian Client Management Information and Operational Data Store
- Commonwealth Government's Medicare Benefits Schedule
- Commonwealth Government's Pharmaceutical Benefits Scheme.

The merged dataset helped the Commission to understand, at a de-identified individual level, the use of relevant services. Ethics approval was obtained from the Australian Institute of Health and Welfare to integrate these datasets, and the merged data was accessed through The Sax Institute.

The Commission is grateful to the Commonwealth Department of Health for providing the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme data. In using these datasets, the Commission ensured it always complied with relevant legislation and regulations, including the *Health Records Act 2001* (Vic), *Mental Health Act 2014* (Vic) and *Privacy and Data Protection Act 2014* (Vic).

40.7 People and culture

A royal commission is an unusual place to work. There are many moving parts and tight deadlines, and staff need to be flexible, solution-focused and hardworking. The Commission's people were a crucial element of its operations.

Many of the Commission's staff joined the Commission because they were motivated to make a difference and to contribute to real and lasting change in Victoria's mental health system. They were extremely dedicated to the Commission's purpose and worked very hard as a result.

Considering the challenging environment, the Executive Leadership Group and managers focused on providing strong people-support services and driving a positive organisational culture.

Corporate Services provided people and culture services, with support from the Department of Education and Training's HR Shared Services function for its payroll.

40.7.1 Workforce

The people working at the Commission came from a variety of backgrounds, including the Victorian public sector, the health sector, non-government organisations and the private sector.

The Commission was deliberate in recruiting staff with diverse backgrounds to provide breadth in experience and perspective, and depth in its capability. The Commission reached out to relevant organisations to promote job advertisements in order to encourage people with lived experience to apply. It also advertised for roles through standard channels such as the Careers.Vic website and the Jobs and Skills Exchange, an internal web portal set up to find talent within the Victorian public service.

The Commission engaged its staff under various arrangements including secondment and fixed-term appointments. Where necessary, some staff were also directly employed on contract.

Due to the variability of the Commission's work, and the need to build operations quickly and to wind down quickly, staff numbers fluctuated greatly. A core contingent of about 45 staff were present for most of the Commission's timeline.

40.7.2 Culture

One challenge of a royal commission is quickly bringing together a range of people, many of whom have not worked together before, to work in a pressured environment to solve complex problems within tight deadlines.

Recognising this challenge, and as fitting for a royal commission into mental health, the Executive Leadership Group prioritised initiatives to foster a collaborative, supportive and innovative culture. They wanted to build high-performing teams in which everyone supported each other, shared ideas and worked together towards a common goal. This included being willing to share the workload, take on additional responsibilities and do what was needed to deliver on the Commission's objectives.

Despite staff having specific roles and responsibilities, there was always the understanding that everyone was working together for the same purpose and outcome. There was support from different teams and across functions to ensure work was produced efficiently and delivered on time.

The Commission prioritised a range of cultural initiatives including workshops focusing on team values and behaviours, social activities, opportunities to share and tell stories, and flexible work arrangements.

The Commission was dedicated to continuous improvement and regularly reviewed processes and implemented what was learned.

Two important aspects of the Commission's culture were wellbeing and staff learning and development. These are outlined further below.

40.7.3 Wellbeing

The Executive Leadership Group recognised that staff could be affected by the Commission's high-pressure environment and its sensitive and critical subject matter. Commission staff were often exposed to accounts of traumatic events and various other confronting information. To mitigate any negative impact on staff, the Commission established a *Wellbeing Framework* to support its people to care for their own and each other's mental health and wellbeing. This framework was developed collectively by staff and was supported and maintained by Corporate Services. It covered four pillars: mind, body, connection and purpose.

Staff were encouraged to integrate mindfulness into their work and to be aware of their colleagues' mental health. To support this, the Commission engaged Carfi Psychological and Rehabilitation Services, and Carfi became embedded in Commission operations. Staff could contact Carfi confidentially at any time or have one-on-one sessions with them.

Carfi checked on staff welfare by walking the office floor and chatting with them. They also facilitated debriefs after challenging milestones such as community consultations and hearings, and ran group support sessions. During the COVID-19 restrictions, for example, they ran sessions for staff who had to balance their work with caring responsibilities.

The Executive Leadership Group encouraged staff to maintain work-life balance and to eat well, move regularly and look after their physical wellbeing more generally.

The Executive Leadership Group focused on creating opportunities for people to connect and share—for example, by celebrating milestones and important days. There were also informal ways staff continued to connect with each other such as weekly staff stand-up meetings hosted by the CEO and regular staff gatherings.

While the Executive Leadership Group initiated many activities, they were supported by the Commission's Health and Safety Committee. The director of Corporate Services chaired the committee, which included people with specific health and safety roles such as first aid officers, wardens and health and safety representatives. The committee met many times to consider staff health and safety, and ways it could be improved.

A committee was also formed to lead the Commission's health and safety response to the COVID-19 pandemic, overseeing:

- implementation of related policies and procedures such as the Commission's COVIDSafe Plan
- more frequent cleaning of the office
- support for staff to work effectively from home during lockdown
- management of the recovery after restrictions were eased.

Commissioners also actively supported staff health, safety and wellbeing, and the CEO and the Leadership Group provided regular reports to them about human resources and culture.

40.7.4 Learning and development

While many staff said they joined the Commission primarily out of a desire to contribute to lasting change in the Victorian mental health system, they also joined to learn and grow professionally and personally. In response to this, the Leadership Group and managers worked with staff to agree on development plans that comprised work, self and team goals. These plans aligned with Victorian public sector development and progression frameworks.

The Commission provided staff with opportunities for formal learning, particularly to help them understand aspects of the mental health system. This comprised cultural awareness training and workshops on lived experience run by people with lived experience. The Commission ensured as many staff as possible were provided with this training before attending consultations and hearings.

Carfi ran several information sessions to educate and inform staff on how to best manage the challenges that lay ahead during their time at the Commission.

Training and briefing sessions were held about operational matters such as the Commission's responsibilities under the Inquiries Act, IT security, privacy and information management, and hearings operations.

40.7.5 Transition support services

In recognition of the contributions staff made to the Commission and to further support their personal and professional growth, the Commission provided transition support services to help staff move to their next work venture. This included a series of workshops for staff on career growth mindset, career planning, the job market, résumé and job application writing, and interview skills.

40.8 Office accommodation

As there was little vacancy in government-owned accommodation when the Commission was established in February 2019, it occupied a small office space made available by the Department of Premier and Cabinet. Assisted by the Department of Treasury and Finance's Shared Service Provider, the Commission found a floor to lease at 271 Collins Street in Melbourne's central business district.

The office location was close to public transport options, and the building had bike storage facilities and showers for staff who wanted to ride, walk or run to and from work. The office was already suitably fitted out and mostly furnished, which helped staff move in quickly and kept accommodation costs down.

In March 2020, when the COVID-19 pandemic worsened, the Commission transitioned staff to work from home. When staff were still working in the office, the Commission ensured appropriate cleaning, hygiene and safety processes were in place, and that staff and visitors followed the Commission's COVIDSafe Plan.

40.9 Risk management, business continuity and security

The Commission put assurance frameworks and activities in place to manage risks and ensure business continuity and the security of its staff, stakeholders, assets and office.

40.9.1 Risk management

Risk management was crucial to ensuring the Commission successfully managed and delivered its work.

The Commission built on existing Victorian Government risk management guidance and implemented its own risk management framework. It developed and implemented a strategic risk register and operational risk registers for important areas such as IT. These were used to outline, measure and assess the likelihood and impact of adverse events, and ways of dealing with them.

Risk management processes and documentation were also implemented for deliverables such as the interim and final report, and for major community engagement activities such as community consultations and forums, hearings and workshops. This ensured coverage for risks in delivering these highly complex products and activities.

The risk registers were regularly updated and discussed at Executive Leadership Group meetings to ensure there was a holistic view of the Commission's risks and how they were being addressed.

The risk framework was managed by Corporate Services and overseen by the Commission's Executive Leadership Group. The Commission also received monthly reports on strategic risks and engaged with the Executive Leadership Group and staff to manage risk.

40.9.2 Business continuity

The Commission implemented business continuity planning as part of its risk management framework. This was particularly critical in IT, given the Commission's reliance on the IT environment in delivering its reports. The Commission successfully enacted parts of its plan when the COVID-19 pandemic struck and staff started working from home.

40.9.3 Security

Security was a priority for the Commission. Security considerations were important in all aspects, particularly IT and physical security.

As mentioned above, special care was taken in establishing and maintaining the IT environment and protecting the sensitive information the Commission held.

Physical security was considered in relation to the Commission's office environment. For example, the Commission's office was not publicly accessible, with all staff and any invited visitors needing to use a swipe card to gain entry.

Physical security was also provided at public-facing events such as hearings. In considering the level and types of security services it engaged, the Commission was careful to strike the right balance between protecting staff, contractors and the public while creating a welcoming atmosphere.

40.10 Concluding operations

In anticipation of the processes required to conclude the Commission's operations, Corporate Services began the planning phase as early as possible. The main considerations in closing the Commission's operations were transitioning of staff, transferring records, decommissioning the IT environment, disposing of assets and vacating the office space.

40.10.1 Staff

As described above, the Commission provided staff with transition support services to help them move to their next venture. Staff began finishing up with the Commission in October 2020, gradually dispersing until February 2021 when only a few staff remained to wrap up operations.

40.10.2 Records

The Commission's substantial inquiries will become an important part of the history and public record of Victoria. The Commission wanted its records to be useful to subsequent Royal Commissions or boards of inquiry, and to provide insight into how the Commission operated.

As noted above, the Commission worked with the Department of Premier and Cabinet and Public Record Office Victoria to transfer Commission records to the Department of Premier and Cabinet and then to Public Record Office Victoria, in accordance with the relevant legislation.

This ensures that documents relating to the Commission's inquiries are considered permanent records. It means that they will be held for the public record at Public Record Office Victoria for a designated period. Temporary records, such as those about the operation of the Commission, were transferred to the Department of Premier and Cabinet or destroyed.

The Commission also took care to apply caveats to certain classes of records to ensure privacy and other interests were protected, consistent with relevant requirements.

40.10.3 IT environment, assets and accommodation

A major part of the Commission's winding up was sanitising and disposing of IT assets. The Commission invested in high-quality IT equipment to ensure it could function effectively, and it was important that any assets that were still working well were returned to the government for continued use. The Commission's managed service providers helped ensure the IT environment was properly decommissioned before assets were passed on.

1 *Inquiries Act 2014* (Vic), sec. 16.

2 RCVMHS, Practice Direction No. 1—Public Hearings: Released 24 May 2019, 2019.

3 RCVMHS, Practice Direction No. 2—Production of Materials and Document Management Protocol: Released 5 June 2019, 2019.

4 Victorian Government, Protocol Between the Royal Commission into Victoria's Mental Health System and the Crown in Right of the State of Victoria, 2019.

5 Victorian Government, Protocol Between the Royal Commission into Victoria's Mental Health System and the Crown in Right of the State of Victoria, 2019.

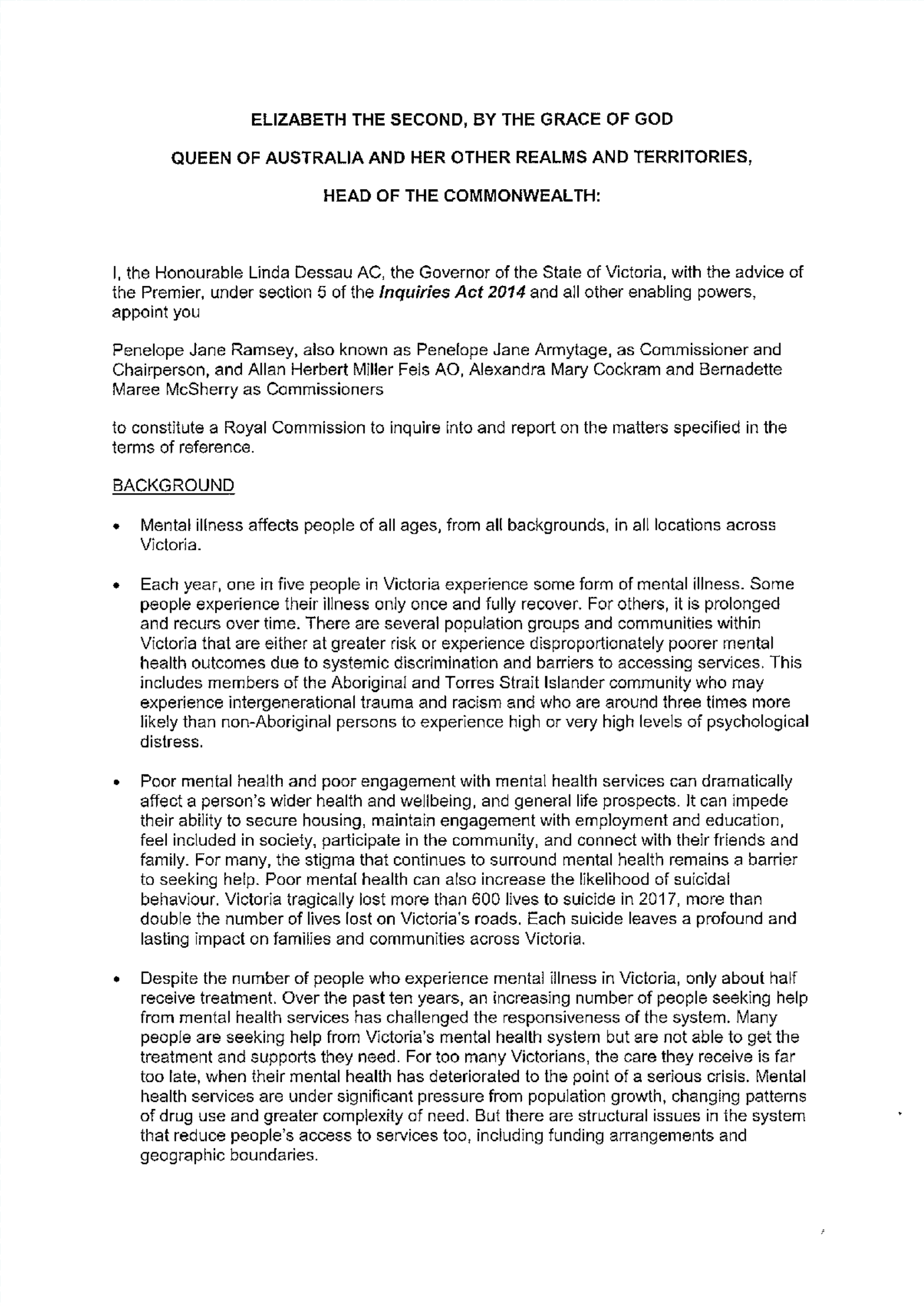
6 *Inquiries Act 2014* (Vic), sec. 17.

7 *Inquiries Act 2014* (Vic), sec. 9.

8 *Public Records Act 1973* (Vic), sec. 12.

Appendices

Appendix A.1: Letters patent



ELIZABETH THE SECOND, BY THE GRACE OF GOD

QUEEN OF AUSTRALIA AND HER OTHER REALMS AND TERRITORIES,

HEAD OF THE COMMONWEALTH:

I, the Honourable Linda Dessau AC, the Governor of the State of Victoria, with the advice of the Premier, under section 5 of the ***Inquiries Act 2014*** and all other enabling powers, appoint you

Penelope Jane Ramsey, also known as Penelope Jane Armytage, as Commissioner and Chairperson, and Allan Herbert Miller Fels AO, Alexandra Mary Cockram and Bernadette Maree McSherry as Commissioners

to constitute a Royal Commission to inquire into and report on the matters specified in the terms of reference.

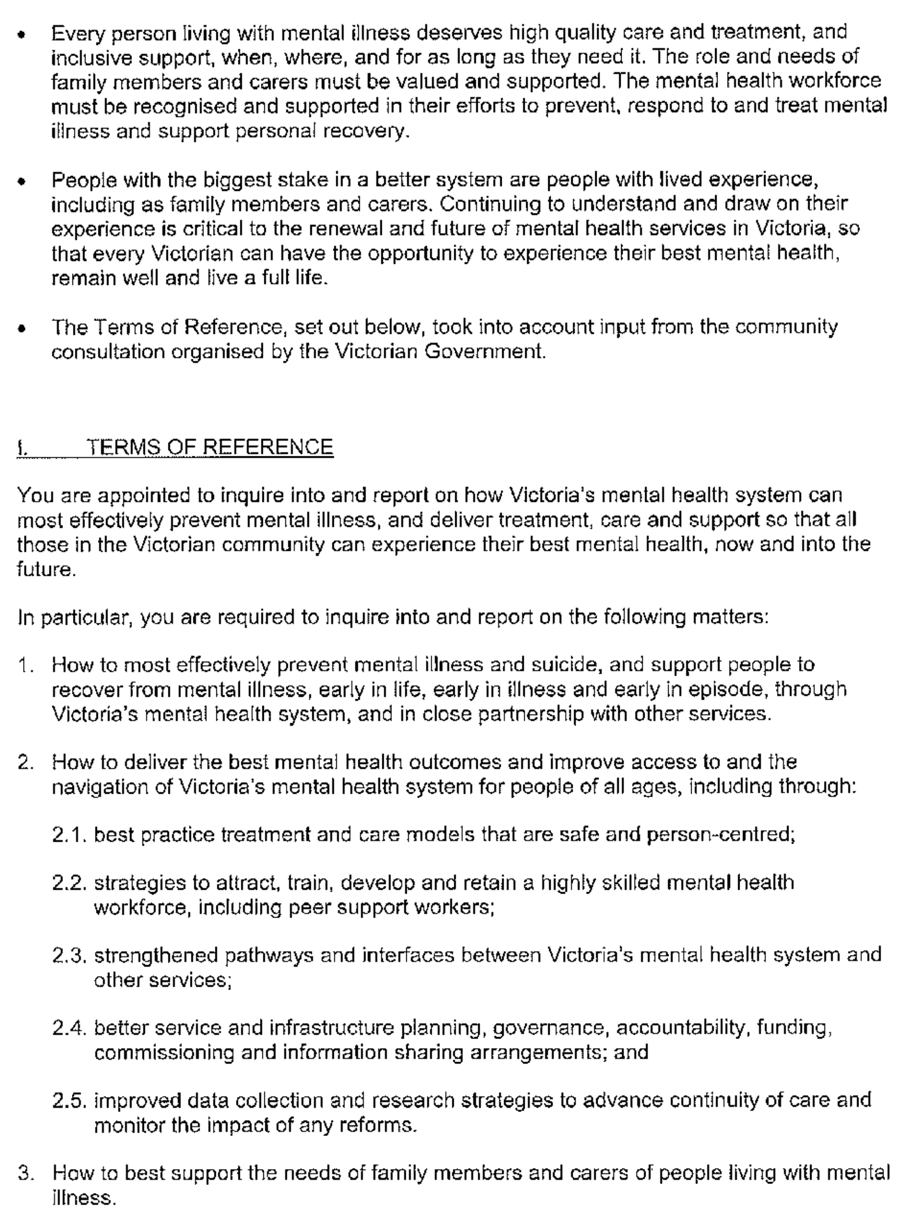
BACKGROUND

- Mental illness affects people of all ages, from all backgrounds, in all locations across Victoria.

- Each year, one in five people in Victoria experience some form of mental illness. Some people experience their illness only once and fully recover. For others, it is prolonged and recurs over time. There are several population groups and communities within Victoria that are either at greater risk or experience disproportionately poorer mental health outcomes due to systemic discrimination and barriers to accessing services. This includes members of the Aboriginal and Torres Strait Islander community who may experience intergenerational trauma and racism and who are around three times more likely than non-Aboriginal persons to experience high or very high levels of psychological distress.

- Poor mental health and poor engagement with mental health services can dramatically affect a person's wider health and wellbeing, and general life prospects. It can impede their ability to secure housing, maintain engagement with employment and education, feel included in society, participate in the community, and connect with their friends and family. For many, the stigma that continues to surround mental health remains a barrier to seeking help. Poor mental health can also increase the likelihood of suicidal behaviour. Victoria tragically lost more than 600 lives to suicide in 2017, more than double the number of lives lost on Victoria's roads. Each suicide leaves a profound and lasting impact on families and communities across Victoria.

- Despite the number of people who experience mental illness in Victoria, only about half receive treatment. Over the past ten years, an increasing number of people seeking help from mental health services has challenged the responsiveness of the system. Many people are seeking help from Victoria's mental health system but are not able to get the treatment and supports they need. For too many Victorians, the care they receive is far too late, when their mental health has deteriorated to the point of a serious crisis. Mental health services are under significant pressure from population growth, changing patterns of drug use and greater complexity of need. But there are structural issues in the system that reduce people's access to services too, including funding arrangements and geographic boundaries.



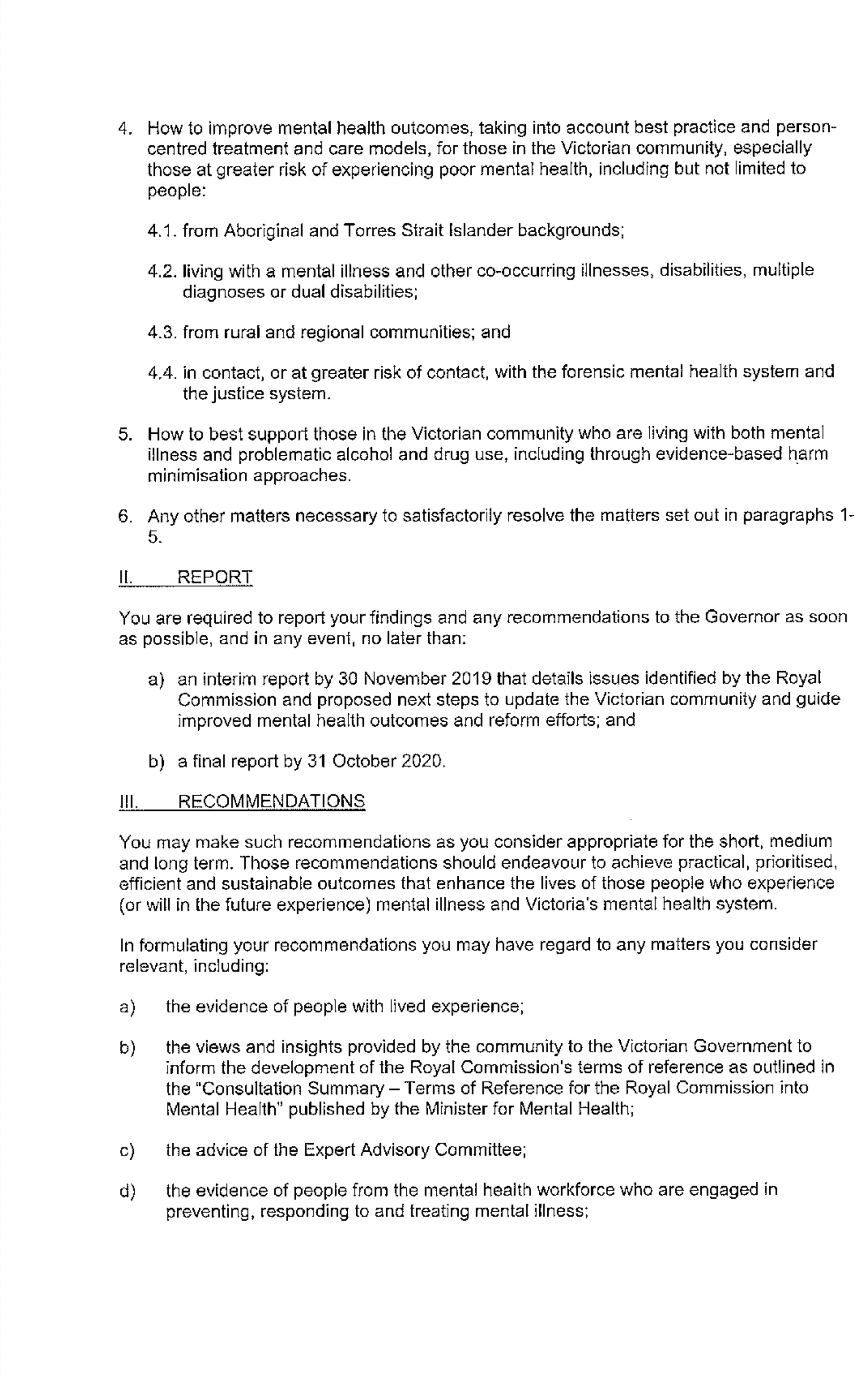
- Every person living with mental illness deserves high quality care and treatment, and inclusive support, when, where, and for as long as they need it. The role and needs of family members and carers must be valued and supported. The mental health workforce must be recognised and supported in their efforts to prevent, respond to and treat mental illness and support personal recovery.
- People with the biggest stake in a better system are people with lived experience, including as family members and carers. Continuing to understand and draw on their experience is critical to the renewal and future of mental health services in Victoria, so that every Victorian can have the opportunity to experience their best mental health, remain well and live a full life.
- The Terms of Reference, set out below, took into account input from the community consultation organised by the Victorian Government.

I. TERMS OF REFERENCE

You are appointed to inquire into and report on how Victoria's mental health system can most effectively prevent mental illness, and deliver treatment, care and support so that all those in the Victorian community can experience their best mental health, now and into the future.

In particular, you are required to inquire into and report on the following matters:

1. How to most effectively prevent mental illness and suicide, and support people to recover from mental illness, early in life, early in illness and early in episode, through Victoria's mental health system, and in close partnership with other services.
2. How to deliver the best mental health outcomes and improve access to and the navigation of Victoria's mental health system for people of all ages, including through:
    - 2.1. best practice treatment and care models that are safe and person-centred;
    - 2.2. strategies to attract, train, develop and retain a highly skilled mental health workforce, including peer support workers;
    - 2.3. strengthened pathways and interfaces between Victoria's mental health system and other services;
    - 2.4. better service and infrastructure planning, governance, accountability, funding, commissioning and information sharing arrangements; and
    - 2.5. improved data collection and research strategies to advance continuity of care and monitor the impact of any reforms.
3. How to best support the needs of family members and carers of people living with mental illness.



4. How to improve mental health outcomes, taking into account best practice and person-centred treatment and care models, for those in the Victorian community, especially those at greater risk of experiencing poor mental health, including but not limited to people:

    4.1. from Aboriginal and Torres Strait Islander backgrounds;

    4.2. living with a mental illness and other co-occurring illnesses, disabilities, multiple diagnoses or dual disabilities;

    4.3. from rural and regional communities; and

    4.4. in contact, or at greater risk of contact, with the forensic mental health system and the justice system.

5. How to best support those in the Victorian community who are living with both mental illness and problematic alcohol and drug use, including through evidence-based harm minimisation approaches.

6. Any other matters necessary to satisfactorily resolve the matters set out in paragraphs 1-5.

II. REPORT

You are required to report your findings and any recommendations to the Governor as soon as possible, and in any event, no later than:

a) an interim report by 30 November 2019 that details issues identified by the Royal Commission and proposed next steps to update the Victorian community and guide improved mental health outcomes and reform efforts; and

b) a final report by 31 October 2020.

III. RECOMMENDATIONS

You may make such recommendations as you consider appropriate for the short, medium and long term. Those recommendations should endeavour to achieve practical, prioritised, efficient and sustainable outcomes that enhance the lives of those people who experience (or will in the future experience) mental illness and Victoria's mental health system.

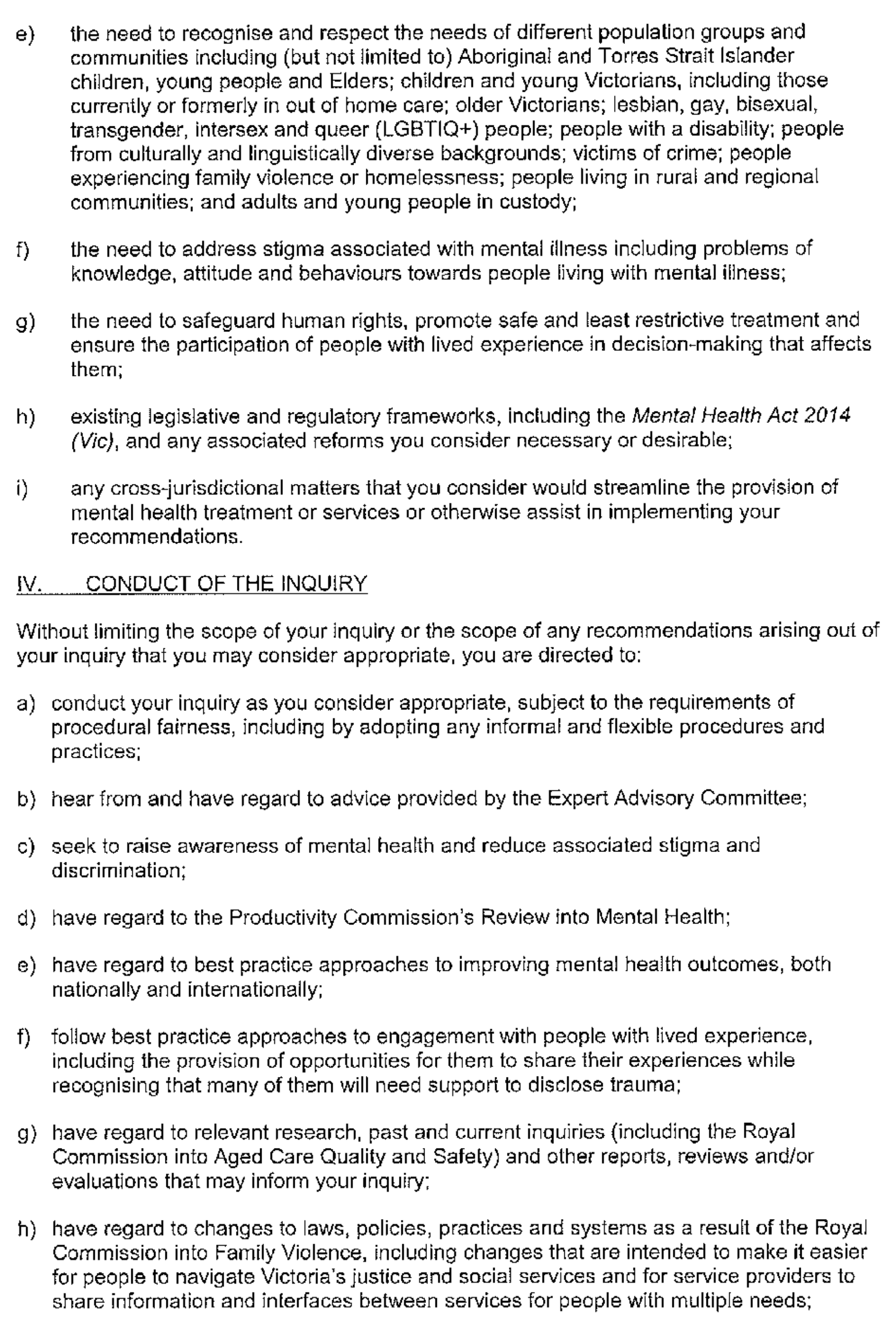
In formulating your recommendations you may have regard to any matters you consider relevant, including:

a) the evidence of people with lived experience;

b) the views and insights provided by the community to the Victorian Government to inform the development of the Royal Commission's terms of reference as outlined in the "Consultation Summary – Terms of Reference for the Royal Commission into Mental Health" published by the Minister for Mental Health;

c) the advice of the Expert Advisory Committee;

d) the evidence of people from the mental health workforce who are engaged in preventing, responding to and treating mental illness;



e) the need to recognise and respect the needs of different population groups and communities including (but not limited to) Aboriginal and Torres Strait Islander children, young people and Elders; children and young Victorians, including those currently or formerly in out of home care; older Victorians; lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+) people; people with a disability; people from culturally and linguistically diverse backgrounds; victims of crime; people experiencing family violence or homelessness; people living in rural and regional communities; and adults and young people in custody;

f) the need to address stigma associated with mental illness including problems of knowledge, attitude and behaviours towards people living with mental illness;

g) the need to safeguard human rights, promote safe and least restrictive treatment and ensure the participation of people with lived experience in decision-making that affects them;

h) existing legislative and regulatory frameworks, including the *Mental Health Act 2014 (Vic)*, and any associated reforms you consider necessary or desirable;

i) any cross-jurisdictional matters that you consider would streamline the provision of mental health treatment or services or otherwise assist in implementing your recommendations.

IV. CONDUCT OF THE INQUIRY

Without limiting the scope of your inquiry or the scope of any recommendations arising out of your inquiry that you may consider appropriate, you are directed to:

a) conduct your inquiry as you consider appropriate, subject to the requirements of procedural fairness, including by adopting any informal and flexible procedures and practices;

b) hear from and have regard to advice provided by the Expert Advisory Committee;

c) seek to raise awareness of mental health and reduce associated stigma and discrimination;

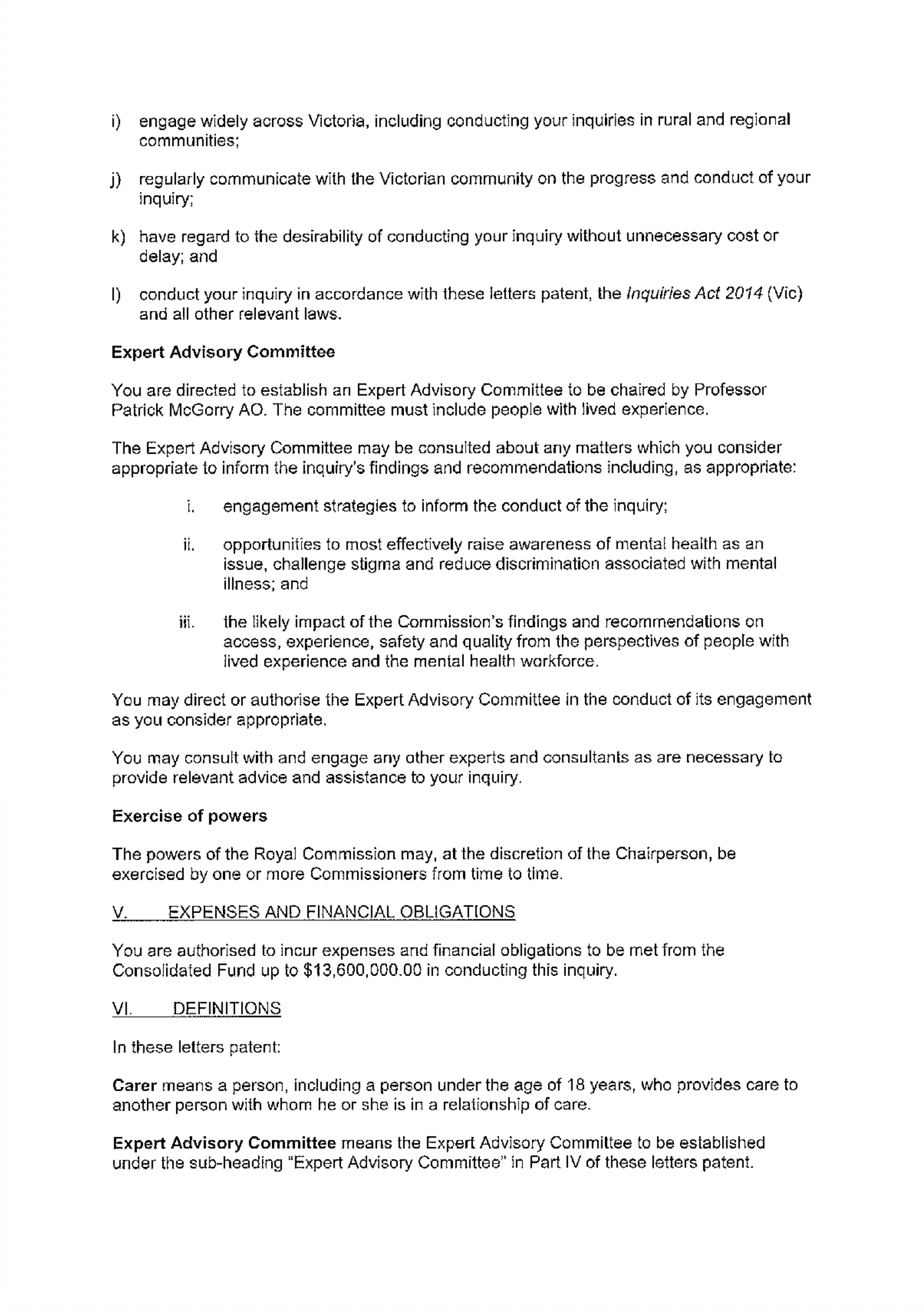
d) have regard to the Productivity Commission's Review into Mental Health;

e) have regard to best practice approaches to improving mental health outcomes, both nationally and internationally;

f) follow best practice approaches to engagement with people with lived experience, including the provision of opportunities for them to share their experiences while recognising that many of them will need support to disclose trauma;

g) have regard to relevant research, past and current inquiries (including the Royal Commission into Aged Care Quality and Safety) and other reports, reviews and/or evaluations that may inform your inquiry;

h) have regard to changes to laws, policies, practices and systems as a result of the Royal Commission into Family Violence, including changes that are intended to make it easier for people to navigate Victoria's justice and social services and for service providers to share information and interfaces between services for people with multiple needs;



i) engage widely across Victoria, including conducting your inquiries in rural and regional communities;

j) regularly communicate with the Victorian community on the progress and conduct of your inquiry;

k) have regard to the desirability of conducting your inquiry without unnecessary cost or delay; and

l) conduct your inquiry in accordance with these letters patent, the *Inquiries Act 2014* (Vic) and all other relevant laws.

Expert Advisory Committee

You are directed to establish an Expert Advisory Committee to be chaired by Professor Patrick McGorry AO. The committee must include people with lived experience.

The Expert Advisory Committee may be consulted about any matters which you consider appropriate to inform the inquiry's findings and recommendations including, as appropriate:

i. engagement strategies to inform the conduct of the inquiry;

ii. opportunities to most effectively raise awareness of mental health as an issue, challenge stigma and reduce discrimination associated with mental illness; and

iii. the likely impact of the Commission's findings and recommendations on access, experience, safety and quality from the perspectives of people with lived experience and the mental health workforce.

You may direct or authorise the Expert Advisory Committee in the conduct of its engagement as you consider appropriate.

You may consult with and engage any other experts and consultants as are necessary to provide relevant advice and assistance to your inquiry.

Exercise of powers

The powers of the Royal Commission may, at the discretion of the Chairperson, be exercised by one or more Commissioners from time to time.

V. EXPENSES AND FINANCIAL OBLIGATIONS

You are authorised to incur expenses and financial obligations to be met from the Consolidated Fund up to $13,600,000.00 in conducting this inquiry.

VI. DEFINITIONS

In these letters patent:

Carer means a person, including a person under the age of 18 years, who provides care to another person with whom he or she is in a relationship of care.

Expert Advisory Committee means the Expert Advisory Committee to be established under the sub-heading "Expert Advisory Committee" in Part IV of these letters patent.

Family may refer to either family of origin and/or family of choice.

Forensic mental health services mean mental health services that provide assessment, treatment and care to people living with a mental illness who are in contact with the justice system, including the youth justice system. Forensic mental health services can be provided to people in both custodial and community settings and can be provided to people who have offended or are at-risk of offending.

Mental health workforce means those who deliver mental health assessment, treatment and care to people experiencing a mental illness. It includes but is not limited to general practitioners, psychologists, psychiatrists, counsellors, mental health nurses, peer support workers, social workers and occupational therapists.

Mental illness means the experience of symptoms which impact thinking, perceptions, emotions, behaviour and relationships to others, or a combination of these.

Person-centred means treating a person receiving healthcare with dignity, respecting their preferences, needs and values and involving them in all decisions about their health treatment. The term recognises that a person's needs may be broader than their mental health treatment and care.

Other services mean the range of services supported by the Victorian Government that seek to address the wider determinants of mental health, such as housing, homelessness, disability, education, alcohol and other drug, family violence, health, justice and employment services. It also includes Commonwealth subsidised mental health services, Commonwealth funded and co-funded services, primary care type services and supports funded by the National Disability Insurance Scheme.

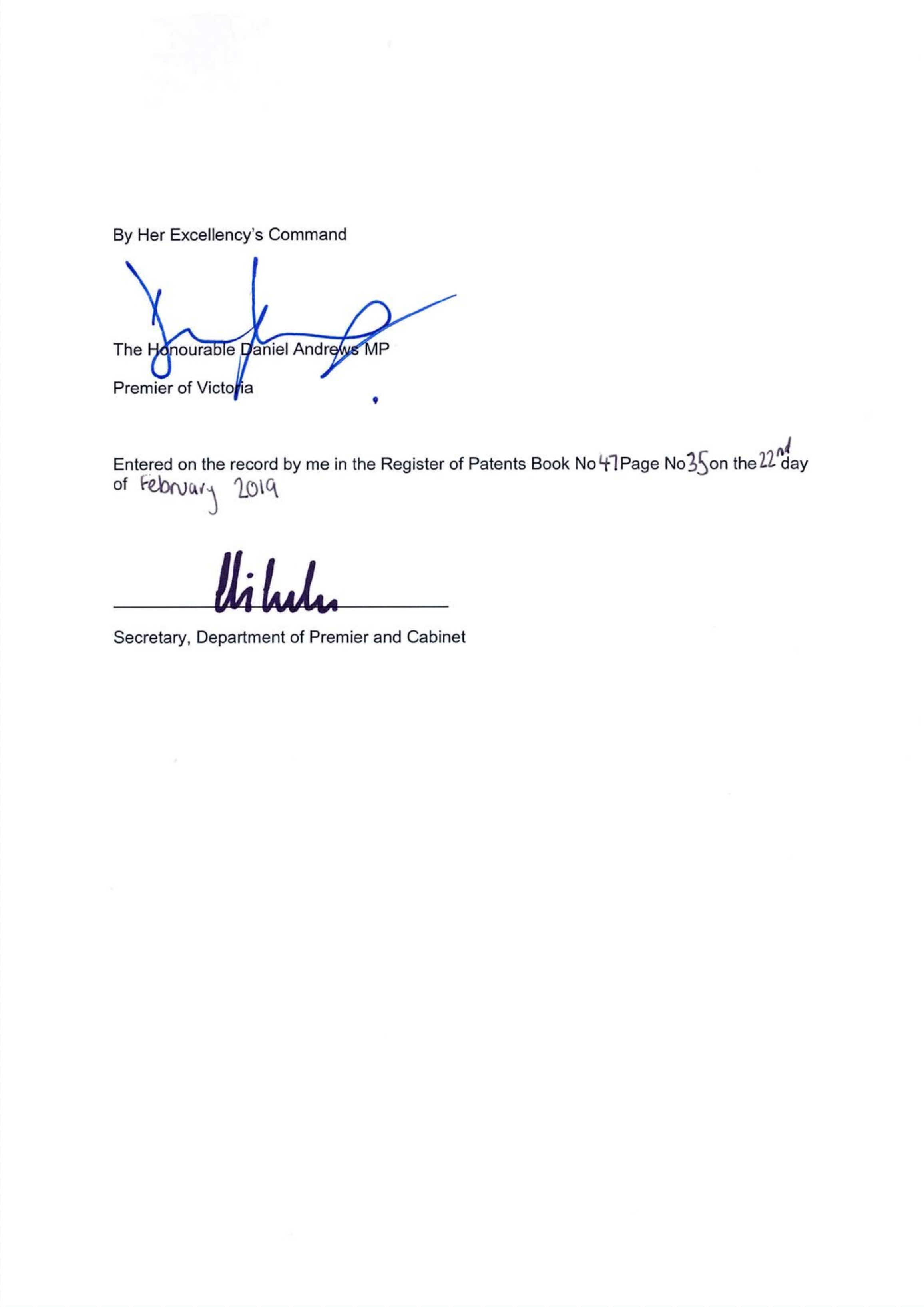
People with lived experience means people living with mental illness, their family members and carers.

Victoria's mental health system means any mental health services that are funded (whether wholly or in part) by the Victorian Government that support mental health and respond to mental illness. This includes clinical services delivered by area mental health services and community-based services that focus on activities and programs that help people manage their own recovery and maximise their participation in community life. It also includes consumer-run services, forensic mental health services, as well as specialist mental health services.

These letters patent are issued under the Public Seal of the State.

WITNESS

Her Excellency the Honourable Linda Dessau, Companion of the Order of Australia, Governor of the State of Victoria in the Commonwealth of Australia at Melbourne this 22nd day of February two thousand and nineteen.



By Her Excellency's Command

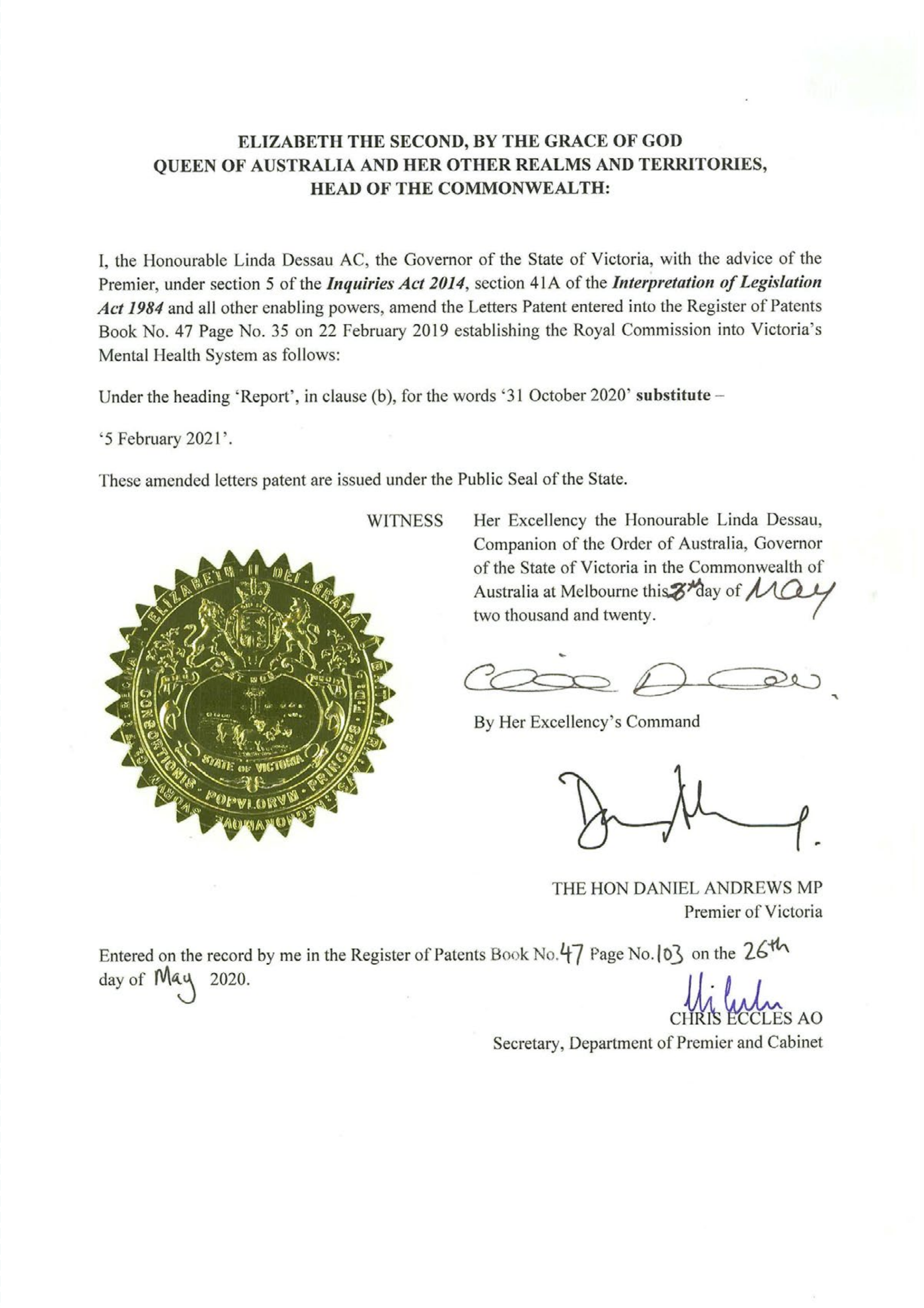
The Honourable Daniel Andrews MP

Premier of Victoria

Entered on the record by me in the Register of Patents Book No 47 Page No 35 on the 22nd day of February 2019

Secretary, Department of Premier and Cabinet

Appendix A.2: Amended letters patent



ELIZABETH THE SECOND, BY THE GRACE OF GOD
QUEEN OF AUSTRALIA AND HER OTHER REALMS AND TERRITORIES,
HEAD OF THE COMMONWEALTH:

I, the Honourable Linda Dessau AC, the Governor of the State of Victoria, with the advice of the Premier, under section 5 of the ***Inquiries Act 2014***, section 41A of the ***Interpretation of Legislation Act 1984*** and all other enabling powers, amend the Letters Patent entered into the Register of Patents Book No. 47 Page No. 35 on 22 February 2019 establishing the Royal Commission into Victoria's Mental Health System as follows:

Under the heading 'Report', in clause (b), for the words '31 October 2020' **substitute** –

'5 February 2021'.

These amended letters patent are issued under the Public Seal of the State.

WITNESS Her Excellency the Honourable Linda Dessau, Companion of the Order of Australia, Governor of the State of Victoria in the Commonwealth of Australia at Melbourne this 8th day of May two thousand and twenty.

By Her Excellency's Command

THE HON DANIEL ANDREWS MP
Premier of Victoria

Entered on the record by me in the Register of Patents Book No. 47 Page No. 103 on the 26th day of May 2020.

CHRIS ECCLES AO
Secretary, Department of Premier and Cabinet

Appendix B: Data quality statement

B.1 Quality assurance

The data contained in this report was largely prepared by Commission staff. The data was reviewed by the relevant data custodians for accuracy, where relevant, and validation, where possible.

The Commission is grateful for the support provided by data custodians. The Commission also acknowledges the contribution of Department of Health and Human Services, Australian Institute of Health and Welfare and Queensland Centre for Mental Health Research, University of Queensland, for advice and support on the Commission's analysis.

The Commission has endeavoured to use the most accurate, up-to-date and recent data and information available to inform this report, drawn from a range of data sources that are referenced throughout.

B.2 Definition of mental illness

The Commission has used the definition of 'mental illness' as found in section 4 of the *Mental Health Act 2014* (Vic), being 'a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory'.

The Commission has used the mental and behavioural disorders categorised in Chapter 5 of the *International statistical classification of diseases and related health problems, Tenth revision, Australian modification* in its analysis of data.

When undertaking analysis of external sources such as the Australian Institute of Health and Welfare and the Australian Bureau of Statistics, the definition of mental illness in the original data source has been retained and noted in the relevant section of the report.

Mental health-related presentations from the Victorian Emergency Minimum Dataset were identified based on if the presentation either:

- resulted in an admission to a mental health bed (inpatient or residential)
- received a mental health-related diagnosis ('F' codes, or some selected 'R' and 'Z' codes (R410, R418, R443, R455, R4581, Z046, Z590, Z609, Z630, Z658, Z765)
- was defined to be 'intentional self-harm'
- involved an interaction with a mental health practitioner.

This definition may depart from the public reporting approach used by the Department of Health and Human Services and the Victorian Agency for Health Information.

B.3 Sources

Most of the data sources are Victorian collections managed by Victorian Government departments or agencies.

The key data sources used in this report are the:

- Department of Health and Human Services, Victorian Integrated Data Resource v1812
- Department of Health and Human Services, Victorian Integrated Data Resource v1906
- Department of Health and Human Services, Client Management Interface/Operational Data Store (extracted 1 October 2020)
- Department of Health and Human Services, Victorian Emergency Minimum Dataset 2019–20 (extracted 8 October 2020)
- Department of Health and Human Services, Victorian Admitted Episodes Dataset 2019–20 (extracted 8 October 2020)

These data sources are supplemented by other data collections, such as the Australian Institute of Health and Welfare and Australian Bureau of Statistics.

Where relevant, the Commission has identified limitations of the relevant data in footnotes alongside figures.

For some data, the most recently available information is 2014–15 or even earlier. This is because some data (for example, population-based surveys) is only collected periodically. As stated above, the Commission has used the most recently available data where possible.

B.4 Presentation

In this report:

- values reported (for example, in the columns and rows of tables) may not sum to the totals shown, due to missing and not stated values or rounding
- percentages reported may not sum to 100 due to rounding
- percentages reported exclude missing and not stated values, unless otherwise stated
- totals reported include missing and not stated values, unless otherwise stated
- some data may not have been included to avoid identifying individuals or where estimates are based on small numbers, resulting in low reliability. Information that results in attribute disclosure has not been included, unless agreement was obtained from the custodian to publish the data.

B.5 Subject to revision

This report draws data from a range of data sets, which the Commission understands may be subject to change. For example, such changes may arise from the nature and timing of the data collection, or from program updates or maintenance. This may result in discrepancies between the data contained in this report and any published data.

B.6 Population rates

Crude rates were calculated using either one of two methods (unless stated otherwise):

- Historical data—the Australian Bureau of Statistics estimated resident population (ERP) at the midpoint of the data range. For example, if the data related to a calendar year, rates were calculated using the ERP at 30 June or, if the data related to a financial year, rates were calculated using the ERP at 30 June.
- Future estimates—the Department of Environment, Land, Water and Planning, Victoria in Future 2019. For example, bed rates for 2019–20 were calculated using the Victoria in Future estimated population at 30 June 2020.

B.7 Annual rates of change

Annual rates of change or growth rates have been calculated as geometric rates:

Compound annual growth rate = ((Pn/Po)^(1/n) –1) x 100

where Pn = value in later time period

Po = value in earlier time period

n = number of years between the two time periods.

Where the compound annual growth rate is not stated as the measure for calculating the annual rate of change, the average annual growth rate (linear measure) is used.

B.8 Confidence intervals

A confidence interval is a range of values that is used to describe the uncertainty around an estimate, usually from a sample survey. Confidence intervals generally describe how different the estimate could have been if the underlying conditions stayed the same, but variability in sampling (that is, selecting a different sample from the population) had led to a different set of data.

Confidence intervals are calculated with a stated probability (commonly 95 per cent); this means there is a 95 per cent chance that the confidence interval includes the true value.

B.9 Recording of patient information in Client Management Interface/Operational Data Store

For further information, please refer to <www2.health.vic.gov.au/mental-health/research-and-reporting/reporting-requirements-for-clinical-mental-health-services>

B.10 Estimated demand

The Commission estimates that in 2019–20, 209,000 Victorians of all ages had a level of need for specialist mental health services equivalent to the three highest-intensity consumer streams described in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*. They are the short-term treatment, care and support stream, the ongoing treatment, care and support stream and the ongoing intensive treatment, care and support stream.

As shown in Figure 1, of those 209,000 people, Victoria's current public specialist mental health services saw only 77,471 (37.1 per cent).

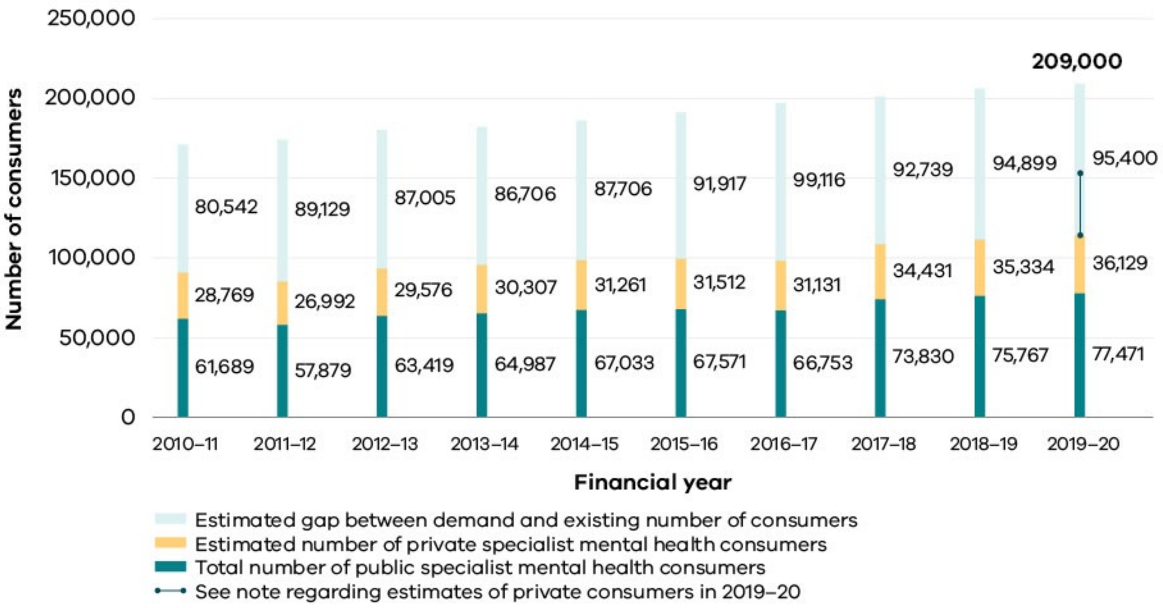
Of those 209,000 people, a further estimated 36,129 people (17.3 per cent) to 75,421 people (36.1 per cent) accessed specialist mental health services in the private health system in 2019–20. Private specialist mental health services might include mental health services provided in a private hospital or multiple Medicare-subsidised psychiatric services (refer to Figure 7.1). Such private services are not accessible to all—for example, those with lower incomes or those in areas with limited private sector supply.

Figure 1 also shows the service gap—the proportion of those 209,000 people in 2019–20 who were estimated to require services who did not get them in either the public or private systems. This service gap was estimated to be between 56,108 people (26.8 per cent) and 95,400 people (45.6 per cent).

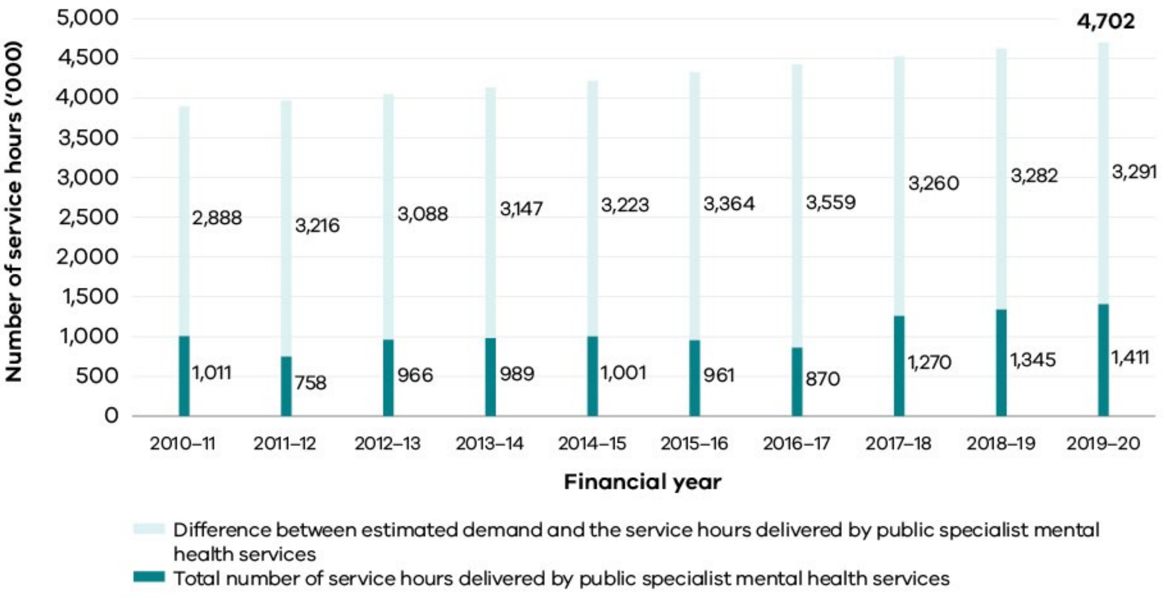
The second part of Figure 1 shows that in 2019–20 public specialist mental health services delivered only 1,411,000 (30.0 per cent) of the estimated 4,702,000 hours of care required by Victorians. This data does not include the gaps in access to wellbeing supports. This suggests that many people who need these services are not getting them.

Figure 1: The difference between the actual number of people receiving specialist mental health services/actual consumer-related community service hours delivered and estimated demand, all ages, Victoria, 2010–11 to 2019–20

A. Consumers



B. Service hours



Source: A. Calculation by the Commission based on Department of Health (Commonwealth), *National Mental Health Service Planning Framework*; Australian Bureau of Statistics, Australian Demographic Statistics, June 2020, cat. no. 3101.0, Canberra; Department of Health and Human Services, Client Management Interface/Operational Data Store 2010–11 to 2019–20; Department of Health and Human Services, Victorian Admitted Episodes Dataset, 2010–11 to 2018–19; Australian Government Services Australia, Medicare Benefits Schedule, 2017–18.

B. Calculation by the Commission based on Department of Health (Commonwealth), *National Mental Health Service Planning Framework*; Australian Bureau of Statistics, Australian Demographic Statistics, June 2009 to June 2019, cat. no. 3101.0, Canberra; Department of Health and Human Services, Client Management Interface/Operational Data Store 2010–11 to 2019–20.

Note: 2010–11, 2012–13, 2015–16 and 2016–17 data collection was affected by protected industrial action. The collection of non-clinical and administrative data (public specialist mental health services) was affected, with impacts on the recording of community mental health service activity and client outcome measures.

A. Consumers: The estimated number of private clients using the private system is based on the proportion of overall people admitted to a private hospital in Victoria for a mental health reason between 2010–11 and 2018–19. There may be consumers receiving mental health services in both public and private specialist services that are double counted. There may also be people receiving specialist mental health services from other private providers that are not counted with this methodology.

This analysis does not include 'unregistered clients'. Each year there are a number of contacts delivered to consumers that are not registered in the Client Management Interface/Operational Data Store which in 2019–20 was 16 per cent of total contacts.

For 2019–20, there are two alternative estimates of the number of private specialist mental health consumers in 2019–20. First, 36,129 consumers which would mean there is an estimated gap of 95,400. This estimate is based on the proportion of people that had a mental health admission to a private hospital. Second, 75,421 consumers which would mean there is an estimated gap of 56,108. This includes all people that received more than one service from a medicare-subsidised psychiatrist or had a mental health-related admission to a private hospital. Anyone that also received public specialist mental health services has been excluded to avoid double counting.

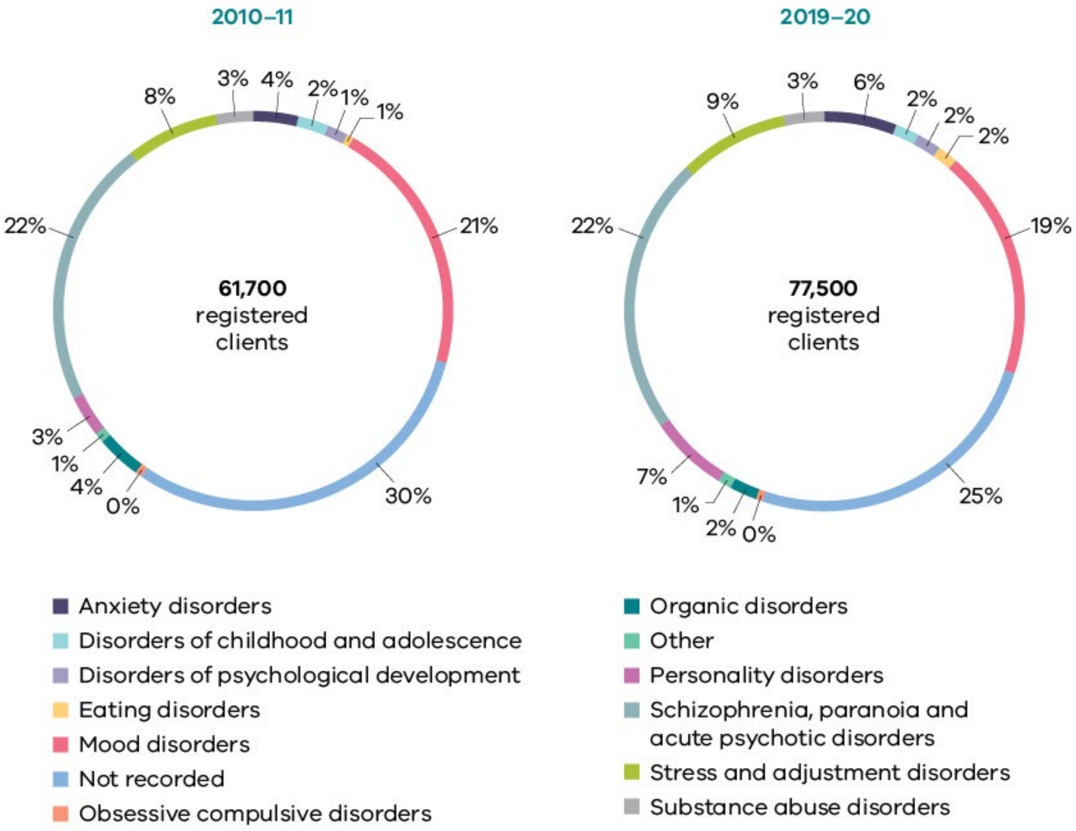
B. Service hours: Some of the gap may be met through services delivered in the private mental health system Consumer-related service hours are defined in the *National Mental Health Service Planning Framework* as time spent working with or for a client. This includes direct activity, for example assessment, monitoring, and ongoing management, care coordination and liaison, respite services, therapies, peer work, review, intervention, prescriptions, pharmacotherapy reviews, carer peer work and support services and community treatment teams. It does not include administration, training, travel, clinical supervision and other activities that do not generate reportable activity on a consumer's record.

B.11 Diagnosis trends

The International Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM) classifies diagnosis as follows: anxiety disorders includes generalised anxiety disorders, social phobias, specific phobias and panic disorders; disorders of childhood and adolescence includes attention deficit hyperactivity disorder and conduct disorder; disorders of psychological development include developmental language disorder, learning disorders and autism spectrum disorders; eating disorders include anorexia and bulimia nervosa; mood disorders includes depressive and bipolar disorders; organic disorders includes dementia, delirium, disorders due to medical conditions; personality disorders includes dissocial personality disorder and borderline personality disorder; schizophrenia and other psychotic disorders includes acute psychotic disorders, schizoaffective, etc; stress and adjustment disorders includes acute and/or severe stress, post-traumatic stress or adjustment disorders; substance abuse disorders includes behaviour patterns associated with alcohol, cannabis, hallucinogens, inhalants, opioids, stimulants etc; other includes disorders not classified elsewhere; and not recorded includes cases where diagnosis was not recorded due to collection error or the case did not warrant the allocation of a diagnosis.

Figure 2 shows the principal diagnosis trends of people treated by the public specialist mental health system, Victoria, 2010–11 and 2019–20.

Figure 2: Principal diagnosis trends of people treated by the public specialist mental health system, Victoria, 2010–11 and 2019–20



Source: Department of Health and Human Services, Client Management Interface/Operational Data Store, 2010–11 and 2019–20.

Note: The reported diagnosis is recorded based on the International Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM). A diagnosis is the decision reached by the treating clinician, after assessment, of the nature and identity of the disease or condition of a patient. It represents the major or principal condition and other primary conditions, complications or comorbidities and associated conditions treated or investigated during the relevant episode of care. Diagnoses must be coded in accordance with the Victorian additions to the Australian coding standards and the Department of Health and Human Services ICD: clinical coding information.

The Commission acknowledges the concerns of many consumers about their lack of involvement in diagnostic processes and the impacts of these labels on them. Terms such as 'disorder' can be pathologising and stigmatising, so the Commission retains them only if others use them to convey a specific meaning.

Since 2014–15, data quality improvements have reduced the proportion of 'not recorded' diagnosis.

Methodology to derive principal diagnosis based on the Department of Health and Human Services Mental Health Services Annual Report approach.

B.12 COVID-19 Restrictions

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

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

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

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

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

Appendix C: Consultation and engagement

Appendix C.1 Community consultations undertaken by the Royal Commission

The Commission hosted 61 community consultations between 5 April and 22 May 2019 across the 21 locations.

5 April 2019 – Whittlesea
9 April 2019 – Pakenham
11 April 2019 – Warrnambool
11 April and 12 April 2019 – Hamilton
15 April 2019 – Geelong
16 April 2019 – Ballarat
17 April 2019 – Sunshine
1 May 2019 – Mildura
1 May 2019 – Swan Hill
3 May 2019 – Melbourne
8 May 2019 – St Kilda
8 May 2019 – Preston
9 May 2019 – Werribee
9 May 2019 – Melbourne
14 May 2019 – Healesville
14 May 2019 – Seymour
16 May 2019 – Shepparton
17 May 2019 – Bendigo
20 May 2019 – Box Hill
21 May 2019 – Sale
22 May 2019 – Warragul

Appendix C.2 Site visits undertaken by the Royal Commission

The Commission undertook the following site visits over 2019 and 2020.

19 March 2019 – Alfred Health

28 March 2019 – Thomas Embling Hospital

4 April 2019 – Eastern Health Linwood Prevention and Recovery Care Facility

10 April 2019 – Ravenhall Prison

10 April 2019 – Dame Phyllis Frost Prison

12 April 2019 – National Centre for Farmer Health

1 May 2019 – Swan Hill Aboriginal District Health Service

1 May 2019 – Mildura Base Public Hospital (mental health ward and Aboriginal Healing Place)

9 May 2019 – Mercy Hospital, Werribee

14 May 2019 – Goulburn Valley Health

20 May 2019 – Monash Clayton

5 June 2019 – Royal Children's Hospital

6 June 2019 – Royal Melbourne Hospital and Waratah Clinic

7 June 2019 – St Vincent's Safe Haven Café

17 September 2019 – Odyssey, New Zealand

17 September 2019 – Piri Pono, New Zealand

18 December 2019 – Magistrates' Court of Victoria (Assessment and Referral Court (ARC) list)

10 March 2020 – Foundation House

Appendix C.3 Witnesses at the Commission's public hearings 2019

Between 2 and 26 July 2019 the Royal Commission conducted its first round of public hearings. The names of the witnesses who appeared at the public hearings are listed in the table.

Title	Name	Role	Hearing date
Commissioner	Ro Allen	Victorian Commissioner for Gender and Sexuality	17 July 2019
Ms	Ingrid Amann	Program Coordinator, North Fitzroy, Prevention and Recovery Care, Wellways	10 July 2019
Ms	Jane Anderson	Latrobe Health Advocate	19 July 2019
Dr	Ravi Bhat	Divisional Clinical Director, Goulburn Valley Area Mental Health Service, Goulburn Valley Health	15 July 2019
Dr	Michelle Blanchard	Deputy CEO, SANE Australia and Founding Director, Anne Deveson Research Centre	3 July 2019
Dr	Gaynor Blankley	Deputy Clinical Services Director, Mercy Mental Health and Head of Perinatal Mental Health	5 July 2019
Mr	Daniel Bolger	Witness	2 July 2019
Ms	Gail Bradley	Interim Operations Director, NorthWestern Mental Health Service, Melbourne Health	9 July 2019
Dr	Peggy Brown AO	Psychiatrist who has held a number of leadership roles in the mental health sector	24 July 2019
Associate Professor	Peter Burnett	Director, Clinical Governance, NorthWestern Mental Health, Melbourne Health	23 July 2019
Mr	Adam Burns	Senior Mental Health Clinician, Wadamba Wilam, Melbourne Health	16 July 2019
Mr	Matiu Bush	Founder, One Good Street and Deputy Director, Health Transformation Lab, RMIT	19 July 2019
Ms	Janet Butler	Witness	9 July 2019
Scientia Professor	Helen Christensen AO	Director and Chief Scientist, Black Dog Institute	19 July 2019
Dr	Neil Coventry	Chief Psychiatrist, Department of Health and Human Services	8 July 2019
Mr	Bruce Crossett	Acting CEO, Transport Accident Commission	23 July 2019
Ms	Elizabeth Crowther	CEO, Wellways Australia	10 July 2019
Ms	Rose Cuff	State-wide Coordinator, Families where a Parent has a Mental Illness (FaPMI) and Executive Director and co-founder, Satellite Foundation	12 July 2019

Title	Name	Role	Hearing date
Ms	Julie Dempsey	Witness	26 July 2019
Dr	Paul Denborough	Clinical Director, Alfred Child and Youth Mental Health Service and Headspace, Alfred Health	9 July 2019
Ms	Kate Dillon*	Witness	12 July 2019
Mr	Jeremy Dwyer	Manager, Suicide, Mental Health and General Investigations, Coroners Prevention Unit, Coroners Court of Victoria	22 July 2019
Ms	Vrinda Edan	Acting CEO, Victorian Mental Illness Awareness Council Inc.	11 July 2019
Ms	Nina Edwards*	Witness	26 July 2019
Ms	Aunty Nellie Flagg	Witness; respected Elder and a Taylor-Charles	16 July 2019
Dr	Louise Flynn	Manager, Support After Suicide, Jesuit Social Services	23 July 2019
Professor	David Forbes	Clinical Psychologist and Director, Phoenix Australia Centre for Posttraumatic Mental Health	4 July 2019
Mr	Alistair Gabb	Witness	15 July 2019
Dr	Graham Gee	Clinical Psychologist and Senior Research Fellow, Murdoch Children's Research Institute	16 July 2019
Ms	Louise Glanville	CEO, Victoria Legal Aid	11 July 2019
Mr	Andrew Greaves	Auditor-General, Victorian Auditor-General's Office	25 July 2019
Dr	Chris Groot	Lecturer, Melbourne School of Psychological Sciences, University of Melbourne	3 July 2019
Ms	Georgie Harman	CEO, Beyond Blue	4 July 2019
Ms	Georgia Harraway-Jones	Witness	10 July 2019
Dr	Richard Haslam	Director, Mental Health, Royal Children's Hospital, Melbourne	5 July 2019
Professor	Helen Herrman AO	Academic and President, World Psychiatric Association	4 July 2019
Ms	Melanie Hill*	Witness	4 July 2019
Professor	Malcolm Hopwood	Director, Professional Psychiatry Unit, Albert Road Clinic and Ramsay Health Care Professor of Psychiatry, University of Melbourne	10 July 2019
Dr	Gerard Ingham	General Practitioner	15 July 2019

Title	Name	Role	Hearing date
Mr	Andrew Jackomos PSM	Executive Director, Aboriginal Economic Development, Department of Jobs, Precincts and Regions; a Yorta Yorta man	16 July 2019
Mr	Rod Jackson	Witness	22 July 2019
Ms	Sally Jennings*	Witness	11 July 2019
Dr	Caroline Johnson	General Practitioner	9 July 2019
Ms	Nicole Juniper	Witness	2 July 2019
Dr	Alison Kennedy	Research Fellow, Faculty of Health and National Centre for Farmer Health, Deakin University	15 July 2019
Ms	Helen Kennedy	Chief Operations Officer, Victorian Aboriginal Community Controlled Health Organisation; a Trawlwoolway woman	16 July 2019
Ms	Emma King	CEO, Victorian Council of Social Service	19 July 2019
The Hon.	Robert Knowles AO	A former Victorian Minister whose responsibilities included the Health and Aged Care portfolios	24 July 2019
Ms	Katerina Kouselas	Witness	23 July 2019
Ms	Katie Larsen	General Manager, Diversity, Inclusion and Participation, Mind Australia Limited	17 July 2019
Dr	Margaret Leggatt AM	Founding Director, Wellways Australia, Founder and patron, SANE Australia and Board member, Tandem	12 July 2019
Ms	Tamara Lovett	Witness and a Gunai and Gunditjmara woman	16 July 2019
Ms	Anne Lyon	Executive Director, Mental Health and Alcohol and Other Drugs, Eastern Melbourne Primary Health Network	23 July 2019
Mr	David Martine PSM	Secretary, Department of Treasury and Finance	26 July 2019
Ms	Janet Meagher AM	Advocate for people with lived experience of mental illness	3 July 2019
Ms	Adriana Mendoza	Manager, Victorian Transcultural Mental Health	18 July 2019
Mr	Shaun McClare	Principal, Kalinda Primary School	5 July 2019
Professor	Patrick McGorry AO	Professor of Youth Mental Health, The University of Melbourne and Executive Director, Orygen	5 July 2019
Mr	John McLaren	Community Manager, St Vincent's Area Mental Health, St Vincent's Hospital Melbourne	23 July 2019
Mr	Gregory McMahon	Executive Principal, Hallam Senior College and Strategic Director, Doveton College	19 July 2019
Dr	Ruth McNair AM	General Practitioner	17 July 2019

Title	Name	Role	Hearing date
Professor	Helen Milroy	Professor of Child and Adolescent Psychiatry, University of Western Australia and Commissioner, National Mental Health Commission; a descendant of the Palyku people of the Pilbara region	16 July 2019
Mr	Jesse Morgan	Witness	12 July 2019
Ms	Tracey Morgan	Community Mental Health Services Manager, Casey Area Mental Health Service, Monash Health	11 July 2019
Ms	Amelia Morris	Witness	5 July 2019
Mr	John Murray*	Witness	12 July 2019
Dr	Gerry Naughtin	Held a number of leadership roles across the mental health and community sectors	24 July 2019
Ms	Kali Paxinos	Witness	18 July 2019
Ms	Kym Peake	Secretary, Department of Health and Human Services	25 July 2019
Ms	Mary Pershall	Witness	12 July 2019
Professor	Jane Pirkis	Director, Centre for Melbourne Health, Melbourne School of Population and Global Health, University of Melbourne	22 July 2019
Ms	Marie Piu	CEO, Tandem	18 July 2019
Adjunct Professor	David Plunkett	CEO, Eastern Health	24 July 2019
Associate Professor	Nicola Reavley	Head, Population Mental Health Unit and Deputy Director, Centre for Mental Health, The University of Melbourne	3 July 2019
The Hon.	Andrew Robb AO	Former Federal Member of Parliament	2 July 2019
Mr	Peter Ruzyla	CEO, EACH	10 July 2019
Mr	Wayne Schwass	Former AFL player and CEO, Puka Up	2 July 2019
Ms	Kylie Scoullar	General Manager, Direct Services, Foundation House	18 July 2019
Dr	Ainslie Senz	Director, Department of Emergency Medicine, Footscray Hospital, Western Health	11 July 2019
	Alex Smith*	Witness	17 July 2019
Associate Professor	Simon Stafrace	Program Director, Alfred Mental and Addiction Health, Alfred Health	8 July 2019
Associate Professor	Dean Stevenson	Clinical Services Director, Mercy Mental Health	10 July 2019

Title	Name	Role	Hearing date
Associate Professor	Michelle Telfer	General Paediatrician, Adolescent Medicine Physician and Head, Department of Adolescent Medicine, The Royal Children's Hospital	17 July 2019
	Teresa	Witness	3 July 2019
Ms	Christine Thomas	Witness	15 July 2019
Ms	Rebecca Thomas*	Witness	12 July 2019
Mr	Trevor Thomas	Witness	15 July 2019
Mr	Simon Thomson	Regional Director, Ambulance Victoria	11 July 2019
Ms	Felicity Topp	CEO, Peninsula Health	25 July 2019
Mr	Adwin Town	Witness	18 July 2019
Ms	Susan Trotter*	Witness	22 July 2019
Dr	Sika Turner	Discipline Senior, Adult Mental Health, Monash Health	9 July 2019
Associate Professor	Ruth Vine	Executive Director, NorthWestern Mental Health, Melbourne Health	8 July 2019
Assistant Commissioner	Glenn Weir	Assistant Commissioner, Victoria Police	11 July 2019
Mr	Terry Welch	CEO, Maryborough District Health Service	15 July 2019
Ms	Erica Williams	Witness	8 July 2019
Ms	Jennifer Williams AM	Chair, Northern Health	25 July 2019
Mr	Alan Woodward	Witness	22 July 2019
Mr	George Yengi	Witness	18 July 2019

Note: '*' notes where a pseudonym has been used.

Appendix C.4 2020 witnesses (statement only and panel hearings)

The following people provided a witness statement. The Commission held eight panel hearings.

Title	Name	Role	Hearing date
Ms	Lynne Allison	Associate Program Director, Eastern Health, Child, Youth Mental Health Service	
Professor	Mario Alvarex-Jimenez	Director, Orygen Digital	
Ms	Julie Anderson	Senior Consumer Advisor, Office of the Chief Mental Health Nurse and the Office of the Chief Psychiatrist, Department of Health and Human Services	16 June 2020
Ms	Alice Andrews	Director, Education, Value Institute for Health and Care, and Assistant Professor, Department of Medical Education, Dell Medical School, University of Texas	
	Lisa Annese and David Morrison AO	CEO, Diversity Council Australia (Lisa) and Chair, Board of the Diversity Council Australia (David)	
Mr	Paris Aristotle AO	CEO, Victorian Foundation for Survivors of Torture (Foundation House)	
Associate Professor	Jo-An Atkinson	Managing Director, Computer Simulation and Advanced Research Technologies and Head of Systems Modelling and Simulation, Brain and Mind Centre, University of Sydney	
Ms	Lucy Barker*	Witness	
Ms	Nicole Bartholomeusz	Chief Executive, cohealth	24 June 2020
Ms	Rachel Bateman*	Witness	
The Honourable Professor	Kevin Bell AM QC	Director, The Castan Centre for Human Rights Law, Monash University	
Mr	Sam Biondo	Executive Officer, Victorian Alcohol and Drug Association	
Professor	Bruce Bonyhady AM	Executive Chair, Melbourne Disability Institute, The University of Melbourne	
Professor	George Braitberg AM	Executive Director, Strategy, Quality and Improvement, The Royal Melbourne Hospital	
Mr	John Brogden AM	Chairman, Lifeline Australia	
Mrs	Lucinda Brogden AM	Chair, National Mental Health Commission	

Title	Name	Role	Hearing date
Professor	Lisa Brophy	Discipline Lead in Social Work and Social Policy, Department of Occupational Therapy, Social Work and Social Policy, La Trobe University	20 May 2020
Ms	Rita Brown	President, Australian BPD Foundation	
Mr	Bill Buckingham	Director, Buckingham Consulting	
Ms	Amelia Callaghan	Director, Clinical Service Innovation, Orygen	25 June 2020
Emeritus Professor	Terry Carney AO	Professor of Law, University of Sydney Law School	
Mr	Matthew Carroll	President, Mental Health Tribunal	20 May 2020
Dr	Emma Cassar	Commissioner of Corrections Victoria, Department of Justice and Community Safety	
Professor	David Castle	Consultant Psychiatrist, St Vincent's Hospital Melbourne and Professor of Psychiatry, University of Melbourne	
Dr	Enrico Cementon	Consultant Psychiatrist, NorthWestern Mental Health	
Dr	Kevin Cleary	Deputy Chief Inspector, Care Quality Commission, London	
Professor	David Coghill	Financial Markets Foundation Chair of Developmental Mental Health, Royal Children's Hospital, Melbourne	23 June 2020
Ms	Leona Coleman*	Witness	
Ms	Karyn Cook	Executive Director, Mental Health Services, South West Healthcare, Warrnambool Community Health	
Professor	David Copolov AO	Professor of Psychiatry and Pro Vice Chancellor Major Campuses and Student Engagement, Monash University	
	Mary and Jacob Corbett*	Witnesses	
Mr	Rick Corney	Witness	
	Aynur and Hafize Coskun	Witnesses	
Dr	Lynne Coulson Barr OAM	Victoria's Mental Health Complaints Commissioner	
Mr	Angus Clelland	CEO, Mental Health Victoria	
Dr	Neil Coventry	Chief Psychiatrist, Department of Health and Human Services	

Title	Name	Role	Hearing date
Mr	Gary Croton	Clinical Nurse Consultant, Human Border Victorian Dual Diagnosis Initiative, Albury Wodonga Health	
Ms	Erin Davies*	Witness	
Ms	Indigo Daya	Consumer Academic, Centre for Psychiatric Nursing, The University of Melbourne	
Dr	Adam Deacon	Child and Adolescent Consultant Psychiatrist, Alfred Health	
Mr	Titan Debirioun	Witness	
Dr	Paul Denborough	Clinical Director, Alfred Child and Youth Mental Health Service and headspace, Alfred Health	25 June 2020
Dr	Elizabeth Deveny	CEO, South Eastern Melbourne Primary Health Network	24 June 2020
Ms	Whitney Dwyer	Witness	
Ms	Honor Eastly	Witness	
Ms	Julie Edwards	CEO, Jesuit Social Services	9 June 2020
Dr	Shaymaa Elkadi	Executive Director, Strategy, Planning and Performance, Victorian Institute of Forensic Mental Health	9 June 2020
Ms	Katherine Ellis	CEO, Youth Affairs Council Victoria	
Professor	Karen Fisher	Professor, Social Policy Research Centre, University of New South Wales	
Mr	Robert Fiske	CEO, Victorian Health and Human Services Building Authority	
Dr	Michael Fotheringham	Executive Director, Australian Housing and Urban Research Institute	2 June 2020
Emeritus Professor	Arie Freiberg AM	Chair, Sentencing Advisory Council	
Dr	Claire Gaskin	Forensic Adolescent Psychiatrist, University of New South Wales	
Dr	Piers Gooding	Research Fellow, Melbourne Social Equity Institute and the University of Melbourne Law School	
Dr	Rob Gordon	Clinical Psychologist; President, Australasian Confederation of Psychoanalytic Psychotherapies and Consultant to the Department of Health and Human Services and Red Cross	
Dr	Margaret Grigg	CEO, Victorian Institute of Forensic Mental Health	16 June 2020

Title	Name	Role	Hearing date
Dr	Stefan Gruenert	CEO, Odyssey House	18 June 2020
Ms	Carolyn Gullery	Executive Director Planning, Funding & Decision Support, Canterbury District Health Board, New Zealand	
Ms	Marion Hansen	Co-Chair, Aboriginal Justice Caucus	
Ms	Georgie Harman	CEO, Beyond Blue	
Professor	Louise Harms	Chair and Head, Social Work, Melbourne School of Health Sciences, The University of Melbourne	
Dr	Hila Haskelberg	Program Manager, THIS WAY UP, St Vincent's Public Hospital Sydney	
Ms	Lin Hatfield Dodds	Associate Dean, Australian and New Zealand School of Government, Crawford School, Australian National University	
Miss	Denna Healy	Witness	
Mr	Justin Heazlewood	Witness	
Professor	Ian Hickie AM	Co-Director, Health and Policy, Brain and Mind Centre, University of Sydney	
Ms	Kristen Hilton	Commissioner, Victorian Equal Opportunity and Human Rights Commission	
Professor	Harriet Hiscock	Paediatrician, Centre for Community Child Health and Director Health Services Research Unit, Royal Children's Hospital, Melbourne	23 June 2020
Ms	Anne Hollonds	Director, Australian Institute of Family Studies	
Mr	Douglas Holmes OAM	General Manager, MH-worX, New South Wales	
Ms	Tanya Hosch	General Manager, Inclusion and Social Policy, AFL	
Ms	Catherine Humphrey	CEO, Sacred Heart Mission and Chair of the Board, Council to Homeless Persons	2 June 2020
Ms	Erandathie Jayakody	Witness	
Ms	Sandy Jeffs OAM	Witness	
Mr	Matt Jones	Chair, Victorian and Tasmanian Primary Health Network Alliance and CEO, Murray Primary Health Network	
Miss	Emily John*	Witness	
Professor	Shitij Kapur	Dean, Faculty of Medicine Dentistry and Health Sciences and Assistant Vice Chancellor for Health, University of Melbourne	

Title	Name	Role	Hearing date
Mr	Peter Kelly	Director Operations, NorthWestern Mental Health, Melbourne Health, The Royal Melbourne Hospital	16 June 2020
Ms	Sandra Keppich-Arnold	Director, Operations and Nursing, Mental and Addiction Health, Alfred Health	
Professor	Stuart Kinner	Head, Justice Health Unit, Centre for Health Equity, Melbourne School of Population and Global Health, University of Melbourne	
Dr	Nick Kowalenko	Senior Clinical Advisor, Emerging Minds	
Ms	Robyn Kruk AO	Interim Chair, Mental Health Australia	
Dr	Vinay Lakra	Clinical Director, North West Area Mental Health Service, NorthWestern Mental Health, Melbourne Health	
Mr	Patrick Lawrence	CEO, First Step	
Dr	Stuart Lewena	Director, Emergency Medicine, The Royal Children's Hospital	
Ms	Kim Little	Deputy Secretary, Early Childhood Education, Victorian Department of Education and Training	
Mr	Chris Lockwood	National CEO, MATES in Construction Australia, Queensland	
Professor	Dan Lubman	Executive Clinical Director, Turning Point, Eastern Health and Professor of Addiction Study and Services, Monash University	18 June 2020
Professor Sir	Michael Marmot	Director, Institute of Health Equity at University College London	
Mr	Tim Marney	Principal, Nous Group	
Dr	Christopher Maylea	Senior Lecturer in Social Work, RMIT University, Chair, Committee of Management, Victorian Mental Illness Awareness Council	20 May 2020
Ms	Peta McCammon	Associate Secretary, Department of Justice and Community Safety	
Professor	Patrick McGorry AO	Professor of Youth Mental Health, University of Melbourne and Executive Director, Orygen	
Professor	Alexander McFarlane AO	Professor of Psychiatry, School of Medicine, University of Adelaide	
Professor	Graham Meadows	Professor of Psychiatry, Monash University School of Clinical Sciences, Monash Health	
Ms	Sue Medson OAM	CEO, Gippsland Lakes Complete Health	
Dr	Robyn Miller	CEO, MacKillop Family Services	

Title	Name	Role	Hearing date
Professor	Rob Moodie	Deputy Head of School and Professor of Public Health, University of Melbourne	
Dr	Tim Moore	Senior Research Fellow	
Ms	Christine Morgan	CEO, National Mental Health Commission	
	Tass Mousafaredis and Kent Burgess	Chair of the Board, Star Health (Tass) and Acting CEO, Star Health (Kent)	
Associate Professor	Steven Moylan	Clinical Director, Mental Health, Drug and Alcohol Services, Barwon Health	24 June 2020
Professor	Louise Newman AM	Professor of Psychiatry, University of Melbourne and a practising perinatal and infant clinician	23 June 2020
Professor	Richard Newton	Clinical Director, Peninsula Mental Health Service	
Mr	Dan Nicholson	Executive Director, Criminal Law, Victoria Legal Aid	9 June 2020
Professor	Frank Oberklaid AM OAM	Paediatrician, Royal Children's Hospital, Melbourne and Co-Group Leader of Child Health Policy, Equity and Translation, Murdoch Children's Research Institute	
Distinguished Professor	James Ogloff AM	Executive Director, Victorian Institute of Forensic Mental Health and Distinguished Professor, Centre for Forensic Behavioural Sciences, Swinburne University	
Ms	Mary O'Hagan MNZM	Manager Mental Wellbeing, Te Hiringa Hauora, New Zealand	
Dr	Brendan O'Hanlon	Mental Health Program Manager, Bouverie Centre, La Trobe University	
Ms	Mary-Ann O'Loughlin AM	Deputy Secretary, Skills and Higher Education, New South Wales Department of Education	
Mr	Mark Orr AM	CEO, Flourish Australia and Board Director, Mental Health Coordinating Council	
Mr	Graham Panther	Witness	
Ms	Kym Peake	Secretary, Department of Health and Human Services	
Mr	David Pearl	Innovator, Author and Public Speaker of The Studios, London	
Mr	Dave Peters	Witness	
Dr	Melissa Petrakis	Chair, Tandem	
Dr	Sarah Pollock	Executive Director, Research and Advocacy, Mind Australia	2 June 2020

Title	Name	Role	Hearing date
Ms	Elizabeth Porter*	Witness	
Mr	Frank Quinlan	Former CEO of Mental Health Australia	
Mr	Colin Radford	CEO, Victorian WorkCover Authority	
Associate Professor	Alessandra Radovini	Director, Mindful, The University of Melbourne and Consultant Psychiatrist, Orygen	25 June 2020
Professor	Neil Rees	Witness	
Mr	Kiba Reeves	Witness	
Dr	John Reilly	Chief Psychiatrist, Queensland	18 June 2020
Dr	Sara Renwick-Lau	General Practitioner, Mallacoota Medical Centre	
	Aaron and Kristy Robinson*	Witnesses	
Ms	Cath Roper	Consumer Academic, Centre for Psychiatric Nursing, University of Melbourne	
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	
Miss	Jennifer Rowan	Witness	
Dr	Christopher Ryan	Consultation-Liaison Psychiatrist, Westmead Hospital, Sydney	
Ms	Nicole Sadler	Head, Policy and Practice, Phoenix Australia, Centre for Posttraumatic Mental Health	
Ms	Eva Sifis	Witness	
Mr	Michael Silva*	Witness	
Professor Emeritus	Bruce Singh AM	Clinical Director, Mental Health Services, South West Healthcare, Warrnambool	
Associate Professor	Dan Siskind	Clinical Academic Psychiatrist, Princess Alexandra Hospital	
Ms	Jenny Smith	CEO, Council to Homeless Persons	
Mr	Shane Solomon	Partner, Caligo Health	
Associate Professor	Simon Stafrace	Chief Adviser, Mental Health Reform Victoria	
Dr	Danny Sullivan	Executive Director, Clinical Services, Victorian Institute of Forensic Mental Health	

Title	Name	Role	Hearing date
Professor	Suresh Sundram	Head, Department of Psychiatry, School of Clinical Sciences, Monash University and Director, Research, Mental Health Program, Monash Health	
Mr	Terry Symonds	Deputy Secretary, Health and Wellbeing, Department of Health and Human Services	
Dr	Tricia Szirom	CEO, Victorian Mental Illness Awareness Council	
Professor	Robert Thomas OAM	Deputy Chairperson, Victorian Comprehensive Cancer Centre	
Mr	Grant Todd*	Witness	
Dr	Mariam Tokhi	General Practitioner, DPV Health	
Mr	Jason Trethowan	CEO, headspace	
Mr	Nathan Turner*	Witness	
Associate Professor	Ruth Vine	Director, Victorian Institute of Forensic Mental Health	20 May 2020
Ms	Lynda Watts	Witness	
Professor	Penny Weller	Professor, Centre for Business and Human Rights RMIT University	
Ms	Catherine White	Witness	
Ms	Sue Williams	CEO, Cabrini Health Australia and Board Member, Victorian Institute of Forensic Mental Health	
Mr	Jim Williamson	Witness	
Ms	Anna Wilson*	Witness	

Note: '*' notes where a pseudonym has been used.

Appendix C.5 Roundtables and attendees

The Commission held a total of 56 roundtables during its inquiry; 17 were held across May–December 2019, and 39 across February–October 2020.

Engagement	Date	Title or topic	Attendees
Roundtable	21 May 2019	Traralgon/Latrobe community	• Jane Anderson, Latrobe Health Advocate • Alistair Edgar, Senior Advisor, Latrobe Health Advocate • Ange Gordon, Community Board Member, Latrobe Health Assembly • Jonathan Armstrong, Community Board Member, Latrobe Health Assembly • Linda Reid, Community Board Member, Latrobe Health Assembly • Ian Needham, Executive Officer, Latrobe Health Assembly • Carolyn Whalan, Coordinator, The Gathering Place • Brendan Witt, Senior Alcohol and Other Drugs Clinician, Gippsland and East Gippsland Aboriginal Co-Operative • Ray Naidu, Ramahyuck District Aboriginal Corporation • Maria Garrett, Population Health Planner, Gippsland Primary Health Network • Sharon Fisher, Department of Health and Human Services
Roundtable	14 July 2019	Maryborough District Health	• Terry Welch, CEO, Maryborough District Health Service • Nickola Allan, Director, Clinical Services, Maryborough District Health Service • Lucy Roffey, CEO, Central Goldfields Shire • Sharyn Huggett, Coordinator, Go Goldfields, Central Goldfields Shire • Paul Huggett, Senior Sergeant, Victoria Police • Garry Higgins, Member, Committee for Maryborough • David Sutton, Principal, Maryborough Education Centre • Teresa Bourke, Carer Representative, Tandem

Engagement	Date	Title or topic	Attendees
Roundtable	20 August 2019	Lived experience workforce	• Julie Anderson, Senior Consumer Advisor, Office of the Chief Mental Health Nurse, Department of Health and Human Services • Wanda Bennetts, Senior Consumer Consultant, Independent Mental Health Advocacy • Cate Bourke, Manager and Consumer Carer, Eastern Health • Emma Cadogan, Senior Policy Advisor, Lived Experience Strategy, Department of Health and Human Services • Bianca Childs, Peer Practice Advisor, Mind Australia • Lorna Downes, Family/carer Workforce Development Coordinator, Centre for Mental Health Learning • Julie Dempsey, Senior Consumer Consultant, Forensicare • Vrinda Edan, Acting CEO, Victorian Mental Illness Awareness Council Inc. • Jacinta Kuklych, Carer Lived Experience Workforce Network, Tandem • Jen Maries, Consumer Peer Support Worker, NorthWestern Mental Health • Donna Mathews, Lived Experience Manager, Barwon Health • Catherine Minshall, Consumer Researcher, Recovery and Social Justice Unit, Centre for Mental Health, University of Melbourne • Rory Randall, Peer Support Worker, Prevention and Recovery Care, Neami National • Melanie Ryan, Family/Carer Peer, Peninsula Health Mental Health Service • Michelle Swann, Board Chair, Tandem • Scott Walker, CEO, Carers Victoria • Craig Wallace, Consumer Workforce Development Coordinator, Centre for Mental Health Learning

Engagement	Date	Title or topic	Attendees
Roundtable	21 August 2019	Doctors workforce	• Dr Lee Allen, Director, Training/Psychiatry, Western Region, Austin Health • Dr Cathy Andronis, Royal Australian College of General Practitioners (Victoria) • Dr Dominika Baetens, Consultant Psychiatrist, St Vincent's Hospital Melbourne • Professor Andrew Chanen, Head, Personality Disorder Research, Orygen • Janelle Devereux, Executive Director, Health Systems Integration, North Western Melbourne Primary Health Network • Dr Jennie Hutton, Australasian College of Emergency Medicine • Dr Niroshini Kennedy, Royal Australasian College of Physicians • Dr Vinay Lakra, College Psychiatrists President elect (Vic) and Director, Clinical Services, Melbourne Health • Dr Steven Moylan, Director, Clinical Services, Barwon Health • Professor Richard Newton, Chair, Royal Australian and New Zealand College of Psychiatry (Victoria) • Dr Daniel O'Connor, Office of the Chief Psychiatrist, Department of Health and Human Services • Professor John Prins, Head, Melbourne Medical School, University of Melbourne • Dr Anoop Raveendram, Director, Clinical Services, Ballarat Health Services • Dr Sudeep Saraf, Head, Community Psychiatry, Alfred Health • Dr Ajit Selvendra, Psychiatrist, Australian Medical Association (Victoria) • Dr Danny Sullivan, Executive Director, Clinical Services, Forensicare

Engagement	Date	Title or topic	Attendees
Roundtable	21 August 2019	Nurses workforce	• Duncan Baulch, Manager, Nursing and Midwifery Special Projects, Safer Care Victoria • Melanie Bish, Senior Lecturer, Rural Nursing and Midwifery, La Trobe University • Pip Carew, Assistant Secretary, Australian Nursing and Midwifery Federation (Victoria) • Associate Professor Alicia Evans, Head, School of Nursing, Midwifery and Paramedicine, Australian Catholic University • Professor Kim Foster, Professor, Mental Health Nursing, Australian Catholic University and North Western Mental Health • Professor Richard Gray, Mental Health, Nursing and Midwifery, La Trobe University • Dr Bridget Hamilton, Centre of Psychiatric Nursing, University of Melbourne • Stewart Imrie, Nurse Unit Manager, Child and Adolescent Mental Health Service, Monash Health • Brian Jackson, Director, Nursing, Melbourne Health • Anna Love, Chief Mental Health Nurse, Department of Health and Human Services • Andrew Morgan, Workplace Representative, Mental Health Triage and ED Response Service (Victoria) • Professor Nikki Phillips, Head of School, Nursing and Midwifery, Deakin University • Jo Ryan, Director of Nursing, Forensicare • Honie Thomson, Nurse Unit Manager, Adult Acute, Peninsula Health • Fiona Whitecross, Acute Services Manager, Alfred Health

Engagement	Date	Title or topic	Attendees
Roundtable	22 August 2019	Health professionals	• Kamal Bekhazi, Senior Research and Projects Officer, Health Workers Union • Sarah Castle, Mental Health Nurse and Member, Health and Community Services Union • Professor Kim Cornish, Head of School, Psychological Sciences, Monash University • Professor Ellie Fossey, Head of Department and Graduate Research Coordinator, Monash University • Professor Louise Harms, Chair and Head, Department of Social Work, University of Melbourne • Paul Healey, Acting State Secretary, Health and Community Services Union • Dr Rosemary Kelly, Secretary, Victorian Psychologists Association • Kate Lheude, Occupational Therapist, Melbourne Health • Craig McGregor, Secretary, Victorian Allied Health Professionals Association • Associate Professor Melissa O'Shea, Deakin University • Debra Parnell, Manager, Social Policy and Advocacy, Australian Association of Social Workers • Rachel Starbuck, Occupational Therapist, St Vincent's Health • Jacqueline White, Victorian State Chair, Australian Psychological Society • Leon Wiegard, Assistant Branch Secretary, Australian Services Union • Professor Sarah Wilson, Head of School, Psychological Sciences, University of Melbourne

Engagement	Date	Title or topic	Attendees
Roundtable	27 August 2019	Culturally and linguistically diverse people and communities	• Zuleika Arashiro, Advocacy Leader, Ethnic Communities' Council of Victoria • Paris Aristotle AO, CEO, Victorian Foundation for Survivors of Torture Inc. (Foundation House) • Rebecca Eckard, Director, Policy and Research, Refugee Council of Australia • Carmel Guerra OAM, CEO, Centre for Multicultural Youth • Demos Krouskos, CEO, Centre for Culture, Ethnicity and Health • Adriana Mendoza, Manager, Victorian Transcultural Mental Health • Adele Murdolo, CEO, Multicultural Centre for Women's Health • Associate Professor Harry Minas, Director, Centre for Mental Health (Global and Cultural Mental Health Unit), University of Melbourne • Dr Tram Nguyen, Medical Director, Cabrini Asylum Seeker and Refugee Health Hub • Silvio Pontonio, Acting CEO, Spectrum • Ela Stewart, Policy Officer, InTouch Multicultural Centre against Family Violence • Hakki Suleyman, Chairperson, Migrant Resource Centre, North West Region Inc. • Sylvia Wan, Manager, Health and Wellbeing, Southern Migrant and Refugee Centre • Professor Suresh Sundram, Head, Department of Psychiatry, School of Clinical Sciences, Monash University and Director of Research, Mental Health Program, Monash Health • Denise Goldfinch, Executive Officer, Diaspora Action Australia
Roundtable	28 August 2019	Aboriginal people and communities	• Raelene Stephens, Nurse Manager, Social and Emotional Well-Being Team, Mallee and District Aboriginal Services • Wayne Freeman, Senior Adviser, Commission for Children and Young People • Michael Graham, Chairperson, Victorian Aboriginal Health Service • Daniel Bolger, Community Witness • Tamara Lovett, Community Witness • Andrew Jackomos PSM, Executive Director, Aboriginal Economic Development, Department of Jobs, Precincts and Regions • Helen Kennedy, Chief Operations Officer, Victorian Aboriginal Community Controlled Health Organisation • Trevor Pearce, Acting Chief Executive Officer, Victorian Aboriginal Community Controlled Health Organisation

Engagement	Date	Title or topic	Attendees
Roundtable	4 September 2019	LGBTIQ+ people	• Commissioner Ro Allen, Victorian Commissioner for Gender and Sexuality • Brenda Appleton, Chair, Transgender Victoria • Joe Ball, CEO, Switchboard Victoria • Marina Carmen, Research Fellow, Australia Research Centre in Sex, Health and Society, La Trobe University • Nathan Despott, Brave Network • Dr Jaco Erasmus, Monash Gender Centre • Karen Field, CEO, Drummond Street • Caz Healy, Executive Lead Services, cohealth • Janet Jukes, Lifeworks • Richard Keane, CEO, Living Positive Victoria • Kochava Lilit, Committee Member, Bisexual Alliance Victoria • Dr Ruth McNair AM, General Practitioner • Ruby Mountford, President, Melbourne Bisexual Network • Micah Scott, CEO, Minus 18
Roundtable	4 September 2019	Alcohol and other drugs	• Laurence Alvis, CEO, UnitingCare Regen • Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association • Yvonne Bonomo, Director, Department of Addiction, Medicine, St Vincent's Hospital • Emily Box, Coordinator, Alcohol and other Drugs, North Western Melbourne Primary Health Network • Andrew Bruun, CEO, Youth Support and Advocacy Service (YSAS) • Dr Jon Cook, Head of Unit, Addiction Medicine, Western Health Services • Sione Crawford, CEO, Harm Reduction Victoria • Stefan Gruenert, CEO, Odyssey House • Anne-Maree Kaser, CEO, Windana • Professor Nicole Lee, Director, 360Edge • Rosemary McClean, Self Help Addiction Resource Centre (SHARC) • Sue Medson OAM, CEO, Gippsland Lakes Complete Health • Stephen McNally, Deputy CEO, Penington Institute • Mel Thomson, Executive Manager, Youth Services, Taskforce

Engagement	Date	Title or topic	Attendees
Workshop	10 September 2019	Older people	• Dr Ravi Baht, Divisional Clinical Director, Goulburn Valley Area Mental Health Service, Goulburn Valley Health • Dr Catherine Barret, Celebrate Ageing • Professor Sunil Bhar, Swinburne University, Wellbeing Clinic for Older Adults • Heather Birch, Senior Policy Adviser, Commissioner for Senior Victorians • Amanda Bond, Carer Representative, Tandem • Bhim Boodram, Clinical Care Coordinator, Aboriginal Community Elders Service • Shellie Braverman, Victorian Mental Illness Awareness Council Inc. • Jan Bruce, Positive Ageing Policy Adviser, Municipal Association of Victoria • Agnes Chong, Program Officer, Mental Health and Alcohol and Other Drugs, Eastern Melbourne Primary Health Network • Coleen Clare, Chair, The Matrix Guild • Angus Clelland, CEO, Mental Health Victoria • Helene Cowley, Chief Social Worker, Aged Persons Mental Health Program, NorthWestern Mental Health • Associate Professor Briony Dow, National Ageing Research Institute • Debra Fast, Service Manager Mental Health, Baptcare • Freda Goldbert, Carer Representative, Tandem • Michael Gourlay, CEO, Elder Rights Advocacy • Dr David Huppert, Deputy Chief Psychiatrist, Department of Health and Human Services • Melanie Joosten, Policy Officer, Senior Rights Victoria • Sinisha Krstov, Access and Support Worker, Ethnic Communities' Council of Victoria • Tara Laursen, Manager, Mental Health and Alcohol and Other Drugs, Eastern Melbourne Primary Health Network • Anne Muldowney, Senior Policy Advisor, Carers Australia • Dr Gerry Naughtin, Strategic Adviser, Mental Health in the Strategic Advisers and Research Division, National Disability Insurance Agency • Donela Perry, Residential Care and Services Manager, Baptcare • Dr Chris Plakiotis, Head of Division, Aged Mental Health Research Unit, Monash University • Gabriele Rukas, Sector Development, Innovation and Inclusion, Ethnic Communities' Council of Victoria • Helen Small, General Manager Operations, Wintringham Specialist Aged Care • Sonya Stanley, Primary Health Network and Government Engagement Manager, Beyond Blue • Dr Maria Tsanglis, Director, Aged and Liaison Psychiatry Service, Alfred Health • Rhonda Watson, Home and Community Care/ Planned Activity Group Manager, Aboriginal Community Elders Service

Engagement	Date	Title or topic	Attendees
Roundtable	12 September 2019	Aboriginal people and communities	• Raelene Stephens, Mallee and District Aboriginal Services (MDAS) • Wayne Freeman, Commission for Children and Young People • Michael Graham, Victorian Aboriginal Health Service (VAHS) • Daniel Bolger, Community Witness • Tamara Lovett, Community Witness • Helen Kennedy, Victorian Aboriginal Community Controlled Health Organisation (VACCHO) • Trevor Pearce, Victorian Aboriginal Community Controlled Health Organisation (VACCHO) • Adam Burns, Wadamba Wilam, NEAMI • Ruby Warber, Victorian Aboriginal Community Controlled Health Organisation (VACCHO) • Jeannie McIntyre, Victorian Aboriginal Health Service • Shirley Slann, Victorian Aboriginal Child Care Agency • Claire Horsfall, Victorian Aboriginal Child Care Agency • Tracy Mason, Victorian Aboriginal Child Care Agency • Duane Luki, Wathaurong Aboriginal Co-operative • Shaun Coade, Wathaurong Aboriginal Co-operative • Indi Clark, Koori Youth Council • Banok Rind, Koori Youth Council • Douglas Briggs, Koori Youth Council
Roundtable	18 September 2019	Economics	• Professor Cathy Mihalopoulos, Chair and Head, Deakin Health Economics, Deakin University • Tim Marney, Principal, Nous Group • Associate Professor Liz Schroeder, Centre for the Health Economy and Faculty of Medicine, Macquarie University • Professor Martin Knapp, Care Policy and Evaluation Centre • Professor Rowena Jacobs, Centre for Health Economics • Rosalyn Bell, Assistant Commissioner, Productivity Commission • Professor Yuting Zhang, Health Economics, University of Melbourne • Professor Leonie Segal, Allied Health and Human Performance, University of South Australia • Dr Stephen Duckett, Health Program Director, Grattan Institute • Professor Michael Shields, Centre for Health Economics • Claire De Oliveira, Centre for Health Economics

Engagement	Date	Title or topic	Attendees
Roundtable	30 October 2019	Neurocognitive and intellectual disabilities and mental illness	• Dr Tareq Abuelroos, Consultant Psychiatrist, Victorian Dual Disability Service • Dr Chad Bennett, Clinical Director, Victorian Dual Disability Service • Professor Andrew Carroll, Chair, Faculty of Forensic Psychiatry Subcommittee, Royal Australian and New Zealand College of Psychiatrists • Evelyn Culnane, Transition Support Service, Royal Children's Hospital, Melbourne • Sarah Forbes, Advocacy Manager, VALiD • Dr Jennifer Harrison, Neurodevelopmental Stream, Alfred Health • Dr Angela Livingston, Consultant Psychiatrist, Victorian Dual Disability Service • Colleen Pearce, Public Advocate, Office of the Public Advocate • Andrew Pridding, Nurse Practitioner, Victorian Dual Disability Service • Fiona Sharkie, CEO, Amaze • Dr Jane Tracy, Centre of Developmental Disability Health Victoria • Andrew Walby, Director, Emergency Department, St Vincent's Hospital

Engagement	Date	Title or topic	Attendees
Roundtable	19 November 2019	Housing	• Chris Hotham, Deputy Secretary, Housing and Infrastructure and Director, Housing, Department of Health and Human Services • Sherri Bruinhout, Director, Housing Pathways and Outcomes, Department of Health and Human Services • Dr Michael Fotheringham, Australian Housing and Urban Research Institute • Professor Guy Johnson, Director, Centre for Applied Social Research, School of Global, Urban and Social Studies, RMIT • Jenny Smith, CEO, Council to Homeless Persons • Lesley Dredge, CEO, Community Housing Industry Association Victoria • Amanda Donohoe, CEO, Servants Community Housing • Ellie Francis-Brophy, State Manager Victoria, Housing Choices Australia • Cathy Humphrey, CEO, Sacred Heart • Trudi Ray, Chief Operations Officer, Haven: Home, Safe • Darren Smith, CEO, Aboriginal Housing Victoria • Lesley Tarves, Chief Operating Officer, EACH Community Housing • Katheryn Atkinson, Housing Services Manager, HousingFirst • Bryan Lipmann, CEO, Wintringham Specialist Aged Care • Bevan Warner, CEO, Launch Housing • Debbie Selman, Team Leader, Homeless Outreach Psychiatric Service • Associate Professor Simon Stafrace, Program Director, Alfred Mental and Addiction Health, Alfred Health • Dr Sarah Pollock, Executive Director, Research and Advocacy, Mind Australia • Maree Bennett, Co-Director, Mental Health, Drugs and Alcohol Services, Barwon Health • Susanne Birks, Acting Director, Operations, Alfred Mental and Addiction Health, Alfred Health • Jenelle Linton, General Manager, Mental Health and Addiction Medicine, St Vincent's Hospital • Laura Collister, Director, Mental Health, Wellways • Maryann Croatto, Manager, Community, Mercy Mental Health

Engagement	Date	Title or topic	Attendees
Roundtable	12 December 2019	Criminal justice services	• Nadia Baille, General Counsel, Forensicare • Sophia Blosfelds, Civil Lawyer, Victorian Aboriginal Legal Service • Hannah Brown, Director, Health Policy and Strategy, Department of Justice and Community Safety • Laura Burke, Senior Legal Policy Adviser, Federation of Community Legal Centres • Emma Cassar, Commissioner, Corrections Victoria, Department of Justice and Community Safety • Ariel Couchman, Director, Youth Law • Karen Fletcher, Managing Lawyer, Public Interest Law, Fitzroy Legal Service • Dr Margaret Grigg, CEO, Forensicare • Monique Hurley, Lawyer, Human Rights Law Centre • Charlotte Jones, General Manager, Mental Health Legal Centre • Sonia Law, Program Manager, Mental Health and Disability Advocacy, Victoria Legal Aid • Tim Marsh, Chief Counsel, VLA Chambers, Victoria Legal Aid • Serina McDuff, CEO, Federation of Community Legal Centres • Catherine Neville, Executive Director, Advocacy and Strategic Communications, Jesuit Social Services • Dan Nicholson, Executive Director, Criminal Law Services, Victoria Legal Aid • Colleen Pearce, Public Advocate, Office of the Public Advocate • Ryan Phillips, Deputy Secretary, Corrections and Justice Services, Department of Justice and Community Safety • Isabel Robinson, Policy, Research and Advocacy Officer, Victorian Aboriginal Legal Service • Marius Smith, CEO, Victorian Association for the Care and Resettlement of Offenders • Sophia Spada-Rinaldis, Policy Officer, Office of the Public Advocate • Brigid Sunderland, Deputy Secretary, Youth Justice, Department of Justice and Community Safety • Vaughan Winther, CEO, Australian Community Support Organisation • Cath Williams, Chief Operations Officer, Australian Community Support Organisation

Engagement	Date	Title or topic	Attendees
Roundtable	18 December 2019	Court services	• Kirsten Aaskov, Principal Solicitor, Policy and Specialised Legal Division, Office of Public Prosecutions • Louise Anderson, CEO, Court Services Victoria • Sophia Blosfelds, Civil Lawyer, Victorian Aboriginal Legal Service • Anna Beesley, Reference Team Leader, Victorian Law Reform Commission • Magistrate Jennifer Bowles, Children's Court of Victoria • Kate Bundrock, Program Manager, Summary Crime, Victoria Legal Aid • Laura Burke, Senior Legal Policy Adviser, Federation of Community Legal Centres • State Coroner John Cain, Coroners Court of Victoria • Anna Faithfull, Deputy Secretary, Justice Policy and Data Reform, Department of Justice and Community Safety • Paul Gardiner, Superintendent, Victoria Police • Rebecca Halpin, Priority Communities Division, Victoria Police • Magistrate John Hardy, Magistrates' Court of Victoria • Sonia Law, Program Manager, Mental Health and Disability Advocacy, Victoria Legal Aid • Taryn Lee, Executive Director, Justice System Reform, Department of Justice and Community Safety • Peta McCammon, Deputy Secretary, Service Delivery Reform, Coordination and Workplace Safety, Department of Justice and Community Safety • Serina McDuff, CEO, Federation of Community Legal Centres • Corri McKenzie, Deputy Secretary, Police, Fines and Crime Prevention, Department of Justice and Community Safety • Dan Nicholson, Executive Director, Criminal Law Services, Victoria Legal Aid • Rachel Powning, General Manager, Neighbourhood Justice Centre • His Honour Judge Mark Taft, County Court of Victoria • Nerita Waight, Director, Victorian Aboriginal Legal Service

Engagement	Date	Title or topic	Attendees
Roundtable	18 February 2020	Future focus system Hosted by Monash Sustainable Development Institute	• Martin Stewart-Weeks • Professor Kim Cornish, Director, Turner Institute and Chair, Million Minds Mission • Kerry Jones, Director Systems Initiatives, The Australian Centre for Social Innovation • Professor Janine O'Flynn, Professor of Public Management, University of Melbourne and Australia and New Zealand School of Government • Ben Rimmer, Deputy Secretary and Director, Housing, Department of Health and Human Services • The Hon. Jenny Macklin, Former Federal Minister responsible for National Disability Insurance Scheme and Vice-Chancellor's Fellow, Melbourne School of Government • Kate Cornick, CEO, LaunchVic • Chelsea Lang, YLab Manager, Foundation for Young Australians • Professor Rod Glover, Monash Sustainable Development Institute • Associate Professor Peter Bragge, Senior Research Fellow, BehaviourWorks Australia, Monash Sustainability Institute • Dr Lara Werbeloff, Manager, Strategic Initiatives, Monash Sustainable Development Institute
Roundtable	26 February 2020	Future focus system Hosted by Monash Sustainable Development Institute	• Catherine Keating, Medibank • Robyn Mildon, CEO, Centre for Evidence and Implementation • Professor Sharon Goldfeld, Director, Centre for Community Child Health and Co-Group Leader of Policy and Equity, Murdoch Children's Research Institute • Graeme Samuel, Chair, Dementia Australia and Professorial Fellow, Business School and School of Public Health and Preventative Medicine, Monash University • Professor Rob Moodie, Nossal Institute of Global Health, University of Melbourne • Dr Jane Burns, Founder, InnoWell Pty Ltd. Young and Well Cooperative Research Centre • Ron Ben-David, Head, Essential Services Commission • Tom Bentley, Executive Director, Policy and Impact and a Vice-Chancellor's Innovation Professor, RMIT University • Professor Rod Glover, Monash Sustainable Development Institute • Sherry-Rose Bih Watts, Foundation for Young Australians • Associate Professor Peter Bragge, Senior Research Fellow, BehaviourWorks Australia, Monash Sustainability Institute • James Button, Monash Sustainable Development Institute • Mark Elliot, Collabforge

Engagement	Date	Title or topic	Attendees
Roundtable	9 June 2020	Antidiscrimination and human rights	• The Honourable Professor Kevin Bell QC AM, Director Castan Centre for Human Rights Law, Monash University • Julian Gardner AM, Royal Commission into Victoria's Mental Health System's Expert Advisory Committee • Louise Glanville, CEO, Victoria Legal Aid • Rob Hulls, Director, Centre for Innovative Justice, RMIT University • Dr Helen Szoke AO • Professor Penny Weller, RMIT University • Stan Winford, Associate Director, Research, Innovation and Reform, RMIT University
Roundtable	16 June 2020	Social connectedness – Community wellbeing	• Larry Kamener, Boston Consulting Group • Jane-Frances Kelly, Australia and New Zealand School of Government • Dr Pradeep Philip, Deloitte Access Economics • Professor Rob Moodie, Nossal Centre for Global Health, University of Melbourne • Elizabeth Deveny, South Eastern Melbourne Primary Health Network

Engagement	Date	Title or topic	Attendees
Roundtable	16 June 2020	Forensic mental health	• Julie Dempsey, Senior Consumer Consultant, Forensicare • Donna Vos, Family Carer Consultant, Forensicare • Professor James Ogloff AM, Executive Director, Victorian Institute of Forensic Mental Health and Distinguished Professor, Centre for Forensic Behavioural Sciences, Swinburne University • Dr Margaret Grigg, CEO, Forensicare • Dr Danny Sullivan, Executive Director, Clinical Services, Forensicare • Rowan McRae, Executive Director, Civil Law, Victoria Legal Aid • Associate Professor Andrew Carroll, Chair, Faculty of Forensic Psychiatry Subcommittee, Royal Australian and New Zealand College of Psychiatrists • Dr Paul Denborough, Clinical Director, Alfred Child and Youth Mental Health Services and headspace, Alfred Hospital • John Chesterman, Office of the Public Advocate • Jacinta Pollard, CEO, Caraniche • Frances Diver, CEO, Barwon Health • Detective Inspector Steven Cooper, Victoria Police • Emma Cassar, Corrections Commissioner, Department of Justice and Community Safety • Hannah Brown, Executive Director, Justice Health, Department of Justice and Community Safety • Shane Quinn, Acting Assistant Director, Programs and Performance, Mental Health Branch, Department of Health and Human Services • Anna Love, Chief Mental Health Nurse, Department of Health and Human Services • Megan Boland, Acting Assistant Director, System Performance and Integration, Mental Health Branch, Department of Health and Human Services • Vaughan Winther, CEO, Australian Community Support Organisation • Anthea Lemphers, Director, Psychological Services, Forensicare • Dr Neil Coventry, Chief Psychiatrist, Department of Health and Human Services • Dr Kate Roberts, Director, Clinical Services – Prisons, Forensicare • Ken Lay AO APM, Board Chair, Forensicare

Engagement	Date	Title or topic	Attendees
Roundtable	18 June 2020	Innovation, hosted by LaunchVic	• Kate Cornick, CEO, LaunchVic • Professor Rod Glover, Director of the Monash Sustainability Development Institute • Katie Liddicoat, General Manager, Culture and Engagement, LaunchVic • Janey Martino, Founder of Smiling Mind • Dr Michelle Blanchard, Research Centre Sane Australia • Addie Wootten, CEO of Smiling Mind • David Chung, Founder of Limbr and Senior Ventures Manager at BUPA • Chris Naoumidis, Founder of Mindset • Alex Naoumidis, Founder of Mindset • Rosie Thomas, Founder of Project Rockit • Lucy Thomas, Founder of Project Rockit • Christopher Marr, Co-founder and Chief Commercial Officer of Sonder • Dr Buzz Palmer, Co-founder and CEO of MedTech Actuator (RMIT) • Shol Blustein, ImpactCo • Cormach Evans, Ngarramili • Honor Eastly, Big Feels Club • Rachel Yang, Giant Leap Fund
Roundtable	2 July 2020	Mental health services for children and young people in the youth justice system	• Katherine Ariola, Project Officer, Koori Youth Justice Taskforce, Commissioner for Aboriginal Children and Young People • Paris Aristotle, CEO, Foundation House • Dr James Belshaw, Melbourne Health • Megan Boland, Department of Health and Human Services • Liana Buchanan, Principal Commissioner for Children and Young People • Her Honour Judge Amanda Chambers, President, Children's Court of Victoria • Assistant Commissioner Luke Cornelius APM, Victoria Police • Dannii de Kretser, Deputy Secretary, Youth Justice, Department of Justice and Community Safety • Dr Adam Deacon, Alfred Health • Dr Paul Denborough, Clinical Director, Alfred Child and Youth Mental Health Services and headspace, Alfred Hospital • Julie Edwards, CEO, Jesuit Social Services • Commander Tim Hansen, Victoria Police • Jodi Henderson, Youth Justice Commissioner, Department of Justice and Community Safety • Dan Nicholson, Executive Director, Criminal Law, Victoria Legal Aid • Professor James Ogloff AM, Executive Director, Victorian Institute of Forensic Mental Health and Distinguished Professor, Centre for Forensic Behavioural Sciences, Swinburne University • Joshua Smith, Deputy Secretary, Aboriginal Justice, Department of Justice and Community Safety

Engagement	Date	Title or topic	Attendees
Roundtable	7 July 2020	Social connectedness – Effectiveness of community-led initiatives involving social connection in supporting mental wellbeing: A rapid review of evidence and practice	• Chelsea Lang, Manager, YLab, Foundation for Young Australians • Jennifer Beckett, University of Melbourne • Professor Judy Lowthian, Head of Research and Principal Research Fellow, Bolton Clarke • Kerry Jones, Director, Systems Initiatives, The Australian Centre for Social Innovation • Jodie Belyea, Founder, Women's Spirit Project • Zachary Schlosser, Resilient Connections • Ian Forsyth, Shannon Company
Roundtable	8 July 2020	Primary care	• Dr Cathy Andronis, General Practitioner, Royal Australian College of General Practitioners • Caroline Radowksi, Network Director Clinical and Practice Excellence, community health centre general practitioner, cohealth • Sara Renwick-Lau, General Practitioner, Mallacoota Medical Centre • Professor Graeme Meadows, Department of Psychiatry, Monash University, • Vikki Ryall, Executive Director, Clinical Practice, headspace • Margaret McDonald, CEO, Cobaw Community Health Service • Joe Fishburn, FirstStep • Anne Lyon, formerly Eastern Melbourne Primary Health Network • Matt Jones, CEO, Murray Primary Health Network
Roundtable	8 July 2020	Crisis response	• Karyn Cook, Executive Director, Mental Health Services, SouthWest Healthcare • Fran Timmins, Director of Nursing, Mental Health, St Vincent's Hospital • Ivan Frkovic, Commissioner, Queensland Mental Health Commission • Dr Aaron Groves, Chief Psychiatrist, Tasmania • Tracey Morgan, Community Services Manager, Casey area, Monash Health • Georgie Harman, CEO, Beyond Blue • Dr Murray Wright, Chief Psychiatrist, New South Wales Government • Susan Murray, Practice Leader, Zero Suicide Institute of Australasia • Dr Kathryn Turner, Clinical Director, Mental Health and Special Services, Gold Coast Hospital and Health Service • Peter Kelly, Director, Operations, NorthWestern Mental Health
Roundtable	8 July 2020	Forensicare Consumer Advisory Group	• Forensicare Consumer Advisory Group members

Engagement	Date	Title or topic	Attendees
Roundtable	14 July 2020	Responding effectively to consumers with severe and enduring mental illness and complex multiagency needs	• Caz Healy, Executive Lead Services, cohealth • Dr Gerry Naughtin, Strategic Adviser, Mental Health, Strategic Advisers and Research Division, National Disability Insurance Agency • Professor Carol Harvey, Director, Psychosocial Research Centre, University of Melbourne and Consultant Psychiatrist, NorthWestern Mental Health • Professor Lisa Brophy, Professor of Social Work and Social Policy, La Trobe University • Dr Neil Coventry, Chief Psychiatrist, Department of Health and Human Services • David Clarke, Clinical Director, Monash Health • Dr David Huppert, Deputy Chief Psychiatrist, Department of Health and Human Services • Dr Greta Moon, St Vincent's Hospital • Jacinta Pollard, CEO, Caraniche • Peter Kelly, Director, Operations, NorthWestern Mental Health • Shane Beaumont, Manager, Multiple and Complex Needs Initiative, Department of Health and Human Services • Karenza Louis-Smith, CEO, ermha365 • Dr Ravi Bhat, Divisional Clinical Director, Goulburn Valley Area Mental Health Service, Goulburn Valley Health • Associate Professor Sathya Rao, Executive Clinical Director, Spectrum Personality Disorder Service
Roundtable	15 July 2020	Primary health networks	• Janine Wilson, CEO, Eastern Melbourne Primary Health Network • Adjunct Associate Professor Christopher Carter, CEO, North Western Primary Health Network • Elizabeth Deveny, CEO, South Eastern Melbourne Primary Health Network • Rowena Clift, CEO, Western Victorian Primary Health Network

Engagement	Date	Title or topic	Attendees
Roundtable	15 July 2020	Consultation liaison services	• Associate Professor Alex Holmes, Psychiatrist, Royal Melbourne Hospital • Professor Steve Ellen, Psychiatrist, Peter MacCallum Cancer Centre • Dr David Kissane, Academic Psychiatrist, Monash University • Dr Ravi Bhat, Divisional Clinical Director, Goulburn Valley Area Mental Health Service, Goulburn Valley Health • Melody Sutton, Occupational Therapist and Coordinator Secondary Consultation and Community Education, Eastern Health Children Youth Mental Health Service • Katrina Richardson, Senior Social Worker, Alfred Children Youth Mental Health Service • Dr Manoj Kumar, Lead Consultant Psychiatrist, Mercy Health • Professor Suresh Sundram, Head, Department of Psychiatry, School of Clinical Sciences, Monash University and Director of Research, Mental Health Program, Monash Health • Ziver Talat, Senior Social Worker, Royal Children's Hospital Child and Adolescent Mental Health Service Secondary Consultation Service
Roundtable	15 July 2020	Finding and accessing care, treatment and support	• Maureen Lewis, Director, Priority Programs, Mental Health Branch, NSW Health • Dr Paul Denborough, Clinical Director, Alfred Child and Youth Mental Health Service and headspace, Alfred Health • Dr Steven Moylan, Director, Clinical Services, Barwon Health • Jason Davies-Kildea, Head, Policy and Advocacy, Beyond Blue • Associate Professor Philip Tune, Clinical Director, Mental Health Services, Bendigo Health • Bronwyn Lawman, Director, Operations, Peninsula Health

Engagement	Date	Title or topic	Attendees
Roundtable	21 July 2020	Public health	• John Batho, Executive Director Fairer Victoria, Department of Premier and Cabinet • Dr Bruce Bolam, Executive Director, Health Protection, Department of Health and Human Services • Professor Cathy Mihalopoulos, Chair and Head, Deakin Health Economics, Deakin University • Dr Gaynor Blankley, Deputy Clinical Services Director, Mercy Mental Health and Head of Perinatal Mental Health • Carolyn Nikoloski, Chief Strategy Officer, Beyond Blue • Professor Helen Herrman AO, Head, Vulnerable and Disengaged Youth Research, Orygen and Professor of Psychiatry, Centre for Youth Mental Health, University of Melbourne, President, World Psychiatric Association • Kerry Jones, Director Systems Initiatives, The Australian Centre for Social Innovation • Professor Patrick McGorry AO, Professor of Youth Mental Health, University of Melbourne and Executive Director, Orygen • Professor Rob Moodie, Nossal Institute of Global Health, University of Melbourne • Associate Professor Peter Bragge, Monash Sustainable Development Institute • Dr Sandro Demaio, CEO, VicHealth • Dr Stephen Carbone, Executive Director, Prevention United • Thea Snow, Centre for Public Impact, Australia and New Zealand • Kristan Corben, Executive Manager, VicHealth
Roundtable	21 July 2020	Alcohol and other drugs	• Laurence Alvis, CEO, UnitingCare Regen • Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association Inc. • Dr Stefan Gruenert, CEO, Odyssey House • Ann-Maree Kaser, CEO, Windana • Gary Croton, Clinical Nurse Consultant, Victorian Dual Diagnosis Initiative • Andrew Brunn, CEO, Youth Support and Advocacy Service (YSAS) • Professor Dan Lubman, Turning Point • Professor James Ogloff AM, Executive Director, Victorian Institute of Forensic Mental Health and Distinguished Professor, Centre for Forensic Behavioural Sciences, Swinburne University • Heather Pickard, CEO, Self Help Addiction Resource Centre (SHARC) • Sione Crawford, Harm Reduction Victoria

Engagement	Date	Title or topic	Attendees
Roundtable	22 July 2020	Community integrated mental health services	• Frances Cook, Director, Vision 2030, National Mental Health Commission • Professor Ian Hickie, Co-Director, Health and Policy, Brain and Mind Centre, Sydney University • Kent Burgess, Acting CEO, Star Health • Professor Richard Newton, Clinical Director, Mental Health, Peninsula Health • Brian Kennedy, Director, Community Operations Adult Mental Health, Albury Wodonga Mental Health • Dr Sarah Pollock, Executive Director, Research and Advocacy, Mind Australia • Tass Mousaferiadis, Chair of the Board and Chair, Executive Performance and Development Committee, Star Health • Laura Collister, Director, Mental Health Services, Wellways
Roundtable	23 July 2020	Infant and child mental health	• Professor Frank Oberklaid, Paediatrician, Royal Children's Hospital, Melbourne and Co-Group Leader of Child Health Policy, Equity and Translation, Murdoch Children's Research Institute • Alison Smith, Divisional Manager, Child and Youth Mental Health, Austin Health • Dr Richard Haslam, Director, Mental Health, Royal Children's Hospital, Melbourne • Dr Vibhay Raykar, Clinical Director, Child and Adolescent Mental Health Service, Goulburn Valley Health • Dr Louise Newman, Professor of Psychiatry, University of Melbourne and practising perinatal and infant clinician • Allison Cox, Director, Take Two, Berry Street • Professor Christel Middeldorp, Professor of Child and Youth Psychiatry, Children and Health Research Centre Queensland and Queensland's Child and Youth Mental Health Service • Associate Professor Campbell Paul, Consultant Infant and Child Psychiatrist, Royal Children's Hospital, Melbourne; Honorary Principal Fellow, Department of Psychiatry, University of Melbourne and Member, Board of Directors, World Association for Infant Mental Health • Jacquie O'Brien, CEO, Tweddle • Helen Lees, Municipal Association of Victoria Maternal and Child Health Nurse Consultant

Engagement	Date	Title or topic	Attendees
Roundtable	29 July 2020	Community integrated mental health services	• Professor David Castle, St Vincent's Health • Frances Cook, Director, Vision 2030, National Mental Health Commission • Professor Ian Hickie, Co-Director, Health and Policy, Brain and Mind Centre, Sydney University • Kent Burgess, Acting CEO Star Health • Brian Kennedy, Director, Community Operations Adult Mental Health, Albury Wodonga Mental Health • Tass Mousaferiadis, Chair of the Board and Chair, Executive Performance and Development Committee, Star Health • Laura Collister, CEO, Wellways • Dr Sarah Pollock, Executive Director, Research and Advocacy, Mind Australia
Roundtable	29 July 2020	Bed-based services	• Stefano Scalzo, Director, Victorian Health and Human Services Building Authority • Francis Diver, CEO, Barwon Health • Professor David Copolov, Monash University • Cayte Hoppner, Executive Director, Mental Health and Chief Mental Health Nurse, Latrobe Regional Hospital • Professor Nicholas Lintzeris, University of Sydney • Sebastian Rosenberg, Head, Mental Health Policy Unit, Centre for Mental Health, Australian National University • Sean Hegarty, General Manager, Wellways
Roundtable	30 July 2020	Suicide prevention and response	• Dr Jaelea Skehan OAM, Special Adviser, National Suicide Prevention Taskforce • Jo Robinson, Head, Suicide Prevention Research Orygen • Maureen Lewis, Director, Priority Programs, Mental Health Branch, NSW Health • Janet Martin, Director, Clinical Governance, Queensland Health • Alan Woodward, Commissioner, National Mental Health Commission • Judge John Cain, State Coroner, Coroners Court of Victoria • Professor Jane Pirkis, Director, Centre for Mental Health, Melbourne School of Population and Global Health • Bronwen Edwards, CEO, Roses in the Ocean • Joe Ball, CEO, Switchboard

Engagement	Date	Title or topic	Attendees
Roundtable	4 August 2020	Australian Health Practitioner Regulation Agency (AHPRA)	• Martin Fletcher, CEO, Australian Health Practitioner Regulation Agency • Dr Peggy Brown AO, Senior Clinical Advisor, Australian Commission on Safety and Quality in Health Care and Member, Agency Management Committee, Australian Health Practitioner Regulation Agency • Associate Professor Ruth Vine, Deputy Chief Medical Officer for Mental Health, National Mental Health Commission and Member, Victorian Board of the Medical Board of Australia • Dr Debra O'Brien, Chair, Victorian Board of the Medical Board of Australia • Dr Rachel Phillips, Chair, Psychology Board of Australia • Sally Cunningham, Member, Occupational Therapy Board of Australia • Lynette Cusack, Chair, Nursing and Midwifery Board of Australia • Renee Owens, Chair, Aboriginal and Torres Strait Islander Health Practice Board of Australia • Dr Clarissa Martin, State Manager, Australian Health Practitioner Regulation Agency • Nick Lord, National Director, Government Relations, Australian Health Practitioner Regulation Agency • Helen Townley, National Director, Policy, Australian Health Practitioner Regulation Agency
Roundtable	4 August 2020	Youth mental health	• Professor Patrick McGorry AO, Professor of Youth Mental Health, University of Melbourne and Executive Director, Orygen • Dr Paul Denborough, Clinical Director, Alfred Child and Youth Mental Health Service and headspace, Alfred Health • Andrew Bruun, CEO, Youth Support and Advocacy Service (YSAS) • Jason Trethowan, CEO, headspace • Dr Leaanne Fisher, Clinical Director, Child and Youth, Austin Health • Dr Liam O'Connor, Faculty Chair, Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatry and practising child and adolescent psychiatrist, Bendigo Child and Adolescent Mental Health Service • Dean McCaughan, Services Manager, headspace • Lynne Allison, Associate Program Director, Child and Youth Mental Health Service, Eastern Health • Dr John Cooper, Consultant Psychiatrist, Phoenix Australia

Engagement	Date	Title or topic	Attendees
Roundtable	5 August 2020	Governance and commissioning	• Terry Symonds, Deputy Secretary, Health and Wellbeing, Department of Health and Human Services • Elda Colagrande, Senior Analyst, Service Delivery and Reform, Department of Treasury and Finance • Dr Jane Opie, Board Member, Victorian Primary Health Network • Bronwyn Lawman, Director, Mental Health Operations, Peninsula Health • Kent Burgess, Acting CEO, Star Health • Ivan Frkovic, Mental Health Commission, Queensland • Dr Leanne Beagley, CEO, Mental Health Australia • Dr Ravi Bhat, Divisional Clinical Director, Goulburn Valley Area Mental Health Service, Goulburn Valley Health • Dr Stephen Duckett, Health Program Director, Grattan Institute • Professor Hal Swerissen, Visiting Fellow, Grattan Institute
Roundtable	7 August 2020	Aged persons mental health services	• Gerard Mansour, Commissioner for Senior Victorians • Dr Daniel O'Connor, Deputy Chief Psychiatrist (Aged), Department of Health and Human Services • Dr Brett Coulson, Director, Clinical Services, NorthWestern Mental Health • Dr Maria Tsanglis, Director, Aged and Liaison Psychiatry Service, Alfred Health • Associate Professor Briony Dow, National Ageing Research Institute • Dr Gerry Naughtin, Strategic Adviser, Mental Health, Strategic Advisers and Research Division, National Disability Insurance Agency • Associate Professor Mark Yates, Executive Director, Ballarat Innovation and Research Collaboration for Health • Mark Silver, Wellbeing Clinic for Older Adults, Swinburne University
Roundtable	12 Aug 2020	Digital fireside chat Hosted by Jennifer Westacott, Business Council of Australia	• Jennifer Westacott, CEO, Business Council of Australia • Greg Ellis, CEO, MYOB • Ingrid Jenkins, Director, Human Resources, Microsoft • Samantha Yorke, Senior Government Affairs and Public Policy Manager, Google • Kara Hinesley, Head, Public Policy, Twitter Australia

Engagement	Date	Title or topic	Attendees
Roundtable	19 August 2020	Workforce needs of the future and enabling transformation	• Michaela Cronin, Director, Future Social Services Institute • Robyn Mildon, Executive Director, Centre for Evidence and Implementation • Professor Chris Davey, Head, Department of Psychiatry, University of Melbourne • Dr Tom Foley, National Health Service Digital (UK) • Gill Callister, CEO, Mind Australia • Adele Beasley, Manager, Policy and Campaigns, Mind Australia • Larry Kamener, Centre for Public Impact, Boston Consulting Group • Professor Emeritus Bruce Singh AM, University of Melbourne • Dr Rosemary Charleston, Centre for Mental Health Learning • Kylie Boucher, Senior Project Lead, Centre for Mental Health Learning • Angus Clelland, CEO, Mental Health Victoria • Associate Professor Bridget Hamilton, Director, Centre for Psychiatric Nursing, University of Melbourne • Erandathie Jayakody, Royal Commission into Victoria's Mental Health System's Expert Advisory Committee and Assistant Director, National Disability Insurance Agency
Roundtable	25 August 2020	Mentally healthy workplaces, mentally healthy Victoria	• Chris Wilks, Group Manager, Safety, Health and Wellbeing, Linfox • Marian Merrigan, Healthy Fox Program Manager, Linfox • Nicci Horton, Injury and Wellbeing Manager, Bunnings • Kylie Bishop, People and Culture Leader, Medibank • Chris Akayan, Head, Culture and Capability, Mirvac • Susan Ferrier, Group Executive, People and Culture, National Australia Bank Limited • Jacquie Lyon, Head of Health and Wellbeing , Metro Trains • David Brewster, Chief Legal and Safety Officer, Coles • Angela Konstantopoulos, General Manager, Safety, Coles • Sue Davies, Executive General Manager, People and Culture, Australia Post • Alex Badenoch, Group Executive, Transformation, Communications and People, Telstra • Tanya Hosch, General Manager, Inclusion and Social Policy, AFL • Kate Hall, Head, Mental Health and Wellbeing, AFL • Claire Spencer AM, Chair, Arts Wellbeing Collective and CEO, Arts Centre Melbourne • Annie Reeves, Executive Director, People and Culture, Department of Jobs, Precincts and Regions • Dr Kate Cornick, CEO, LaunchVic • Alistair Carmichael, Associate Partner, McKinsey and Company • Helen Steele, CEO, The Shared Value Project

Engagement	Date	Title or topic	Attendees
Roundtable	26 August 2020	Governance and commissioning	• James Downie, CEO, Independent Hospital Pricing Authority • Elda Colagrande, Senior Analyst, Service Delivery and Reform, Department of Treasury and Finance • Terry Symonds, Deputy Secretary, Health and Wellbeing, Department of Health and Human Services • Dr Jane Opie, Board Member, Western Victoria Primary Health Network • Kent Burgess, Acting CEO, Star Health • Ivan Frkovic, Mental Health Commission, Queensland • Dr Leanne Beagley, CEO, Mental Health Australia • Dr Ravi Bhat, Divisional Clinical Director, Goulburn Valley Area Mental Health Service, Goulburn Valley Health • Professor Hal Swerissen, Visiting Fellow, Grattan Institute • Jennifer Williams, Chair, Northern Health • Abbe Anderson, General Manager, Health Alliance • Dr Stephen Duckett, Health Program Director, Grattan Institute
Roundtable	27 August 2020	Virtual help and the future of digital services	• Oliver Bladek, Deputy CEO, Design, Digital and Strategy, National Disability Insurance Agency • Emma Constantine, General Manager, Quality and Service Development, Wellways • Rohan Hammet, Director, Deloitte • Cinnamon Pollard, Chief Experience Officer, Beyond Blue • Mario Alvarez-Jimenez, Director, Orygen Digital • Ramesh Kumar, CEO, Southern Migrant and Refugee Centre • Dr Steven Moylan, Director, Clinical Services, Barwon Health • Associate Professor Neil Thomas, Deputy Director, Centre for Mental Health, Swinburne • Addie Wootten, CEO, Smiling Mind • Dr Katherine James, Clinical Director, Mildura Base Hospital • Dr Kean-Seng Lim, Mount Druitt Medical Centre, New South Wales

Engagement	Date	Title or topic	Attendees
Roundtable	8 September 2020	Professional colleges and bodies	• Dr Cathy Andronis, Chair, Royal Australian College of General Practitioners, Victoria • Anneka Farrington, Victorian and ACT Branch Manager, Australian Association of Social Workers • Grant Coultman-Smith OAM, VA, BJ, JP, Victorian President, Australasian Institute of Emergency Services • Dr Kerryn Rubin, Chair, Royal Australian and New Zealand College of Psychiatry (Victoria) • Professor Judy Savige, Chair, Victorian Regional Committee, Royal Australasian College of Physicians • Alex Hillman, Mental Health Clinician and Occupational Therapist, Occupational Therapy Australia • Jacqueline White, Victorian State Chair, Australian Psychological Society
Roundtable	15 September 2020	East Gippsland Roundtable Hosted by Selena Gillham, Executive Officer, East Gippsland Primary Care Partnership	• Peter Quinn, Mental Health Clinician, Royal Flying Doctor Service • Lauren Zappa, Health Services Manager, Royal Flying Doctor Service • Kelly Duncan, Department of Education and Training • Terri McNeil, Lucknow Primary School • James Bush, Youth Advisory Group, headspace • Brydie Bourke, Community Engagement Officer, headspace • Matt Zagami, Farmers, Farmers Voice East Gippsland • Katie Zagami, Farmers, Farmers Voice East Gippsland • Jamie Williamson, CEO, Gippsland and East Gippsland Aboriginal Co-Operative • Vicki Farthing, CEO, Orbost District Health • Robyn Hayles, CEO, Bairnsdale Regional Health • Sue Mulkearns, Manager, Mental Health East Gippsland, Latrobe Regional Hospital • Sue Medson OAM, CEO, Gippsland Lakes Complete Health • Sarah Clarke, Manager, Regional Services, Gippsland Primary Health Network • Jo Grzelinska, Special Projects, Gippsland Primary Health Network • Daniel Poynton, Executive Officer, GippSport • Selena Gillham, Executive Officer, East Gippsland Primary Care Partnership

Engagement	Date	Title or topic	Attendees
Roundtable	15 September 2020	Forensic mental health	• Dr Margaret Grigg, CEO, Forensicare • Professor James Ogloff AM, Executive Director, Victorian Institute of Forensic Mental Health and Distinguished Professor, Centre for Forensic Behavioural Sciences, Swinburne University • Dr Neil Coventry, Chief Psychiatrist, Department of Health and Human Services • Hannah Brown, Acting Director, Justice Health, Department of Justice and Community Safety • Associate Professor Ruth Vine, Deputy Chief Medical Officer for Mental Health, National Mental Health Commission
Roundtable	16 September 2020	Youth justice and youth forensic mental health	• Professor James Ogloff AM, Executive Director, Victorian Institute of Forensic Mental Health and Distinguished Professor, Centre for Forensic Behavioural Sciences, Swinburne University • Professor Andrew Chanen, Director, Clinical Programs and Services, Orygen Youth Health • Dr Paul Denborough, Clinical Director, Alfred Child and Youth Mental Health Service and headspace, Alfred Health • Dr Neil Coventry, Chief Psychiatrist, Department of Health and Human Services • Dr John Cooper, Consultant Psychiatrist, Bendigo Child and Adolescent Mental Health Service
Roundtable	22 September 2020	Regulation and oversight	• Claire Noone, Principal, Nous Group • Liana Buchanan, Principal Commissioner for Children and Young People • Dr Stephen Duckett, Health Program Director, Grattan Institute • Renee Cassidy, Assistant Auditor-General • Melissa Skilbeck, Deputy Secretary, Regulation, Health Protection and Emergency Management, Department of Health and Human Services
Roundtable	24 September 2020	North eastern Victoria Hosted by Simone Hogg, Director, Community Development, City of Wodonga	• David Noonan, CEO, Albury Wodonga Aboriginal Health Service • Lucie Shanahan, Executive Director, Mental Health, Albury Wodonga Health • Karina Kerr, Centre Manager, headspace, Albury Wodonga • Jacki Eckert, General Manager, Gateway Health • Dominic Sandilands, CEO, Corryong Health • Kasey Holyman, Manager, Child, Youth and Families, Uniting • Jodie Farrugia, Community Advocacy Officer, Albury Wodonga Ethnic Communities Council • Nerida Kerr, CEO, AgBiz Assist • Simone Hogg, Director, Community Development, City of Wodonga

Engagement	Date	Title or topic	Attendees
Roundtable	1 October 2020	Compulsory treatment	• Nino Di Pasquale, Director, Nursing, Mental Health Services, Barwon Health • Susanne Birks, Manager, St Kilda Road Clinic, Alfred Health • Dr Leeanne Fisher, Clinical Director, Children and Youth Mental Health Service, Austin Health • Dr Raju Lakshmana, Director, Psychiatry, Goulburn Valley Health, Shepparton and Clinical Director, Perinatal Mental Health, Ramsey Health Care, Mitcham • Dr Kerryn Rubin, Head, Acute Adult Psychiatry, Peninsula Health
Roundtable	7 October 2020	Trauma	• Dr Rob Gordon, Clinical Psychologist and President, Australasian Confederation of Psychoanalytic Psychotherapies • Karen Hogan, Forum Convener, Centres Against Sexual Assault • Paris Aristotle, CEO, Foundation House • Dr David Denborough, Director, Dulwich Centre • Dr Robyn Miller, CEO, MacKillop Family Services • Dr John Read, Professor of Clinical Psychology, University of East London, London, UK • Patrick Lawrence, CEO, First Step • Michael Struth, Senior Clinical Lead Mental Health, Western Victoria, Primary Health Network • Caroline Radowksi, Network Director, Clinical and Practice Excellence, cohealth • Dr Charu Gandhi, Clinical Director, Speciality Services Directorate, Austin Health • Associate Professor Harry Minas, Head, Global and Cultural Mental Health Unit, University of Melbourne

Appendix C.6 Human-centred design activities

The Commission held 53 human-centred design activities over 2019–2020.

Activities undertaken as part of Phase one

Date	Attendees/topic focus	Location
19 November 2019	Aged 18–65 with experience of mental health services in an outpatient and/or clinical setting in the last 12 months	Wangaratta
19 November 2019	Aged 65+ with experience of geriatric/aged mental health services	Wangaratta
20 November 2019	Aged 18–65 with experience of acute mental health services in inpatient facilities in the last 12 months (but not currently in an inpatient facility)	Frankston
20 November 2019	Aged 65+ with experience of geriatric/aged mental health services	Frankston
25 November 2019	Aged 18–65 with experience of mental health services in an outpatient and/or clinical setting in the last 12 months	Bairnsdale
25 November 2019	Aged 18+ with experience caring for people experiencing mental illness	Bairnsdale
26 November 2019	Aged 16–25 with lived experience of child and youth mental health services in the last two years	Traralgon
26 November 2019	Aged 18–65 with experience of acute mental health services in inpatient facilities in the last 12 months (but not currently in an inpatient facility)	Traralgon
27 November 2019	Aged 18–65 with experience of acute mental health services in inpatient facilities in the last 12 months (but not currently in an inpatient facility)	Melbourne
29 November 2019	Aged 18–65 with experience of mental illness and alcohol and other drugs (AOD) services	Melbourne
29 November 2019	Aged 18+ with experience of forensic/justice mental health services	Melbourne
30 November 2019	Aged 18+ with experience caring for people experiencing mental illness	Melbourne
30 November 2019	Aged 16–25 with experience caring for people experiencing mental illness	Melbourne
10 December 2019	Young people (16–25) with a lived experience of mental illness, including those with caring responsibilities	Melbourne
24 February 2020	Forensicare Consumer Advisory Group	Melbourne
26 February 2020	Men over 25 years old with experience of mental illness and recent experience of the justice system	Melbourne
26 February 2020	Young men 16+ years old with experience of mental illness and recent experience of the justice system, including Youth Justice	Melbourne
28 February 2020	Women over 25 years old with experience of mental illness and recent experience of the justice system	Melbourne

Date	Attendees/topic focus	Location
28 February 2020	Young women 16+ years old with experience of mental illness and recent experience of the justice system, including Youth Justice	Melbourne
12 May 2020	Frontline workers in the allied and community health sector	online
13 May 2020	Frontline psychiatrists and clinical psychologists from public and private sectors	online
22 May 2020	Those caring for a young person/people under the age of 12 experiencing mental illness	online
27 May 2020	Carers who identify as LGBTIQ+ caring for a person/people experiencing mental illness	online
2 June 2020	Frontline nurses	online
3 June 2020	Carers who identify as culturally and linguistically diverse caring for a person/people experiencing mental illness	online
4 June 2020	Young people over 16 and under 25 years old caring for a person/people experiencing mental illness	online
9 June 2020	Consumer and carer lived experience and peer workers	online

Activities undertaken as part of Phase two

Date	Attendees/topic focus	Location
30 June 2020	Carers who have recent experience of crisis responses	online
30 June 2020	People who have recent experience of crisis responses	online
6 July 2020	Carers and consumers who have tried to access services across the spectrum	online
7 July 2020	People who have lived experience of both AOD service use and mental illness	online
7 July 2020	Carers of people who have lived experience of both AOD service use and mental illness	online
10 July 2020	People with lived experience of suicidal crisis including carers	online
10 July 2020	People with lived experience of bereavement by suicide	online
13 July 2020	Carers of adults (18+) with experiences of community-based services	online
13 July 2020	Adults (18+) with experiences of community-based area mental health services, community health organisations and Primary Health Network services	online
17 July 2020	People that have experienced mental illness and housing challenges or homelessness	online

Date	Attendees/topic focus	Location
20 July 2020	Carers of people with experiences of community-based area mental health services, community health organisations and Primary Health Network services	online
27 July 2020	People who have had a recent experience in an adult community or hospital bed-based setting	online
27 July 2020	Carers of people who have had a recent experience in an adult community or hospital bed-based setting	online
3 August 2020	Consumers who wish to discuss information sharing, including the pros and cons of using technology to support moving between services, timely support and choices about when/what information is shared	online
4 August 2020	Carers who wish to discuss information sharing, including the pros and cons of using technology to support moving between services, timely support and choices about when/what information is shared	online
5 August 2020	Young consumers aged 16+ with experience of mental health services	online
7 August 2020	Those caring for a young person/people under the age of 12 experiencing mental illness	online
7 August 2020	Those caring for a young person/people between 12 and 25 experiencing mental illness	online
3 September 2020	Those who identify as being culturally and linguistically diverse who have experience with the mental health system	online
4 September 2020	Restrictive practices with lived experience experts, including carers to develop questions for the combined session	online
4 September 2020	Restrictive practices with lived experience experts, carers and clinicians	online
10 September 2020	Restrictive practices lived experience experts including carers	online
14 September 2020	Speaking From Experience Group, Independent Mental Health Advocacy	online
15 September 2020	Speaking From Experience Group, Independent Mental Health Advocacy	online
6 October 2020	Community workshop with a range of community members in North Eastern Victoria	online
7 October 2020	Community workshop with a range of community members in Southern Metropolitan Melbourne	online

Appendix C.7 Consumer Foundations Working Group members

In July 2020, the Commission established the Consumer Foundations Working Group which comprised seven members who together brought a range of skills, expertise, experiences and perspectives to their work. Working Group members provided advice on reforms related to consumer leadership, with a view to creating an enduring foundation for a future mental health system that is grounded in consumer expertise.

The members of Commission's Consumer Foundations Working Group were:

- Cath Roper
- Erandathie Jayakody
- Gareth Edwards
- Heather Pickard
- Ian Watts
- Indigo Daya
- Dr Tricia Szirom

The group was facilitated by Sarah Jane Haywood.

Appendix C.8 The Commission's expert systems advisory function

This appendix provides an overview of the systems design advice provided to support the Commission's system design approach.

The Commission established an expert systems advisory function in November 2019. The advisory function had a flexible membership to reflect the specific needs of each stage of the Commission's inquiry. It included diverse expertise in systems reform from across Australia and overseas.

The following people supported the Commission through this function:

- Professor Luis Salvador-Carulla, Head, Centre for Mental Health Research, Research School of Population Health, College of Health and Medicine, Australian National University, Canberra
- Professor Richie Poulton, Co-Director, National Centre for Lifecourse Research, University of Otago, New Zealand
- Ms Allison Costello, Director, Policy and Innovations Branch, Ontario Ministry of Health and Long-Term Care, Canada
- Dr Robyn Mildon, Founding Executive Director, Centre for Evidence and Implementation, Melbourne
- Professor Iven Mareels, Chair of Electrical and Electronic Engineering, Electrical and Electronic Engineering, Melbourne University
- Professor Ezekiel Emanuel, Vice Provost for Global Initiatives, University of Pennsylvania, United States.

They contributed to the Commission but were in no way associated with its final deliberations and findings.

The Commission's system design approach was also informed by Professor Rod Glover and the team at Monash Sustainable Development Institute.

The Commission also acknowledges Dr Seanna Davidson, Director, The Systems School and Dr Fiona McKenzie, Director, Orange Compass, who provided content drafting support for the systems design chapter of this report.

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.